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# Culture Counts: An Analysis of Cultural Awareness and Competency among Nursing Students

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# Culture Counts: An Analysis of Cultural Awareness and Competency among Nursing Students

An Honors Thesis  
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The University Honors Program  
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By

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**Accepted by the Honors Faculty**

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### Abstract

As cultural diversity becomes increasingly significant in the field of nursing, so does its inclusion in accredited Bachelor of Science in Nursing (BSN) and Associate Degree in Nursing (ADN) programs. An analysis of one university's school of nursing program curriculum was conducted to measure the cultural awareness and competency of nursing students progressing through BSN and ADN accredited programs, using the Cultural Awareness Scale (CAS) survey and a qualitative survey. Results indicated BSN students and senior level students score higher on average compared to ADN students and junior level students respectively. However, low means overall and only 15% to 18% of participants stating they felt very prepared to provide culturally competent care suggested a lack of effectiveness and need for further investigation by the school of nursing to make necessary improvements in their cultural awareness and competency curriculum.

*Keywords:* cultural awareness, cultural competency, Cultural Awareness Scale (CAS)

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## **CHAPTER I**

### **Introduction**

The United States of America is a melting pot of different cultures, including ethnicities, races, genders, sexual orientations, religions, and socioeconomic statuses. By the year 2050, members of cultural and ethnic minorities will comprise 50% of the United States population (Roberts, 2014). As our country grows in cultural diversity, it becomes imperative that our healthcare system accommodate the needs of all of these cultural groups by possessing the skills of cultural awareness and competency necessary to provide all patients the best care possible. In the field of nursing, it is particularly crucial that nurses have high levels of cultural awareness and competency since they maintain the most direct contact with patients in a healthcare setting.

Recognizing this need, nursing schools and programs across the country have incorporated cultural awareness and competency into their curriculums. Collegiate accreditation organizations such as the National League for Nursing Accrediting Commission, Inc. and the Commission on Collegiate Nursing Education dictate that graduating nursing students must be culturally aware, knowledgeable, and competent. The school of nursing analyzed in this study included in its nursing student handbook the overall goal of graduating students who are, “prepared to practice patient centered nursing care that is culturally competent, holistic and professional within the context of a global environment in a manner that influences nursing and health care policy and practice.” Furthermore, the curriculum is based on the professional standards of The American Association of Colleges of Nursing (AACN) Essentials of Baccalaureate Education for Professional Nursing Practice as well as The National League for Nursing (NLN) Outcomes and Competencies for



Graduates of Practical/Vocational, Diploma, Associate Degree, Baccalaureate, Master's, Practice Doctorate, and Research Doctorate Programs in Nursing. These professional standards mandate cultural awareness and competency of nursing students upon degree completion.

In spite of these professional accreditation agencies' requirements for cultural competency, numerous nursing programs and schools do not provide effective cultural awareness and competency education in their curriculums. Many nursing students rank themselves as being overall moderate to poor with knowledge and comfort of other cultures (Ah, 2013). Due to the fact cultural competency has been a requirement for nursing program curriculums for accreditation, graduating nursing students should report a high level of cultural awareness and competency through the curriculum and experiences they have had throughout the program.

### **Problem Statement**

As healthcare has become global and health disparities exist among different cultural groups, nurses must be able to provide professional culturally competent patient-centered care to a broader spectrum of cultures; nursing programs need to increase their focus on cultural awareness and competency to include more critical understanding and application of cultural concepts and dimensions to prepare nurses to meet this requirement. Before nursing programs can increase the significance of cultural awareness and competency in their curricula, they first need to be able to identify and assess the effectiveness of their curricula. Although, there is an abundance of research on the significance of cultural awareness and competency in nursing education curricula, few studies have been done to specifically measure and assess the effectiveness of nursing program curricula in cultural awareness and

competency. Nursing programs continually evaluate the knowledge based content and clinical skills in their curricula, but lack in assessing inclusion of cultural competence education. Therefore, with no evaluation of their cultural competence education, a nursing program cannot know whether or not their curriculum is effective in the area of cultural awareness and competency. For this reason, it is essential that nursing programs assess the efficiency of the cultural awareness and competency education provided by their curriculum.

### **Research Questions/Assumptions**

This research seeks to answer the following questions: “What is the cultural awareness and competency of first year and second year Associate Degree in Nursing (ADN) students within the school of nursing?” “What is the cultural awareness and competency of sophomore, junior, and senior Bachelor in Science in Nursing (BSN) students within the school of nursing?”

Cultural awareness and cultural competency as a requirement of accreditation for collegiate nursing programs will be integrated into both ADN and BSN curriculums. Since BSN nursing students take more nursing courses and receive a comprehensive education, it can be assumed BSN nursing students will receive more cultural awareness and competency education and experience. Consequently, BSN nursing students should exhibit higher levels of cultural awareness and competency compared to ADN nursing students. Moreover, graduating nursing students at the senior level should exhibit higher levels of cultural awareness and competency compared to underclass nursing students in the program.

## CHAPTER II

### Literature Review

Before the research and study could be conducted, there were several sources of background literature and studies that were reviewed and analyzed to understand the information available and how it supported this study on cultural awareness and competency among nursing students. The components of culture, cultural awareness, cultural competence, existing health disparities, nursing theories, and several other similar studies were examined to build this study's foundation as well as its role in adding to the research to fill gaps not being well addressed.

#### Culture

Culture is a very broad term that has been defined several different ways. According to Dr. Lucy Hood, a professor at St. Luke's College of Health Sciences, culture is "an integrated pattern of socially transmitted behaviors, including all products of human work and thoughts specific to a group of persons, that guides formulation of worldviews and decision-making processes" (Hood, 2014). Culture encompasses racial, ethnic, religious, gender, sexual orientation (Lesbian, Gay, Bisexual, Transgender, Questioning/Queer or LGBTQ), deaf/hard of hearing, blind/visually impaired, occupation (the culture of nursing, medicine, or the military), age (culture of youth, adolescence, old age), or socioeconomic status (culture of poverty or affluence, culture of the homeless) social groups. Besides this definition, the Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses defines culture as "a learned, patterned behavioral response acquired over time that includes implicit versus explicit beliefs, attitudes, values, customs, norms, taboos, arts, and life ways accepted by a community of individuals" (Tool kit, 2008). Through these two

different definitions it is evident how different sources can provide similar, but differing views of culture. The Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses makes it a point to acknowledge the implicit and explicit beliefs, attitudes, values, and norms of a community of individuals while Hood focuses on broader thoughts of groups of persons and how that formulates their decisions and perspectives. Therefore, with such a varying and broad concept of culture, it is understandable why cultural awareness and competency education for nursing students is not cohesive or standardized since it can be addressed in so many different ways.

Roberts, S., Warda, M., Garbutt, S., & Curry, K. (2014) in their research article delved into further explaining how culture is important to healthcare. They noted individuals' culture can influence definitions of health and illness, when and where they should go to seek medical attention, and the healing process in general. If these cultural concepts are not addressed, actions by these cultural groups are misunderstood and the care of the patient can be immensely affected. Additionally, Roberts et al. (2014) explained the demographic change in the United States and the reasons it is concerning for being able to adequately address culture in healthcare. Soon minorities will outnumber the majority Caucasian population, and this demographic change is concerning because the nursing labor force lacks in cultural diversity with Caucasian females making up 83.2% of registered nurses while minority populations face higher burdens of chronic illness and disease, and societal influences such as discrimination, individual healthcare professional prejudices, and internalized racism exist preventing patients of different cultures from having their culture being an integral part of their healthcare treatment (Roberts, 2014). With all of these factors present, it is more important than ever to educate nurses that are culturally aware in the workforce.

