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Cultural Bias Education of Nursing Faculty

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Cultural Bias Education of Nursing Faculty

by

Frank Castelblanco

A capstone project submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

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Approval Page

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Abstract

A cultural bias education seminar was presented to nursing faculty at a private university in Western North Carolina in an attempt to increase the level of cultural competence. Leininger's "Culture Care and Universality"; a nursing theory was used as the theoretical framework for the project and Campinha-Bacote's Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals, Revised (IAPCC-R) was employed to measure the pre- and post-cultural competence levels of the nursing faculty. The faculty voluntarily completed the pre-assessment, the seminar was completed and 17 participants completed the post assessment. The statistical findings illustrated an increase in total cultural competence from a pre-intervention mean of 67.5 (SD=7.29) or culturally aware, to a post intervention mean of 74.53 (SD=9.24) or culturally competent. The findings proved to be statistically significant (level of significance $\alpha = 0.05$) with a p value of 0.01. There was an eight-fold increase in the number of nursing faculty deemed culturally competent in the post assessment as measured by the IAPCC-R.

Keywords: Implicit Bias Education, Cultural Bias, Cultural Competence, Nursing Faculty

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CHAPTER I

Introduction

Census reports indicate that the United States population is rapidly growing and is currently comprised of more than 150 diverse ethnic groups from other nations and cultures (Halloran, 2009). The growth in U.S. population diversity is due to a combination of such factors as immigration, birth rates, and an aging Caucasian population (Passel, 2011). These trends will continue to bring more of the world's cultures to our towns and cities. It is inevitable that these diverse groups will need healthcare services. The increase in the diversity of cultures in the U.S. population poses two major questions for healthcare: How do we provide care that is culturally sensitive and effective, and is it important to do so?

Nurses, about 2.3 million in number, comprise the largest component of the healthcare workforce (Bureau of Labor Statistics, 2012) in the United States. The nursing profession should not only be culturally competent in order to meet the needs of these culturally diverse patients (Maier-Lorentz, 2008), but is also charged to do so according to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standards (Office of Minority Health, 2001) and the American Association of Colleges of Nursing (AACN), 2008. The need for cultural competence training in nursing education is evident, and although certain measures have been initiated, very few are focused on those who are providing nursing education, the nursing faculty. This project, Cultural Bias Education of Nursing Faculty, is an attempt to provide and measure the effect of one specific aspect of cultural competence by providing a cultural bias education seminar.

Problem Statement

Social cognitive processes or cultural bias is an important component of cultural competence because it can possibly affect outcomes of care (Smedley, Stith, & Nelson, 2003). A report from the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* asserts the research on healthcare disparities, decrees these need to be addressed through cultural competence training, and brings to light the concept of unconscious or implicit bias among healthcare professionals (Smedley et al., 2003). Nursing faculty that train and educate nurses should possess the necessary skills and knowledge about culture and specifics, such as cultural bias, in order to prepare current and future nurses (Campinha-Bacote, 2007). There is no standard cultural bias education for nursing faculty. This project, Cultural Bias Education of Nursing Faculty, is an attempt to increase a nursing faculty's cultural competence level by creating and implementing a cultural bias education seminar.

Justification of Project

Nursing education is currently facing numerous challenges: curriculum changes (content to concept), nursing instructor shortages, pressure to achieve high National Council Licensure Examination for Registered Nurses (NCLEX-RN) passing rates, and meeting the healthcare education demands of a changing industry. The increase in the diversity of the US population is helping to drive some of these changes. Minorities are expected to become the majority by 2042 and half of the children in the US will be from a minority group by 2023 (Office of Minority Health, 2011). Hospital accrediting agencies such as The Joint Commission (TJC) (2010) are requiring hospitals to provide

culturally appropriate care to patients of diverse backgrounds through interpreters and staff education (The Joint Commission, 2010; Office of Minority Health, 2012).

Nursing programs are also responding to the requirements of state nursing boards' to provide instruction to nursing students on how to give patient-centered culturally competent care (North Carolina Nursing Practice Act, 2009). The National League for Nursing (NLN) (2005) included specific terminology about the changing societal needs and demands in their call to action position statement. The statement by the NLN on the profession's commitment to diversity education reaffirms the league's position "It will take all nurses, working together as colleagues, to create safe, diverse environments of healing. Faculty have the potential to be instruments of hope." (National League for Nursing, 2009).

It is a combination of these drivers that has led to the inclusion of cultural competence education within the curricula of many nursing programs; however, there is not a set standard cultural competence curriculum for nursing programs. This has consequently resulted in varying levels of cultural competence among students and faculty within these programs (Campinha-Bacote, 2008; Kardong-Edgren et al., 2010). The nursing faculty of these programs is charged with educating and providing culturally competent nurses to care for an ever-increasing diverse population (AACN, 2008).

The need for a standard cultural competence curriculum was addressed by the American Association of Colleges of Nursing, which suggested a basic cultural competence curriculum outline (AACN, 2008). Cultural bias is one aspect of cultural competence education that promotes awareness about non-conscious processes that can affect patient outcomes (Stone & Moskowitz, 2011). Cultural competence education may

assist nursing faculty in teaching nursing students to provide care that is sensitive to diverse populations and may aid in decreasing healthcare disparities (Smedley et al., 2003). These disparities are a result of low socio-economic status, reduced or limited access to healthcare, and a plethora of other factors. Cultural bias is just one of those factors that contributes to such health disparities and has largely been unexamined (Dovidio & Fisk, 2012).

Cultural bias may be defined as a social cognitive process that leads to a decision or action and is based upon a conscious or unconscious perception (Smedley et al., 2003; White-Means, Dong, Hufstader, & Brown, 2009). A healthcare provider is constantly making decisions about care and performs actions based upon those decisions. Cultural bias may affect decisions that healthcare providers make and therefore affect their actions, which in turn ultimately leads to patient outcomes that contribute to health disparities (Dovidio & Fisk, 2012). A study that demonstrates bias by nursing and other pre-professional healthcare students is one that revealed implicit race and skin tone bias preference for Whites and lighter skin over Blacks and darker skin (White-Means, et al., 2009). This study and others like it are examples of the role and potential influence that cultural bias education can play (White-Means et al., 2009; Green et al., 2007; Schulman et al., 1999).

Cultural competence education in nursing programs is varied and may be based upon prioritization of topics, content experience, clinical experiences and ad hoc implementation which are not purposely planned out (Kardong- Edgren et al., 2010; Momeni, Jirwe, & Emami, 2008). The variation or lack of a standard cultural competence curriculum has resulted in different levels of cultural education attainment as measured in

several studies (Hunter & Krantz, 2010; Campinha-Bacote, 2008; Kardong-Edgren et al., 2010; Momeni et al., 2008; Seneque, 2008). The variation in cultural competence curriculums and levels of attainment produces nurses who are not prepared to care for culturally diverse populations. A cultural bias education module as a specific component of a cultural competence curriculum may increase awareness of bias and add to the overall cultural competence level of the nursing faculty. This capstone project measured the cultural competence level of nursing faculty before and after attending a cultural bias education seminar.

