CULTURAL COMPETENCY OF ASSOCIATE DEGREE NURSING FACULTY

by

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Abstract

The primary purpose of this study was to examine the level of cultural competency, associated transcultural teaching behaviors and demographics among faculty in associate degree nursing programs in the New York metropolitan area. The Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R) comprised 41 Likert items to measure 5 subscales of cultural competence representing Campinha-Bacote's (2006) model, and a 6th subscale to measure transcultural teaching behaviors (TTB). The demographic and professional characteristics section was expanded to a total of 18 questions. The questionnaire was administered via the Internet over a 4-week period. Demographic comparisons were made with those of New York state and the national nursing population. A multiple regression analysis of each cultural competence subscale related to demographics, professional characteristics, and cultural teaching practices showed total cultural competence subscale (TCCS) to be higher for non-Whites ($\beta = -.26$, $p = .002$) and for full-time instructors ($\beta = .17$, $p = .04$). Compared with previous studies examining the cultural competency of nursing faculty teaching at the associate and baccalaureate levels, these findings showed that associate degree nursing faculty scored significantly higher on the TCCS, but not consistently higher on the TTB subscale. This study revealed that the majority of the 138 respondents perceived themselves as being culturally proficient ($n = 105$, 76%) or cultural experts ($n = 20$, 14.5%) in all of the 5 subscales of the CDQNE–R and 93.5% ($n = 129$) agreed that they include transcultural teaching behaviors in the courses they teach.

Dedication

This dissertation is dedicated to my parents, Paddy and Angela Smith, who were always so proud that I had pursued a college education. Spiritually they will be with me at my graduation. In memory of my uncles, Hugh O'Kelly and Sean (John) Supple, also Aoife Carroll, a light blown out too soon. My Aunt Brigidh Supple, who shared her passion for living and nursing, and supported me throughout this tough journey.

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Go raibh míle maith agaibh go léir

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CHAPTER 1. INTRODUCTION

Introduction to the Problem

As the United States moves toward an increasingly diverse population, nursing education needs to understand the cultures of both students and the community. Cultural competency is an important component of undergraduate nursing education. The American Association of Colleges of Nursing (AACN), the American Nurses Association (ANA), and the National League for Nursing (NLN) include cultural competency as an integral part of the nursing curriculum. The literature demonstrates that most nursing faculty teach cultural competency without any formal training (Campinha-Bacote, 2006; Kardong-Edgren, 2007; Ryan, Carlton, & Ali, 2000; Sealey, 2003). Campinha-Bacote reported that since 1983, when the NLN issued the first guidelines on cultural diversity in the nursing curriculum, there remains a shortage of nursing faculty prepared to teach cultural competence. Both Sealey and Kardong-Edgren highlighted the need for continuing education as a significant factor in increasing the level of cultural competency among nursing faculty. The current trend of an increasingly diverse society emphasizes the need for nursing educators to address cultural issues effectively. Nurse educators must strive to become culturally proficient and understand the diverse backgrounds of the population they serve.

The ability to provide culturally congruent care to a diverse population is a necessary skill for new graduates. However, the nursing workforce is not reflective of the United States population. Statistics published by the AACN (2004) demonstrate that men represent 5.8% and minorities 9% of the nursing workforce. A lack of diversity in the nursing workforce was identified as one of the factors contributing to healthcare disparities among minorities (Institute of Medicine [IOM], 2002). Sullivan's (2004) report called for an increasingly diverse nursing workforce in an effort to improve access to care for minorities. The AACN (2001), the ANA (2003), and the NLN (2005) have focused on successful strategies to improve the recruitment and retention of minority students. The NLN (2009) reported that in 2007 23.6% of new graduates were from minority backgrounds and 12% were male. With the increasing diversity of nursing students, faculty need to become culturally proficient and aware of cultural differences associated with teaching/learning (Campbell, 2008). The 2010 IOM report on the future of nursing education stresses the importance of developing "a more diverse nursing workforce adequate in both number and competencies to meet the needs of diverse populations across the lifespan" (p. x). It is essential that nursing faculties are culturally proficient and rise to the challenge of preparing a culturally competent, diverse workforce.

Since the ANA (1965) first proposed the baccalaureate degree as the minimum preparation for professional nursing, the debate regarding entry level requirements has continued to divide the nursing community. Associate degree nursing (ADN) programs provide the majority of entry level graduates each year (Mahaffey, 2002). Del Bueno (2005) in a 10-year study of new graduates' clinical judgment skills found no significant

differences related to educational preparation. Recognizing the need for multiple entry points to nursing licensure the IOM (2010) advocates for innovative articulation and consortium agreements to provide career progression. The National Council of State Boards of Nursing (2008) performed a practice analysis of new graduates 3 three years; no difference was found when comparing ADN versus baccalaureate graduates. Transcultural teaching behaviors of nursing faculty teaching at the associate-degree level will be compared with those of nursing faculty teaching at the baccalaureate level.

Background of the Study

As the population of the United States becomes more diverse, there is a need to increase the cultural component in the nursing curriculum. The nursing curriculum needs to be inclusive, incorporating multicultural theories and provide staff development for faculty (Leininger & McFarland, 2002). Fueled by reports of healthcare disparities (IOM, 2002, 2003), there is an increased emphasis on the inclusion of cultural care theories. Campinha-Bacote (2003) examined the IOM report that outlined healthcare disparities of minorities and concluded that some of the disparities are related to "racism on the part of healthcare professionals" (p. 239). Nurse educators must employ innovative teaching strategies to incorporate cultural care theories into the curriculum and act as role models, demonstrating cultural proficiency to students. As the demographics in the United States become increasingly diverse, nursing faculty must prepare their students to provide culturally competent care. It is necessary for graduating nurses to possess the knowledge and skills to provide culturally congruent care that addresses present healthcare

disparities. Without a strong knowledge base and awareness of the importance of cultural competence, how can nursing faculty teach cultural competence to students?

Despite the emphasis of cultural competence in nursing education, it is surprising that so little of the research has focused on the level of cultural competency among nursing faculty. In the nursing literature, there were seven studies that examined the cultural knowledge and teaching behaviors of nursing faculty. Kelly (1991) examined nursing faculty's education in transcultural nursing, concluding that there was a lack of prepared faculty. Yoder (1996) studied the cultural awareness of nursing faculty when responding to diverse students, and concluded that there was a lack of cultural awareness among nursing faculty. Grossman, Massey, Blais, and Geiger (1998) surveyed deans and directors of nursing programs in Florida regarding the integration of cultural competence into the program. Even though most of the respondents stated that cultural competence was an integral part of the nursing program, the need to improve cultural knowledge and awareness was identified. A descriptive research study conducted by Ryan et al. (2000) found that nursing faculty lacked the preparation to teach transcultural nursing. All of the studies identified the need for increased cultural knowledge, awareness, and skill among nursing faculty. Sealey (2003) developed the Cultural Diversity Questionnaire for Nurse Educators (CDQNE), a tool that measured Campinha-Bacote's five subscales of cultural competence. The CDQNE included a sixth subscale that measured transcultural teaching behaviors and questions regarding demographic and professional characteristics. Sealey evaluated the cultural competency and teaching behaviors of nursing faculty teaching at the baccalaureate level. Kardong-Edgren (2004) compared the cultural competence of scores of nursing and health education faculty teaching at the baccalaureate level.

Most studies related to cultural competency have focused on baccalaureate faculty (Kardong-Edgren, 2004; Kelly, 1991; Ryan et al., 2000; Sealey, 2003). Even though the majority of the nurses who pass the National Council Licensure Examination (NCLEX–RN) graduate from associate-degree programs, only one study evaluated the cultural competency of nursing faculty teaching at the associate-degree level (Yates, 2008). Using a revised version of Sealey's tool (the CDQNE), Yates examined the cultural competence and teaching behaviors of ADN faculty in Ohio. Cultural competency is an important component of nursing education at every level. Continued research is needed to identify factors that affect cultural competence and examine transcultural teaching behaviors at both the associate- and baccalaureate-degree level.

Statement of the Problem

It is not known to what extent nursing faculty teaching at the associate-degree level in a diverse community are culturally competent or if they utilize culturally appropriate teaching practices. It is not known how the cultural competence of nursing faculty teaching at the associate-degree level compares with that of nursing faculty teaching at the baccalaureate level. This nonexperimental, cross-sectional correlation study is designed to explore the attitudes and teaching practices of nursing faculty teaching at the associate-degree level in New York. The study examined the relationship between demographic variables and the overall cultural competency score of nursing faculty. Demographics include age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certifications, ethnic background of students taught, and preparation in transcultural nursing. The examination of

demographics was important to this study because characteristics and factors that contribute to higher scores of cultural competency were identified.

Previous studies that examined the cultural competency of nursing faculty highlighted the need for continued research regarding cultural competency in nursing education. Ongoing evaluation of the cultural competency of nursing faculty is needed to include faculty at the associate-degree level, examine the effect of continuing education on cultural competence, and assess curriculum content and instructional methods. This study was designed to replicate Sealey's (2003) study of nursing faculty teaching at the baccalaureate level and Yates's (2008) study of faculty teaching at the associate-degree level. Comparisons were made with both studies regarding factors that affect cultural competence and teaching behaviors.

Purpose of the Study

The purpose of this quantitative study was to examine the level of cultural competence among faculty teaching in ADN programs in the New York metropolitan area. The study explored the relationship between cultural competency, faculty demographics, and teaching behaviors, and examined those factors that contributed to cultural proficiency. The data were compared to previous studies by Sealey (2003) and Yates (2008). Nursing faculty teaching at the associate-degree level are the focus of this study as these programs prepare more than two thirds of all registered nurses (RNs) at the state level and more than half the RNs nationwide (New York State Education Department, Office of the Professions [NYSED OEP], 2008).

Rationale

This study identified factors associated with the levels of cultural competence of nursing faculty teaching at the associate-degree level. Nursing faculty's teaching behaviors and inclusion of cultural competence in the curriculum were examined. The educational preparation of nursing students taking the RN licensing exam varies in length and outcomes. In 1995, the AACN published a report clarifying the roles and responsibilities based on nursing education, fueling the minimum entry level debate. There are four pathways to enter into the nursing profession: diploma, associate degree, baccalaureate degree, and direct-entry graduate programs. Regardless of the nursing program, upon graduation all four pathways lead to the same licensing exam. Diploma nursing programs are usually associated with a hospital and combine classroom and clinical instruction over 3 years. With the move toward a more academic preparation the numbers of diploma nursing programs have decreased. Associate-degree programs provide classroom and clinical instruction, varying in length from two to two and a half years. The baccalaureate degree is a four year, university based degree leading to a Bachelor of Science in Nursing (BSN). The direct entry graduate program provides a nontraditional option for individuals with a nonnursing baccalaureate degree to obtain a graduate nursing degree. The debate surrounding the baccalaureate as the minimum educational level for entry into nursing has been argued for the past 40 years. Both New York and New Jersey state legislatures propose bills that would require all RNs to obtain a BSN within 10 years of graduating. This proposal, known as the "BSN in 10," has provoked discussion regarding the need for higher educational level to deal with an increasingly complex healthcare system.

According to the *Occupational Handbook* (U.S. Department of Labor, 2008), associate-degree programs prepared more than half of all graduating nurses in 2006. The second highest number of registered nurses graduated from 4-year baccalaureate-degree programs, and the remaining graduates were diploma school nurses. ADN programs outnumber their baccalaureate counterparts and contribute a higher proportion of graduate nurses (Colalillo, 2007). Numerous ADN programs are offered through community colleges. Community colleges provide an entry level for nontraditional and minority students, including those from immigrant populations, older students, and those seeking a second career (Colalillo, 2007; IOM, 2010; Kupina, 2006). In New York, there are 95 programs approved to provide nursing education: one diploma, 60 associate-degree, and 34 baccalaureate programs (NYSED OEP, 2008). There were 5,033 graduates from associate-degree programs, 1,943 from baccalaureate programs, and 10 from diploma programs (NYSED OEP, 2008). In New York, where the overwhelming numbers of new nursing graduates are from associate-degree programs, it is imperative that the cultural competency of nursing faculty teaching in these programs be examined.

Research Questions

The following research questions guided this study:

1. How culturally competent are faculty teaching in associate degree nursing programs in the New York City metropolitan area, as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R)?
2. What is the predictive value of faculty characteristics for cultural competence?

3. What is the relationship between cultural competency scores of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level?
4. How is cultural competence related to teaching behaviors?

Nature of the Study

This nonexperimental, descriptive, correlation study used a quantitative, cross-sectional survey method to assess the cultural competency of nursing faculty teaching at associate-degree programs in New York. This method was chosen to provide a direct comparison to both Sealey's (2003) study and Yates's (2008) study, using the revised version of Sealey's CDQNE tool. The CDQNE–R tool measures each of the five constructs of Campinha-Bacote's (1998) theory of cultural competency, participant demographics, and teaching behaviors. Data were collected from nursing faculty teaching in associate-degree programs at both public and private colleges in the New York metropolitan area.

Significance of the Study

This study will add to the body of knowledge regarding variables that impact nursing faculties' cultural competence. Examining teaching behaviors related to transcultural nursing offers guidance for curriculum development and design. Suggestions to improve practice and innovative teaching/learning strategies are proposed. The information presented in this study could impact the development of continuing education programs that focus on improving both the cultural competency and teaching

skills of nursing faculty. As suggested by Kardong-Edgren (2004), cultural competency assessments can be used as a benchmark for faculty competence, identifying the need for faculty development. Comparing the results of this study with prior research by Sealey (2003), Yates (2008), and Kardong-Edgren will provide a deeper understanding of the factors that affect the cultural competency of nursing faculty. It is crucial that nurse educators understand the level of culture competence and teaching behaviors of faculty who teach at the associate-degree level.

Definition of Terms

For the purposes of this study, the following terms were defined:

Acculturation. The process of giving up most of the attributes from their original culture and incorporating some of the cultural traits of another society through contact with that culture (Purnell & Paulanka, 2008).

Cultural competency. A continuous process in which the nurse strives to work within the cultural context of an individual, family, or community from a diverse cultural background (Campinha-Bacote, 1994).

Cultural imposition. "The tendency of an individual or group to impose their beliefs, values and patterns of behavior upon another culture for varied reasons" (Leininger, 2002, p. 51).

Culturally congruent care. This term was used first by Leininger in the 1960s; it "refers to use of sensitive, creative, and meaningful care practices to fit with the general values, beliefs, and lifeways of clients for beneficial and satisfying health care, or to help

them with difficult life situations, disabilities, or death" (Leininger & McFarland, 2002, p. 12).

Culture. "Shaped by values, beliefs, norms, and practices that are shared by members of a cultural group" (Giger & Davidhizer, 2008, p. 2).

Diversity. "The variations and differences among and between cultural groups resulting from differences in lifeways, language, values, norms, and other cultural aspects" (Leininger & McFarland, 2002, p. 53).

Ethnicity. "Refers to a group whose members share a common social and cultural heritage passed on to each successive generation" (Giger & Davidhizer, 2008, p. 71).

Ethnocentrism. "The universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways" (Purnell & Paulanka, 2008, p. 6).

Health disparities. Gaps in the quality of health and health care across racial and ethnic groups' population-specific differences in the presence of disease, health outcomes, or access to care (U.S. Department of Health and Human Services [USDHHS], 2000).

Minority group. A racial, ethnic, religious, political, national, or other group thought to be different from the dominant group of which it is a part (Giger & Davidhizer, 2008).

Multiculturalism. A belief that many different cultures exist in the world and that this diversity should be understood and valued (Leininger & McFarland, 2002).

Race. "Genetic in origin and includes physical characteristics that are similar among members of the group, such as skin color, blood type, and hair and eye color" (Purnell & Paulanka, 2008, p. 6).

Stereotyping. "An oversimplified conception, opinion, or belief about some aspect of an individual or group" (Purnell & Paulanka, 2008, p. 7).

Transcultural. "Across all world cultures whether a nation or not" (McDonald, 2008, p. 35).

Transcultural nursing. "A formal area of study and practice focused on comparative human-care differences and similarities of the beliefs, values, and patterned Lifeways of cultures to provide culturally congruent, meaningful, and beneficial health care to people" (Leininger & McFarland, 2002, p. 6).

Assumptions and Limitations

The main assumption in this study is that participants answered the survey honestly. Other assumptions inherent in this study are that there is a need for assessment of cultural competence of nurse educators, and that the definition and evaluation of cultural competence can be defined and assessed.

The following limitations are present in this study:

1. The use of a self-reporting tool to assess cultural competence. The study's use of a self-reporting tool may cause participants to answer the survey in a socially desirable manner (Kardong-Edgren, 2004).

2. The use of a convenience sample of ADN faculty in the New York metropolitan area. Findings of this study can only be generalized to faculty teaching at the associate-degree level in a similar urban community.
3. The use of an online survey to collect the data may limit the participants to those who are more proficient with and have access to the technology.
4. There may be an element of self-selection bias, participants who have an interest in transcultural nursing are more likely to complete the survey.