### **Cultural Awareness**

The term cultural awareness from *The Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses* (2008) defines cultural awareness as “being knowledgeable about one’s own thoughts, feelings, and sensations, as well as the ability to reflect on how these can affect one’s interactions with others” (Tool kit, 2008). Another similar term that Marianne Jeffreys used in her article is diversity awareness. Diversity awareness builds on the previous definition because it is referred to as “an active, ongoing conscious process” (Jeffreys, 2008). This means that cultural awareness is being able to recognize one’s own culture consciously over time in addition to being able to recognize how those cultural beliefs are affecting one’s interaction with and care for the patient.

Furthermore, Jeffreys addresses the significance of how cultural awareness is important to patient care. If nurses ignored diversity and people of other cultures, it would negatively affect patient outcomes and patient safety. One example given was a nurse who lacked self-confidence about her cultural awareness ability, which led her to avoid performing cultural assessments. The result was that the nurse did not obtain vital information about folk medicine and herbal supplements the patient was using and the patient had a bad reaction to a medication the nurse administered (Jeffreys, 2008). In addition to adverse effects on patients, Jeffreys explained how diversity awareness applied to healthcare professionals and their co-workers. The workplace environment and nurses’ interactions with their co-workers could be negatively impacted without appropriate diversity and cultural awareness, background knowledge, and sensitivity (Jeffreys, 2008). For example, a new graduate nurse who emigrated from China prior to getting her associate degree speaks with a heavy accent, and the charge nurse assigns the nurse to a Korean patient, saying she is sure

she should not have trouble communicating with the patient based on the nurse's accent. A scenario like this one lacks cultural awareness and could result in a poor patient outcome and work relation problems between the nurse and the charge nurse (Jeffreys, 2008).

Dr. Chenit Ong-Flaherty (2015) in his nursing journal article explored another concept about cultural awareness by examining different dimensions of culture. The dimension of collectivism-individualism had the most influence on cultural awareness perspectives in his opinion. The concept is that different cultures are either of a collectivist mind or an individualistic mind which determines their worldview about "self" and ultimately how they communicate and make decisions. A collectivist culture would connect "self" to the group making actions reflect everyone in the group and maintaining harmony vital. However in an individualistic culture "self" would be the autonomous individual and actions would reflect just on the individual, making concern about others or maintaining harmony irrelevant (Ong-Flaherty, 2015). Therefore, these cultural dimension differences could result in misinterpretation or miscommunication errors implicating nursing care of patients. On the other hand, Ong-Flaherty explained that a person could develop a sufficiently high level of cultural awareness to allow them to almost switch it on and off depending on the circumstance and this would be considered a characteristic of a culturally competent individual.

### **Cultural Competence**

In an article by Alexander (2006), cultural competence is viewed as a process rather than an end point. The author defines several stages of cultural competence: unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence that an individual can be in at a point in time. These stages create a range that goes from an

unconscious incompetent individual who is not aware of lacking knowledge about other cultures to an unconscious competent individual who automatically provides culturally appropriate care (Alexander, 2006). Also, the article addresses rationales for culturally competent care including meeting legislative and accreditation mandates, improving patient outcomes and quality of services, eliminating health disparities, responding to the demographic change, and decreasing likelihood of malpractice claims (Alexander, 2006).

Since cultural competence is a requirement of accreditation agencies for nursing programs, author Shonta Collins (2006) in her article described what The American Nurses Association believes culturally competent nurses should understand including, “how cultural groups understand life processes, how cultural groups define health and illness, how healers cure and care for members of the group, and how the cultural background of the nurse influences the way in which care is delivered” (Collins, 2006). In her research article, Jeffreys (2008) further explains how culturally competent care by nurses can be promoted. Jeffreys argues cultural competent care starts with a nurse performing a thorough cultural assessment which is integrated into the health assessment and it follows through all the phases of assessment, planning, implementing, and evaluation of patient care. Hood (2014) takes Jeffreys idea to another level by actually giving steps for nurses to obtain cultural competence. The steps to acquiring cultural competence are examining personal values, beliefs, biases, and prejudices, building cultural awareness, learning culturally specific communication strategies, interacting with people from different cultures, identifying and acknowledging mistakes, and finally remediating cultural mistakes.

Besides just addressing the significance of cultural competency and how it should be incorporated into patient care, Ong-Flaherty (2015) in his article argues for how cultural

competency education currently needs to be readdressed to solve the issues that still persist. His point is that the current didactic approach to cultural competency is outdated and not effective for developing nursing students' ability to critically understand different cultural dimensions. Roberts et al. (2014) also analyzed current approaches of teaching cultural competence and found them to lack consistency and effectiveness. They looked at the different curriculum models to integrate cultural competence such as clinical scenarios through use of simulation, computerized scenarios, integration throughout the curriculum, and a single devoted class to cultural competency. All of these approaches were not meeting the mark, and they explained how it called for a shift for new approaches that are comprehensive, cumulative, and integrate didactic content with a progression of opportunities for application of the theoretical concepts of culture (Roberts, 2014).

### **Health Disparities**

One of the largest reasons for the great need for culturally competent nursing care is the existence of vast disparities in healthcare. Health disparities can be defined as “differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States” (Tool kit, 2008). In addition, health disparities include the disadvantaged social groups that have consistently and systematically experienced worse health or greater health risks than other more advantaged groups. This can be attributed to conscious or unconscious bias, provider bias, and institutional discriminatory policies towards patients of minority culture groups (Tool kit, 2008). According to Alexander (2006), there is often a disconnection between the values supposedly held by individuals or healthcare organizations and those that actually guide daily interaction with patients. Furthermore, the author states there are four cultures



operating simultaneously that need to be examined to fix this disconnect, which include the patient's culture, the clinician's culture, the organizational culture, and the American culture (Alexander, 2006).

Anderson, N. L. R., Calvillo, E. R., & Fongwa, M. N. (2007) in their research on community-based approaches to strengthen cultural competency included health disparities in their discussion of how important it is to teach healthcare practitioner's cultural awareness and competency to prevent disparities among minorities. Minorities can encounter barriers to access healthcare such as language, geography, and cultural familiarity. It is vital for healthcare workers to realize the complexity of these disparities because of factors like living conditions ability to access care, and numerous others can impact these cultural groups (Anderson, 2007).

According to the 2012 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality (2013), "health care quality and access are suboptimal, especially for minority and low-income groups and overall quality is improving, access is getting worse, and disparities are not changing." These are two of the main highlights of the report that point to the evidence that culture, despite being taught and a requirement of accreditation, is still lacking in healthcare and failing to be provided sufficiently for patient care. The data compiled in the 2012 National Healthcare Disparities Report showed that African Americans received worse quality of care than Whites and Hispanics received worse quality of care than non-Hispanic Whites. Furthermore, this report studied different cultural groups across the United States called priority populations to further examine the highly evident disparities among racial and ethnic minorities, low-income groups, residents of rural areas, women, older adults, and children, individuals with disabilities or chronic care needs,

and LGBT individuals. These groups of people are the ones the disparity report found were being the most disadvantaged from receiving proper healthcare.