As will be detailed further in the subsequent chapter of this Capstone Project, a thorough study of the background literature was conducted. A literature review on the subjects of cultural competence, cultural bias, implicit bias, and racial discrimination from the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database yielded numerous articles. For this capstone project, Cultural Bias Education in Nursing Faculty, the areas of nursing, psychology, sociology, and education were also explored.

Purpose

The purpose of this capstone project, Cultural Bias Education of Nursing Faculty, was to examine the effect of a cultural bias education seminar on the cultural competence level of nursing faculty in a nursing program. In order to create awareness and impart knowledge about cultural bias, a cultural bias education seminar was created and presented to a group of nursing faculty at a private university in Western North Carolina. The cultural competence level of the nursing faculty was measured prior to and following the intervention in order to measure the effectiveness of the seminar. Cultural bias education is an important component of cultural competence, as it may affect non-

conscious stereotyping and prejudice and therefore result in health disparities (Stone & Moskowitz, 2011).

The measure of nursing faculty cultural competence outcomes will add to the current knowledge base of cultural competence education. The results may also suggest a recommended format by which a particular cultural competence module, such as cultural bias, may be more successfully taught. The current lack of a set standard cultural competence curriculum validates the need for the project and more importantly the need to instruct nursing faculty in the specifics of cultural bias.

Project Question

The project question that was examined by this project: What effect will a cultural bias seminar have on the cultural competence level of nursing faculty?

Definition of Terms

The following definitions of terms will provide a guide to better understand cultural competence:

Culture is a combination of values, beliefs, norms, practices that are acquired and typically passed on through generations (Tomey & Alligood, 2006).

Environmental context refers to the way the patient's experiences with their physical, sociocultural and situational settings can guide their decisions and actions (Tomey & Alligood, 2006).

Ethnohistory the past experiences and events (the cultural history) of an individual or group (Leininger, 2001; McFarland & Eipperle, 2008).

Etic refers to the knowledge and beliefs of an event from a professional perspective (Leininger, 2001; Tomey & Alligood, 2006).

Explicit bias refers to conscious stereotypes, judgments, and negative beliefs (Boysen, 2009).

Human care and caring may be defined as a focused and supportive way to assist others in order to improve health, a human circumstance, a lifeway, a disability, or the dying process (Tomey & Alligood, 2006).

Implicit bias is unconscious or automatically activated judgments and actions whose causality is unaware to a person (Boysen, 2009).

Summary

There is a need for a standardized cultural competence curriculum. This project measured the implementation of one specific component, cultural bias education. The project measured the effectiveness of this education module in the nursing faculty. Leininger's Cultural Care and Universality Theory provided the framework and Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) tool (Appendix A) was utilized to measure the nursing faculty's cultural competence level (Campinha-Bacote, 2007). The results of this project may enhance and extend the current literature on cultural competence education and create greater awareness of the role of cultural bias.

CHAPTER II

Research-Based Evidence

In response to the change in U.S. demographics, cultural competence, diversity, and bias have garnered a great deal of attention in healthcare alone. The literature reflects this increase through a plethora of articles on the subjects. This literature review is a focused representation of the articles relevant to the cultural competence education, nursing faculty education, and cultural bias aspects of cultural competence in nursing. The literature review examined the disciplines of nursing, psychology, and education in order to provide a thorough and complete background on the subject. This project measured the implementation of one specific component, cultural bias education. The project measured the effectiveness of this education seminar in nursing faculty.

Cultural Competence Education

A Swedish study compared nursing school curricula content and analyzed it to find the extent of transcultural education within the various programs. The authors suggest there is a disconnect between the school educational plans and the practical implementation of cultural education resulting in the nursing students being inadequately prepared to care for diverse patients. An enlightening statement is proposed by the authors; they stress the importance and need of nursing faculty to experience culturally sensitive care education prior to teaching the didactic component. The study demonstrated that although Sweden experienced an increase in immigration, its cultural competence education for nursing students did not increase (Momeni et al., 2008).

A study in the United States that compared nursing students from six different Baccalaureate of Science in Nursing (BSN) programs concluded that all were effective at

attaining fundamental cultural competency (Kardong- Edgren et al., 2010). The study demonstrated an association between higher scores on the instrument and older age; previous degrees; certified transcultural nursing faculty; nursing students who had travelled outside of the US, and programs with more diverse nursing students. The authors suggest that perhaps the goal for nursing programs should be ‘cultural awareness’ instead of ‘cultural competency’ since the majority of the students were found to be ‘culturally aware’ and not ‘culturally competent’ (Kardong- Edgren et al., 2010).

In contrast, a single site study by Hunter and Krantz (2010) demonstrated an effective transcultural education nursing program that achieved equally positive results through an online setting as well as a traditional classroom one. The Transcultural Theory is the conceptual framework for the class as well as the study, and it entails understanding that values, truths, realities, and perspectives differ from person to person and that constructivism is the study of differing interpretations (Hunter & Krantz, 2010). The study measured the students’ cultural competence based upon the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R) before and after the cultural competence course. The Transcultural theory takes into account the individuals past experiences to help construct their own personal knowing or truth (Hunter & Krantz, 2010). Although the concept of cultural desire, the healthcare professional’s intentional wish to be culturally competent (Campinha-Bacote, 2007), was not formally taught in the class, it showed the largest gain in the results.

Waite and Calamaro (2010) posit that cultural competence education and training lead to improved patient outcomes, and describe the attainment of this knowledge as a journey and a process. The article describes cultural competence concepts in nursing

education and the application or misapplication of them through case studies. The authors emphasize the importance of educating nursing faculty, the instruction methods, and the incorporation of cultural competence in nursing curriculums and practice.

A Canadian study employed a trans-Atlantic nursing student exchange between senior Canadian nursing students and British, Estonian, Finish, and Swedish students in order to augment their cultural competence education (Koskinen et al., 2009). The qualitative study was conducted over a period of two years and examined the nursing student experiences through written accounts of their experiences known as critical incident technique (CIT). The results of the study demonstrated five main categories: cross cultural ethical issues, cultural and social differences, healthcare inequalities, population health concerns, and personal and professional awareness (Koskinen et al., 2009). The learning categories and the nursing students' reflections on their experiences would be implemented by the nursing faculty to enhance future cultural competence education.

A similar qualitative study by Maltby and Abrams (2009) described a nursing student immersion program as an approach to enhance cultural competence. The study examined the students' experiences through journal entries. The major themes that emerged were: Beginning to See, Thinking about the Seen, Wanting to Change the Seen, and Transformed by the Seen (Maltby & Abrams, 2009). The authors conclude that immersion is not the only method to achieve cultural competence, and that it is a process which can intensify that competence. Their process helps the students realize their belief systems and values in an expedited manner.

Seeleman, Suurmond, and Stronks (2009) address the topic of cultural competence education for doctors. The authors propose that cultural competence education is an “instrument” to help educate doctors and prepare them to plan care for populations with ethnic diversity. The lack of a strategy and definition is stated as being not fully developed in cultural competency education. The article puts forth a conceptual model with knowledge, attitudes, and skills as the concepts for the framework. This article illustrates a need for cultural competence education in the physician instruction arena, as well as other healthcare areas.