Theoretical Framework

The main theoretical framework for this study is that of Campinha-Bacote's (1998) theory of cultural competence. Campinha-Bacote's framework includes five constructs: cultural desire, awareness, knowledge, skill, and encounters. She described these constructs as having an interdependent relationship and cultural competency as a journey or process. Cultural awareness is an examination of one's own cultural background, beliefs, and values. Campinha-Bacote (1999) cautioned that being "aware of one's prejudices and biases towards other cultures does not ensure the development of culturally responsive interventions" (p. 204). Cultural knowledge builds on cultural awareness and, according to Kardong-Edgren (2007), "includes information about health beliefs and practices, disease incidence and prevalence, and treatment efficacy" (p. 360). Cultural skill is the ability to apply both awareness and knowledge to practice, specifically when conducting a cultural assessment (Campinha-Bacote, 1999). Cultural encounters refer to interactions with members of different cultures. Lastly, cultural desire is the motivation to become culturally competent. Campinha-Bacote provided a visual

image of a volcano, demonstrating that cultural desire is the impetus for the other four constructs of awareness, knowledge, skill, and encounters.

Organization of the Remainder of the Study

The remainder of this study is be divided as follows: Chapter 2 presents a literature review of the history of transcultural nursing, changing demographics, disparity in healthcare outcomes for minorities, cultural competency as it relates to nursing education, the increasingly diverse student body, curricular content, and current research related to cultural competency of nursing faculty. Chapter 3 provides a detailed outline of the research design, methods, data collection, and analysis. Chapter 4 presents the analysis of the data. Chapter 5 discusses the findings of this study, conclusions, limitations, and recommendations for future research.

CHAPTER 2. LITERATURE REVIEW

Introduction

The first theme in the literature review is that of cultural competence in nursing with a focus on Campinha-Bacote's (1998) theory. Campinha-Bacote's theory defined cultural competence as "the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client" (p. 6). Each of the five components of Campinha-Bacote's model are described. The second theme is the need for culturally competent nurses to provide appropriate care to an increasingly diverse population and reduce present inequalities in the healthcare system. Changing demographics in the United States, research regarding health disparities for minority populations, and the need for nurses prepared to meet the challenges are presented.

The third theme examines the present nursing education system, the professional background of nursing faculty with respect to cultural competence, and the need to recruit and retain an increasingly diverse student population. The fourth theme presents studies of how cultural competence has been integrated into the nursing curriculum. Innovative teaching strategies that enhance students' cultural competence are examined. Lastly, previous research related to cultural competence in nursing education is presented. Comparisons and contrasts of Sealey's (2003), Kardong-Edgren's (2004), and Yates's

(2008) studies are presented. All three research studies utilized Campinha-Bacote's theory of cultural competence as the underlying framework for their research regarding the study of cultural competence among nursing faculty.

Cultural Competence

Campinha-Bacote's process of cultural competence in the delivery of healthcare services model provides a framework for nurses to examine their cultural competence, useful tools for cultural assessments, and challenges to continue on the journey to cultural competence. Campinha-Bacote (2007b) cited Cross, Bazron, Dennis, and Isaac's definition of cultural competence as being the most widely accepted: "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 9). The ultimate goal of culturally competent care is to provide quality healthcare that meets the needs of the individual regardless of his or her cultural background. Campinha-Bacote began her journey toward cultural competence in 1969; blending her passion for culture and healthcare, she developed the current model in 1991, with four constructs. In 1998, the model was revised with the addition of cultural desire as the fifth construct. Campinha-Bacote revised the pictorial model in 2002, depicting cultural desire as the force that motivates the other four concepts. The five concepts that form the building blocks of her theory are cultural awareness, skill, knowledge, encounters, and desire. Campinha-Bacote used the mnemonic ASKED (awareness, skill, knowledge, encounters, and desire) to represent self-examination questions for each of the concepts.

McDonald (2008) described culture as a mental map of a person's world that guides decisions and behaviors. This has significance for nurses when planning patient care, as culture is a vital part of the patient's healthcare beliefs and behaviors. Covington (2001) stated, "It is imperative that all nurses, regardless of cultural background be competent to provide holistic care that is predicated on knowledge, respect, and understanding of the impact of culture on health behaviors without stereotyping or being judgmental" (p. 521). Delivering culturally congruent care is becoming a major quality issue for nursing education and a necessary skill set for all clinicians. Pesquera, Yoder, and Lynk (2008) described cultural competence as "raising self-awareness and increasing knowledge about populations that provide encounters, understanding cultural and health beliefs of different groups" (p. 118). With increasing cultural encounters, nurses develop skills and knowledge when dealing with diverse populations. If culturally congruent care is provided to clients, they will have a greater desire to achieve mutually agreed-upon healthcare goals. Awareness is the first step on the journey to cultural competence. One must be willing to acknowledge prejudice and bias and commit to caring for patients regardless of their culture.

Cultural Awareness

Cultural awareness is recognized as one of the first steps on the journey toward cultural competence. Campinha-Bacote (2007b) described cultural awareness as "the deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us" (p. 27). She stressed that personal biases may be so deep that awareness may not be easily available. Campinha-Bacote (2007b) stated that "without becoming aware of the impact

our cultural values have on our interaction with others, there is risk that the healthcare professional may engage in cultural imposition" (p. 28). Sealey (2003) included Mason, Cross, Rider, and Friesen's "concept of acceptance and acknowledgement of differences" (p. 44) within the concept of cultural awareness. Nurses need to be aware of their culture, their deficits and competencies as a first step in providing culturally competent care (Leininger & McFarland, 2002). Self-awareness was identified by Leininger (2002) as the sixth principle guiding a comprehensive, cultural assessment. Purnell (2002) and Campinha-Bacote (1996) described the different levels of cultural awareness along a continuum from unconscious competence through conscious incompetence, conscious competence and, finally, unconscious competence. Brathwaite (2005) employed two tools to increase cultural self-awareness among public health nurses. The first tool was a self-assessment questionnaire using Purnell's six domains of culture; the second was a simulation game. In addition to self-assessment, it is vital for nurse educators to assess the nursing and organizational culture of their workplace as the first step on the journey to cultural competence.

Cultural Skill

Campinha-Bacote (2007b) described cultural skill as "the ability to collect relevant cultural data regarding the client's presenting problem, as well as accurately performing a culturally based, physical assessment in a culturally sensitive manner" (p. 49). Just as cultural assessment is the first step on the journey to cultural competence, assessment is the first step of the nursing process. Cultural competence is a necessary prerequisite to performing a culturally appropriate nursing assessment and a culturally based physical assessment (Yates, 2008). Campinha-Bacote used the Dreyfus and

Dreyfus framework for describing the skill acquisition from novice through the five levels of proficiency to expert. She described the *competent* nurse as having 2–3 years of experience conducting cultural assessments with culturally diverse clients, but lacking in "the speed and flexibility of the proficient" (p. 67) nurse. The *proficient* nurse has worked 3–5 years with a culturally diverse population, with the ability to identify the patient's problem related to culture. Finally, the *expert* nurse is one who has vast knowledge and experience working with a culturally diverse population, using intuition to guide the cultural assessment. With increased practice and subsequent cultural encounters, the nurse moves from novice to expert. Applying the concept to nursing education, it is expected that nurse educators should be at the level of cultural proficiency or expert.

Campinha-Bacote (2007b) presented an overview of the various assessment tools, frameworks, and mnemonics to assist the healthcare professional when performing a cultural assessment. She stressed the importance of integrating cultural assessment as a part of the overall client assessment, thereby not singling out culture. Leininger and McFarland (2002) provided a comprehensive cultural assessment tool that assesses 12 domains of inquiry. Another tool provided by Leininger and McFarland is the Acculturation Health Care Assessment Guide for Cultural Patterns Traditional and Non-Traditional Lifeways that is used to determine if the patient's orientation is more traditional or nontraditional. Giger and Davidhizer (2008) first introduced their transcultural assessment model in 1991. Since then, it has been used in various clinical settings and has been refined through research. The model provides a cultural assessment that incorporates six cultural domains: communication, space, social organization, time, environmental control, and biological variations. Purnell's (2009) framework assesses 12

domains, common to all cultures that are an important component of cultural assessment. Campinha-Bacote cautioned that the assessment tools discussed may not be appropriate for recent migrants to the United States. She provided two alternative assessment tools from Jacobsen and Chong. Both of these tools assess the reason for immigrating to the United States, level of social support, and acculturation. Another important skill, according to Campinha-Bacote, is the ability "to conduct a culturally sensitive medication assessment" (p. 55). She gave two examples of medication assessment tools (Gaw, 1999; Kudzma, 2001) that are culturally sensitive.

Healthcare professionals must be aware of cultural variations when conducting a physical assessment. Biological differences are identified by Giger and Davidhizer (2001) as an important component of cultural assessment. Campinha-Bacote (2007b) stated, "As healthcare professionals we tend to have more of a Eurocentric, rather than melanocentric, approach to skin assessment" (p. 63). Yet skin disorders in clients who have darker skin may present differently due to variations in pigmentation. Purnell (2009) discussed the importance of increasing healthcare providers' awareness of skin variations related to ethnicity and race. When assessing darker skinned patients for pressure ulcers, cultural skill and knowledge are imperative to identify those patients at risk (Campinha-Bacote, 2007b). Alternative methods when assessing for jaundice and oxygenation are provided for darker skinned patients (Purnell, 2009). The nursing curriculum must include content that integrates cultural variations, assessment, and assessment tools.

Cultural Knowledge

Cultural knowledge is pivotal to identifying biological variations among cultural, racial, and ethnic groups. Yates (2008) described cultural knowledge as "seeking and

obtaining information regarding world views, biological variations, health conditions and other meaningful cultural data" (p. 21). Nurses must possess cultural knowledge and understand the impact of culture and traditional or folk treatments on healthcare practices (McDonald, 2008). Delaney (2009) identified cultural knowledge as one of "two critical need areas for nurses to accommodate the global trends in cultural diversity and health care disparities" (p. 240).

Cultural nursing research has focused on knowledge about health beliefs and practices of different ethnic and racial groups. "Each cultural group has a set of beliefs, behaviors, values, languages, and custom. The extent to which an individual within each culture adheres to these varies tremendously" (Pesquera et al., 2008, p. 116). Campesino (2008) noted that a limitation with this narrow focus on cultural knowledge and the expectation that all clients be treated equal ignores the influence of social hierarchies. Furthermore, increasing cultural knowledge does not automatically translate into effective and culturally sensitive care. According to Campesino, "Simply learning about the cultural patterns of groups of people does not necessarily dismantle biased attitudes that nurses may have internalized" (p. 299). Campinha-Bacote (1999) cautioned that potential stereotyping may occur when intraethnic variations are not considered.

Cultural Encounters

Cultural encounters were described by Campinha-Bacote (2007b) as "the act of directly interacting with clients from culturally diverse backgrounds" (p. 71). Campinha-Bacote stated that cultural encounters with a diverse population "will refine or modify one's existing beliefs about a cultural group and prevent stereotyping" (p. 71). Language competence is an important component of cultural encounters. Campinha-Bacote

provided several examples of mnemonic models to guide nurses during cultural encounters.

Cultural encounters can be described as *face-to-face* or *non-face-to-face*. A potential for conflict arises when the patient first enters the healthcare setting regardless of the type of encounter. Campinha-Bacote (2007b) cautioned that even though conflict may be an outcome of cultural encounters, it can provide the impetus for the nurse to develop compassion. Compassion is always the goal when there is cross-cultural conflict. Campinha-Bacote described compassion as "an emotion of shared suffering and the desire to alleviate or reduce such suffering as well as demonstrating kindness to those who suffer" (p. 79). Campinha-Bacote provided strategies to overcome cultural conflict and develop compassion using self-reflection and in-depth examination of the conflict.

Non-face-to-face cultural encounters are another potential source of conflict. Examples of non-face-to-face encounters are the telephone, Internet, e-mail, and texting. Telephone encounters may lead to conflict when a high-context patient who relies on nonverbal communication is speaking to a low-context healthcare provider. Campinha-Bacote (2007b) defined high-context and low-context communication as "the degree to which we rely on factors other than direct speech to convey our messages" (p. 83).

Cultural Desire

The final and pivotal concept of Campinha-Bacote's theoretical framework is that of cultural desire or the force that speeds the journey toward cultural competence. Campinha-Bacote (2007b) defined cultural desire "as the motivation of the healthcare professional to 'want to' engage in the process of becoming culturally competent; not the 'have to'" (p. 21). The concepts of caring and love, sacrifice, social justice, and humility

are discussed as they relate to cultural desire. Donahue (2009) described cultural desire as "a genuine passion to be open and flexible with others, to accept differences and build on similarities" (p. 120). She described how nurse educators can share in the learning experience, looking to students as "cultural informants" (p. 120).

A commitment to social justice and caring are necessary components of cultural competence. As research demonstrates the negative impact of inequality on health outcomes, it is imperative that nurses link cultural competence with social justice (Campinha-Bacote, 2007a). Nurses need to work with community leaders in an effort to identify inequalities in healthcare and overcome barriers. Humility and service are necessary components in developing the desire to become culturally competent. Campinha-Bacote described humility as "a quality of seeing the greatness in others and coming into the realization of the dignity and worth of others" (p. 25). Without the desire to become culturally competent, nurse educators will fail to become culturally proficient. If nurse educators stagnate at the culturally aware or competent level, they will have insufficient knowledge and skills to teach cultural care to the next generation of nurses.

Changing Demographics

It is predicted that the population of the United States will become increasingly diverse. This increase in the nation's cultural diversity will present major challenges for both nursing and nursing education (Amaro, Abriam-Yago, & Yoder, 2006; McDonald, 2008; Roy, 2000; Speziale & Jacobson, 2005). The 16 trends that Marx (2006) predicted are applicable to nursing education. Marx identified the rapidly changing demographics and an increasingly diverse population as the second trend. Marx assumed that with

continuing changes, the "majority will become the minority" (p. 43). This change is reflected in the growth of minority populations within the United States. The Hispanic and Asian populations are increasing in both numbers and as a percentage of the population (U.S. Census Bureau, 2005). It is projected that the Hispanic population will nearly triple during the 2008–2050 period, doubling from 15% to 30% of the total population (U.S. Census Bureau, 2005). The predicted increase in minority populations has consequences for healthcare, requiring culturally competent providers and a more diverse workforce.

One universal recommendation found in the literature to alleviate racial and ethnic disparities is to prepare a diverse workforce. *Healthy People 2010* (USDHHS, 2000) recommended an increase in the number of minority healthcare providers and an increase in the number who hold academic degrees. Grossman and Jorda (2008) stated, "Increasing the proportion of minority nurses is crucial not only because of the increasing diversity of the population, but also because racial and ethnic minorities suffer from serious health disparities" (p. 545). This is consistent with the goal of the ANA and the NLN to provide a more diverse workforce. As the largest group of healthcare workers in the United States, minority nurses are underrepresented when compared to that of the general population (Morgenthaler, 2009; Noone, 2008; Yarbrough & Klotz, 2007). To close the gap, nursing needs to actively recruit minority students, improve retention and graduation rates, and increase the number of minority students at the graduate level. The NLN (2009) reported that in the past decade, the percentage of ethnic/minority graduate nurses decreased from 13.3% to 12.3%. To be successful, nurse educators need to change the culture of the organization, integrate cultural care into the curriculum, increase the

content of cultural care at the graduate level, and improve the recruitment and retention of diverse students at all levels of nursing.

Meeting the Needs of Diverse Patients

A major goal of *Healthy People 2010* (USDHHS, 2000) is to reduce the inequalities and health disparities due to gender, race, or ethnicity. Other negative variables that were identified are health literacy and poverty that can adversely affect access to care and treatment (Leonard, 2006). The IOM (2002) report, *Unequal Treatment*, highlighted that minorities receive lower quality care, leading to disparities in healthcare. In 2003, the IOM published *Crossing the Quality Chasm*, which stressed the need for cultural competence training for healthcare providers. The training focuses on cross-cultural interactions to improve communication and provide culturally congruent care.

The Agency for Healthcare Research and Quality (2008) published the *National Health Disparities Report* that identified specific areas of health disparities. The IOM (2002) noted, "Health disparities exist even when differences in treatment attributable to insurance, access to care, health status and other factors are eliminated" (p. 160). In addition to racial and ethnic diversity, there are cultural, linguistic, and socioeconomic factors that impact health behaviors and access to care.

Developing cultural competence may reduce disparities that are attributed to patient–provider interactions. Leonard (2006) examined numerous studies that demonstrated positive health outcomes when culturally congruent care was offered. When cultural care is provided that takes into account the patient's values and beliefs,

there is increased compliance with medications and access to healthcare. Misunderstandings regarding patients' health beliefs can contribute to poor outcomes and noncompliance. Campinha-Bacote (2007b) reported, "There is compelling research and documentation supporting that the lack of cultural competence among healthcare professionals can result in poor health outcomes" (p. 12). Nurses need to understand the influence of culture on health practices, beliefs, and access to care. McDonald (2008) stated that nurses are ideally situated as patient advocates to help "cross-cultural patients through the process of adjusting to an unfamiliar, confusing medical environment" (p. 37).