### **Nursing Theories**

Besides all of the current issues today with culture, cultural awareness, cultural competency, and health disparities that support a great need for better culturally inclusive nursing education, there are several nursing theories and models developed to back-up a focus on cultural factors for optimal nursing care practice. The theories researched in this literature review included Giger and Davidhizar's Model of Transcultural Nursing, Campinha-Bacote Model of Cultural Competence, Leininger's Cultural Care Diversity and Universality Theory, and Purnell's Model of Transcultural Health Care. Each model has its own unique perspective for examining culture, but together they support the idea of a nursing process that includes cultural aspects to provide culturally competent care, especially in the nursing assessment phase.

**Giger and Davidhizar's model of transcultural nursing.** The Transcultural Assessment Model developed by Giger and Davidhizar centers on nursing assessment and intervention from a transcultural perspective. The model looks at six areas of human diversity that it identifies as aspects present in all cultural groups: communication; space; social orientation; time; environmental control; and biological variations. In this model questions are created under each of the six areas to obtain information useful in assessing and planning the individual's needs. Compared to other models this one can be utilized as a learning tool and encourages patient involvement in the cultural assessment process (Tool kit, 2008).

**Campinha-Bacote model of cultural competence.** According to the Campinha-Bacote Model of Cultural Competence, cultural competence is reached by first demonstrating

an intrinsic motivation to engage in the process. The main concepts of this model include cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. Cultural awareness means the nurse is consciously being sensitive to the cultural beliefs of a patient and not imposing his/her own cultural beliefs in patient care. Next, cultural knowledge is the stage when the nurse would find more information about other cultural groups to build his/her confidence. Then cultural skill occurs when the nurse carries out a cultural assessment based upon the gained knowledge, which is followed by the cultural encounter or exposure to cross-cultural interactions. The last element is cultural desire or the nurse's self-motivation to learn to become culturally competent. Ultimately, the model's main emphasis is on reinforcing a cultural assessment for every patient before providing care (Tool kit, 2008).

**Leininger's cultural care diversity and universality theory.** Madeleine Leininger's Cultural Care Diversity and Universality Theory and the Sunrise Model which illustrates her theory are probably the best known culture related nursing theory. The theory is based on transcultural nursing practice and promotes comprehension of universally held understandings and culture-specific beliefs that form a particular interaction with a patient (Tool kit, 2008). Some assumptions that Leininger's theory makes are that caring is essential to curing and healing as well as a client who experiences non-congruent culture care will show signs of cultural conflict and noncompliance. Based upon the concepts contained in the Leininger Theory, a culturally competent nurse would consciously acknowledge the fact culture affects the nurse-client relationship, compassionately inquire a cultural assessment of every client, include cultural practices within the care plan as much as possible, and would strive to continue to gain knowledge and improve their cultural sensitivity (George, 2011).

**Purnell's model of transcultural health care.** Purnell's model conceptualizes progression of cultural competence through learning and practice. The model consists of two sets of factors described as the macro aspects and the micro aspects. The macro aspects form the wider outer circles of the model and move from global society to community to family to the person. Then the micro-aspects are represented by pie-shaped segments which comprise the twelve domains: overview/heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, healthcare practices, and healthcare practitioners. All of the domains are interconnected and allow for a more focused cultural analysis (Purnell, 2002).

### **Similar Studies**

Rew, L., Becker, H., Cookston, J., Khosropour, S., & Martinez, S. (2003) executed a similar study to measure cultural awareness of nursing students and evaluate nursing program cultural competency outcomes by developing an instrument called the cultural awareness scale (CAS), the same instrument used in this research study on measuring cultural awareness. Their study methods included two phases. Phase one developed the CAS of 37 items based on literature review with a Cronbach's alpha reliability coefficient of .91 from a nursing student sample. In phase two, the items were reviewed by an expert panel which determined a content validity index of .88 and reduced the CAS items to 36. Afterwards, the CAS instrument was administered to a sample of 118 nursing students to support the construct validity. The results of the combined samples supported the reliability and validity of the CAS for measuring the concept of cultural awareness in nursing students. However,

there were some limitations to the study results including a small sample of participants from one university which made the findings ungeneralizable.

Rew, L., Becker, H., Chontichachalalauk, J., & Lee, H. Y. (2014) conducted another study to reanalyze the cultural awareness scale (CAS) and determine its validity and differences among nursing students of different educational levels. The methods for this study involved using a sample of 150 nursing students from four various classes at a university. Two classes were lower level nursing students yet to begin their clinical nursing courses, one class was a senior leadership class in which cultural concepts had been discussed, and the final class was a master's level advanced psychosocial nursing course. The CAS was administered, and results showed evidence of significant differences among educational levels with lower level students scoring higher than upper level students. Also, findings displayed students who took a course on cultural diversity or global health generally outscored those who had not taken such a course. In terms of the reliability of the CAS tool, in two out of the three subscales measured the reliabilities were strong with .80 and .89, but in the clinical experiences subscale the reliability was lower at a 0.70. Rew et al. (2014) discussed some of these findings and explained how the lower level nursing students could have scored higher on average than the upper level students, citing the fact that the lower level students were recruited from a global health class. The study overall supported the three subscale structure of the CAS, a contrast from the original five-factor structure in the previous study.

Another similar pilot study was performed by Krainovich-Miller, B., Yost, J. M., Norman, R. G., Auerhahn, C., Dobal, M., Rosedale, M., Lowry, M., & Moffa, C. (2008) to measure nursing student cultural awareness by duplicating phase two of Rew, L., Becker, H.,

Cookston, J., Khosropour, S., & Martinez, S. (2003) study using the CAS. The design of this study included administering the CAS to nursing students in three different nursing programs: bachelor's, master's, and doctoral. The Cronbach's alpha for the CAS was 0.869 with subscales ranging from 0.687 to 0.902, which was supportive and agreeable to findings found by Rew et al. (2003). Krainovich-Miller et al. (2008) based on results recommended further research in the psychometric testing of the CAS among nursing students, including improvement of the CAS instrument as well as conducting further studies with nurses in the actual health care field.

An additional study on cultural competency of undergraduate nursing students was conducted by Ah, D. V. & Cassara, N. (2013) at a Midwestern University. The design of the study was administering an electronic questionnaire to enrolled undergraduate nursing students using the Caffrey Cultural Competence in Healthcare Scale (CCCHS). The CCCHS was a 28-item 5-point Likert self-rating scale to measure contact with other cultures, self-perceived knowledge, self-awareness, and comfort with cultural competence skills. The results found that students rated their comfort highest when working with a translator and their lowest scores related to knowledge with death and dying and other cultural practices. Also, only 28% of students perceived themselves as very comfortable and 15% as very skillful with culturally competent care. These findings support the notion that despite cultural competence education in curricula, nursing students feel inadequately prepared to provide culturally competent care.

Besides measuring nursing student cultural awareness between different educational levels, Mesler, D. M. (2013) study researched to determine if one of three curriculum types is more efficacious than the others to improve cultural competency. The three types of curricula

studied were having a nursing culture course, a non-nursing culture course, and an integrated throughout the curriculum approach. The Inventory for Assessing the Process of Cultural Competency among Healthcare Professionals (IAPCC-R) and the Transcultural Self-Efficacy Tool (TSET) were the instruments used to measure cultural competence and self-efficacy in the study. The results showed that a nursing culture course included in the curriculum allowed more nursing students to reach the level of cultural competence. Furthermore, the study implicated that an integrated curriculum for culture competency may not be a priority.