The use of simulation in nursing education was implemented by nursing faculty at Old Dominion University in an original manner (Rutledge, Barham, Wiles, & Benjamin, 2008). The nursing faculty set up a web-based virtual hospital, a high-performance simulator or mannequin, and connected the two through videotaped interviews of nursing students and the simulated patients. The scenarios employed the simulated patients in culturally diverse settings in order to provide feedback to the nursing students upon review of the videotaped interactions. The nursing faculty also added a personal response system during the feedback sessions to be able to direct specific learning points. The outcomes from the program included more culturally diverse education in the program and positive student experiences in a controlled setting where nursing students learn culturally appropriate care on simulated patients (Rutledge et al., 2008).

Haas, Seckman, and Rea (2010), all faculty at the Goldfarb School of Nursing at Barnes-Jewish College, employed similar cultural competence education through the use of patient care scenarios utilizing high fidelity patient simulators that are capable of verbal responses to student questions and simulation. The authors focused on the

humanistic components of caring as the construct for cultural competence education in the setting of simulation. (Haas et al., 2010).

Campinha-Bacote (2011) proposes that cultural competence is actually an extension of patient-centered care. The author further defines cultural competence as a set of skills that will aid the nurse in providing patient-centered care in the setting of cultural conflict. Campinha-Bacote's (2007) cultural competence model is applied as the conceptual framework for the paper. Campinha-Bacote provides Mnemonics to aid the reader in remembering the correct and complete way to perform a cultural assessment (Campinha-Bacote, 2011).

The review of the literature revealed two studies that utilized the Humanities or English departments to assist with cultural competence education by employing culturally significant novels or narrative vignettes as a medium (Burger, 2011; Slade, Thomas-Connor, & Tsao, 2008). The use of novels and vignettes or Pathography was an attempt to expose the nursing students to cultures and varied ways of living in a different format. In the case of the Pathography study, the students also practiced how to critically interpret and write about these transcultural interactions (Slade et al., 2008).

Mancuso (2011) outlines an ideal vision for teaching cultural competence. The author details the process; beginning with a conceptual model (Campinha-Bacote's in this case), defining the concepts or operational definitions, performing needs assessment, reviewing the literature, establishing annual education, developing contact hour cultural competence education, and establishing the overall vision. Mancuso points out that cultural competence education is a process and proceeds to describe the implementation of this process in a community hospital (Mancuso, 2011).

Hoffman (2011) presents a different perspective on cultural competence. The author presents the actual legal background for taking care of patients with limited English proficiency (LEP). The mandates include the Civil Rights Act of 1964, LEP Regulations and the 14 Culturally and Linguistically Appropriate Services (CLAS) standards. Hoffman suggests adherence to the five points of the Revised Guidelines in order for an entity or institution to be compliant with the mandates (Hoffman, 2011).

Nursing Faculty Cultural Competence Education

The report by Secor (2011) details the experience of a nursing faculty member that travelled to Haiti and taught in Leogane for 18 days. The report presents the perspective from the faculty as opposed to a nursing student and how the nursing faculty member learned firsthand about cultural competence through travel and teaching. The author employs Well's Institutional Cultural Model and describes the journey through the various phases as evidenced by the nursing faculty member's trip experience (Secor, 2011).

A detailed immersion experience by Streets (2011), describes a year-long commitment by the author to establish a foundation for being a culturally competent practitioner in the area of counseling psychology. The author, Barbara Faye Streets, refers to previous research that demonstrated that cultural immersion experiences aided in training to address racism and promote cross cultural competency. Streets posits that only through an immersion experience, the "conscious and unconscious biases that exist deep within" can we generate a "vulnerability and erase familiarity" in order to begin to comprehend our feelings about specific groups (Streets, 2011). In addition to describing 10 lessons learned during her immersion experience, Streets makes the recommendation

that teachers and teacher educators generate opportunities for students in cultural immersion both domestically and internationally. Streets states that bias exists within everyone but particularly in the context of familiarity, therefore by placing ourselves into the unfamiliar are more able to really delve inside and examine these biases.

A 2007 report by the Society of Internal Medicine Health Disparities Task Force outlines a basic cultural competence curriculum for physicians, but state that it may be applied to healthcare professionals in any specialty. The authors indicate three major objectives: first, acquire and develop comprehension of attitudes which may include implicit bias, mistrust and stereotyping; second, achieve a thorough understanding of health disparities, their sources and effects; and lastly, acquire the proficiency in communicating with different cultures, in different languages and across literacy levels (Smith et al., 2007). The authors suggest that teachers function as the local cultural competence experts and role models for their institutions and have a personal commitment to reducing healthcare disparities. The article recommends that institutions train faculty through professional societies, local experts, and other methods and, that this cultural competence disparities curriculum training be provided at the undergraduate and post-graduate level. The paper concludes by validating the magnitude and difficulty initiating this type of work but cites a staggering statistic; some 800,000 lives could have been saved in the previous 10 years if there had not been health disparities.

Bartels (2007) makes recommendations to improve nursing education. The author suggests that the anticipated roles of nursing educators need to be examined and supported in order to provide these educators. The preparation of these educators, particularly at the baccalaureate and master levels, is discussed and suggest that they be

doctoral prepared. This recommendation is based upon the need to expand from a practice based focus to a research and academic scholar focus. Based upon nursing data, Bartels posits that by providing support to these educators the quality of education and nursing practice may improve through internal motivation, collaboration, and process improvement.

Lin, Lake, and Rice (2008) propose a specific anti-bias curriculum for teacher preparation programs. The article highlights the changing landscape of the student population and the need to integrate and implement an anti-bias curriculum to prepare teachers to effectively meet their students' needs. The authors cite that only 20% of teachers felt they were well prepared to meet these needs, and refer to a "lack of pedagogical strategies" as a basis for the proposed anti-bias curriculum. The specific strategies for the program include: inviting parents (from diverse backgrounds) into class as guest speakers, scheduled home visits (by student teachers), reflection through journals and small group discussions, role play exercises, and service learning activities. The goals of the anti-bias program are to integrate the following: "inclusion, positive self-esteem for all, empathy and activism in the face of injustice" into all levels of teacher preparation.

A paper by Chun (2010) details the specifics of initiating cultural competence training for surgeons in a post-graduate training program. The author refers to the mandates requiring the education but also the ethical component of providing "optimum care, regardless of a patient's cultural background. The perspective however is from an advice approach, the author details the difficulties, lessons learned, and the resistance that the program encountered during initiation. The specific concepts Chun cites as being

necessary for success are: understanding of terminology, commitment from the organization and the individuals, and the utilization of validated tools or assessments to measure outcomes.

An article by LeLacheur and Straker (2011) discusses physician assistant education in the area of cultural competence. The Accreditation Standards for Physician Assistant Education explicitly state that the curriculum must include instruction to prepare the physician assistant to care for diverse patients (Accreditation Review Commission on Education for the Physician Assistant, 2010). The authors address the issue of subconscious bias and stereotyping based upon race, and further explicates how race classification is important for measurement of health disparities. They caution, however, not utilize it to generalize populations due to the greater differences within a racial group. Another caution given by the authors is not to assume the patient's race particularly in light of that information being placed in the medical record and thus creating possible false data. The authors propose that physician assistants ask about race and not base their assessment on assumptions but on assessment and the patient's subjective statements.