Communication is one of the key issues in providing culturally competent nursing care. McDonald (2008) stressed the importance of listening skills and careful nonverbal and verbal communication with patients who are different. Problems arise during cultural encounters due to poor communication or miscommunication between the patient and the provider. Misunderstandings due to poor communication and language barriers are a main cause of medical errors that have a negative impact on patient safety. The Agency for Healthcare Research and Quality (2008) reported that poor communication is more likely when the patient is from an ethnic/racial minority or has less than a high school education. The U.S. Census Bureau (2005) reported that in New York City, there were more than 1,000 languages or dialects spoken in 2000. It is imperative that nurses have the ability to communicate both verbally and nonverbally with patients who do not speak the dominant language (Purnell & Paulanka, 2008). A nurse needs to assess the client's comprehension of written and verbal healthcare instructions. Literacy is defined as the ability to read and write English (Chang & Kelly, 2007). Patients who have limited

English proficiency may not be able to read in their primary language. Even if a patient's primary language is English, he or she may not be able to comprehend healthcare instructions. Health literacy is defined as the "degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (USDHHS, 2000, p. 1).

Campinha-Bacote (2007b) identified one of the first steps in linguistic competence is to determine the patient's written and spoken language preference. Spencer (2008) identified communication as one of the primary concerns when working with diverse populations. The USDHHS Office of Minority Health implemented a set of standards that guide improved communication and patient–provider interactions with a goal to reducing health disparities (American Institutes for Research, 2002). The Culturally and Linguistically Appropriate Service (CLAS) standards have three groups of 14 standards (USDHHS, 2000). The first group consists of Standards 1–3 and focuses on Culturally Competent Care, incorporating a diverse workforce, and continuing education and training of staff. The second group consists of Standards 4–7, Linguistically Appropriate Services, with an emphasis on communication and provision of trained interpreters. It is important to note that during times of stress and illness, patients may need an interpreter (Chang & Kelly, 2007). The last group consists of Standards 8–14, Organizational Supports for Cultural Competence, and includes the development and implementation of a plan that incorporates the 14 CLAS standards into the organization's strategic plan with community collaboration. DeSantis and Lipson (2007) cautioned that implementation of the CLAS standards are "dependent, to a great degree, on the cultural

competence of individual health care providers" (p. 8S). The CLAS standards provide guidelines for healthcare facilities, but they are applicable to a school of nursing.

For nurse educators, it is necessary to know specific risk factors regarding access to health care, risk factors, incidence, and outcomes specific to the population served. Some studies that highlight discrepancies in healthcare follow. Pesquera et al. (2008) reported differences in cancer screening, prevention, and treatment related to race and ethnicity. They presented statistics from the National Cancer Institute that demonstrate that even though Black women have a lower incidence of breast cancer than White women, the mortality rate is higher. Bull and Fitzgerald Miller (2008) identified factors such as "behavioral, biological, environmental, cultural, political, and economic" (p. 157) that contribute to health disparities among diverse groups. Kataoka-Yahiro, Ceria, and Yoder (2004) reported that "Filipino American elders have a higher incidence of diabetes and higher risk factors for coronary heart disease such as hypercholestremia and hypertension" (p. 110). Pesquera et al. stressed the importance for healthcare providers to address disparities in cancer screening, communication, and lack of patient knowledge and access to care in an effort to reduce disparities and prevent delay in diagnosis. They predicted that as racial and ethnic minorities continue to grow, delivery of quality cancer care will become more complex. Continued research is necessary to provide evidence that cultural competence training impacts patient adherence and health outcomes.

Cultural Competence in Nursing Education

Since Leininger (1997) first introduced the concept of transcultural nursing more than 40 years ago, the field has grown to support a variety of nursing theories. DeSantis

and Lipson (2007) presented a history of cultural content in nursing education, with a focus on transcultural nursing in the 1970s, building on Leininger's pioneering work. The Transcultural Nursing Society was founded in 1974, giving emphasis to improving knowledge for advanced practice nurses (DeSantis & Lipson, 2007; Leininger & McFarland, 2002). The Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission included diversity as one of the criteria for accreditation. In 1983, the NLN developed curricula that called for the inclusion of cultural content (DeSantis & Lipson, 2007; Fitzpatrick, 2008). The ANA Council on Cultural Diversity in Nursing Practice developed a guide to include diversity as an integral part of the curriculum in 1986 (DeSantis & Lipson, 2007; Tanner, 2007). The NLN's (2001) *A Vision for Nursing Education Reform* called for curricula revisions with special attention to "the multicultural, multiracial and growing diversity of both individual and family lifestyles" (p. 1). The ANA (2003) initiated a strategic plan, The Nursing's Agenda for the Future, that focuses on recruiting and retaining diverse nursing students. In 2006, the AACN, in conjunction with the California Endowment Fund, developed *Preparing a Culturally Competent Nursing Workforce*, with a focus on patient safety. One of the core knowledge requirements by the AACN includes human diversity, with the expectation that graduates understand the effect that culture, race, religion, gender, lifestyle, and age have on health behaviors. In 2008, the American Academy of Nursing's expert committee produced the document *Cultural Competency in Baccalaureate Nursing Education* identifying five competencies. The document breaks down each competency, with content information, teaching strategies, and expected outcomes. Even though the AACN competencies pertain to baccalaureate nursing

students, the strategies and outcome evaluation can be applied to associate-degree programs.

The Culture of Nursing

Campinha-Bacote (2007b) described healthcare professionals "as a cultural group with unique values, beliefs, practices and language" (p. 72). According to Leininger (2002), it is important to study the culture of nursing as becoming aware of the values and beliefs inherent within the culture of nursing can guide the nurse in caring for patients. Another reason to understand the culture of nursing specific to the United States is to "appreciate differences and similarities among nursing cultures regionally, nationally, and worldwide" (Leininger, 2002, p. 183). As nursing faculty function in an increasingly global environment, it is imperative that they comprehend local, national, and international differences within the culture of nursing. Nursing education is a subculture of nursing. Leininger defined a subculture of nursing as a "subgroup of nurses who show distinctive values and Lifeways that differ from the dominant or mainstream culture of nursing" (p. 183). Leininger went on to describe four distinctive "Tribes of Nursing" (p. 195) within the United States: Friendly, Novel, Historic, and Blue Collar tribes. The Historic tribe is primarily from the northeast coastal region of the United States. Leininger identified some of the traits of the Historic tribe as ethnocentric, conservative, and reluctant to change or accept transcultural nursing theories. This is significant as the study population will be from the region of the Historic tribe. Demographics collected will identify the region in which educators received their nursing education. Results will be compared with the overall cultural competency scores.

Just as cultural competence must start at the local level (Pesquera et al., 2008), so too must nurse educators understand the community they serve, who their students are, and what services are available. One of the difficulties facing nursing faculty is that nursing education is based on a Eurocentric model of education (Hassouneh, 2006; Leonard, 2006; Sutherland, 2002). This may lead to cultural conflicts and miscommunication, and adversely affect the retention of minority faculty and the success of students from diverse backgrounds. Kupina (2006) concluded that there is

> A need for increased awareness by nursing faculty of the unconscious white privilege and the Euro American cultural framework of nursing that affects minority nursing students' success. When White nurse educators fail to recognize the privilege and position of power that they occupy the disempowering process remains hidden. (p. 3)

Hassouneh warned that because those in power have a vested interest in maintaining the status quo and ignoring racism in nursing education, a negative effect is created for both minority students and faculty. Nurses who take on the challenge of addressing racism and other forms of oppression need ongoing support.

Nurse educators need to perform a cultural self-assessment and identify their values, beliefs, and biases as they relate to nursing education (Bell-Scriber, 2008; Fitzpatrick, 2008; Sommer, 2001; Sutherland, 2002). Bell-Scriber suggested that schools of nursing create "an ongoing plan for assessing bias related to gender, culture and other factors including faculty development" (p. 149). Nurse educators must develop necessary skills and knowledge to integrate theories of cultural care into the curriculum and evaluate teaching strategies that successfully prepare culturally competent students.

Preparation of Nursing Faculty

Leininger and McFarland (2002) contended that the shift to a multicultural perspective from a unicultural perspective has been a major challenge for nursing education. This is partly due to the lack of nursing faculty prepared to teach transcultural nursing. The literature reveals that most nursing faculty teach cultural competency without any formal training (Campinha-Bacote, 2006; Kardong-Edgren, 2007; Mixer, 2008; Ryan et al., 2000; Sealey, Burnett, & Johnson, 2006; Yates, 2008). Leininger and McFarland (2002) found that less than 20% of nursing faculty received formal education in transcultural nursing. Kardong-Edgren (2004) examined the content of cultural competence in nursing faculties' education. Her findings were as follows: 16.4% of nursing faculty received no cultural content in a BS/BSN program, 15.3% reported no cultural content in an MS/MSN program, and 8.85% reported no cultural content in a doctoral program.

The qualifications of nursing faculty who teach cultural competence was examined by Ryan et al. (2000) and findings demonstrated a serious shortage of prepared faculty. Mixer (2008) reported, "Few participants had received any formal transcultural nursing education from their professional preparation, continuing education, or reading; and thus, did not describe care actions and decisions based on a conceptual framework" (p. 26). Campinha-Bacote (2006) made a point that only 75 nurses hold the Transcultural Nursing Society's international certification. This is significant as nurses who hold a certification in a specialty have to pass an exam and are recognized as experts in that field. Sealey et al. (2006) found that none of the 163 faculty surveyed held the transcultural certification, even though "five respondents listed transcultural nursing as a

specialty area" (p. 136). Other studies reported that the majority of nursing faculty were not experts in the field of transcultural nursing (Mixer, 2008; Yarbrough & Klotz, 2007; Yates, 2008).

Kardong-Edgren (2004, 2007) and Sealey (2003) highlighted the need for continuing faculty development in the area of cultural competency. Continuing education in transcultural competence impacted positively on nursing faculties' overall scores of cultural competence (Kardong-Edgren, 2004; Sealey, 2003). Healthcare institutions across the United States are implementing educational programs for staff related to cultural competency (Carol, 2007). However, there are few educational programs specific to nursing faculty. Leininger and McFarland (2002) identified the urgent need for graduate-prepared nursing faculty to provide teaching, research, and curricular reform, especially at the doctoral level. Graduate nursing programs with a focus on transcultural nursing need to be developed (Boyle, 2000; Bull & Fitzgerald Miller, 2008; Leininger & McFarland, 2002; Sealey, 2003; Yates, 2008) However, Leininger and McFarland report that, of doctoral nursing students, only 2% receive transcultural nursing content. Kardong-Edgren (2004) found that 8.85% of nursing faculty reported receiving no cultural content at the doctoral level, 15.3% at the master's level, and 16.4% at the undergraduate level. The level of cultural content varied from a free standing culture course, a prerequisite anthropology/culture course, to occasionally mentioned. Ongoing faculty development in transcultural nursing is needed to improve cultural competency, incorporate innovative teaching strategies that lead to successful recruitment and retention of diverse students and faculty.

Nursing Students

One of two issues facing nursing education identified by Leonard (2006) and Sutherland (2002) is the need to prepare student nurses to provide culturally appropriate care. Nursing educators worldwide are challenged to prepare a culturally competent nursing workforce (Leininger & McFarland, 2002; Sutherland, 2002). The second issue identified by Leonard (2006) and Sutherland (2002) relates to recruiting and retaining a diverse student body that is more reflective of a diverse, multicultural society. Barbee and Gibson (2001) identified the lack of racial diversity as one of the major problems facing nursing. Sutherland stressed that a culturally diverse classroom requires skills and teaching strategies to meet the needs of culturally diverse students. However, Leonard questioned the commitment of nursing programs to include diversity as a vital component and highlighted the need for continued research.

Recruitment and Retention of Diverse Students

Billings and Kowalski (2008) predicted that nursing classrooms are becoming increasingly diverse; as the number of minority students graduating high school increases, so will admissions to nursing programs. With the increasing diversity of nursing students, faculty need to become culturally proficient and aware of cultural differences associated with teaching/learning (Amaro et al., 2006; Campbell, 2008; Leonard, 2006; Spencer, 2008). The problem is evident in nursing education where minorities are not reflected proportionally in the student body and most nurse educators are White (Barbee & Gibson, 2001; Fitzpatrick, 2008; Sutherland, 2002). Barbee and Gibson provided a number of strategies that are needed to improve the diversity of the

nursing workforce: recognize that racism is endemic in nursing programs, eliminate and acknowledge racially biased attitudes and beliefs, and institutional support for recruitment and retention of non-White students. Nurse educators need to be aware of factors that contribute to recruitment and retention of diverse nursing students. Providing a safe classroom for all students and modeling culturally competent behaviors are factors in retaining diverse students.

Male students and ethnically diverse students have higher attrition rates than White students (Bell-Scriber, 2008; Leonard, 2006; Noone, 2008). First-time pass rates on the NCLEX–RN were lower for nursing programs with a high percentage of African American students (Noone). First-time pass rates on the NCLEX–RN "have long acted as the gold standard signifying nursing program quality" (Giddens, 2009, p. 123). The NLN utilizes first-time pass rates on the NCLEX–RN as a benchmark when evaluating nursing programs for accreditation purposes. This emphasis on first-time pass rates may work against nursing programs that are working to increase the number of minority students.

Students identified cultural differences as barriers to their success in education. Faculty need to be aware of barriers and factors that contribute to student success. Leonard (2006) examined causes related to the high attrition rate of non-White students in nursing education. Students reported overcoming the barriers of isolation and discrimination through connections with ethnic student associations or other diverse students. Noone (2008) reported that ethnically diverse nursing students may feel isolated and are more likely to suffer educational and economic challenges than their White peers. The lack of ethnic role models has been identified as a barrier to minority students' success (Amaro et al., 2006; Noone, 2008). According to Morgenthaler (2009),

leadership roles for underrepresented groups are needed to "provide positive role models to students considering nursing as a profession" (p. 342). A more diverse nursing faculty provides cultural encounters for peers and acts as a role model for students (Yates, 2008). This was confirmed by Amaro et al.'s findings that ethnically diverse faculty acted as role models and provided positive support. Amaro et al. advocated that nursing programs liaise with ethnic professional organizations to provide mentors and tutoring and facilitate peer study groups. It is clear that the same values and beliefs that contribute to culturally congruent care also lead to culturally congruent teaching behaviors.

Of four factors identified by Amaro et al. (2006) that successfully impacted ethnically diverse students, one of the most important was that of teachers and their attitudes. Yoder (1996) described five patterns of behavior observed when nursing faculty respond to diverse students. The five responses ranged from generic (low level of cultural awareness), mainstreaming, culturally nontolerant, struggling to bridging (high level of cultural awareness). Amaro et al. described the characteristics of bridging teachers as valuing cultural diversity, respecting cultural differences, providing encouragement, and being mentors. Nursing faculty need to examine their cultural awareness, knowledge, and skills when it comes to teaching and retaining a diverse student body.

Curriculum Integration

Tanner (2007) reported on the NLN's education reform of the nursing curriculum from a content-laden behaviorist model to a "caring" (p. 51) curriculum, creating new pedagogies that focus on multicultural values. Tanner (2003) recommended that the nursing curriculum should move from a focus on procedure and medicine to the concepts

of "caring, holism, critical thinking and evidence based practice" (p. 3), merging culturally sensitive care and ethical practice. Leininger and McFarland (2002) advocated incorporating curricular and teaching strategies to prepare students to care for an increasingly diverse population. Campesino (2008) stated that "despite the movement toward standardization of cultural curricular content, there remains a lack of consensus regarding the pedagogical approaches to cultural education in nursing" (p. 298). Morgenthaler (2009) stressed the need for the nursing curricula to "embrace the richness of the nation's multifaceted population in order to ensure the highest quality of care to patients of all ethnic and cultural backgrounds" (p. 337). There is a need to incorporate transcultural nursing concepts throughout the curricula from associate-degree through doctoral programs (Mixer, 2008). The curriculum should include factors that contribute to health disparities and vulnerability, research practices, and action research projects (Bull & Fitzgerald Miller, 2008).

Four approaches to multicultural education were identified by Banks and Banks (2009): contributions, additive, transformation, and decision making/social action. Each approach consists of five dimensions: content integration, knowledge contraction, prejudice reduction, equitable pedagogy, and empowering school culture. Byrne, Weddle, Davis, and McGinnis (2003) developed the multicultural inclusion model, incorporating transformative educational principles and Banks and Banks's content integration. Yates (2008) described transformative education as "changing the underlying beliefs and social structures of the learner" (p. 46). Another strategy for reinforcing transcultural nursing concepts is through the discussion of cultural–ethical issues (Yarbrough & Klotz, 2007).

Campesino (2008) proposed looking at transcultural nursing from a critical theory approach.

Knowledge is crucial to successfully teaching transcultural nursing theories. Sommer (2001) and Sealey (2003) identified a lack of knowledge as one of the barriers to incorporating cultural care in to the nursing curricula. The nursing curricula should integrate cultural knowledge and skills, incorporating ethics and the need to reduce health disparities (Bull & Fitzgerald Miller, 2008; Yarbrough & Klotz, 2007). Tanner (2007) stated that "organizing information into a conceptual framework allows for greater 'transfer'" (p. 51). Leininger and McFarland (2002) warned that the failure to make the transition to transcultural nursing care may result in conflicts and negative outcomes for both students and patients. Boyle (2007) reported "that cultural content is implemented on an ad hoc basis" (p. 21S) where there are committed nursing faculty. But these courses are in danger of being eliminated when content is overloaded. With a content-laden curriculum, cultural care becomes another theory to be covered (Carlton, Ryan, Ali, & Kelsey, 2007).