The final study reviewed was a bi-national simulation study between a school of nursing in North America and a school of nursing in Norway as a way to improve cultural awareness in nursing students conducted by Grossman, S., Mager, D., Opheim, H. M., & Torbjornsen, A. (2012). The research questions answered by this study included, “Does the use of simulation with cultural content have an effect on students’ cultural awareness based on Transcultural Self-Efficacy Tool (TSET) scores?; what is the difference between Norwegian and American students’ perceived cultural awareness based on TSET scores post-simulation?; and how do Norwegian and American students perceive the meaning of cultural awareness?” The results of this study found that statistically significant improvement occurred in scores on the TSET after practicing the simulations and students reported more confidence in cultural awareness and competency. Overall the findings suggested simulations could be useful for teaching cultural awareness and competency.

### **Gaps in Literature**

After a thorough literature review and analysis of the references above, several gaps were noted in relation to cultural awareness and competency. Although there was an abundance of information about culture, cultural awareness, and cultural competency and its significance for best nursing practice, less information was available about the best methods of teaching these concepts in nursing curriculum. Furthermore, even though there were studies conducted to measure cultural awareness and competency of nursing students, they were few and far in between and varied in the direction or sample in which they researched. For example, some research studies focused on measuring differences of cultural awareness between educational levels, and others concentrated on other aspects such as the most efficient curriculum type based on nursing student cultural awareness scores. Therefore, the studies analyzed were not very consistent and varied on the aspects of cultural awareness and competency focused on by the researchers.



## CHAPTER III

### Methods

The design for this research study was both quantitative and qualitative in nature. A quantitative survey was distributed to gather data about participants' cultural awareness and competency including attitudes and beliefs about other cultures and their experiences with cultural awareness within their nursing program. In addition, a qualitative survey was distributed to gather feedback and perceptions about cultural awareness and competency participants received from their nursing courses. This methodology was chosen for its ease of administration to a larger number of participants and its convenience to sample nursing courses at a small faith-based university. The principal investigator surveyed five different nursing cohorts, three in the Bachelors of Science in Nursing (BSN) program and two in the Associate Degree of Nursing program (ADN). The BSN program had three years of nursing courses and the ADN program had two years of nursing courses. Each class surveyed represented a year or level within the two different programs, ranging from sophomore to senior BSN and first to second year ADN.

### Setting

These surveys were administered in classrooms at the small faith-based university. The classrooms were located in The College of Health Sciences Building of the school of nursing and in another academic campus building, Elliott Hall. For each class surveyed, the professor provided permission for the surveying to be conducted during their allotted class time. In addition, the Dean of the school of nursing granted permission for this research study to be conducted and a copy of this can be seen in Appendix A. It is important to note that due to very tight course schedules, some of the classes surveyed took the surveys on a test day, so

that course content lectures did not need to be interrupted. Potentially, this factor could have had an impact on their focus and thoroughness when completing the surveys, especially the open-ended qualitative survey.

### **Sample**

A convenience sample of a total population of  $n = 166$  nursing students were surveyed. The population of BSN students was  $n = 79$  and the population of ADN students was  $n = 87$ . The breakdown of the three BSN courses and two ADN courses surveyed included NURS 261: Introduction to Nursing, NURS 361: Maternal/Child Nursing, NURS 441: Nursing Care of the Older Adult, NURS 114: Basic Concepts in Clinical Nursing, and NURS 290: Associate Degree Nursing Practice in Contemporary Society. Distinctions were made between the BSN and ADN student populations and distinctions were made between the senior levels (4<sup>th</sup> year BSN and 2<sup>nd</sup> year ADN) and junior levels (2<sup>nd</sup> and 3<sup>rd</sup> year BSN and 1<sup>st</sup> year ADN). The sample size of this study was similar in size to samples used in Rew, L., Becker, H., Chontichachalalauk, J., & Lee, H. Y. (2014) study and in Ah, D. V. & Cassara, N. (2013) study, which both had a sample size of 150 nursing students.

### **Instrumentation**

The instrument administered in this study was the Cultural Awareness Scale (CAS) developed by Rew, L., Becker, H., Cookston, J., Khosropour, S., & Martinez, S. (2003) at The University of Texas at Austin School of Nursing. Permission was requested by the principal investigator to utilize the CAS, and permission was granted by Lynn Rew. Documentation of this correspondence and permission can be seen in Appendix B.

The CAS assessment tool measures nursing students' perspectives of their level of cultural awareness and competency. The survey consists of 36 questions addressing cultural

awareness and competency with five subscales including general experiences, awareness and attitudes, nursing classes and clinical, research issues, and clinical practice. These subscales were applied to get a multifaceted outlook of the nature of cultural awareness and competency education and were supported by the literature reviewed performed by Rew, L., Becker, H., Cookston, J., Khosropour, S., & Martinez, S. (2003) when the CAS was developed. The most recent psychometric properties for the CAS survey included a Comparative Fit Index (CFI) of 0.868, Tucker-Lewis Index (TLI) of 0.854, Root Mean Square Error of Approximation (RMSEA) of 0.065, Standardized Root Mean Squared Residual (SRMR) of 0.086, and a Cronbach's alpha range from 0.70 to 0.89 (Rew, 2014). These confirmatory factor analysis findings supported the validity and applicability of the CAS and its utilization in this study to measure cultural awareness of nursing students.

Participants completed the CAS survey by marking their answers on a 7-point Likert scale ranging from strongly disagree to strongly agree for different statements in each subscale. For example, a student would read the statement, "Since entering this school of nursing my understanding of multicultural issues has increased," and rate this statement with the level the student agreed or disagreed with it based on their perception and self-reporting. Furthermore, if the participant felt that the statement did not apply for whatever reason, the participant could mark not applicable or N/A as their response. The CAS instrument distributed in this study can be found in Appendix C.

In addition to the CAS instrument, the principal research investigator created a qualitative focus questions survey to get open-ended feedback and data from the participants specifically related to their cultural awareness and competency education within the school of nursing. The qualitative survey consisted of three questions pertaining to activities or

cultural-specific content included in their nursing courses, their perceived level of cultural competency preparedness, and recommendations for improvement of cultural awareness and competency education in the school of nursing. Participants could choose to share this information by writing in responses to these questions or they could choose to leave them blank. The qualitative focus questions survey distributed in this study can be found in Appendix D.

### **Data Collection**

Prior to the study instruments being distributed and the data collected, the principal research investigator applied for and obtained approval from the Institutional Review Board (IRB). An exempt review request was granted by the IRB as the risk involved in this study was determined to be no more than minimal. The IRB approval letter can be found in Appendix E. Next, the principal investigator, with the help of the thesis advisor, identified the classes to include in the sample and planned when to distribute the surveys to each class. Data collection for this study occurred between April 2016 and May 2016. The principal research investigator visited each of the classes included in the sample and explained the research being conducted by reading an informed consent form (Appendix F) to the participants making sure to notify the participants of the voluntary nature of the surveys. The informed consent included the purpose of the study, subjects' rights for participating in research, potential risks and benefits, and the contact information for principal investigator, thesis advisor, and the university IRB. The principal investigator left the room while participants completed the surveying process, which took approximately fifteen to twenty minutes. Once surveying was complete, the participants returned completed and uncompleted

surveys by placing them into a large envelope labeled with the appropriate class and program.