Bias

The study by Sabin and Greenwald (2012) focused on four conditions: Pain, Urinary Tract Infections, Attention Deficit Hyperactivity Disorder, Asthma and Pediatrician implicit bias. The authors studied pediatrician attitudes toward racial groups and the treatment given to these groups in the four common illnesses. The study employed: a survey that contained questions about explicit attitudes toward racial groups such as "my feelings toward African Americans are..." and would rate them from 0=cold

to 10=warm; four case vignettes that contained a degree of uncertainty (which can contribute to bias); and an Implicit Association Test which is a timed social cognition test. The results demonstrated a statistically significant result in the prescribing pattern of pain medication by pediatricians. The results imply an implicit bias in the readiness to prescribe pain medicine for African American patients.

A study in cardiology found that women and blacks were less likely to be referred for a heart catheterization as compared to men and whites (Schulman et al., 1999). This was a groundbreaking study because it was one of the first to demonstrate that once all extraneous factors were accounted for, a disparity existed and could be directly attributable to physicians and classified as bias.

Rathore and Krumholz (2004) propose that healthcare disparities need to be examined through a particular framework that is based upon clinical equity that measures treatment related to clinical need and whether or not they are equal for all groups. The paper makes the specific point of differentiating between variations in care, racial disparities, and bias. An initial point made by the authors is to clarify that utilization rate as a standard measure is inappropriate due to differences in need, preferences, benefit, and access to care. Therefore, it is incorrect to employ equal use as a measure, and suggest that under-treatment of a group has led to a health disparity. Instead, Rathore and Krumholz (2004) suggest that a three-tiered method for examining racial healthcare variations is: bias, disparity, and difference. The difference reflects a variation in healthcare that is observed. A disparity occurs when this difference is due to inappropriate care, which may resemble many forms, and results in a gap in healthcare outcomes. Bias occurs when disparities are a result of system structure such as insurance

status, financial drivers, and “treatment by poorer-quality healthcare providers”. The authors caution that careful examination of the data and, in relation to differences, disparities and bias should be the basis for policy or system changes.

In order to decrease provider bias, a group of researchers proposed a framework of strategies and skill sets: enhance internal motivation to reduce bias, raise understanding about the psychological origin of bias, boost provider’s confidence to interact with socially dissimilar patients, improve emotional regulation skills, and increase the aptitude to create patient partnerships (Burgess, Ryn, Dovidio, & Saha, 2007). The authors cite that the lack of progress in mending health disparities may be attributable to unconscious provider stereotypes and their lack of effective interactions with minority groups. The term “unconscious bias” is referred to as “habits of the mind” which once learned and repeated is highly resistant to change (Burgess et al., 2007). The authors’ intent is to increase awareness of bias and build confidence in motivated providers through changing the focus from viewing a group to viewing individuals and their attributes. There is also a focus on promoting positive emotional interactions and empathy by building effective partnerships. The proposed framework is evidence-based but not studied formally, and the recommendation by the authors is to utilize the framework as a basis to launch a program and evaluate, collect data, and review outcomes that may reduce racial bias in healthcare.

The role of physician bias was addressed from a legal perspective in a report by McClellan, White, Jimenez, and Fahmy (2012). The authors examined the question/perception that patients who are socioeconomically disadvantaged file more lawsuits against physicians. Examples of physician unconscious bias are detailed,

possible causes are listed and a strategy/solution of increasing culturally competent care is proposed. The results of the studies they reviewed demonstrated that litigation rates were in fact lower in the socioeconomic disadvantaged patients. In this report the authors, all attorneys, present cultural bias from a different perspective: the legal one.

Gaps in Literature

There is an extensive amount of literature on the topic of cultural competence education (American Association of Colleges of Nursing, 2008; Burger, 2011; Campesino, 2008; Campinha-Bacote, 2007; Chang & Kelly, 2007; Chun, 2010; Haas et al., 2010; Hunter & Krantz, 2010; Joint Commission, 2010; Kardong-Edgren et al., 2010; Koskinen et al., 2009; Lin et al., 2008; Maltby & Abrams, 2009; Mancuso, 2011; Mixer, 2008; Sargent, Sedlak, & Martsolf, 2005). The literature demonstrated that a limited amount of data exists on the topic of nursing faculty cultural competence education (Bartels, 2007; Lin et al., 2008; Smith et al., 2007; and Secor 2011). From a review of the literature, it was found that cultural bias has been examined by several researchers (Boysen, 2009; Burgess et al., 2007; Dovidio & Fiske, 2012; Lin et al., 2008; McClellan et al., 2012; Rathore & Krumholz, 2004; Sabin & Greenwald, 2012; Shulman et al., 1999; Smedley, Stith, & Nelson, 2003; Stone & Moskowitz, 2011; White-Means et al., 2009). There was some research about cultural bias education for healthcare professionals (Burgess et al., 2007; Sabin & Greenwald, 2012; Smedley et al., 2003; Stone & Moskowitz, 2011; and White-Means et al., 2009). There were no articles located on cultural bias education of nursing faculty. The absence of cultural bias education for nursing faculty validated this project and will add to the topic in literature.

Theoretical Framework

Dr. Madeleine Leininger is the nursing theorist that is credited with founding transcultural nursing, developing the Cultural Care and Universality Theory, as well as illustrating the process through the Sunrise Enabler Model (Leininger, 2001, Appendix B). Leininger's Culture Care Theory (Leininger, 2001) established a connection between culture and caring for the nursing profession (Maier-Lorentz, 2008). Leininger's theory has laid a foundation to emphasize how nurses provide culturally competent care and the culture of the patients who receive the care. Leininger's Culture Care Theory was the theoretical framework used to delineate the elements of the project.

The conceptual model for this project revolves around culture. The patient has a collection of influences and social structures that form their cultural history or ethnohistory (Leininger, 2001). The nurse concurrently provides care based upon the healthcare values or ethic within structured system. The propositional statements may be considered relational propositions due to the nature of the concept of culture. Leininger's Culture Care Theory intertwines the concept of culture and the relational propositions of cultural care practices and expressions (Leininger, 2002). The empirical research methods for this study included: a cultural competence seminar as the research intervention, a sample of nursing educators, Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) tool (Appendix A), and analysis of the data from the intervention.

The Cultural Care Theory stresses the differences or diversity and the similarities or universalities within transcultural care knowledge and practice with a goal of providing culturally congruent nursing care (Leininger, 2001; McFarland & Eipperle,

2008). Leininger believes that care is at the heart of nursing and culturally-based care for individuals, families, and groups is essential to curing and healing (Leininger, 2001; McFarland & Eipperle, 2008). If there is not congruence between the patient and the care provided then the incongruence can lead to culturally incompetent care. There are three modes of care within the theory (Culture care preservation and/or maintenance, Culture care accommodation and/or negotiation, and Culture care restructuring and/or repatterning), which Leininger created to assist nurses so that they may generate individualized culturally congruent care plans (Leininger, 2001; McFarland & Eipperle, 2008).