As transcultural nursing theories are incorporated into the curriculum, continued research and evaluation are necessary to assess terminal competencies or outcomes. Amaro et al. (2006) concluded that although most of the programs included cultural content, the amount and integration into the curriculum were not consistent. Sealey et al. (2006) and Ryan, Twibell, Miller, and Brigham (1996) recommended a system for tracking how much content of transcultural nursing is incorporated in the curriculum. Amaro et al. advised evaluating student competencies "to ensure graduates can provide culturally competent patient care and display cultural sensitivity" (p. 253). Another area

that nurse educators need to evaluate is that of content, including textbooks and instructional media used in the classroom. Nursing textbooks may not reflect the diversity of the population (Bell-Scriber, 2008; Noone, 2008). Byrne (2001) found the presence of racial bias in the history, culture, and physical assessment sections of textbooks. Campesino (2008) noted that "textbook discourse reflect[s] a dominant White middle class perspective that may silence or marginalize the experiences of non-dominant populations" (p. 300). Even though nursing literature has included discussions surrounding the concept of race, this is not always reflected in undergraduate nursing textbooks. Billings and Kowalski (2008) and Sealey (2003) proposed that nurse educators examine images, text, and course materials to ensure they are free from bias or omission of information regarding specific groups. Just as "providing culturally competent care requires a commitment on behalf of an entire institution" (Pesquera et al., 2008, p. 116), nursing programs need the commitment of administration and faculty to integrate cultural competence into the curriculum. Boyle (2007) pointed out that nursing education has yet to agree on standardized cultural content with limited standardized competencies. Without agreeing on competencies, how can nursing faculty evaluate and compare outcomes of nursing programs?

Strategies for Teaching

The literature supports a wealth of information regarding the content of cultural competence and how it is taught. Faculties are asked to add content to the already-full curriculum (Tanner, 2007), with a focus on what to teach rather than how to teach. The first step is becoming aware of one's own values and how that influences and facilitates

learning. Teaching strategies may vary depending on the length of time and level of the nursing program (Yates, 2008). For example, in a 2-year associate-degree program, it is not feasible to add a cultural immersion program. A comprehensive review of the literature that evaluates transcultural nursing teaching strategies was presented by Mixer (2008). Some of the pedagogies examined by Mixer were the evaluation and discussion of ethnographies that addressed cultural issues, experiential learning, immersion programs, and the use of storytelling for cultural assessment. Billings and Kowalski (2008) provided a list of learning strategies that can be used to incorporate cultural care, including role play, virtual communities, reflection papers, and simulation. Sealey (2003) "contend[ed] that nursing faculty also need to critically examine their preparation for implementing current or new strategies for teaching transcultural nursing" (p. 123).

Suggestions proposed by Leininger and McFarland (2002) are to have a transcultural nurse expert mentor faculty and to provide immersion experiences where faculties are exposed to different cultures. Bull and Fitzgerald Miller (2008) recruited a nationally recognized minority professor to provide workshops focusing on cultural competence and community-based action research. Amaro et al. (2006) recommended a transcultural nurse expert to provide support for faculty and students. Napholz (1998) examined cultural competency skills of two groups of junior-level nursing students; the group that received three additional 2-hour consultations with an expert in cultural nursing demonstrated a statistically different increase in posttest scores. The addition of a transcultural nurse expert was seen as a positive experience for both faculty and students.

Leonard (2006) identified strategies to "insure diversity" (p. 94), such as developing courses that focus on diversity, integrating concepts of diversity into the

curriculum, studying different cultures, and requiring courses that stress diversity. Barbee and Gibson (2001) concluded that

> Talking and writing about cultural diversity without consciously and forthrightly dealing with racism in nursing education, and then genuinely building a plan that sets diversity as a priority, are essentially empty exercises that will continue to perpetuate the status quo. (p. 244)

Citing Caffery et al.'s study that compared the integration of cultural content in an undergraduate nursing program with a 5-week international immersion program, it was found that the latter program increased students' cultural competence (Mixer, 2008).

Delaney (2009), utilizing Campinha-Bacote's theory of cultural competency, described a "learning activity that integrates the theory of transcultural nursing care and informatics with a focus on the global health of women" (p. 249). Students participated in an interactive class and readings relating to culture, prior to being given a case study. Students had to develop a culturally competent plan using Leininger's theory of culture care, diversity, and universality. Boyle (2007) provided examples of simulation scenarios that were used to link cultural content to practice situations. Billings and Kowalski (2008) gave a specific strategy for an introductory activity that asked the students to address both similarities and differences among the class.

Ryan et al. (2000) conducted a survey to assess teaching and learning experiences at the baccalaureate and master's level. They found great diversity among schools about what was taught related to culture and transcultural nursing and how the content was taught. Boyle (2007) identified the missing link of cultural content to practice. Boyle stressed the need to evaluate the effect of cultural competence on practice and recommended researching the impact of cultural knowledge on nursing care. Ongoing

evaluation and research is needed to identify innovative teaching practices that impact the cultural competence of nursing students. Educators must use evidence-based teaching practices and evaluate innovative strategies for their impact on the skills and behaviors of nursing students.

Duffy (2001) cited the lack of evidence that teaching cultural competence in nursing increases cultural understanding or sensitivity. Studies examined by Mixer (2008) found that introducing cultural concepts and cultural care of diverse people into a course did not increase students' awareness of cultural competence. Coffman, Shellman, and Bernal (2004) found that "ethnicity, previous course work and educational experiences can increase nurses' self-efficacy in delivering culturally competent care" (p. 185). The nurses concluded that formal transcultural nursing education is required.

Research Related to Cultural Competence of Nursing Faculty

Three dissertation studies that evaluated nursing faculties' cultural competence were those of Sealey (2003), Kardong-Edgren (2004), and Yates (2008). All three studies utilized Campinha-Bacote's theory of cultural competence as a foundational framework. Sealey studied the cultural competence of baccalaureate nursing faculty in Louisiana. Kardong-Edgren evaluated cultural competency of nursing and health education faculty at 4-year baccalaureate colleges, and in 2007, she evaluated the cultural competence of baccalaureate nursing faculty. These studies concluded that the nursing faculty at baccalaureate-level programs were culturally competent, but the authors identified several areas for concern, recommendations, and potential for future research. Yates studied the cultural competence of ADN faculty in Ohio. She concluded those nursing

faculties were culturally competent, but she recommended continuing education programs and additional research related to cultural competence.

Sealey (2003) and Kardong-Edgren (2004) focused on the cultural competency of faculty teaching at the baccalaureate level. However, ADN programs outnumber their baccalaureate counterparts and contribute a higher proportion of graduate nurses (Colalillo, 2007). When comparing both studies of cultural competency—Kardong-Edgren and Sealey—Sealey's provided a more comprehensive analysis of cultural competency specific to nursing education.

Sealey (2003) concluded that a limitation of the study was not being able to generalize the findings beyond nursing faculty of baccalaureate nursing programs. Sealey et al. (2006) cautioned that the mean cultural competency score of 3.73 (on a scale of 0–5) appeared to be less than "would be expected among those charged with the responsibility of preparing nurses to care for clients in an increasingly diverse society" (p. 139). Both studies reported that nursing faculty who had the most cultural encounters (Sealey, 2003) or were from a state with the most immigrants (Kardong-Edgren, 2004, 2007) scored higher on the Cultural Competency scale.

All three studies used a primarily quantitative research design. Kardong-Edgren (2004, 2007) utilized Campinha-Bacote's (1994) Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals–Revised (IAPCC–R) in her studies of nursing and healthcare faculty. Campinha-Bacote developed the IAPCC–R tool to measure the five constructs of her model of cultural care. The IAPCC–R is a quantitative tool that consists of 25 items measuring five constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters (Campinha-Bacote,

2007c). The tool uses a 4-point Likert-type scale with four different responses for each category. According to Kardong-Edgren (2004) and Campinha-Bacote, the tool computes the total score to determine the participant's level of cultural competence; scores between 91 and 100 indicate cultural proficiency; 75 to 90, cultural competence; 51 to 74, cultural awareness; and 25 to 50, cultural incompetence. According to Campinha-Bacote, the reliability of the tool is reported on the transcultural Clinical, Administrative, Research & Education website as having a Cronbach alpha of 0.80 to 0.90. The content and face validity has been established through review by experts in the field of nursing. A limitation of the IAPCC–R is the lack of racial/ethnic demographic information included (Kardong-Edgren, 2004). Another limitation of the tool is that it does not address specific teaching practices. A third limitation is the substantial cost associated with using the tool. Kardong-Edgren (2004) identified potential problems when comparing nurses and health education faculty due to the wording of the questionnaire. Health education faculty found the use of the word *patient* confusing. Kardong-Edgren (2004) acknowledged that a major omission was her failure to collect data on the race and ethnicity of the study participants. Her recommendations for future research included replicating the study with other healthcare professionals, having accreditation agencies use the tool for benchmarking every 5 years, and using the tool as a program evaluation tool.

Kardong-Edgren (2004, 2007) found that the mean cultural competency score for all nursing faculty was 75.72 (culturally competent). When she adjusted the statistics to those from states with the least immigrants, the mean score was 74.28 (culturally aware). The nursing faculty teaching in states with the most immigrants had significantly higher cultural competence scores. However, there was no significant difference with the

cultural competency of healthcare faculty teaching in states with high immigrant populations. Kardong-Edgren (2004) included one open-ended question with her survey, asking participants what had been the most helpful in increasing their comfort level in teaching cultural competence to people. The most frequent response was cultural encounters; this substantiated Sealey's (2003) findings.

Sealey (2003) used the CDQNE, an instrument that was adapted from research by Campinha-Bacote, Goode, Mason, and Ward. The CDQNE is a two-part, 5-point Likert-type scale measurement tool. The first part consists of 55 items measuring Campinha-Bacote's five constructs of cultural competence and a sixth subscale measuring transcultural teaching behaviors. The second part of the questionnaire contains 17 questions to collect specific data regarding demographics, teaching experience, and area of specialization. The questionnaire was initially field tested with nursing faculty not currently teaching in a baccalaureate program. Sealey reported the reliability of each subscale separately. The Cronbach alpha of each subscale is as follows: Teaching Behaviors, 0.79; Cultural Awareness, 0.63; Cultural Knowledge, 0.82; Cultural Skills, 0.69; Cultural Encounters, 0.68; and Cultural Desire, 0.78. Cronbach alpha is a measure of internal consistency, the closer the alpha is to 1.00, the greater the internal consistency (George & Mallery, 2007). Content validity was reviewed by a panel of four experts.

Sealey (2003) and Sealey et al. (2006) examined each of the five constructs (desire, awareness, knowledge, skill, and encounters) separately. Findings demonstrated that cultural knowledge and cultural encounters explained 87% of the variance in cultural competency. Cultural knowledge was the most critical in predicting cultural competence.

Yates (2008) used a revised version of Sealey's (2003) CDQNE tool. Findings of the research demonstrated that nursing faculty teaching in associate-degree programs in Ohio were culturally competent. The overall cultural competency score was 3.88 compared to Sealey's score of overall competency of 3.73. Using Kardong-Edgren's (2004) comparison to states with the most immigrant populations, this difference may be explained by a higher percentage of immigrants in Ohio versus Louisiana. Camarota (2007) listed New York as second, after California, with the percentage of immigrants at 21.6%. Ohio was ranked 19th, with a 3.7% immigrant population, and Louisiana was ranked 34th, with a 2.7% immigrant population. This is significant as it would support Kardong-Edgren's (2004, 2007) findings that states with a higher immigrant population have significantly more culturally competent faculty.

All three studies highlighted the need for continued research regarding cultural competency in nursing education. There is a need for ongoing evaluation of the cultural competency of nursing faculty, to include faculty at the associate-degree level, the impact of continuing education on overall cultural competency scores, assessment of instructional methods, and inclusion of cultural issues in the curriculum. The major limitation of these studies was the use of a self-reporting tool with a focus on quantitative analysis. This research study will use a self-reporting tool to provide a direct comparison with Sealey's (2003) and Yates's (2008) research, offering a deeper perspective and understanding of factors that influence the cultural competency of nursing faculty.

CHAPTER 3. METHODOLOGY

Introduction

The purpose of this chapter is to describe the procedures used to answer the research questions regarding cultural competency of ADN faculty teaching in a diverse urban community. The subjects studied are described and the methodology used in selecting them is explained. Also included in this chapter is a detailed description of the instrument and procedures used for human rights protection, data collection and analysis.

The primary purpose of this study was to examine the level of cultural competence among faculty teaching in ADN programs in the New York metropolitan area. The study identified factors associated with the levels of cultural competence and compared cultural competency levels to that of Sealey's (2003) study of nursing faculty teaching at the baccalaureate level and Yates's (2008) study of nursing faculty teaching at the associate-degree level. Issues related to time, cost, accessibility, and accuracy were examined and identified. Initially, demographic data, a cultural and transcultural teaching behaviors assessment was collected using Sealey's CDQNE–R tool. This research method was chosen so that a direct comparison can be made to previous studies of nursing faculty—Sealey and Yates.

Statement of the Problem

It is not known to what extent nursing faculty teaching at the associate-degree level in a diverse urban area are culturally competent or if they utilize culturally appropriate teaching practices. This nonexperimental, cross-sectional correlation study was designed to explore the attitudes and teaching practices of nursing faculty teaching at the associate-degree level in New York. The study examined the relationship between demographic variables and the overall cultural competency score of nursing faculty. Demographics include age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certifications, ethnic background of students taught, and preparation in transcultural nursing. The examination of demographics was important to this study because characteristics and factors that contributed to higher scores of cultural competency were identified. The CDQNE–R survey is a 41-item tool that employs a 5-point Likert-type scale and 18 demographic questions (Sealey, 2003; Yates, 2008).

Previous studies have evaluated health education faculty (Kardong-Edgren, 2004) and nursing faculty (Kardong-Edgren, 2007; Sealey, 2003) teaching at the baccalaureate level. Yates (2008) examined the cultural competency and teaching behaviors of nursing faculty teaching at the associate-degree level in Ohio. These studies highlighted the need for continued research regarding cultural competency in nursing education. Ongoing evaluation of the cultural competency of nursing faculty is needed to include faculty at the associate-degree level, examine the effect of continuing education on cultural competence, and assess curriculum content and instructional methods. This study was designed to replicate Sealey's study of nursing faculty teaching at the baccalaureate level

and Yates's study of faculty teaching at the associate-degree level. Comparisons were made with both studies regarding factors that affect cultural competence and teaching behaviors.

Research Questions

The following research questions guided this study:

1. How culturally competent are faculty teaching in associate degree nursing programs in the New York City metropolitan area, as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R)?
2. What is the predictive value of faculty characteristics for cultural competence?
3. What is the relationship between cultural competency scores of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level?
4. How is cultural competence related to teaching behaviors?

Research Methodology

This study used a quantitative, cross-sectional survey method. A survey is the preferred method of data collection as it allows a direct comparison to two previous studies—Sealey (2003) and Yates (2008). Sealey reported the cultural competency and teaching practices of nursing faculty teaching at the baccalaureate level in Louisiana. Yates examined the cultural competency and teaching practices of nursing faculty teaching at the associate-degree level in Ohio. Data collection used the CDQNE–R tool, a

self-reporting questionnaire. The data were collected from nursing faculty teaching at both private and public ADN programs in the New York metropolitan area. Contact information was obtained from the listing of ADN programs on the NYSED website (NYSED OEP, 2007). SurveyMonkey was utilized to contact nursing faculty in the New York area via e-mail. Data were collected during the Fall 2010 semester.

Population and Sampling Procedure

The population consists of a convenience sample of nursing faculty who teach at the associate-degree level in the New York metropolitan area. The New York metropolitan area includes Manhattan, Queens, the Bronx, Brooklyn, and Staten Island. Limiting the study population to nursing faculty at the associate-degree level in a diverse urban setting affects the timeliness and cost. Targeting faculty who teach at the associate-degree level provided electronic access via the NYSED website. A list of the 60 nursing programs offering an associate degree in nursing was obtained from the NYSED OEP (2007); of these, 15 programs were identified within the tri-state area. The total sample consisted of 365; of this, 128 are full-time and 237 are adjunct (part-time) faculty. Accessibility is a factor when including adjunct faculty. In nursing, most adjunct faculty teaches in the clinical area and spend minimum time at the college, but all have access to a college e-mail account. Another potential issue is that some nursing faculties hold multiple positions, both full and part-time in more than one of the participating schools. To avoid duplication the opening page of the survey asks the participant not to complete the survey more than once, and if they hold multiple positions in more than one of the participating schools they are asked to complete the survey for the school in which they

are employed full-time. Permission was obtained from the study university's Institutional Review Board (IRB) to survey faculty in the study university's schools. A total of five private schools gave permission to survey the faculty; one of the schools did not provide written permission and, therefore, was not included in the research study. The sample consisted of a total of 138 completed surveys from the initial 365 surveys sent out. Demographics were collected and compared to characteristics of nursing faculty at the national level. Differences were identified that may potentially create a sample error or bias.