The safety measures implemented during data collection included features to maintain participant confidentiality, data safety, and voluntary participation. To maintain participant confidentiality, no names or identifying information were included on the surveys and the principal investigator was not present during survey completion. Also, data safety was maintained by storing collected survey data hard copies in a locked file cabinet as well as via the principal investigator's computer under password protection. The nature of voluntary participation was preserved by reading participants the informed consent, which stated they could decline to participate in the study at any time and that their consent to participate was determined by their completion of the survey instruments. If subjects chose not to participate, they could leave the survey instruments blank and turn them in with the other completed surveys in the large envelope.

### **Data Analysis**

Data collected from the CAS surveys was entered into a Microsoft Excel spreadsheet on the principal investigator's computer. Then IBM® SPSS® Statistics Version 23 was used to analyze the results. Data were screened to ensure homogeneity of variance. Missing data was excluded from analysis. Only subscale sections where all questions contained within the subscale were answered were included in analysis. An independent t-test was used to compare the cultural awareness and competency of ADN nursing students and BSN nursing students. Another independent t-test was used to compare the cultural awareness and competency of combined ADN and BSN junior level students and combined ADN and BSN senior level students.

The data collected from the qualitative focus questions survey was analyzed by grouping similar responses to individual questions together in both the ADN and BSN programs. Therefore, all similar ADN responses were compared to similar BSN responses to look for any correlation and/or differences between perspectives of the two programs. In addition, the same analysis process was repeated by grouping similar responses between the combined ADN and BSN junior level students and the combined ADN and BSN senior level students to compare and contrast nursing student perspectives based on junior or senior status in the school of nursing.

## CHAPTER IV

### Results

#### CAS Quantitative Survey

The results of the independent t-test to compare the cultural awareness and competency of ADN and BSN nursing students by comparing subscale means were analyzed. Analysis found no significant differences between ADN students for the CAS subscales *General Experiences* (n = 86), *Nursing Classes and Clinical* (n = 81), *Research Issues* (n = 73), and *Clinical Practice* (n = 84), and BSN students for the CAS subscales *General Experiences* (n = 77), *Nursing Classes and Clinical* (n = 73), *Research Issues* (n = 63), and *Clinical Practice* (n = 79). Also, BSN students reported a higher mean score than ADN students in the CAS subscales *General Experiences* (BSN = 5.57, ADN = 5.23), *Awareness and Attitudes* (BSN = 4.60, ADN = 4.34), *Nursing Classes and Clinical* (BSN = 4.89, ADN = 4.87), and *Clinical Practice* (BSN = 5.51, ADN = 5.31). ADN program students did score a higher mean than BSN program students in the CAS subscale *Research Issues* (ADN = 5.08, BSN = 4.93). Overall, results found only one statistically significant difference between the ADN students and the BSN students. Scores for the Awareness and Attitudes CAS subscale were significantly different between ADN students (n = 87,  $M = 4.34$ ,  $SD = .85$ ) and BSN students (n = 78,  $M = 4.60$ ,  $SD = .78$ ), with BSN students scoring higher than ADN students,  $t(163) = -2.05$ ,  $p = .042$ . Results of comparisons of CAS subscales between ADN students and BSN students are listed in Table 1.

Table 1

*Comparison of Cultural Awareness Subscales between ADN and BSNs*

| Subscale                     | AND  | BSN  | <i>p</i> value |
|------------------------------|------|------|----------------|
| General Experiences          | 5.23 | 5.57 | .133           |
| Awareness and Attitudes      | 4.34 | 4.60 | .042*          |
| Nursing Classes and Clinical | 4.87 | 4.89 | .915           |
| Research Issues              | 5.08 | 4.93 | .545           |
| Clinical Practice            | 5.31 | 5.51 | .145           |

Note. \* $p < .05$ , two-tailed.  $p^{**} < .01$ , two-tailed.

The average scores for all subscales aligned with the responses “no opinion,” or “slightly agree,” without rounding upward. Students across both programs in all subscales of cultural awareness on average seemed to report having no opinion to only a little awareness and agreeableness with the cultural awareness and competency education received as well as their self-perception of having cultural awareness and competency skills.

The results of the independent t-test to compare the cultural awareness and competency of combined ADN and BSN junior level students and combined ADN and BSN senior level students by comparing subscale means were analyzed. Analysis found no significant differences between junior level students ( $n = 89$ ) and senior level students ( $n = 76$ ) for the CAS subscale *Awareness and Attitudes*, and between junior level students ( $n = 90$ ) and senior level students ( $n = 73$ ) for the CAS subscale *Clinical Practice*. In addition, combined ADN and BSN senior level students reported a higher mean score than combined ADN and BSN junior level students in all five CAS subscales, including *General Experiences* (Senior = 5.88, Junior = 4.97), *Awareness and Attitudes* (Senior = 4.58, Junior =



4.35), *Nursing Classes and Clinical* (Senior = 5.05, Junior = 4.74), *Research Issues* (Senior = 5.44, Junior = 4.59), and *Clinical Practice* (Senior = 5.50, Junior = 5.33). Several statistically significant differences between junior level and senior level students were found. Scores for the *General Experiences* subscale were significantly different between junior level students ( $n = 87$ ,  $M = 4.97$ ,  $SD = 1.44$ ) and senior level students ( $n = 76$ ,  $M = 5.88$ ,  $SD = 1.28$ ), with senior level nursing students scoring higher than junior level students,  $t(161) = -4.25$ ,  $p = .000$ . The scores for the *Nursing Classes and Clinical* subscale were significantly different between junior level students ( $n = 87$ ,  $M = 4.74$ ,  $SD = .66$ ) and senior level nursing students ( $n = 67$ ,  $M = 5.05$ ,  $SD = .77$ ), with senior level nursing students scoring higher than junior level students,  $t(152) = -2.72$ ,  $p = .007$ . The final set of significant scores were for the *Research Issues* subscale with a significant difference between junior level students ( $n = 69$ ,  $M = 4.59$ ,  $SD = 1.40$ ) and senior level nursing students ( $n = 67$ ,  $M = 5.44$ ,  $SD = 1.35$ ), with senior level nursing students scoring higher than junior level nursing students,  $t(134) = -3.63$ ,  $p = .000$ . Results of comparisons of CAS subscales between combined ADN and BSN junior level students and combined ADN and BSN senior level students are listed in Table 2.

Table 2

*Comparison of Cultural Awareness Subscales between Junior and Senior Levels*

| Subscale                     | Junior Level | Senior Level | <i>p</i> value |
|------------------------------|--------------|--------------|----------------|
| General Experiences          | 4.97         | 5.88         | .000**         |
| Awareness and Attitudes      | 4.35         | 4.58         | .074           |
| Nursing Classes and Clinical | 4.74         | 5.05         | .007**         |
| Research Issues              | 4.59         | 5.44         | .000**         |
| Clinical Practice            | 5.33         | 5.50         | .200           |

Note. \* $p < .05$ , two-tailed.  $p^{**} < .01$ , two-tailed.

The average scores for all subscales in the comparison between junior level and senior level nursing students aligned with the responses “no opinion,” or “slightly agree,” without rounding upward. Although senior level students scored higher on average in every subscale and significantly higher in three subscales, their averages still only are within the “slightly agree” range and suggest lower self-perceived cultural awareness and competency being received from the cultural awareness and competency education provided.