Leininger's Sunrise Enabler Model (Appendix B) illustrates the influences that a nurse should consider or "discover" when providing culturally congruent care (Leininger, 2001; Mixer, 2008). These influences include technological, religious, philosophical, kinship, social, political, legal, economic, and educational factors, in addition to cultural values, beliefs, and lifeways (Mixer, 2008). The patient influences are all part of the patient's worldview and should be assessed by the nurse in light of the patient's environmental context, language and ethnohistory, or cultural history (McFarland & Eipperle, 2008). The relationship between influences and the patient's contexts help to guide nursing actions and decisions (McFarland & Eipperle, 2008).

According to Tomey and Alligood (2006), Leininger's Cultural Care and Universality Theory employs the concepts of human care, caring, culture, emic, etc, health, and environmental context as a basis for the theory. Leininger's concepts not only form the framework for the Cultural Care Theory but also guide the nurse in giving

culturally congruent care which is then adapted to the patient's cultural values and lifestyle (Gebbru, Ahsberg, & Willman, 2007).

The Holarchy (Figure 1) includes the IAPCC-R as the tool to measure the nursing faculty cultural competence level. Campinha-Bacote's theory of Process of Cultural Competence in the Delivery of Healthcare Services is the theory that is applied due to its practical application of the concepts of cultural desire, awareness, knowledge, and skill in educational and healthcare settings (Transcultural C.A.R.E. Associates, 2011).

Leininger's Cultural Care and Universality Theory frames the process by incorporating a "Worldview" of the process and the fact that nursing faculty may be the initiators of cultural competence through their teaching and Leininger's Sunrise Model (Appendix A) suggests the interrelatedness of Culture Care and all of the factors that influence the outcome (Leininger, 2001).

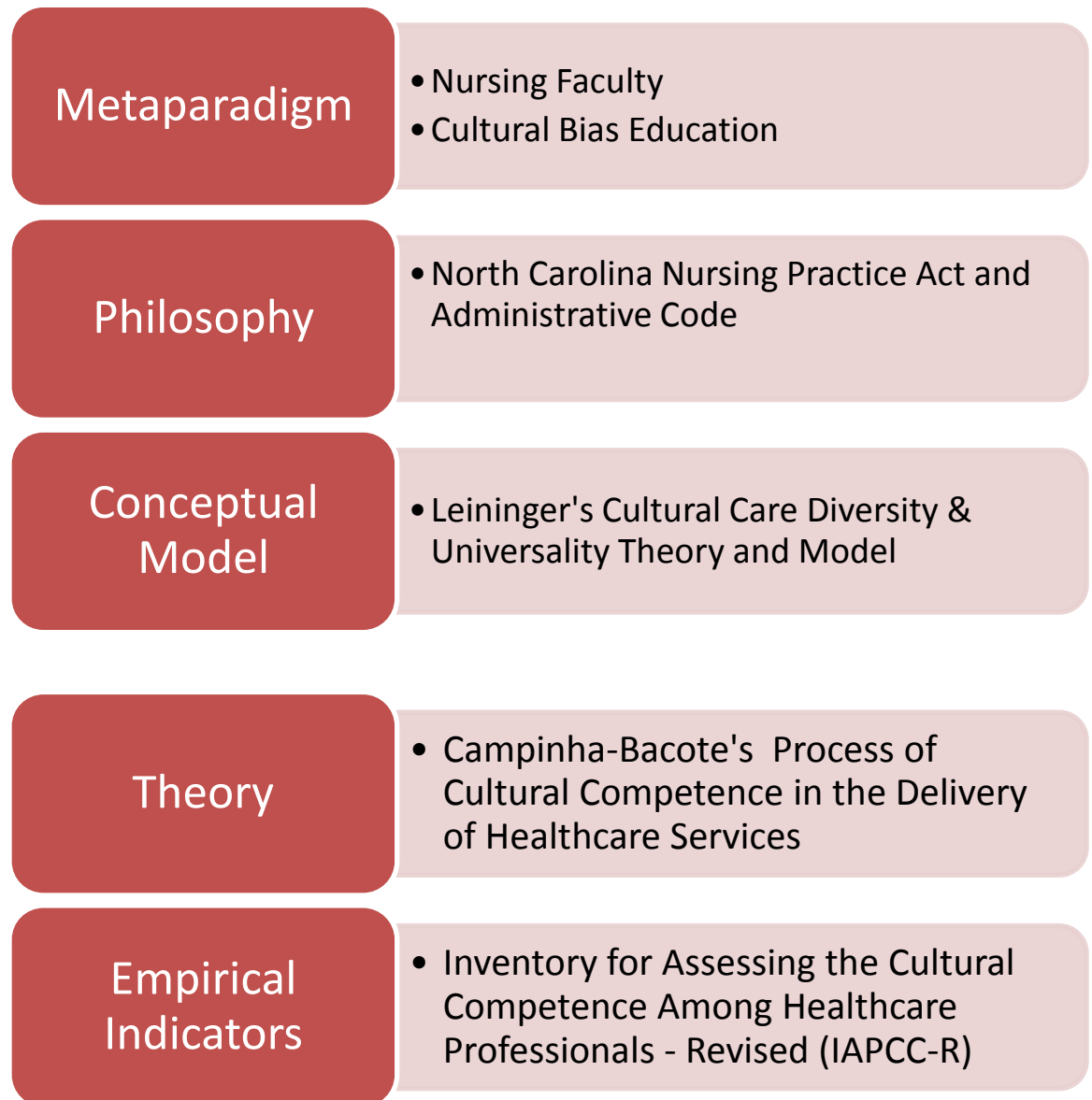


Figure 1: Holarchy

Summary

These studies represent specific topics concerning cultural competence, nursing faculty education, and bias. Case studies, research studies on concepts and cultural competence education, and surveys, comprised a fair amount of the final studies in the literature review. There is a significant amount of research on cultural competence and

health disparities. There is a very limited amount on nursing faculty education in relation to cultural competence. There are several studies that demonstrate bias in healthcare. There are no studies or papers that describe or are similar to the proposed capstone project, Cultural Bias Education of Nursing Faculty. This extensive review presents a representation of the current evidence-based practice literature.

CHAPTER III

Project Description

Social cognitive processes or cultural bias is an important component of cultural competence due to the possibility of it affecting outcomes of care (Smedley et al., 2003). The Institute of Medicine's 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* asserts the research on healthcare disparities, decrees the need for a plan to address these disparities through cultural competence training, and brings to light the concept of unconscious or implicit bias among healthcare professionals (Smedley et al., 2003). Nursing faculty that train and educate nurses should possess the necessary skills and knowledge about culture and specifics, such as cultural bias in order to prepare current and future nurses (Campinha-Bacote, 2007). There is no standard cultural bias education for nursing faculty. This project, Cultural Bias Education of Nursing Faculty, was an attempt to increase a nursing faculty's cultural competence level by creating and implementing a cultural bias education seminar.

The measure of nursing faculty cultural competence outcomes will add to the current knowledge base of cultural competence education. The results may also suggest a recommended format by which a particular cultural competence module, such as cultural bias, may be more successfully taught. The current lack of a standard cultural competence curriculum validated the need for the project and more importantly the need to instruct nursing faculty in the specifics of cultural bias.