Instrumentation

Sealey (2003) utilized Campinha-Bacote's theory of cultural competence as the underlying framework for the CDQNE, organized using the five concepts defined by Campinha-Bacote. The CDQNE has two parts: The first consists of a 5-point Likert-type scale of 55 items measuring cultural competence; the second contains 17 questions related to demographic characteristics and teaching experience. The 55 items in the first part measure Campinha-Bacote's five constructs of cultural competence: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. A sixth subscale measures transcultural teaching behaviors. The second part of the questionnaire contains 17 questions to collect specific data regarding demographics, teaching experience, and area of specialization. The questionnaire was initially field tested with nursing faculty not currently teaching in a baccalaureate program. Sealey reported the reliability of each subscale separately. The Cronbach alpha of each subscale is as follows: Teaching Behaviors, 0.79; Cultural Awareness, 0.63; Cultural Knowledge, 0.82; Cultural

Skills, 0.69; Cultural Encounters, 0.68; and Cultural Desire, 0.78. Cronbach alpha is a measure of internal consistency, the closer the alpha is to 1.00, the greater the internal consistency (George & Mallery, 2007). Content validity was reviewed by a panel of four experts (Sealey, 2003).

Yates (2008) adapted the CDQNE tool based on Sealey's (2003) factor analysis. "The fourteen items with low factor loading scores that did not meet the criteria set for retention at < 3 were deleted" (Yates, 2008, p. 91). Negatively stated items were changed to read as positive statements. The first section of the CDQNE–R contains 41 items related to cultural confidence and 11 items related to transcultural teaching behaviors. Participants are asked to indicate if they *strongly agree*, *agree*, are *undecided*, *disagree*, or *strongly disagree* for each item (Yates, 2008). A numerical value is assigned to each response, ranging from 5 for *strongly agree* to 1 for *strongly disagree*. The completion time is 10–12 minutes and scores range from 1–5. With the revised CDQNE, Yates found that Cronbach alpha coefficient was higher for the overall Cultural Competence scale and for four of the six subscales. The Cronbach alpha coefficient for each of the subscales was as follows: Teaching Behaviors, 0.84; Cultural Awareness, 0.77; Cultural Knowledge, 0.85; Cultural Skills, 0.77; Cultural Encounters, 0.66; and Cultural Desire, 0.74. Revisions resulted in higher internal consistencies for the first four subscales when compared to Sealey's earlier study. The last section of the CDQNE–R contained nine demographic and professional characteristics questions.

For this study, the CDQNE–R contained the 41 items related to cultural confidence and 11 items related to transcultural teaching behaviors. However, the study contained 16 of the original demographic and professional characteristics questions rather

than the nine questions as adapted by Yates. The tool contains a question regarding continuing education related to transcultural care within the last 5 years, as Sealey (2003) found this significant. Two additional demographic questions were included identifying the region in which the participants received their nursing education and lived the longest. Five additional questions related to the level of cultural content in participant's academic preparation and the level of cultural content in the program that they presently teach (see Appendix A for a copy of the research instrument, the CDQNE–R).

Data Collection Procedures

The data were collected between September and October 2010 electronically via the Internet. There were five preliminary steps prior to data collection. First, a database of participating schools was developed. Contact information was obtained from the listing of ADN programs on the NYSED OEP (2007) website. The second procedure was to upload the questions to SurveyMonkey. Third, the chair/director/dean of the school were contacted via e-mail. This e-mail was followed up with a phone call, requesting permission to utilize their school as a research site and noting the number of full-time, part-time, male and female faculty teaching at the associate-degree level. The fourth step was to send the survey to three nursing faculty teaching at the baccalaureate level who had previously taught at the associate-degree level. Prior to the fifth step, the initial database was checked and updated to accommodate changes in positions. Once permission was obtained and IRB approval received, each chair/dean/director was sent an e-mail asking them to distribute the survey to their staff. Each recipient received an invitation via e-mail with a link providing access to an introductory letter, the

questionnaire, and instructions for submitting the online survey. Participants were informed that the average completion time of the survey is 10 minutes. Once confirmation that the initial invitational e-mail was sent; two reminders to complete the survey were sent.

Cost was a major feasibility issue for conducting electronic research surveys; the use of SurveyMonkey provided a convenient, inexpensive method of contacting faculty. The method was more timely and cost effective than mailing the survey, and also allowed the researcher to send automatic reminders for completion. However, two of the limitations were that it is a web-based questionnaire requiring access to the Internet and the time interval needed to complete.

Assumptions included the following:

- NYSED has a current listing of accredited nursing programs.
- Individual programs provided a current listing of faculty teaching in the proposed area.
- Both full- and part-time faculty have access to a college e-mail address.
- Faculty who participated answered the questions accurately.

Data Analysis Procedures

Data were analyzed using SPSS version 17. Descriptive statistics were collected regarding demographics, professional characteristics, and cultural teaching practices of all participants. Once the data from the CDQNE–R and demographic data were collected, statistical analysis was conducted. An exploratory descriptive (frequency and percentage) analysis of the demographic data was completed. Statistics included percentages, range,

mean, and standard deviation. Demographic comparisons were analyzed with those of the New York state nursing statistics and the general nursing population. Discrepancies may indicate a weakness in the study or the need to expand the population sample.

Differences between cultural competence scores of full-time and part-time faculty were determined by a *t* test for independent sample. In this study, subscales of each construct (Cultural Awareness, Knowledge, Skills, Encounters, and Desire) were created. Appendix B lists the category of each subscale for each of the questions on the CDQNE–R. Each subscale was checked for reliability using Cronbach alpha coefficient and results were compared with the questionnaire developers' reports. A multiple regression analysis of each Cultural Competence subscale related to demographics, professional characteristics, and cultural teaching practices was performed. The five dependent variables were age, ethnic background, specialty area, certification, and continuing education in Transcultural nursing within the past 5 years. George and Mallery (2007) stated that "in multiple regression analysis, any number of variables may be used as predictors" (p. 193). Regression analysis computes which variable is the most predictive of the dependent variable. Finally, a multiple regression analysis was conducted to determine the relationship between each subscale of the CDQNE–R and overall cultural competence. Results were compared to those of Sealey's study.

Results were compared with those of Kardong-Edgren's 2004 study of health education faculty's cultural competence and her 2007 study of nursing faculty's cultural competence. Results were examined related to New York's status as one of the five states with the highest immigrant population (Camarota, 2007). A more in-depth comparison was made with Sealey's (2003) study of nursing faculty teaching at the baccalaureate

level, identifying demographic characteristics that impacted the overall cultural competency scores. A comparison with both Sealey's (2003) and Yates's (2008) studies provides a deeper insight as to the relationship between subscales on the CDQNE–R and the overall score of cultural competency as these differ across samples.

Ethical Considerations

Prior to implementation of this study, the IRB of both Capella University and the study university approved the protocol for data collection for this study. Aggregate data were reported.

The study presented minimal risk to participating subjects. All participants were informed of the nature and purpose of the study, maintenance of study results, Capella University's IRB approval and contact information, and the researcher's contact information. The participating schools within the study university were provided with additional information regarding the university-wide IRB approval and the contact information for the university-wide IRB administrator.

Data are stored electronically in a secure manner. The invitational e-mail contained all the elements of informed consent, except for the signature. Returned surveys implied consent of the participants to participate in the study. The e-mail contained information regarding how confidentiality and anonymity will be maintained, the purpose of the study, and how the results will be used. Participants were informed that consent will be obtained by accessing the link provided.

Summary

In summary, 138 nursing faculty teaching at the associate-degree level participated in this study, completing a surveyed the CDQNE–R and a demographic survey. Respondents also answered an open-ended question.

CHAPTER 4. RESULTS

This chapter presents the results of the research study describing the cultural competence levels of associate-degree nurse educators teaching in the New York metropolitan area. The degree to which they include cultural content in the courses they teach as measured by the scales of the CDQNE–R is described. Descriptive and reliability statistics are presented followed by the scores obtained on the CDQNE–R survey and its six subscales. The sample for this study consisted of 365 nursing faculty teaching at both private and public ADN programs in the New York metropolitan area. Data were collected electronically during fall, 2010 semester. This chapter reviews the participant responses and provides a detailed description of the study findings.

Demographic Characteristics

Table 1 displays the frequency counts for selected demographic characteristics of the respondents. The CDQNE–R was sent to 365 nursing faculty teaching at the associate-degree level. There were 144 surveys returned, for a 35% overall response rate with a total of 138 completed surveys. As expected, most (n = 131, 94.9%) of the respondents were women. Their ages ranged from 26 to 75 (Mdn = 50.5 years). The largest number of respondents were between the ages of 46 and 55 (n = 63, 45.7%). The age group with the smallest number of respondents was 66 and over (n = 8, 5.8%). The

age group with the second smallest number of respondents was 35 and younger (n = 10, 7.2%). The study sample was predominantly White (n = 89, 64.6%). African Americans (non-Hispanics) comprised the second largest ethnic group (n = 25, 18.1%). Almost a quarter of respondents (23.9%) listed the country of origin as other than the United States. English was identified as the only language spoken by the majority of respondents (n = 85, 61.6%).

Table 1. Selected Demographic Characteristics of Study Participants (N = 138)

Characteristic	*n*	%
Age[a]		
26–35	10	7.2
36–45	18	13.0
46–55	63	45.7
56–65	39	28.3
66–75	8	5.8
Sex		
Male	7	5.1
Female	131	94.9
Race/ethnicity		
African American (non-Hispanic)	25	18.1
American Indian/Alaskan Native	1	0.7
Asian American	4	2.9
Hispanic	2	1.4
White (non-Hispanic)	89	64.6
Other	17	12.3
Country of origin		
United States	105	76.1
Other	33	23.9
English only		
Yes	85	61.6
No	53	38.4

[a]Age: *Mdn* = 50.5 years.

Professional Characteristics

Table 2 describes the frequency counts for selected professional characteristics of the respondents. The majority of the respondents were full-time faculty (n =105, 76.1%), with a total of 33 respondents who were part-time/adjunct. The amount of experience teaching nursing reported by the respondents ranged from 1 month to 47 years (M = 10.28, SD = 10.18). More than half of the respondents reported having less than 11 years' experience in nursing education and 31.2% (n = 43) reported teaching nursing for less than 5 years. For academic rank, the most common categories were assistant professor (n = 50, 36.2%) and instructor (n = 49, 35.5%). The majority of respondents reported having a master's degree as their highest degree earned (n = 122, 88.4%) and 14 (10.4%) reported having a doctoral degree. More than half of the respondents (59.4%) reported they had attended or completed a continuing education program in transcultural nursing within the past 5 years. Many respondents reported having more than one specialty area; however, adult health (n = 73, 52.9%), community nursing (n = 25, 18.1%) and child health (n = 24, 17.4%) were the most frequently listed specialty areas. Close to half of the participants were certified in at least one specialty areas. Only five respondents (3.6%) listed transcultural nursing as a specialty area, and only one respondent reported being certified in that area.

Table 2. Selected Professional Characteristics of Study Participants (N = 138)

Characteristic	*n*	%
Full-time		
Yes	105	76.1
No	33	23.9
Years in nursing education[a]		
< 5	43	31.2
6–10	51	36.9
11–15	16	11.6
16–24	14	10.1
25–33	7	5.1
34–47	7	5.1
Academic rank		
Full professor	9	6.5
Associate professor	30	21.7
Assistant professor	50	36.2
Instructor	49	35.5
Highest degree earned		
Bachelor's	2	1.4
Master's	122	88.4
Doctorate	14	10.4
Continuing education		
Yes	82	59.4
No	56	40.6
Nursing specialty area*		
Adult health	73	52.9
Community health	25	18.1
Child health and illness	24	17.4
Childbearing	14	10.1
Psychiatric nursing	19	13.8
Women's health	17	12.3
Nursing administration	22	15.9
Transcultural nursing	5	3.6
Gerontology	20	14.5
Hold certifications		
Yes	70	50.7
No	68	49.3

[a]Experience: M = 10.28, SD = 10.18.
*Multiple responses given.

Reliability Statistics

Table 3 presents the psychometric characteristics for the six summated subscales. For this study, subscales of each construct (Cultural Awareness, Knowledge, Skills, Encounters, and Desire) and for transcultural teaching behaviors were analyzed. Appendix B lists the category of each subscale for the questions on the CDQNE–R.

The total cultural competency score was created based on the aggregate of the five construct subscales. Each subscale and the overall cultural competency score were checked for reliability using Cronbach alpha coefficient to determine internal consistency. Creswell (2008) stated that "if the items are scored as continuous variables, the alpha provides a coefficient to estimate consistency of scores on an instrument" (p. 17).

Table 3. Psychometric Characteristics for Summated Scale Scores ($N = 138$)

Construct	No. items	*M*	*SD*	Low	High	A
Cultural Awareness	8	4.29	0.45	2.88	5.00	.74
Cultural Skills	8	4.07	0.51	2.63	5.00	.82
Cultural Knowledge	11	4.03	0.51	2.18	5.00	.86
Cultural Encounters	6	3.86	0.59	1.67	5.00	.64
Cultural Desire	8	4.15	0.49	2.13	5.00	.79
Total Cultural Competency score[a]	5	4.08	0.42	2.39	5.00	.88
Transcultural Teaching Behaviors	10	4.20	0.47	2.60	5.00	.84

[a]Total cultural competence was created based on the aggregate of the five subscale scores.

The Cronbach alpha reliability coefficients ranged from $\alpha = .64$ to $\alpha = .88$, with the median sized alpha being $\alpha = .82$. This suggested that all scales had adequate levels of internal reliability (Creswell, 2008).

Cultural Competence Levels

The first research question asked, "How culturally competent are faculty teaching in associate degree nursing programs in the New York City metropolitan area, as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R)?" To answer this question, participants' completed the CDQNE–R which measured the five subscales of Campinha-Bacote's (2007b) model of cultural competence and a sixth subscale of transcultural teaching behaviors. An index was created for each subscale by computing the mean of the respondents' scores on the combined items of each subscale (Table 3). Using Benner's (1984) theory of novice to expert and those scores established by Sealey (2003), the following categories were created to interpret the responses: Cultural Novice (1–1.5), Culturally Advanced Beginner (1.6–2.5), Culturally Competent (2.6–3.5), Culturally Proficient (3.6–4.5), and Cultural Expert (4.6–5).

Table 4 displays the frequency counts for the six CDQNE–R subscale scores and the total cultural competence index. The highest score was for the Cultural Awareness subscale; 95% ($n = 132$) of respondents agreed that they were either culturally proficient or cultural experts in this scale. Cultural awareness is an examination of one's own cultural background, beliefs, and values and is recognized as one of the first steps on the journey toward cultural competence. The majority of the respondents ($n = 125$, 90.6%)

agreed that they were culturally proficient or cultural experts in the Cultural Desire (M = 4.16, SD = 0.48) subscale. Campinha-Bacote (1999) described cultural desire as the impetus for the other four constructs of awareness, knowledge, skill, and encounters. The Cultural Skill subscale (M = 4.07, SD = 0.51) indicated that the 85.5% (n = 118) of respondents agreed that they are either culturally proficient or cultural experts.

Table 4. Frequency Counts for the CDQNE–R Scores Based Categories (N = 138)

Variable	Category	*n*	%
Cultural Awareness	Culturally Competent	6	4.4
	Culturally Proficient	83	60.1
	Cultural Expert	49	35.5
Cultural Skills	Culturally Competent	20	14.5
	Culturally Proficient	90	65.2
	Cultural Expert	28	20.3
Cultural Knowledge	Culturally Advanced Beginner	2	1.4
	Culturally Competent	21	15.2
	Culturally Proficient	96	69.6
	Cultural Expert	19	13.8
Cultural Encounters	Culturally Advanced Beginner	3	2.2
	Culturally Competent	34	24.6
	Culturally Proficient	86	62.3
	Cultural Expert	15	10.9
Cultural Desire	Culturally Advanced Beginner	1	0.7
	Culturally Competent	12	8.7
	Culturally Proficient	93	67.4
	Cultural Expert	32	23.2
Total Cultural Competence [a]	Culturally Advanced Beginner	1	0.7
	Culturally Competent	12	8.7
	Culturally Proficient	105	76.1
	Cultural Expert	20	14.5
Transcultural Teaching Behavior	Culturally competent	9	6.5
	Culturally Proficient	93	67.4
	Cultural Expert	36	26.1

[a]Total cultural competence was created based on the aggregate of the five subscale scores.