### **Qualitative Survey**

The results of the qualitative focus questions survey developed by the principal investigator showed various similarities and differences between the ADN and BSN programs as well as between senior and junior level nursing students. Firstly, the response of having to do a cultural project research presentation was mentioned by 50% of ADN students and 23% of BSN students. Also, both ADN students and BSN students reported doing case studies, 10% of ADNs and 8% of BSNs, as a method utilized to learn cultural awareness and competency. A difference noted between the programs in response to the first question about

culture-specific content covered was 16% of ADN students reported learning about culture-related illnesses, risk factors, and cultural beliefs and practices while 9% of BSN students mentioned learning content through some type of online module or simulation. In regards to the second question on the level of cultural competence, ADN students responded with 15% feeling very prepared and 8% feeling they have minimal or decreased preparedness. Some examples of decreased preparedness responses by students included, "I believe I am prepared to provide culturally competent care, however; I could be more prepared and tend to get nervous around patients who have strict beliefs/values because I am afraid of hurting their feelings," as well as, "I feel like on a scale of 1 to 10, 1 being not competent at all and 10 being as competent as I'll ever be, I'm at a 4." Only slightly more BSN students responded with feeling very prepared at 18% and the same percentage as ADNs, 8%, reported feeling having minimal or decreased preparedness. A few BSN student statements about their preparedness were, "We live in an area that is not very diverse, so as far as clinicals we are not very exposed to different cultures. We have talked about the major cultural differences we might face, but it's hard to apply or understand until we're actually exposed to those people," "Not very well at all," and "I feel like they have prepared me, though I wish we could do more." Finally, the third question asked for responses of improvements that could be made to the school of nursing for cultural awareness and competency education from both programs. 40% of ADN students and 53% of BSN students reported no recommendations and 38% of ADN students and 32% of BSN students did not complete the qualitative survey, leaving it blank. Of the responses received, a noted recommendation was including more cultural simulations, which 4% of BSN students recorded, with at least one response from every level, sophomore to senior.

Besides comparing the qualitative responses between the ADN and BSN programs, results were also analyzed and responses compared between combined ADN and BSN senior level nursing students and combined ADN and BSN junior level nursing students. The results of the first question about cultural content incorporated into their courses showed that the majority of senior level students, 57%, completed a cultural project that increased their perception of their cultural awareness and competency. One senior level student commented, “We also place a high emphasis on learning about different cultures and implementations for nurses to remain culturally respectful through various research assignments and presentations.” On the other hand, 21% of junior level students reported their main source of culture specific content was from lecture about beliefs, practices and diets of different cultural groups. Both senior and junior level students mentioned case studies as another source of cultural-based content with 12% and 7% respectively. The results of the second question of self-perceived cultural competence and preparedness showed a large difference between the level of preparedness felt by seniors and the level of preparedness felt by juniors. 51% of senior level students reported a range of adequately to very prepared to provide culturally competent care, while only 32% of junior level students reported being at least adequately prepared. This difference in preparedness can be seen by comparing the response of a senior level student and a junior level student as an example. One senior level student reported, “I feel very competent in caring for patients of different cultures because of information I’ve learned and resources to research information,” while another junior level student reported, “I do not feel prepared yet, however I am better than I used to be.” Furthermore, these findings seemed to correlate with results from the last question about improvements for including and covering cultural awareness and competency in the

curriculum. For example, 51% of senior level students responded to this question with no recommendations, the same percentage that felt they were adequately culturally competent based on their received education. However, 29% of senior level students did not complete the quantitative survey. In comparison, 42% of junior level students reported no recommendations and an even higher percentage of 40% did not complete the survey. Some participants did give feedback though to some actual ways to improve the cultural competency education. Among these suggestions were culturally sensitive simulations mentioned by both senior and junior level students, obtaining community and clinical experience, studying abroad, and inclusion of more cultural discussions.

## CHAPTER V

### Discussion

The purpose of this study was to measure and analyze the cultural awareness and competency of ADN and BSN nursing students in a small faith-based university. The assumptions made by the principal investigator were BSN students would score higher than ADN students as well as senior level students scoring higher than junior level students. By identifying the means and significant differences using  $p$  values for each CAS subscale and comparing them between the cohorts, inferences could be made about whether these assumptions were correct and the factors that influenced them.

Based on the results from analysis the assumption that BSN students would score higher than ADN students for the most part was correct as BSN students scored higher in every subscale except *Research Issues*, which was still not a significant difference. However, although BSN students scored higher overall, they only scored significantly higher in the *Awareness and Attitudes* subscale. The conclusion the principal investigator made about this was even though the assumption was correct, the fact that only one significant difference was found as well as the mean scores only aligning with “no opinion,” or “slightly agree,” signified both the ADN and BSN programs were similar in their outcomes of student perceptions of cultural awareness and competency. Furthermore, this similarity could be interpreted as negative because these average mean results are lower and they leave room for necessary improvement to the effectiveness of the cultural awareness and competency education being provided to nursing students in these programs. The comparison of the qualitative survey results between ADN and BSN students also supported this conclusion as the responses to the second question about their level of preparedness to provide culturally

competent care were very similar and showed room for improvement with only 15% and 18% feeling very prepared respectively, and 8% for both feeling they had minimal or decreased preparedness.

The other assumption made by the principal investigator about the outcome of the study was combined ADN and BSN senior level students would score higher than combined ADN and BSN junior level students. By analyzing the results, the principal researcher concluded that this assumption was accurate as senior level students scored higher in every subscale on the CAS, including three significantly higher scores in *General Experience*, *Nursing Classes and Clinical*, and *Research Issues*. These findings could be attributed to a number of factors, including but not limited to a higher number of nursing classes taken by senior level students, more clinical experiences than junior level students, and cultural research projects completed by senior level students. Moreover, this conclusion was reinforced by responses received on the qualitative surveys. 57% of senior level students reported they completed a cultural research project presentation that helped them increase their cultural awareness and competency, while 21% of junior level students reported their cultural content was gained through lecture based learning, which suggests because junior level students have yet to take the nursing course with the cultural research project they perceived themselves as less culturally aware and competent. In addition, when asked to rate their level of preparedness to provide culturally competent care, 51% of senior level students reported to being adequately to very prepared, much higher than the junior level students reported 32%.

Some other inferences could be drawn from the results of the qualitative surveys. The responses to the qualitative surveys were scarcer than the CAS survey with 38% Of ADN

and 32% of BSN students choosing to leave the survey completely blank. When broken down from the senior level and junior level perspective, 29% of senior level ADN and BSN students and 40% of junior level ADN and BSN students did not complete the survey. An inference as to why the lack of participation noted by the principal investigator was related to the circumstances and times some of the cohorts took the surveys. For instance, both of the ADN cohorts due to scheduling constraints were administered the surveys prior to taking a nursing test which might have deterred some not to complete the voluntary qualitative survey because it required a little more time and written feedback as well as some may have wanted to quickly start the test they had been studying for and not shift their focus. Some other explanations could have been that some students did not have any opinions on the matter of cultural awareness and competency and therefore did not feel the need to fill out the qualitative survey, or because both the CAS survey and qualitative survey were administered together some may have either felt overwhelmed and just answered the CAS survey, did not notice the survey, or forgot to answer the qualitative survey behind the CAS survey.

Besides the inferences that can be drawn about the lower response return for the qualitative survey, the student feedback about recommendations for improvement to the cultural awareness and competency at the school of nursing allowed for conclusions to be made about ways students felt could make them become more knowledgeable and culturally competent. Based on the responses the principal investigator concluded students perceived a lack of effectiveness in applying their cultural awareness and competency knowledge and skills. Supporting evidence included the majority of responses mentioning methods which were application based, such as cultural simulations, working in different communities, modules, case studies, and clinical experiences.