Project Implementation

The purpose of this capstone project, Cultural Bias Education of Nursing Faculty, was to examine the effect of a cultural bias education seminar on the cultural competence

level of nursing faculty in a nursing program. In order to create awareness and impart knowledge about cultural bias, a cultural bias education seminar was created and presented to a group of nursing faculty. The cultural competence level of the nursing faculty was measured prior to and after the intervention to assess the effectiveness of the seminar.

Project Design

The Capstone Project provided a continuing education in-service Cultural Bias Education of Nursing Faculty program, for licensed registered nursing faculty employed at a private university in Western North Carolina. An invitation was extended to both full-time and part-time faculty. The program awarded two Continuing Education Units (CEUs) to those nursing faculty who attended. It also provided the nursing faculty with knowledge of awareness of their cultural bias. The in-service design included an interactive presentation which utilized video, activities of self-reflection, and skill building lessons. The Continuing Education Needs Assessment (CENA) (Appendix C) data (Table 2) established quantitative data to support the proposed capstone project. The design of the project was a quantitative study using a pre-post-test design to determine the effect of the IAPCC-R tool on nursing faculty at a private university in Western North Carolina.

The CENA (Appendix C) measured level of employment; highest level of education attained; the number of times attendees participated in cultural competence events; self-perceived level of proficiency with; CLAS Standards, Health Disparities; Knowledge of other Cultures and US Demographics; and areas of interest within Cultural Competence that would interest them. A total of 15 CENAs were returned prior to the

seminar. The breakdown of the demographic data (Table 1), levels of self-perceived proficiency and levels of interest are illustrated in (Table 2).

Table 1

CENA -Demographic Data

Demographic	N	Percentage of group
Employed Full time	15	100%
MSN Degree	6	40%
PHD Degree	5	33%
DNP Degree	3	20%
No previous Cultural Competence Event	9	60%
One previous Cultural Competence Event	2	13%
Two or more previous Cultural Competence Events	4	27%

Table 2

CENA -Levels of Self-Perceived Proficiency and Interest

Self-perceived Proficiency	VERY	SOMEWHAT	NOT AT ALL
CLAS Standards	7%	27%	67%
Health Disparities	13%	73%	13%
Knowledge of other cultures	27%	73%	None
US Demographics	13%	87%	None
Level of interest within Cultural Competence	VERY	SOMEWHAT	NOT AT ALL
Self-Awareness	40%	60%	None
Educational Resources	73%	27%	None
Cultural Bias	73%	27%	None
Knowledge & Skills	53%	47%	None

Setting

The setting for the Capstone project was a private, liberal arts university in Western North Carolina. The participants for the project were 16 nursing faculty employed at the School of Nursing who instruct in: Associate, Baccalaureate, Master's, Doctorate, and Nurse Practitioner programs. The nursing faculty was informed of the seminar and voluntarily participated. There were also three non-nursing faculty that participated in the seminar. The setting was a traditional classroom and an optional supplemental online exercise. The cultural bias curriculum was an interactive power point presentation with videos, self-reflection, and activities.

Sample

The sample for the needs assessment, the cultural bias seminar, and the post assessment for the Capstone Project were recruited from full-time and part-time nursing faculty teaching in the School of Nursing. The nursing faculty was recruited from a private university in Western North Carolina who volunteered to attend the in-service cultural bias education seminar.

Procedures

The project began with a thorough literature review to evaluate the current state of knowledge regarding cultural bias of nursing faculty. Literature regarding cultural bias substantiated recommendations to increase awareness and education of cultural bias.

The CENA of nursing faculty's self-perceived cultural competence level offered a baseline level for the Project Administrator and to validate the need for the seminar. The CENA for the project was completed in the university setting in Western North Carolina,

and collected basic demographic information, self-perceived cultural competence levels and interest levels (Appendix C).

Utilizing the data collected from the literature review and the CENA, the Project Administrator developed an in-service program, the Cultural Bias Education of Nursing Faculty. The recommendations included formal assessment of nursing faculty's level of cultural competence. An Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) tool (Appendix A) was employed and measured. A formal request was made to the author, Dr. Campinha-Bacote, for use of the tool and permission was granted (Appendix D). Following development of the in-service program, an application was made to a local tertiary care hospital for approval to award Continuing Education Hours (CEUs) for the two contact hours required for the in-service “Cultural Bias Education of Nursing Faculty”. A tertiary care hospital approved and provided two contact hours of CEU credit to the nursing faculty.

Protection of Human Subjects

The project administrator submitted an application to the perspective nursing program Institutional Review Board (IRB) before any research was conducted. The IRB application was to assure the level of commitment to the ethical principles for the protection of human subjects in research as established by IRB committees. The purpose of the IRB application was to protect the project participants from harm. It included a detailed plan of project procedures and process including a copy of the tool and a copy of the informed consent that the participants received and had to complete before they were able to participate in the project. The IRB was approved prior to conducting the project.

Instrument

The measurement tool that was utilized to assess the nursing faculty's cultural competence was the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) (Appendix A) developed by Campinha-Bacote in 2002 and revised in 2007. The tool was designed to measure the level of cultural competence of nurses in health professions (Campinha-Bacote, 2007).

The tool is a 25-item Likert scale self-assessment test that measures awareness, knowledge, desire, skill, and encounters and classifies the nurse as culturally: incompetent, aware, competent, or proficient. The Likert scale offers the participant the following four choices: strongly agree, agree, disagree, and strongly disagree. The estimated completion time is 10-15 minutes and the scores range from 25-100. The items are scored according to a specific scoring key and range from 1-4 points per question. The cultural competence levels are classified based upon the final score: Culturally Incompetent 25-50, Culturally Aware 51-74, Culturally Competent 75-90, & Culturally Proficient 91-100 (Campinha-Bacote, 2007).

The IAPCC-R tool has been utilized in several studies and the Reliability Coefficient Cronbach's Alpha was cited as substantiation for the use of the tool. A Cronbach Alpha greater than .7 is normally accepted as valid and reliable. These studies include A Comparison of Nursing Student's Levels of Knowledge: Cultural Competence in Providing Care Public versus Private Colleges by Wilson in 2011- Cronbach's Alpha .793, Psychometric Testing and the Effects of a Cultural Competence Education Module on the Cultural Competence of Student Physical Therapists: A Pilot Study by Okere, Gleeson, Melzer, Olson, and Mitchell in 2011 – Cronbach's Alpha .75, Through Service

Learning to Develop Cultural Competence Among Nursing Students by Hsiu-Chin in 2010 – Alpha .76, Assessment of Cultural Diversity Training: An Experiment for Hawaii Nursing Students by Young in 2009 – Cronbach’s Alpha .84, and Psychometric Testing of a Proposed Student Version of the Tool, “Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised” by Cronin and Campinha-Bacote in 2008 – Cronbach’s Alpha .783 (Transcultural C.A.R.E. Associates, 2011).

Data Collection

The CENA data (Table 1) that was collected prior to the seminar was utilized for classification and descriptive purposes. The demographic data was de-identified and did not have any other personal identifiers. The IAPCC-R tools were also collected prior to the seminar and were the basis for pre seminar baseline data. The IAPCC-R tools were given immediately after the seminar and were the measure for the post-intervention. The project administrator collected all the data.