Cultural skill is the ability to apply both awareness and knowledge to practice, specifically when conducting a cultural assessment (Campinha-Bacote, 1999). Most of the respondents (n = 115, 83.4%) reported that they were culturally proficient or cultural experts in the Cultural Knowledge (M = 4.03, SD = 0.51) subscale. Cultural knowledge is pivotal to identifying biological variations among cultural, racial, and ethnic groups. Respondents scored the lowest on the Cultural Encounters subscale (M = 3.86, SD = .59) with 73.2% (n = 101) at the culturally proficient or cultural expert level. Cultural encounters can be described as *face-to-face* or *non-face-to-face* interactions with people from different cultures. The majority of respondents reported they were culturally proficient (n = 105, 76%) or cultural experts (n = 20, 14.5%) in the total cultural competence subscales (M = 4.08, SD = 0.42). The Transcultural Teaching Behaviors subscale indicated that 93.5% (n = 129) of respondents agreed that they were culturally proficient or cultural experts.

Research Question 2 asked, "What is the predictive value of faculty characteristics for cultural competence?" As an initial analysis, Table 5 displays the Pearson product–moment correlations for the total Cultural Competency scores, transcultural teaching, and selected demographic and professional characteristics. Pearson product–moment correlation summarizes the relationship between two continuous variables.

Table 5. Correlations for Transcultural Teaching Behaviors and Total Cultural Competency Score With Selected Variables ($N = 138$)

Variable	TTB	TCCS
Dataset	.11	.14
Work full-time	.13	.15
Academic rank	–.10	–.06
Teaching in years	.12	.05
Age range	.12	.05
Born in the U.S.[a]	.08	–.17*
African American[a]	.10	. 17 *
White American[a]	–.11	–.25**
English only[a]	–.07	–.15
Spanish[a]	.11	.11
Adult health specialty[b]	.04	.06
Community health specialty[b]	.10	.11
Child health and illness specialty[b]	.11	.11
Childbearing specialty[b]	.03	.05
Psychiatric nursing specialty[b]	.03	–.01
Women's health specialty[b]	.04	.09
Nursing administration specialty[b]	.11	.11
Gerontology specialty[b]	.01	.02
Certifications[b]	.16	.14
Transcultural continuing education[b]	–.04	–.10

Note. TTB = transcultural teaching behavior, TCCS = total cultural competency score.
[a]Coding: 0 = *No*, 1 = *Yes*. [b]Multiple responses given.
*$p < .05$. **$p < .005$.

A positive correlation indicates that as the value of the independent variable increases the value of the dependent variable tends to increase (George & Mallery, 2007). The significance of $p < .05$ means that there is less than a 5% probability that the relationship is caused by chance alone. Due to the explanatory nature of this study, alpha findings significant at $p < .05$ will be noted to suggest possible avenues for future research.

Transcultural teaching behavior was not significantly related to any of the 20 variables. The total cultural competency score was significantly related to three of 20 variables (born outside of the United States, African American, and non-White). Specifically, higher total cultural competency score was significantly associated with faculty members born outside the United States ($r = –.17$, $p < .05$), African American faculty members ($r = .17$, $p < .05$), and non-White faculty members ($r = –.25$, $p < .005$; see Table 5).

As further analyses, two stepwise regression models were created using the 20 variables listed in Table 5 for transcultural teaching behavior and total cultural competency score. Based on the inclusion criteria of $p < .05$, no independent variables were included in the model predicting transcultural teaching behavior. Table 6 displays the results of the stepwise regression model used to predict total cultural competence based on selected candidate variables found significant at $p < .05$. The final two-variable model was significant ($p = .002$) and accounted for 9.0% of the variance in the dependent variable. Inspection of the table found total cultural competence to be higher for non-Whites ($\beta = –.26$, $p = .002$) and for full-time instructors ($\beta = .17$, $p = .04$).

Table 6. Prediction of Total Cultural Competence Based on Selected Variables—Stepwise Regression ($N = 138$)

Variable	*B*	*SE*	B	*P*
Intercept	4.10	0.08		.001
White[a]	–0.23	0.07	–.26	.002
Full-time instructor[a]	0.17	0.08	.17	.04

Note. Final model: $F(2, 135) = 6.65$, $p = .002$. $r^2 = .090$.
Candidate variables = 20.
[a]Coding: 0 = *No*, 1 = *Yes*.

Research Question 3 asked, "What is the relationship between cultural competency scores of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level?" To answer this question, Tables 7–9 display the results of the independent *t*-test comparisons for selected studies of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level. The *t* test evaluated the means of two groups to assess if there was a statistically significant difference (Trochim & Donnelly, 2008). The lower the *p* value the more likely that the relationship is significant. Given the multitude of analyses that are done a concern exists about the potential for a Type I error. Therefore, to minimize this risk findings significant at the $p < .001$ will be noted.

Table 7 displays the *t*-test comparisons between the current sample and the Yates (2008) sample, both associate degree nursing programs, for the seven cultural subscales. Transcultural Teaching Behaviors subscale was higher for the current sample at $p < .05$.

The current sample had significantly higher scores on four (Cultural Skill, Knowledge, Encounters, and Overall Cultural Competence) of the seven scales at $p < .001$.

Table 7. Comparison of the Current Study With Yates (2008) for Cultural Competence Variables—*t* Tests for Independent Means

	Current sample $N = 138$		Yates (2008) $N = 137$		
Subscale	*M*	*SD*	*M*	*SD*	*t*
Cultural Awareness	4.29	0.45	4.36	0.45	1.29
Cultural Skills	4.07	0.51	3.79	0.54	4.42**
Cultural Knowledge	4.03	0.51	3.75	0.57	4.29**
Cultural Encounters	3.86	0.59	3.34	0.70	6.63**
Cultural Desire	4.16	0.48	4.10	0.48	1.04
Transcultural Teaching Behaviors	4.19	0.47	4.06	0.51	2.20*
Total Cultural Competence score	4.08	0.42	3.88	0.45	3.81**

*$p < .05$. **$p < .001$.

Table 8 presents the cultural competency scores of nursing faculty teaching at the associate-degree level in the New York metropolitan area and the Sealey (2003) study of nursing faculty teaching at the baccalaureate level in Louisiana. The current sample had significantly higher scores for all seven comparisons. Cultural Awareness was significant at $p < .05$ and the other six subscales were significant at $p < .001$.

Table 8. Comparison of the Current Study With Sealy (2003) for Cultural Competence Variables—*t* Tests for Independent Means

Subscale	Current sample *N* = 138		Sealey (2003) *N* = 172		
	M	*SD*	*M*	*SD*	*t*
Cultural Awareness	4.29	0.45	4.14	0.36	3.26*
Cultural Skills	4.07	0.51	3.65	0.50	7.29**
Cultural Knowledge	4.03	0.51	3.65	0.50	6.59**
Cultural Encounters	3.86	0.59	3.56	0.62	4.33**
Cultural Desire	4.16	0.48	3.67	0.42	9.58**
Transcultural Teaching Behaviors	4.19	0.47	3.97	0.39	4.50**
Total Cultural Competence score	4.08	0.42	3.73	0.38	7.69**

*$p < .005$. **$p < .001$.

Table 9 presents the cultural competency scores of nursing faculty teaching at the associate-degree level in Ohio (Yates, 2008) and the Sealey (2003) study of nursing faculty teaching at the baccalaureate level in Louisiana. Respondents in the Yates study had significantly higher scores for four (Cultural Awareness, Skills, Desire and Total Cultural Competence Score) of seven comparisons. However, the Sealy respondents were significantly higher in the Cultural Encounters subscale ($p < .005$).

Table 9. Comparison of Yates (2008) and Sealy (2003) for Cultural Competence Variables—*t* Tests for Independent Means

Subscale	Yates (2008) *N* = 137		Sealey (2003) *N* = 172		
	M	*SD*	*M*	*SD*	*t*
Cultural Awareness	4.36	0.45	4.14	0.36	4.77***
Cultural Skills	3.79	0.54	3.65	0.50	2.36*
Cultural Knowledge	3.75	0.57	3.65	0.50	1.64
Cultural Encounters	3.34	0.70	3.56	0.62	2.93**
Cultural Desire	4.10	0.48	3.67	0.42	8.39***
Transcultural Teaching Behaviors	4.06	0.51	3.97	0.39	1.76
Total Cultural Competence score	3.88	0.45	3.73	0.38	3.18**

*$p < .05$. **$p < .005$. ***$p < .001$.

Research Question 4 asked, "How is cultural competence related to teaching behaviors?" This question was answered using Pearson product–moment correlations (see Table 10). The determination of an adequate sample size for the regression models was calculated using a formula recommended by Tabachnick and Fidell (2001). They recommended the sample size be calculated based on the following formula: Sample size = 104 + *m*, where *m* equals the number of independent variables. Using this formula, the sample size of 138 was deemed adequate. Table 10 presents a correlation matrix, with each variable listed in the first column and across the first row. The correlation between each variable and itself is 1; the closer the measurement is to 1, the higher the correlation (Trochim & Donnelly, 2008). Transcultural teaching behavior had significant positive

correlations with all six measures of cultural competence, with the highest subscale being Cultural Desire (.88, $p = .001$ $r^2 = .77$) explaining 77% of the variance and the lowest Cultural Encounters (.55, $p = .001$, $r^2 = .30$) explaining 30% of the variance.

Table 10. Intercorrelations Among the Summated Scale Scores ($N = 138$)

Scale	1	2	3	4	5	6	7
1. Cultural Awareness	1.00						
2. Cultural Skills	.53	1.00					
3. Cultural Knowledge	.57	.78	1.00				
4. Cultural Encounters	.49	.50	.59	1.00			
5. Cultural Desire	.74	.65	.66	.62	1.00		
6. Total Cultural Competence	.79	.83	.87	.79	.88	1.00	
7. Transcultural Teaching Behaviors	.77	.72	.71	.55	.88	.87	1.00

Note. All correlations were statistically significant at the $p < .001$.

Summary

In summary, a convenience sample of 365 nursing faculty teaching at the associate-degree level in the New York metropolitan area were surveyed using the CDQNE–R and a demographic survey. This study revealed that the majority of the 138 respondents perceived themselves as being culturally proficient or cultural experts in all of the five subscales of the CDQNE–R and agreed that they include transcultural teaching behaviors in the courses they teach. Transcultural teaching behaviors had significant positive correlations with all five subscales of the total cultural competency score.

In the next chapter, the findings of this study are discussed according to the subscales of the CDQNE–R: Cultural Awareness, Cultural Skills, Cultural Knowledge, Cultural Encounters, Cultural Desire, and Cultural Teaching Behaviors.

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to examine the level of cultural competence among nursing faculty teaching at the associate-degree level in the New York metropolitan area. The CDQNE–R was the instrument used to provide descriptions of cultural competence levels and transcultural teaching behaviors. The questionnaire was sent to 365 associate-degree nurse educators, teaching in a variety of settings. Campinha-Bacote's (2007b) model of cultural competence in the delivery of healthcare services provided the framework for this study. The five concepts that form the building blocks of the model are cultural awareness, skill, knowledge, encounters, and desire. This study explored the relationship between cultural competence, faculty demographics, and teaching behaviors. Factors that contributed to cultural proficiency and transcultural teaching behaviors were examined.

This chapter contains four sections. The first section provides a discussion of the findings from this study using data from the CDQNE–R, its subscales and comparisons with previous studies. The second section provides a discussion on the limitations of the study. The third section discusses implication for nursing education. The final section provides recommendations for future research.

This study sought to examine the cultural awareness, skills, knowledge, encounters, desire and teaching behaviors of associate-degree nurse educators. The following research questions guided this study:

1. How culturally competent are faculty teaching in associate degree nursing programs in the New York City metropolitan area, as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R)?
2. What is the predictive value of faculty characteristics for cultural competence?
3. What is the relationship between cultural competency scores of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level?
4. How is cultural competence related to teaching behaviors?

Discussion of Findings

The questionnaire was sent to associate-degree nurse educators in the New York metropolitan area, teaching in a variety of settings. The total sample consisted of 365; of this, 128 are full-time and 237 are adjunct (part-time) faculty. Three hundred and sixty-five surveys were distributed, with a return rate of 138 completed surveys for a 37.8% response rate. Total full-time respondents consisted of 82% (n = 105) response rate of the 128 full-time participants. However, only 15.1% (n = 36) of the 237 adjunct (part-time) faculty responded. Three of the adjunct (part-time) faculty responded that they had completed the survey at another participating school. The low return rate for the adjunct (part-time) faculty may be explained by the fact that many hold multiple positions in

more than one of the participating schools. Participants were asked to complete the survey for their full-time position. Of the study university's nursing schools offering an associate degree nursing program, all participated in this study. Five of the six private schools participated in this study. The Director of the private school that did not participate did not respond to e-mails or telephone calls requesting permission to survey the nursing faculty.

Demographic and professional characteristics were compared with those of the NLN 2009 survey of nursing faculty and previously reported samples from previous studies. There were three characteristics that differed from the NLN survey and previous studies by Sealey (2003); these were race/ethnicity, country of origin, and highest degree earned. Two characteristics differed from the Yates (2008) study; these were race/ethnicity and country of origin. Age of the study participants was reflective of the general nursing faculty with the majority (n = 102, 74%) of study participants in the 46–65 age group. This is consistent with the NLN survey of full-time nursing faculty with the highest (63%) percentage of nurse educators in the 46–60 age group, and the least (0.7%) under age 30. Gender demographics of this study (male = 7, 5.1%; female = 131, 94.9%) were also reflective of the NLN report of nursing faculty in the United States with male faculty comprising 5% and female 95%. Although White Americans comprised the majority of respondents (64.6%, n = 89) the percentage of African Americans (non-Hispanic) at 18.1% (n = 25) was higher than the 6.6% reported by Yates (2008) and the 11% reported by Sealey. Another difference was in the number (n = 33, 23.9%) of foreign-born nursing faculty in the current study compared to 4.9% reported by Sealey.

The study participants reported the highest degree earned as a master's (n = 122, 88.4%) and doctorate (n = 14, 10.4%). This is in contrast to the NLN (2009) survey with 67% of full-time nurse educators reported having their Masters' and 25% having their doctorate as the highest earned degree. It is interesting to note that Sealy's (2003) study of baccalaureate nursing faculty is more reflective of the NLN statistics with 68.1% reporting master's and 28.2% reporting their doctorate as the highest earned degree. Yates's (2008) study of associate degree nursing faculty is similar to the current study with 88.3% reporting master's as the highest degree earned. This incongruity may be explained by the fact that it is not a requirement for associate degree nursing faculty to have a doctoral degree to teach. Only 3.6% (n =5) respondents reported transcultural nursing as a specialty area and none of these reported being certified in this area. This reflects Sealey's finding that 3% (n = 5) of subjects reported transcultural nursing as a specialty area, none of whom held certification in this field.

Research Question 1

The first research question asked, "How culturally competent are faculty teaching in associate degree nursing programs in the New York City metropolitan area, as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators–Revised (CDQNE–R)?"

TCCS is a composite of five subscales of the CDQNE–R measuring Campinha-Bacote's components of cultural competence (Cultural Awareness, Cultural Skill, Cultural Knowledge, Cultural Encounters and Cultural Desire). Using Benner's (1984) theory of novice to expert and those established by Sealey (2003), the following categories were created to interpret the responses: Cultural Novice (1–1.5), Culturally

Advanced Beginner (1.6–2.5), Culturally Competent (2.6–3.5), Culturally Proficient (3.6–4.5), and Cultural Expert (4.6–5). The mean of the TCCS was 4.08 (*SD* = 0.42) indicating that the majority of participants agreed that they were Culturally Proficient. This study examined separately each of the five subscales (desire, awareness, knowledge, skill, and encounters) that comprise the TCCS.

Cultural awareness. Cultural awareness is recognized as one of the first steps on the journey toward cultural competence. The eight questions on the cultural awareness subscale address "the recognition of one' own biases, prejudices, and assumptions regarding individuals who are different from oneself" (Yates, 2008, p. 103). The highest index of the five subscales was on the cultural awareness subscale (*M* = 4.29, *SD* = .45). This reflects previous studies where the cultural awareness subscale was reported as having the highest index (Sealey, 2003; Yates, 2008). More than half of the respondents (*n* = 83, 60.1%) agreed that they were culturally proficient in this subscale. Thirty-five percent (*n* = 49) of respondents were categorized as cultural experts. Nursing faculty need to be aware of their culture, their deficits and competencies as a first step in providing culturally competent care (Leininger & McFarland, 2002). This study demonstrates that nursing faculty have achieved the level of cultural awareness to progress on their journey toward cultural competence.

Cultural skills. Participants scored at the culturally proficient (*M* = 4.07, *SD* = .51) level for the subscale cultural skills. Overall, 20.3% (*n* = 28) of respondents agree that they were cultural experts, 65.2% (*n* = 90) culturally proficient and 14.5% (*n* = 20) culturally competent on the cultural skills subscale. Of the eight items in the subscale related to cultural skills a small percentage of respondents (*n* = 6, 4.4%) were undecided

regarding Question 18, “I am confident that I possess the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency.” These findings were in contrast to both Sealey (2003) and Yates (2008). This disparity may be explained by more recent adoption of standards for CLAS throughout the healthcare system (American Institutes for Research, 2002). In the New York area, there is an emphasis on the appropriate use of translators when caring for clients who have limited English proficiency. However, 31.2% (n = 42) of the respondents rated Question 12, “I am knowledgeable of keywords and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program” as *undecided* or *disagree*. These findings reflect those of Jones, Bond, and Mancini (1998), who reported that nurses working with Mexican patients identified either “communicating effectively” (p. 285) or “the language barrier” (p. 285) as major barriers to care. The importance of using a client’s language of preference and the use of appropriately trained translators to avoid errors and misunderstandings is an essential skill. Integration of the CLAS standards throughout nursing programs is one way to break through the language barrier.