**Limitations**

There were several limitations identified in this study which should be noted for interpretation of the research conducted and for future research in this area. First, this study utilized a convenience sample of nursing students attending the same university of the principal investigator instead of a randomized sample. The sample came from a single, small university, and therefore the results cannot be generalized to other universities, schools of nursing, or nursing programs. Also, the CAS instrument and qualitative survey were self-reporting methods of conducting research and collecting data, which means response bias was very likely. Since participants are self-reporting their perceptions, they have the ability to report higher or lower than what they may actually think due to the pressure of social acceptability, therefore manipulating or skewing results. Furthermore, outside variables that could affect participants' cultural awareness and competency other than the cultural awareness and competency education being received from the school of nursing could not be accounted for, such as if participants had been exposed to other cultures by either living in them, studying abroad, or working/clinical experiences.

**Implications for Nursing Education**

The significance of strong cultural awareness and competency education has already been emphasized by the accreditation agencies for nursing programs, but unfortunately like similar studies have found, some nursing students are not perceiving themselves as culturally competent. The results of this study were not the exception as they pointed out the lack of effectiveness and room for improvement necessary to further increase the cultural awareness and competency education received by ADN and BSN students in the school of nursing. An internal investigation by the institution and faculty of the school of nursing was suggested by

the principal investigator to further examine the cultural awareness and competency curriculum to make needed improvements and ensure the education they are providing is more effective and meeting student needs. Not only does the topic need to be discussed, but also the best methods for teaching students with established standards.

There are several methods available to teach cultural awareness and competency education including classroom teaching strategies, clinical teaching strategies, and community-based cultural competency. The method mostly used by the school of nursing in this study was classroom teaching or lecture-based. This could include strategies such as the cultural projects mentioned by the senior level nursing students surveyed, case studies, and developing culturally congruent nursing care plans for specific cultures (Tool kit, 2008). Another method is using clinical teaching strategies, which is not emphasized as much in the school of nursing's curriculum. Clinical teaching strategies try to provide diverse clinical experiences for students to teach them cultural competency and apply their skills. These strategies may include providing different clinical settings, participating in community activities such as clinics or service learning, and keeping a journal of observations, feelings, and care in multicultural encounters with patients (Tool kit, 2008). Anderson, N. L. R., Calvillo, E. R., & Fongwa, M. N. (2007) explored community-based cultural competency approaches to strengthen cultural competency nursing education. Community-based cultural competency education incorporates the intent to provide opportunities for community involvement in research and service learning for students. Some schools of nursing accomplished this through placing students at community-based sites such as outpatient clinics, schools, community agencies, and public health centers (Anderson, 2007). Each of

these strategies can be effective separately, but it is up to the institution or nursing school to implement the one or multiple that will benefit their students the most if carried out correctly.

### **Future Research**

This study can be duplicated by other nursing schools and programs to gain insight and measurements of students' cultural awareness and competency. All accredited nursing programs and schools should measure their cultural awareness and competency curriculum to check its effectiveness and make necessary improvements. Additionally, other studies following the same group of nursing students through every level of a program are recommended to gain accurate information about progression of cultural awareness and competency education throughout the curriculum. Furthermore, even more complex studies on cultural awareness and competency in program curriculums and effective teaching methods should be conducted to find ways to progress and reinforce cultural awareness and competency education.

### **Conclusion**

The results of this study indicated cultural awareness and competency education in the small faith-based university school of nursing was lacking in effectiveness and has sufficient need for re-evaluation and improvement as evidenced by the average scores on the CAS aligning with "no opinion," to only "slightly agree," throughout the ADN and BSN programs based on student perceptions. Although the principal investigator's assumptions were technically correct with BSN students scoring higher on average than ADN students and senior level students scoring higher on average than junior level students, such low means are concerning because they imply only the bare minimum of competency and need for necessary improvements so all nursing students report higher levels of cultural awareness

and competency, especially by their senior year and subsequent graduation. This study should prompt the school of nursing to re-evaluate their cultural awareness and competency curriculum and encourage other schools of nursing to duplicate this study to measure their students' perceptions of cultural awareness and competency.

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Appendix A

Permission to Conduct Study from Dean

March 30, 2016

Dear Ms. Tate:

You are granted permission to conduct your Honors Thesis study titled “Culture Counts: An Analysis of Cultural Awareness and Competency among Nursing Students” in the Hunt School of Nursing.

As indicated in your request for permission, this study will involve the completion of the Cultural Awareness Student (CAS) survey by the sophomore, junior and senior class BSN students as well as the first year and second year ADN students. Participant anonymity and confidentiality will be maintained.

Good luck with your study.

Sincerely,

Sharon Starr, PhD, RN  
Dean, Hunt School of Nursing

## Appendix B

## Consent to Use CAS Instrument

Re: Student Request for Permission to use CAS Tool  
ellerew@gmail.com  
On behalf of  
Lynn Rew <ellerew@mail.utexas.edu>  
Sun 2/21, 7:34 PM Starr Tate

You may certainly use it. Please send me your results when you are finished. I have attached the tool and the most recent publication about its psychometric properties. Best wishes for a successful project.

On Sun, Feb 21, 2016 at 4:37 PM, Starr Tate <[atate5@gardner-webb.edu](mailto:atate5@gardner-webb.edu)> wrote:

Hi Dr. Rew,

My name is Starr Tate and I am a Junior BSN student at Gardner-Webb University in North Carolina. I am contacting you because I would love your permission to use the CAS tool for measuring cultural awareness since I am working on my Honors Thesis in Nursing and am doing a study on the cultural awareness of nursing students in our program. I would also appreciate you sending any other information or tools you recommend in addition to the CAS.

I look forward to hearing from you,

Starr Tate  
[atate5@gardner-webb.edu](mailto:atate5@gardner-webb.edu)  
[704-678-0750](tel:704-678-0750)

-- Lynn Rew, EdD, RN, AHN-BC, FAAN  
Denton & Louise Cooley and Family Centennial Professor in Nursing  
The University of Texas at Austin School of Nursing  
1700 Red River  
Austin, TX 78701  
Phone: 512-471-7941



## Appendix C

## CAS Instrument Distributed

**Cultural Awareness Student survey**  
**Administered by Starr Tate, Student Researcher**  
**Created by Shirin Catterson, Jeff Cookston, Stephanie Martinez, & Lynn Rew**  
**From The University of Texas at Austin School of Nursing**

Use the scale of 1 to 7 (1=Strongly Disagree, 4=No Opinion, 7=Strongly Agree) to indicate how much you agree or disagree with each statement.