Data Analysis

Data analysis was completed using the Statistical Package for Social Sciences (SPSS) Version 21. Analysis of the IAPCC-R measurement tool was conducted using frequency and percent of responses. Descriptive statistics of central tendency and variation were used to describe the faculty participants, the perceived incidence of cultural bias, and the participants’ evaluation of the Cultural Bias in Nursing Faculty program. Analysis to evaluate the IAPCC-R pre and post-test scores was performed utilizing a paired samples *t*-test.

Timeline

The project proposal was presented to an evaluation committee for review and approval was granted. The project administrator then contacted the prospective nursing program and faculty for possible inclusion in the project the semester before the project started to allow for proper planning and coordination. Once the nursing program gave its permission to conduct the project, the project administrator submitted the project for IRB approval from the appropriate agency that governs the project site. Once IRB approval was granted, the project was conducted. The project analysis was completed within one month of the conclusion of the project. The proposed timeline for the entire project was two semesters.

Budget

The needed resources for this project was funding for the use of the research tool, the nursing faculty's time, the curriculum time needed for cultural competence education and evaluation. The cost for the use of the tool per participant is \$8. The anticipated number of participants was between 10 and 16 thus a total cost for the tools was set at \$256 for 32 tools in order to account for the pre and post utilization of the tool. The final count of 32 tools was given in the pre and post setting. The project administrator absorbed the cost for the tools.

Limitations

The project was evaluated on an ongoing basis through formal and informal meetings with the project administrator's committee. Once the committee granted initial approval, the members were updated regularly about project participants, IRB approval, project initiation, and completion in addition to any difficulties encountered. The project

administrator notified the committee if there was to be any variation of the project from the proposed and approved version.

Upon completion of the Capstone Project, a summary was presented to the committee for formal approval and the project was concluded. The research question was answered based upon statistical findings from the data analysis. The results will be presented and discussed in the subsequent chapters.

Summary

This Capstone Project was an attempt to measure, through the IAPCC-R, the effect of a cultural bias seminar on the nursing faculty of a university in Western North Carolina. The proper IRB approval was sought prior to initiating any research. The project administrator conducted the seminar and employed an interactive power point presentation with videos, self-reflection, and skill building activities. Upon completion of the seminar all the data was analyzed and a summary of the findings was presented for review.

CHAPTER IV

Results

The Capstone Project, Cultural Bias Education of Nursing Faculty, was an attempt by the project administrator to examine the effects of a specific cultural competence seminar focused on cultural bias. The review of the literature demonstrated a gap in cultural bias education for nursing faculty validating the need for this project. The CENA measured self-perceived levels of cultural competence and interest in specific topics. A seminar was developed, based upon the CENA and the IAPCC-R, and was given to participants prior to the seminar to obtain pre-intervention (seminar) measurements of cultural competence. The seminar was conducted and the IAPCC-R was given to collect post-intervention measurements. The results of the pre- and post-IAPCC-R were statistically analyzed and the results will be outlined in the subsequent sections of the following chapter.

Sample Characteristics

The final sample for the project consisted of 15 full-time faculty for the pre-intervention CENA (Appendix C) and IAPCC-R and 16 (3 non-nursing faculty) post intervention post intervention IAPCC-R. The sample size is representative of the majority of the nursing faculty employed full time at the private university in Western North Carolina where the seminar, Cultural Bias Education of Nursing Faculty, was conducted.

The CENA provided basic demographic information of the nursing faculty. A total of 15 nursing faculty completed the CENA the month prior to the seminar. The CENA requested educational demographics, self-reported cultural competence levels, level of interest about particular topics, and previous experience with a cultural

competence seminar. The faculty were all full-time faculty with 40% holding a Master's of Science in Nursing (MSN) and the rest possessing either a Doctor of Philosophy (PhD) or Doctor of Nursing Practice (DNP), both terminal doctorate degrees in nursing (Table 1). A total of 60% had no prior experience participating in a cultural competence class.

The CENA self-reported levels of proficiency (Table 2) in cultural competence employed the scale of VERY, SOMEWHAT, and NOT AT ALL for the following categories: CLAS Standards, Health Disparities, Knowledge of other Cultures, and U.S. Demographics. The CLAS Standards represented the lowest self-reported level of proficiency with 34% reporting at least somewhat proficient. The highest self-reported level of proficiency at 100% was Knowledge of other Cultures. The levels of interest (Table 2) employed the same scale and the categories were the following: Self-Awareness, Educational Resources, Cultural Bias, and Knowledge and Skills. A total 73% of the nursing faculty reported that they were VERY interested in Educational Resources and Cultural Bias, thus representing the highest levels of interest for these two topics.

Major Findings

The IAPCC-R pre and post intervention responses were entered into Microsoft Office Excel and verified for accuracy. Missing values were excluded from the analysis which decreased the number of pre IAPCC-R to 10 and post IAPCC-R to 16. The cultural competence scores were computed according to IAPCC-R Scoring Key (Campinha-Bacote, 2007). The data were analyzed using IBM SPSS version 21. The tool was designed to measure the level of cultural competence of nurses in health professions (Campinha-Bacote, 2007). The tool is a 25-item Likert scale self-assessment test that

measures awareness, knowledge, desire, skill and encounters, and classifies the nurse as culturally: incompetent, aware, competent, or proficient. The items are scored according to a specific scoring key and range from 1-4 points per question. The cultural competence levels are classified based upon the final score: Culturally Incompetent 25-50, Culturally Aware 51-74, Culturally Competent 75-90, and Culturally Proficient 91-100 (Campinha-Bacote, 2007).

A total of 15 participants completed the pre evaluation survey and 16 participants (3 non-nursing faculty) completed the post evaluation IAPCC-R survey. Descriptive statistics (mean, median, and standard deviation) for each cultural competence category, and the total score for pre- and post-evaluation were computed in order to summarize the data. Internal consistency of each cultural competence category was assessed using Cronbach's alpha coefficient. The internal consistency was checked for the total scores and for each category (Table 3). The total Cronbach's alpha=0.768 for pre intervention and 0.854 for post intervention.

Table 3

Summary of Internal Consistency

Cronbach's alpha	Awareness	Knowledge	Skill	Encounters	Desire	Total
Pre	-0.552	0.711	0.621	0.591	0.756	0.768
Post	0.418	0.748	0.468	0.487	0.775	0.854

The cultural competence scores for each category and the total cultural competence scores for pre and post evaluation were checked for normality using Shapiro-

Wilk test. Two independent samples *t* test or the Mann-Whitney test were used to compare the pre-and post-evaluation scores depending on the normality of the scores.

The descriptive statistics demonstrated that the participants perceived higher cultural competence in all categories and for total scores at post evaluation compared to pre-evaluation (Table 4 and Figure 2). In particular, the post scores for Skill (M=14.88, SD=2.39) were significantly higher at 0.10 level ($p=0.080$) than pre scores (M=13.23, SD=2.55). The post scores for Desire (M=18.41, SD=1.70) were significantly higher at 0.10 level ($p=0.096$) than pre scores (M=17.25, SD=1.91). The post scores for Encounters (M=14.88, SD=2.39) were significantly higher at 0.05 level ($p=0.009$) than pre scores (M=12.36, SD=2.16). The total post scores (M=74.53, SD=9.24) were significantly higher at 0.05 level ($p=0.011$) than total pre scores (M=67.50, SD=7.29).