Cultural knowledge. The cultural knowledge subscale includes 11 questions related to biological variations, differences in drug metabolism, disease variations, health beliefs and practices. Participants scored at the culturally proficient (M = 4.03, SD = .51) level on the cultural knowledge subscale. Two respondents (1.4%) agreed that they were culturally advanced beginners and 15.2% (n = 21) were culturally proficient in this subscale. Less than half of the respondents (n = 60, 43%) chose *undecided*, *disagree*, or *strongly disagree* when answering Question 60, “I am knowledgeable about variations in

drug metabolism among specific cultural groups." Biological differences are identified by Giger and Davidhizer (2001) as an important component of cultural assessment. Nursing faculty must be aware of cultural variations when teaching physical assessment and drug metabolism. Cultural knowledge is essential to identifying biological variations among cultural, racial, and ethnic groups.

Cultural encounters. The cultural encounters subscale addresses meeting with people of different cultures. Similar to previous studies (Sealey, 2003; Yates, 2008) the cultural encounters subscale was the lowest of the five indexes ($M = 3.86$, $SD = 0.59$). Overall, the majority of respondents reported that they were culturally proficient ($n = 86$, 62.3%). Two of the questions (20 and 23) in this subscale were scored in the lower (*undecided*, *disagree*, or *strongly disagree*) range: Question 20, "I attend holiday celebrations within culturally, racially and ethnically diverse communities," 46% scored in the lower range ($n = 64$); Question 23, "I have spent extended periods of time (i.e., at least 7 consecutive days) living among people from cultural/racial/ethnic groups different from my own," more than half of the respondents scored in the lower range ($n = 73$, 53%). However, perhaps the six questions that comprise the cultural encounter subscale do not adequately reflect the extent of interactions with people from different cultures. This is a potential flaw in the CDQNE–R that could be corrected with the addition of questions related to interactions with both patients and students from diverse cultures. New York is listed as one of the states with the highest immigrant population (Camarota, 2007), which would presumably influence the cultural encounters index in a positive manner. Data were not collected regarding the diversity of the student body in the participating schools. One of the respondents noted that, "My student population is

multicultural and is a point of reference for examining cultural variations." Increased exposure to faculty and students, who are diverse, expands the level of cultural knowledge and reduces the risk of generalizations and stereotyping (Cortis, 2004).

Cultural desire. The cultural desire subscale addresses the motivation and commitment to become culturally competent (Yates, 2008). Participants achieved cultural proficiency in the cultural desire subscale (M = 4.16, SD = .48). It is noteworthy that the majority (n = 93, 67.4%) of respondents scored at the level of culturally proficient. Less than 0.7% (n = 1) rated as culturally advanced beginner and 8.7% (n = 12) as culturally competent in this subscale. The only question in this section that scored less than competent (< 2.6) was Question 24, which deals with screening textbooks and media. This is addressed under the TTB subscale.

Total cultural competence score. The study demonstrated that nursing faculty teaching at the ADN level are culturally competent, consistent with previous research findings—Kardong-Edgren (2004), Sealey (2003), and Yates (2008). The majority of the participants (n = 105, 76.1%) attained the level of culturally proficient and 14.5% (n = 20) obtained the level of cultural expert.

Transcultural teaching behaviors. The TTB subscale is comprised of 10 items related to practices in the classroom and in the clinical area (Sealey, 2003). Questions in the TTB subscale address the commitment to teaching cultural knowledge and skills, and the degree to which they include transcultural nursing concepts in the courses that they teach. Participants agreed (M = 4.19, SD = 0.47) that they are culturally proficient when incorporating transcultural teaching behaviors. The lowest scoring item in the subscale for TTB was Question 24, "I screen books, movies, and other media sources for negative

cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students"; respondents scored (n = 70, 51%) from *undecided* to *strongly disagree*. Previous studies found that this question received the lowest score (Sealey, 2003; Yates, 2008). Sealey noted that "they responded least favorably to question twenty-four (M = 3.29)" (p. 114). The implications for nursing education are immense. Nurse educators need to evaluate content, incorporating the screening of course material and media for appropriate cultural substance. The literature supports the need for nursing faculty to examine images, text, and course materials to ensure they are free from bias or omission of information regarding specific groups (Bell-Scriber, 2008; Billings & Kowalski, 2008; Byrne, 2001; Noone, 2008; Sealey, 2003). Overall, the majority of participants (n = 93, 67.4%) were categorized at the culturally proficient level, with a substantial percentage (n = 36, 26.1%) at the cultural expert level when incorporating transcultural teaching behaviors into the courses they teach.

Research Question 2

Research Question 2 asked, "What is the predictive value of faculty characteristics for cultural competence?" To answer this question, a Pearson product–moment correlation was performed with TCCS and TTB as dependent variables (Table 5) and then significantly correlated variables were entered into a regression analysis. None of the 20 (demographic and professional characteristics) independent variables were found to have any significance related to TTB. However, several independent variables demonstrated a relationship to the dependent variable of TCCS. A small but significant proportion of the variance in the subscales of TCCS was explained by demographic characteristics of the respondents; faculty born outside of the United States (r = –.17, p <

.05), African American faculty members ($r = .17$, $p < .05$) and non-White faculty members ($r = –.25$, $p < .005$). To determine the degree of influence, and reduce the risk that the correlation was due to chance, a stepwise regression was performed. The final two-variable model was significant at $p = < .002$ with non-White faculty ($\beta = –.26$, $p = .002$) and full-time instructors ($\beta = .17$, $p = .04$) accounting for 9% of the variance. These findings both merit further investigation. The higher percentage of non-White faculty responding to this survey may explain some of the variance; however, future studies should examine the diversity among nursing faculty. Frequent cultural encounters and interactions with a diverse nursing faculty may be one of the explanations for the higher score on TCCS in this study. None of the previous studies (Kardong-Edgren, 2004; Sealey, 2003; Yates, 2008) examined the cultural competency of part-time/adjunct nursing faculty. Further examination of the variance attributed to full-time nursing faculty needs to be examined in light of the diversity of the student population.

The quantitative data did not support previous research (e.g., Campinha-Bacote, 2006; Chrisman, 2007; Kardong-Edgren, 2004, 2007; Kupina, 2006; Leiper, Van Horn, Hu, & Upadhyaya, 2008; Sealey, 2003; Yates, 2008) that indicated ongoing faculty development related to cultural competence is needed. This study did not find any significant relationship between TTB or TCCS and attendance at a transcultural education program within the last 5 years. In contrast, Sealey found that continuing education in the field of cultural competence explained 6% of the variance; her study participants ($n = 83$, 50.9%) reported attending a cultural competence program within the past 5 years. The current sample of respondents had a higher rate of ($n = 82$, 59%) attendance at a continuing education program on transcultural/cultural competence within

the past 5 years. Because the length and time of the programs were not assessed (respondents reported that programs ranged from 1–21 hours in length) a comparison is difficult. Also, participants who attended a continuing education program may have increased awareness of what they do not know and therefore score lower on a self-reporting tool. One of the respondents commented, "Yikes, I need greater cultural competence, thanks for the survey."

Research Question 3

Research Question 3 asked, "What is the relationship between cultural competency scores of nursing faculty teaching in baccalaureate programs and those teaching at the associate-degree level?" The findings of this study were compared with both those of Sealey (2003) and Yates (2008) using a *t* test for independent means (Tables 7–9). The mean and standard deviation of each of the five subscales (Cultural Awareness, Cultural Skill, Cultural Knowledge, Cultural Encounters, and Cultural Desire), the TCCS and TTB were compared. All three studies demonstrated that the majority of nursing faculty, both at the associate and baccalaureate levels agreed that they were culturally proficient (3.6 – 4.5). The current study had the highest mean for TCCS (4.08) and TTB (4.19) when compared to previous studies. Yates found that nursing faculty teaching at the associate-degree level in Ohio an overall score of 3.88 on the TCCS and 4.06 on the TTB. Sealey found that nursing faculty teaching at the baccalaureate level in Louisiana scored in the lower range of culturally proficient on the TCCS ($M = 3.73$) and 3.97 on the TTB (3.97).

When comparing the results of ADN faculty teaching in the New York metropolitan area with those teaching in Ohio, statistically significant differences were

found in three of the cultural subscales, TTB and TCCS. There was no difference in the Cultural Awareness ($t = 1.29$) and Cultural Desire subscales ($t = 1.04$) among nursing faculty teaching in New York compared to those teaching in Ohio. A significant difference was found at $p < .05$ for TTB ($t = 2.20$). The subscales cultural skill, cultural knowledge, cultural encounters and TCCS were found to be significantly higher in the current sample at $p \leq .001$. This finding may be related to high immigrant population and increased encounters within the New York population. When comparing the current study with Sealey's (2003) study of baccalaureate nursing faculty, there was a significant difference in all five of the subscales, TTB and TCCS. Examining the relationship between Sealey's study and Yates's (2008) study of associate degree nursing faculty there was no significant difference noted between TTB and the cultural knowledge subscale. However, cultural awareness and cultural desire were found to be significant at $p < .001$, and the cultural encounters subscale and the TCCS at $p < .005$. In conclusion, in both the current study and Yates's previous study, associate degree nursing faculty scored significantly higher than the baccalaureate faculty in the Sealey study on the TCCS, but not consistently higher on the TTB.

Kardong-Edgren (2004, 2007) stratified cultural competency scores according to states with the highest and lowest immigrant population. Results of the current sample were examined related to New York's status as one of the five states with the highest immigrant population; Ohio ranked 19th with a 3.7% immigrant population and Louisiana ranked 34th with 2.7% immigrant population (Camarota, 2007). Study participants scored higher on the TCCS when compared to baccalaureate nursing faculty (Sealey, 2003) and associate degree nursing faculty (Yates, 2008) in states with lower

immigrant populations. Utilizing Kardong-Edgren's strategy it is expected that faculty from New York with one of the highest immigration levels would score higher than faculty from other states on the TCCS. When stratified according to the state with the highest immigrant population associate degree nursing faculty in New York had the highest mean (M = 4.08). Associate degree nursing faculty in Ohio had the second highest TCCS mean (M = 3.88) with a ranking of 19 on the states with the highest immigrant population (Camarota, 2007). Louisiana is one of the states with a lower immigrant population, ranking 34th overall, baccalaureate nursing faculty scored the lowest mean (M = 3.73) of the TCCS. The findings of this study are consistent with Kardong-Edgren's (2004, 2007) studies of baccalaureate nursing faculty.

Research Question 4

Research Question 4 asked, "How is cultural competence related to teaching behaviors?" This study examined each of the five constructs (desire, awareness, knowledge, skill, and encounters) separately relative to total teaching behaviors. A Pearson product–moment coefficient was performed to examine the relationship between TTB and each of the six subscales (Table 10). All of the subscales were significantly associated with TTB. Findings demonstrated that cultural desire (r^2 = .77), had the highest association with TTB. Cultural encounters scored the lowest (r^2 = .55) of all the subscales in relation to TTB. This supports Campinha-Bacote's model of cultural competency with cultural desire being the pivotal and essential force needed to motivate one toward cultural competency. Yet all cultural subscales had moderate to high correlations with transcultural teaching behaviors.

Limitations

There are several limitations to this study that can be addressed and used to guide future research in this area. The overriding limitation was that data were solely based on the self-report of the participants and an inherent assumption was that participants answered the survey honestly. The study's use of a self-reporting tool may cause participants to answer the survey in a socially acceptable manner (Kardong-Edgren, 2004). There may have been an element of self-selection bias; participants who have an interest in transcultural nursing are more likely to complete the survey.

A second limitation is that the study was conducted in the New York Metropolitan area; hence, the population validity logically can only be inferred to faculty teaching at the associate degree level in a similar urban community. A third limitation was the low response rate of the part-time educators (15.1%, $n = 36$). This may have been related to two factors, the number of part-time faculty who held dual positions in participating schools and limited access to college e-mail. The use of an online survey to collect the data may have limited the participants to those who are more proficient with and have access to the technology. Three issues relating to the design of the survey arose. First, Question 44, "At what level in your nursing program do you teach?" did not allow participants to "select all that apply" and as such was deleted from the results. Second, the classification of racial/ethnic background was questioned by several of the respondents. The use of "African American" and "White American" was not as inclusive as respondents stated that they were African or White but non-American. One respondent asked, "Why aren't there more choices to check off in 'our' racial/ethnic background? There are many variations in 'White, non-Hispanic' that could be explored." This echoed

Moscou's (2008) call to shift one's thinking when it comes to how one "use[s] racial and ethnic variables in research" (p. 94). Findings indicated that when race and ethnicity were classified for use in quantitative studies, participants were forced to choose a single identify, failing to capture reliable data.

Lastly, two respondents identified that certain questions related to transcultural teaching behaviors were applicable to the clinical practice area only. Information was not obtained as to whether the respondents taught in the clinical practice area. If respondents did not teach in the clinical practice area results may have been falsely elevated.

Finally, a major limitation was the failure to collect data related to the number of diverse students in the program and the related inability to correlate results with the total cultural competency scores. Sealey (2003) estimated the percentages of students from selected ethnic/racial groups in nursing programs where respondents taught. Sealey found that "the percent Asians and black Hispanics in the program were also associated with increased levels of selected subscale indexes, while the presence of white Hispanics and Caucasian respondents were associated with a decrease in selected subscale indexes" (p. 119). Her findings demonstrated that the number of White Americans in the student body had a negative effect on the total cultural competency scores of nursing faculty.

Implications for Nursing Education

This study provided a deeper insight into the cultural competency and transcultural teaching behaviors of nursing faculty teaching at the associate degree level. This study also validated previous studies of nursing faculty (Kardong-Edgren, 2004; Sealey, 2003; Yates, 2008) demonstrating that nursing faculties self-report cultural

competence. When comparing factors that contribute to the TCCS score, it is significant to note that the findings were different that those of Sealey.

The major difference is that Sealey's (2003) findings for baccalaureate faculty showed both nursing specialty and transcultural continuing education had a positive effect on the variable TCCS. In contrast the current study revealed that full-time faculty and those indicating that they were non-White scored higher on the TCCS score. Differences in predictive independent variables highlight the need for ongoing research in this area. The results may be related to differences in the demographics of the professional populations studied rather than attributable to being either associate degree or baccalaureate nursing faculty.

The number of African American nursing faculty is noteworthy regarding the outcome of this study and may have contributed to the findings that minority race predicted 9% of the variable in TCCS. However, the disparity between the number of Hispanic (n = 2, 1.4%) participants in this study is a concern. The percentage of nursing faculty who are Hispanic is not reflective of the student population in the New York metropolitan area and may present a barrier to progression and retention of Hispanic students. A diverse faculty contributes to a culturally sensitive teaching environment as well as an environment that can enrich cultural encounters (Drayton-Hargrove, 1999; Lowenstein & Glanville, 1995). There is a documented shortage of minority nursing faculty representing the racial and ethnic groups living in the United States (AACN, 2010; NLN, 2006). Educational administrators should be encouraged to seek out, hire, and retain qualified culturally diverse nursing faculty members to enrich the educational environment and facilitate cultural encounters. Having a nursing faculty that is more

reflective of the student body has been found to be a positive factor in recruitment and retention of minority students (Amaro et al., 2006; Morgenthaler, 2009; Noone, 2008; Yates, 2008). This goal is hampered currently by the lack of an adequate pool of faculty applicants who represent minority groups.

This study also highlights the lack of a terminal degree for the majority of full and part-time nursing faculty teaching at the associate degree level. As New York moves toward the requirement of baccalaureate degree within 10 years of license, there is a need for increasing the number of nurse educators who hold a doctorate as their highest degree. The AACN (2010) identified a major issue in filling vacant nursing faculty positions at the baccalaureate level was the limited pool of doctoral prepared faculty. This gap may be greater for faculty in associate degree programs. However, this also raises the issue of the current predominance of associate degree program graduates versus the profession's goal of educating nurses with a minimum of a baccalaureate degree.

Another discrepancy relates to the Sealey (2003) study and the significance of certain nursing specialties as a positive factor on TCCS. Again, this difference may be explained by examining the differences between nursing faculty teaching at the associate degree level and those teaching at the baccalaureate level. Associate degree programs are shorter in length than baccalaureate programs. Because the associate degree nursing program is condensed into a shorter time frame, the majority of faculties teach more than one specialty. For example, a nurse practitioner whose specialty is women's health would typically cover medical–surgical, women's health and newborn content.

This study highlights the need to review curricular content regarding what is taught regarding cultural competency to ensure that there is consistency throughout the

program. Nursing faculty need to evaluate innovative teaching/learning strategies and identify those that are effective in increasing student nurses' cultural competency. Effective teaching strategies will be identified for incorporating cultural care into a content-laden curriculum. The NLN (2009) developed the Cultural Diversity Toolkit, an extensive resource for both administrators and nursing faculty to assess program strengths and integrate curricular content related to diversity.