Please note that the questionnaire is only about your experiences at the Hunt School of Nursing, not the entire University.

|  | General Experiences at this School of Nursing   | Does Not Apply | Strongly Disagree |   |   | No Opinion |   |   | Strongly Agree |
|--|---|----------------|-------------------|---|---|------------|---|---|----------------|
| 1.                                     | The instructors at this nursing school adequately address multicultural issues in nursing.  | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| 2.                                     | This nursing school provides opportunities for activities related to multicultural issues.  | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| 3.                                     | Since entering this school of nursing my understanding of multicultural issues has increased.   | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| 4.                                     | My experiences at this nursing school have helped me become knowledgeable about the health problems associated with various racial and cultural groups. | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| <b>General Awareness and Attitudes</b> |   |                |                   |   |   |            |   |   |                |
| 5.                                     | I think my <i>beliefs and attitudes</i> are influenced by my culture.   | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| 6.                                     | I think my <i>behaviors</i> are influenced by my culture.   | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |
| 7.                                     | I often reflect on how culture affects beliefs, attitudes, and behaviors.   | N/A            | 1                 | 2 | 3 | 4          | 5 | 6 | 7              |

|     |   |     |   |   |   |   |   |   |   |
|-----|---|-----|---|---|---|---|---|---|---|
| 8.  | When I have an opportunity to help someone, I offer assistance less frequently to individuals of certain cultural backgrounds.        | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9.  | I am less patient with individuals of certain cultural backgrounds.   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. | I feel comfortable working with patients of all ethnic groups.  | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. | I believe nurses' own cultural beliefs influence their nursing care decisions.  | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. | I typically feel somewhat uncomfortable when I am in the company of people from cultural or ethnic backgrounds different from my own. | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

#### Nursing Classes and Clinical

|     |  |     |   |   |   |   |   |   |   |
|-----|--|-----|---|---|---|---|---|---|---|
| 13. | I have noticed that the instructors at this nursing school call on students from minority cultural groups when issues related to their group come up in class. | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. | During group discussions or exercises, I have noticed the nursing instructors make efforts to ensure that no student is excluded.                              | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. | I think that students' cultural values influence their classroom behaviors (for example, asking questions, participating in groups, or offering comments.)     | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. | In my nursing classes, my instructors have engaged in behaviors that may have made students from certain cultural backgrounds feel excluded.                   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. | I think it is the nursing instructor's responsibility to accommodate the diverse learning needs of students.   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. | My instructors at this nursing school seem comfortable discussing cultural issues in the classroom.  | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

|     |   |     |   |   |   |   |   |   |   |
|-----|---|-----|---|---|---|---|---|---|---|
| 19. | My nursing instructors seem interested in learning how their classroom behaviors may discourage students from certain cultural or ethnic groups.      | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. | I think the cultural values of the nursing instructors influence their behaviors in the clinical setting.   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. | I believe the classroom experiences at this nursing school help our students become more comfortable interacting with people from different cultures. | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. | I believe that some aspects of the classroom environment at this nursing school may alienate students from some cultural backgrounds.                 | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. | I feel comfortable discussing cultural issues in the classroom.   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. | My clinical courses at this nursing school have helped me become more comfortable interacting with people from different cultures.                    | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. | I feel that this nursing school's instructors respect differences in individuals from diverse cultural backgrounds.                                   | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. | The instructors at this nursing school model behaviors that are sensitive to multicultural issues.  | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. | The instructors at this nursing school use examples and/or case studies that incorporate information from various cultural and ethnic groups.         | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

#### Research Issues

|     |  |     |   |   |   |   |   |   |   |
|-----|--|-----|---|---|---|---|---|---|---|
| 28. | The faculty at this school of nursing conducts research that considers multicultural aspects of health-related issues. | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. | The students at this school of nursing have completed theses and dissertation  | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

|     |   |     |   |   |   |   |   |   |   |
|-----|---|-----|---|---|---|---|---|---|---|
|     | studies that considered cultural differences related to health issues.  |     |   |   |   |   |   |   |   |
| 30. | The researchers at this school of nursing consider relevance of data collection measures for the cultural groups they are studying. | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. | The researchers at this school of nursing consider cultural issues when interpreting findings in their studies.                     | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Clinical Practice**

|     |   |     |   |   |   |   |   |   |   |
|-----|---|-----|---|---|---|---|---|---|---|
| 32. | I respect the decisions of my patients when they are influenced by their culture, even if I disagree.                             | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 33. | If I need more information about a patient's culture, I would use resources available on site (for example, books, videos, etc.). | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34. | If I need more information about a patient's culture, I would feel comfortable asking people I work with.                         | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35. | If I need more information about a patient's culture, I would feel comfortable asking the patient or a family member.             | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. | I feel somewhat uncomfortable working with the families of patients from cultural backgrounds different than my own.              | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 |



Thank you for completing this survey.  
Appendix E

IRB Approval



GARDNER-WEBB UNIVERSITY  
HUNT SCHOOL of NURSING

Dear Ms. Tate and Dr. Waters,

Your research study titled "Culture Counts: An Analysis of Cultural Awareness and Competency among Nursing Students" has been approved by the Gardner-Webb University Hunt School of Nursing's IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Approval Date: 3/31/16

Expiration Date: 3/31/17

#### Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and to obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Should any adverse event or unanticipated problem involving risks to the participants or others occur, the events must be reported immediately to the Hunt School of Nursing IRB representative.

During your study, you must retain all instruments/forms/surveys and data. Prior to the presentation of your data within the Hunt School of Nursing Research Day, you must submit all instruments/forms/surveys along with your data to the IRB representative. Failure to submit this information prior to the presentation will result in an inability to present your findings and will impact your graduation date. Prior to graduation, it is the responsibility of the student and the advisor/chair to ensure that this IRB is closed using the appropriate form.

Please contact me with any questions.

Best wishes on your research.

Sincerely,

Cindy Miller, PhD, RN  
IRB Representative  
Hunt School of Nursing

## Appendix F

### Informed Consent Form

#### Informed Consent

03/12/2016

Dear Research Participant,

My name is Starr Tate and I am a junior nursing student in the Honors Program at Gardner-Webb University. I am conducting a research thesis titled, "Culture Counts: An Analysis of Cultural Awareness and Competency among Nursing Students."

The purpose of this study will be to assess the Hunt School of Nursing's BSN and ADN student's perceptions of cultural awareness and competency. Cultural competency is one of the overall goals outlined in the Hunt School of Nursing Student Handbook and is a requirement of nursing curriculum for collegiate program accreditation. Therefore, I want to measure and analyze the cultural awareness and competency of our student nurses to assess the effectiveness of the Hunt School of Nursing in this area. I will distribute a survey that will take fifteen or twenty minutes to complete. You will be asked to respond to statements addressing issues in cultural awareness and competency by ranking them from strongly disagree to strongly agree. In addition, you will be asked a few focus questions for some open-ended responses and observations. The data collected from this study can be used to demonstrate the effectiveness of the Hunt School of Nursing teaching methods in preparing culturally competent and confident nurses. The implications of the results of this study could be improvements to the current cultural competency education provided in the Hunt School of Nursing curriculum.

The surveys collected will be kept completely confidential. No identifying information such as your name will be included on the survey. All collected surveys will be kept in a locked cabinet to protect the privacy of the information. Confidentiality will be maintained as no individual will have access to the surveys except for those part of the research team, including Starr Tate, Dr. Nicole Waters, and Gardner-Webb University IRB.

Participation in this research study is completely voluntary. You may choose not to participate. You also may quit the survey at any time. You may quit the survey by not completing the survey and turning it in blank. If you do not want to answer parts of the survey you may choose to leave them blank. Incomplete surveys or quitting the survey will

not affect the benefits you are entitled to and confidentiality will be maintained. You will not be contacted again to participate in the study after declining.

If you have any questions or concerns related to the research study or your rights as a participant in the study, at any time you may contact Starr Tate at (704) 678-0750 or the faculty advisor, Dr. Nicole Waters (704) 406-2302.

Thank you for your cooperation.  
Starr Tate