Lastly, the literature recommends the inclusion of transcultural teaching content in graduate programs (Boyle, 2000; Bull & Fitzgerald Miller, 2008; Leininger & McFarland, 2002; Sealey, 2003; Yates, 2008). Continuing education was not a significant predictor of cultural competence or transcultural teaching behaviors in the current study. However, it was demonstrated that more faculty in associate degree programs participate in continuing education on these crucial topics even in the short time since the previous studies were reported. It was predicted that continuing education in the field of transcultural nursing would have a positive effect on the TCCS. However, the study findings did not support this hypothesis nor the findings of Sealey (2003). This disparity may be as a result of how the question regarding continuing education in transcultural nursing was worded or related to the increase in continuing education utilized. A more detailed evaluation related to the length and content of the educational program would have provided more specific data for analyses.

Recommendations for Future Research

Further study is warranted to include research regarding faculty teaching at both the associate and baccalaureate level. Further analysis of the demographic and

professional variables may provide greater insight into factors that contribute to total cultural competence. Replication of this study, incorporating both associate degree and baccalaureate nursing faculty from the same geographic area would add insight to variables that influence cultural competency while controlling for regional variations. A clearer picture of differences related to cultural competency of associate versus baccalaureate nursing faculty might emerge, not clouded by differences in demographics. Research of the perceived factors influencing the development of cultural competence in nursing is necessary. First it is recommended that this study be replicated using both qualitative and quantitative data, a mixed-method research (MMR) approach. Melnyk and Fineout-Overholt (2005) described MMR as "science and art" (p. 129) coming together, a mix of positivist and humanist worldviews. MMR is often used "to offset the weaknesses inherent within one method with the strengths of the other method" (Creswell, 2003, p. 217). According to Creswell (2008), qualitative data collection methods may include observations, interviews, focus groups, case studies, documents, journals and audiovisual materials. There is a need for more mixed studies to build on this and other studies to provide a richer, deeper understanding of factors that influence cultural competence and transcultural teaching behaviors.

Second, research should focus on student learning outcomes. There is a need to evaluate if cultural proficiency in transcultural teaching behaviors translates to positive student learning outcomes. Only two studies examining the cultural competency of baccalaureate nursing students were found in the literature (Kardong-Edgren, 2010; Kardong-Edgren & Campinha-Bacote, 2008). Once again, there is a dearth of studies related to nursing students at the associate degree level. It is imperative that we continue

to examine the level of cultural competency as an outcome for all prelicensure programs. Examining previous research related to cultural competency and transcultural teaching behaviors can provide a guide for RNs to BSN programs regarding curricular content. Utilizing the research to build on the foundation of prelicensure programs and continue on the journey to examining cultural competence.

Conclusion

The findings of this study support previous research that nursing faculty perceive themselves to be culturally competent (Kardong-Edgren, 2004; Sealey, 2003; Yates, 2008). However, there are still many questions left unanswered as to which variables are associated with an increase in cultural competence. More importantly, as educators, one of the primary concerns is whether transcultural teaching behaviors translate into increased cultural competency for students. Kardong-Edgren (2010) presented a comprehensive review of six baccalaureate nursing programs, each using different strategies for teaching cultural competence, with demonstrated no difference in outcomes regardless of the teaching strategy used. There is not a substantive body of literature that can be used to guide teaching practice. Jeffries (2010) provided a website with materials for nursing faculty to plan, implement, and evaluate cultural content in nursing programs. Once again the focus of Jeffries research is at the baccalaureate level, however, the tools and resources can easily be adapted to associate degree programs. Much of the prior research related to cultural competency has focused on nursing faculty, students and curricular methods at the baccalaureate level. As a profession nursing needs to widen the lens and examine all levels of prelicensing programs to identify best teaching practices of

transcultural nursing content. As New York State moves toward the “BSN in 10” requirement, nurse educators should be prepared to build on the foundation of cultural competence.

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APPENDIX A. CDQNE–R

From *Cultural Competence of Faculty of Baccalaureate Nursing Programs* (pp. 131–137), by L. J. Sealey, 2003. Retrieved from Dissertations & Theses: Full Text database. (Publication No. AAT 3182911). Copyright 2003 by L. J. Sealey. Reprinted with permission.

The following statements are about your clinical and teaching practices, and your beliefs and attitudes regarding caring for culturally, racially, and ethically diverse clients. Statements about teaching relate only to your activities with undergraduate nursing students. Please circle the term that most accurately reflects your level of agreement with each statement.

1. I feel confident in using a variety of cultural assessment tools in the health care setting.

   Strongly agree Agree Undecided Disagree Strongly Disagree

2. I make time to include cultural competence in my course content.

   Strongly agree Agree Undecided Disagree Strongly Disagree

3. I am involved socially with cultural/racial/ethnic groups different from my own, outside of my teaching role and health care setting.

   Strongly agree Agree Undecided Disagree Strongly Disagree

4. Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.

   Strongly agree Agree Undecided Disagree Strongly Disagree

5. I am knowledgeable about variations in drug metabolism among specific cultural groups.

   Strongly agree Agree Undecided Disagree Strongly Disagree

6. I avail myself of professional development and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups.

Strongly agree Agree Undecided Disagree Strongly Disagree

7. I am aware that biological variations exist in different cultural, racial, and ethnic groups.

   Strongly agree Agree Undecided Disagree Strongly Disagree

8. I use the appropriate communication style and protocol to communicate with clients who are of different cultural/racial/ethnic backgrounds.

   Strongly agree Agree Undecided Disagree Strongly Disagree

9. My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program.

   Strongly agree Agree Undecided Disagree Strongly Disagree

10. When I care for a client, I consider how the difference between our perceptions of health, illness, and preventive health could affect the outcome of my care.

    Strongly agree Agree Undecided Disagree Strongly Disagree

11. I am knowledgeable about the biological variations that exist among specific cultural, racial, and ethnic groups.

    Strongly agree Agree Undecided Disagree Strongly Disagree

12. I am knowledgeable of keywords and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program.

    Strongly agree Agree Undecided Disagree Strongly Disagree

13. I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.

    Strongly agree Agree Undecided Disagree Strongly Disagree

14. I am knowledgeable about diseases that have a high incidence among cultural/racial/ethnic groups in our service area.

    Strongly agree Agree Undecided Disagree Strongly Disagree

15. I am in contact with individuals who provide health services to groups that are culturally, racially, and ethnically diverse.

    Strongly agree Agree Undecided Disagree Strongly Disagree

16. I require that students be knowledgeable about diseases that have a high incidence among clients in our service area from diverse cultural, racial, and ethnic groups.

    Strongly agree Agree Undecided Disagree Strongly Disagree

17. I have a clear understanding of the differences in meaning of the following terms; acculturation, assimilation, and socialization.

    Strongly agree Agree Undecided Disagree Strongly Disagree

18. I am confident that I posses the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency.

    Strongly agree Agree Undecided Disagree Strongly Disagree

19. I keep abreast of the major health concerns and issues of culturally, racially, and ethnically diverse client populations residing in my program's service area.

    Strongly agree Agree Undecided Disagree Strongly Disagree

20. I attend holiday celebrations within culturally, racially and ethnically diverse communities.

    Strongly agree Agree Undecided Disagree Strongly Disagree

21. My students are expected to demonstrate knowledge of their client's world views, beliefs, and practices by incorporating this knowledge in their plans of care.

    Strongly agree Agree Undecided Disagree Strongly Disagree

22. I am knowledgeable about diseases that are common in the countries of origin of recent immigrants in our service area.

    Strongly agree Agree Undecided Disagree Strongly Disagree

23. I have spent extended periods of time (i.e., at least 7 consecutive days) living among people from cultural/racial/ethnic groups different from my own.

    Strongly agree Agree Undecided Disagree Strongly Disagree

24. I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.

    Strongly agree Agree Undecided Disagree Strongly Disagree

25. I am personally and professionally committed to providing nursing care that is culturally competent.

    Strongly agree Agree Undecided Disagree Strongly Disagree

26. I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.

    Strongly agree Agree Undecided Disagree Strongly Disagree

27. I advocate for the review of my program's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

    Strongly agree Agree Undecided Disagree Strongly Disagree

28. I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen.

    Strongly agree Agree Undecided Disagree Strongly Disagree

29. I am knowledgeable about the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my nursing program.

    Strongly agree Agree Undecided Disagree Strongly Disagree

30. I patronize businesses on my service area that are owned by people who are culturally, racially, and ethnically diverse.

    Strongly agree Agree Undecided Disagree Strongly Disagree

31. I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups.

    Strongly agree Agree Undecided Disagree Strongly Disagree

32. I know the prevailing beliefs, customs, norms, and values of the cultural/racial/ethnic groups, other than my own, residing in our service area.

    Strongly agree Agree Undecided Disagree Strongly Disagree

33. I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse.

    Strongly agree Agree Undecided Disagree Strongly Disagree

34. The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs, and social organization.

    Strongly agree Agree Undecided Disagree Strongly Disagree

35. I am knowledgeable about the population percentages of the major ethnic groups living in my service area.

    Strongly agree Agree Undecided Disagree Strongly Disagree

36. I teach my students that when working with clients who are culturally, racially, or ethnically different they should become familiar with indigenous beliefs and practices.

    Strongly agree Agree Undecided Disagree Strongly Disagree

37. I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients.

    Strongly agree Agree Undecided Disagree Strongly Disagree

38. What I believe about health, illness, and preventative care is influenced by my culture.

    Strongly agree Agree Undecided Disagree Strongly Disagree

39. I have a clear understanding of the differences in meaning of the following terms; immigrant, alien resident, and citizen.

    Strongly agree Agree Undecided Disagree Strongly Disagree

40. I accept that male–female roles may vary among significantly among different cultures and ethnic groups.

    Strongly agree Agree Undecided Disagree Strongly Disagree

41. I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of race or ethnicity different from my own.

    Strongly agree Agree Undecided Disagree Strongly Disagree

Please provide the following information about yourself:

42. Which of the following best describes your employment status?
    1. _____ Fulltime
    2. _____ Part-time
    3. _____ Adjunct

43. What is your academic rank?
    1. _____ Full Professor
    2. _____ Associate Professor
    3. _____ Assistant Professor
    4. _____ Instructor

44. At what level in your nursing program do you teach? (Please check all that apply)
    1. _____ Associate
    2. _____ Baccalaureate
    3. _____ Master's
    4. _____ Ph.D.

45. How long have you been teaching nursing? If less than a year, please give the number of months.
    1. _____Months
    2. _____Years

46. Age range:
    a. Under 25 years __
    b. 26–35 years __
    c. 36–45 years __
    d. 46–55 years __
    e. 56–65 years __
    f. 65–75 years __
    g. over 75 years __

47. Sex: Male _____ Female _____

48. Were you born in the United States?
    1. ____Yes
    2. ____ No

If no, what is your country of origin? _____

49. What is your racial/ethnic background?
    a. African American (non-Hispanic)
    b. American Indian/Alaskan Native
    c. Asian American
    d. Hispanic
    e. Native Hawaiian/Other Pacific Islander
    f. White American (non-Hispanic)
    g. Other

50. What language(s) other than English do you speak?

1. ___ None	4. ____ Arabic	7. ____ German	11. ___ Dutch
2. ___ Spanish	5. ____ Mandarin	8. ____ Portuguese	12. ___ Japanese
3. ___ French	6. ____ Cantonese	9. ____ Italian	13. ___ Other

    Please list:

51. What is your highest degree attained?
    1. _____ Bachelors
    2. _____ Masters
    3. _____ Doctorate

52. What is your nursing specialty area? (Please check all that apply)
    1. ____ Adult Health
    2. _____ Community Health
    3. _____ Child Health and Illness
    4. _____ Childbearing
    5. _____ Psychiatric Nursing
    6. _____ Women's Health
    7. _____ Nursing Administration
    8. _____ Transcultural Nursing
    9. _____ Gerontology
    10. _____ Other _____

53. Do you hold any certifications in your specialty area?
    1. _____ Yes
    2. _____ No
    If yes, please list your certification(s)
    _____

54. Have you attended/completed any continuing education programs on transcultural nursing/cultural competence in the past 5 years?
    1. _____ Yes
    2. _____ No

If yes, approximately how many continuing education hours have you earned in this area?

_____

55. Which geographic region did you receive your entry-level nursing education?
__ Northeast coastal region, United States
__ Midwest region, United States
__ West Coast region, United States
__ Southern region, United States
__ Other

56. Which geographic region have you lived in the longest?
__ Northeast coastal region, United States
__ Midwest region, United States
__ West Coast region, United States
__ Southern region, United States
__ Other

What was the level of cultural content during your academic preparation by program?

57. Diploma School Graduate
N/A None
Integrated
Occasionally mentioned
Prerequisite course
Free standing cultural course

58. Associate Degree in Nursing
N/A None
Integrated
Occasionally mentioned
Prerequisite course
Free standing cultural course

59. Bachelor Science in Nursing
N/A None
Integrated
Occasionally mentioned
Prerequisite course
Free standing cultural course

60. Master's Education
N/A None
Integrated

Occasionally mentioned
Prerequisite course
Free standing cultural course

61. Doctoral Education
N/A None
Integrated
Occasionally mentioned
Prerequisite course
Free standing cultural course

62. What is the level of cultural content in your current teaching program?
None
Integrated
Occasionally mentioned
Prerequisite course
Free standing cultural course

Comments

Thank You!

APPENDIX B. SUBSCALES OF THE CDQNE–R

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Cultural Awareness Subscale

- (7) I am aware that biological variations exist in different cultural, racial, and ethnic groups.

- (10) When I care for a client, I consider how the difference between our perceptions of health, illness, and preventive health could affect the outcome of my care.

- (28) I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen.*

- (31) I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups.*

- (36) I teach my students that when working with clients who are culturally, racially, or ethnically different they should become familiar with indigenous beliefs and practices.*

- (37) I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients.

- (38) What I believe about health, illness, and preventative care is influenced by my culture.

- (40) I accept that male–female roles may vary among significantly among different cultures and ethnic groups.

Cultural Skills Subscale

- (1) I feel confident in using a variety of cultural assessment tools in the health care setting.

- (8) I use the appropriate communication style and protocol to communicate with clients who are of different cultural/racial/ethnic backgrounds.

- (9) My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program.*

- (12) I am knowledgeable of keywords and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program.

- (18) I am confident that I posses the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency.

- (33) I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse.*

- (34) The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs, and social organization.

- (41) I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of race or ethnicity different from my own.

Cultural Knowledge Subscale

- (5) I am knowledgeable about variations in drug metabolism among specific cultural groups.

- (11) I am knowledgeable about the biological variations that exist among specific cultural, racial, and ethnic groups.

- (14) I am knowledgeable about diseases that have a high incidence among cultural/racial/ethnic groups in our service area.

- (16) I require that students be knowledgeable about diseases that have a high incidence among clients in our service area from diverse cultural, racial, and ethnic groups.*

- (17) I have a clear understanding of the differences in meaning of the following terms; acculturation, assimilation, and socialization.

- (21) My students are expected to demonstrate knowledge of their client's world views, beliefs, and practices by incorporating this knowledge in their plans of care.*

- (22) I am knowledgeable about diseases that are common in the countries of origin of recent immigrants in our service area.

- (29) I am knowledgeable about the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my nursing program.

- (32) I know the prevailing beliefs, customs, norms, and values of the cultural/racial/ethnic groups, other than my own, residing in our service area.

- (35) I am knowledgeable about the population percentages of the major ethic groups living in my service area.

- (39) I have a clear understanding of the differences in meaning of the following terms; immigrant, alien resident, and citizen.

Cultural Encounters Subscale

- (3) I am involved socially with cultural/racial/ethnic groups different from my own, outside of my teaching role and health care setting.

- (13) I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.*

- (15) I am in contact with individuals who provide health services to groups that are culturally, racially, and ethnically diverse.

- (20) I attend holiday celebrations within culturally, racially and ethnically diverse communities.

- (23) I have spent extended periods of time (i.e., at least 7 consecutive days) living among people from cultural/racial/ethnic groups different from my own.

- (30) I patronize businesses on my service area that are owned by people who are culturally, racially, and ethnically diverse.

Cultural Desire Subscale

- (2) I make time to include cultural competence in my course content.*

- (4) Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.

- (6) I avail myself of professional developmental and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups.

- (19) I keep abreast of the major health concerns and issues of culturally, racially, and ethnically diverse client populations residing in my program's service are.

- (24) I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.*

- (25) I am personally and professionally committed to providing nursing care that is culturally competent.

- (26) I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.*

- (27) I advocate for the review of my program's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

Transcultural Teaching Behavior Subscale

- (2) I make time to include cultural competence in my course content.*

- (9) My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program.*

- (13) I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.*

- (16) I require that students be knowledgeable about diseases that have a high incidence among clients in our service area from diverse cultural, racial, and ethnic groups.*

- (21) My students are expected to demonstrate knowledge of their client's world views, beliefs, and practices by incorporating this knowledge in their plans of care.

- (24) I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.*

- (26) I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.*

- (28) I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen.*

- (31) I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups.*

- (33) I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse.*