Table 4

Descriptive Statistics and Comparison of Levels (Pre & Post Intervention)

Category	Evaluation	Mean	Median	Standard deviation	p-value
Awareness	Pre	13.75	13.50	1.42	0.249
	Post	14.65	15.00	2.34	
Knowledge	Pre	10.47	10.00	2.80	0.240
	Post	11.71	11.00	3.02	
Skill	Pre	13.23	13.00	2.55	0.080*
	Post	14.88	15.00	2.39	
Encounters	Pre	12.36	12.00	2.16	0.009**
	Post	14.88	15.00	2.37	
Desire	Pre	17.25	17.00	1.91	0.096*
	Post	18.41	19.00	1.70	
Total	Pre	67.50	66.50	7.29	0.011**
	Post	74.53	70.00	9.24	

*Significant at 0.10 level

** Significant at 0.05 level

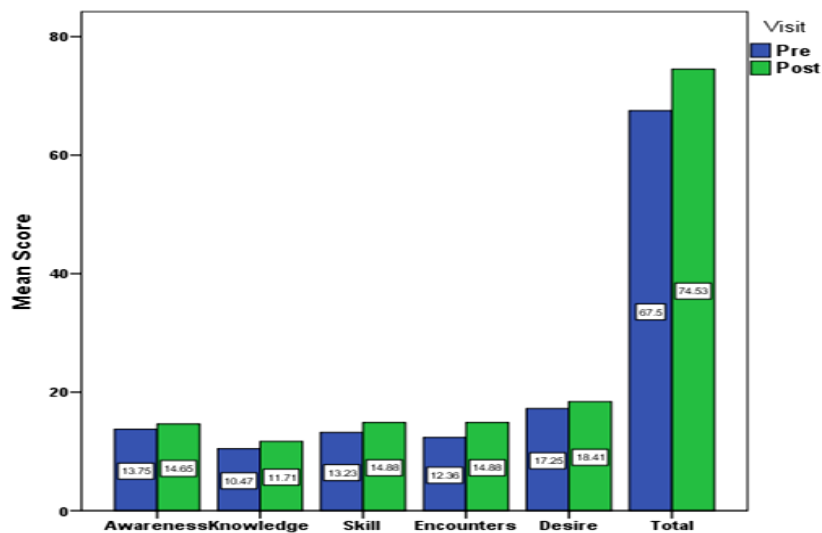
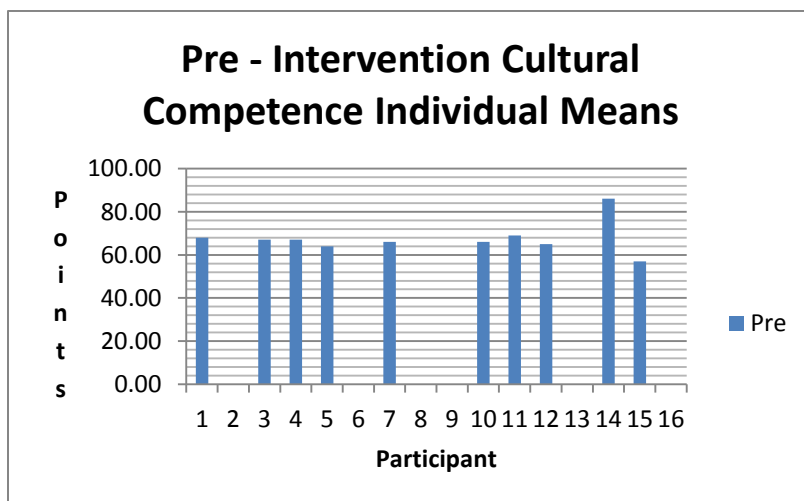


Figure 2: Category & Total Means



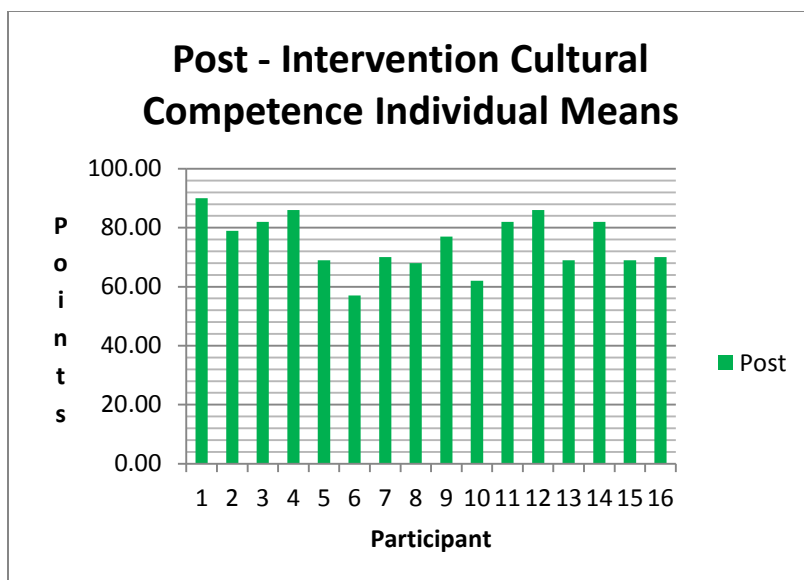


Figure 3: IAPCC-R Pre & Post Intervention Individual Results

IAPCC-R Key	
Culturally Proficient	91-100 Points
Culturally Competent	75-90
Culturally Aware	51-74
Culturally Unaware	25-50

Figure 4: IAPCC-R Categories – Key

Fifteen nursing faculty that completed the pre-intervention IAPCC-R, and 17 who participated in the seminar, 16 of which completed (3 non-nursing faculty) the post-intervention IAPCC-R. The total post-scores ($M=74.53$, $SD=9.24$) were significantly higher at 0.05 level ($p=0.011$) than total pre-scores ($M=67.50$, $SD=7.29$). In the pre and post intervention a total of 26 participants (Figure 3) completed sufficient data (incomplete IAPCC-Rs were not tabulated) to garner the following results:

Pre Intervention Score	
Culturally Proficient	0
Culturally Competent	1
Culturally Aware	9
Culturally Unaware	0
Total	10

Post Intervention Score	
Culturally Proficient	0
Culturally Competent	8
Culturally Aware	8
Culturally Unaware	0
Total	16

Figure 5: IAPCC-R Pre & Post Intervention Categories – Participant Totals

There was an increase in the overall number of nursing faculty that achieved a level of culturally competent according to the IAPCC-R score (Figure 3).

Summary

The purpose of this Capstone Project, Cultural Bias Education of Nursing Faculty, was to examine the effect of a cultural bias education seminar (intervention) on the cultural competence level of nursing faculty. The CENA collected demographic data, self-perceived cultural competence levels, and interest levels. The IAPCC-R measured the pre-intervention cultural competence levels of nursing faculty. The seminar was conducted and the IAPCC-R was repeated as a post-intervention measurement. The statistical results demonstrated several significant findings which will be discussed in the subsequent chapter.

CHAPTER V

Discussion

The increase in the diversity of cultures in the U.S. population poses two major questions for healthcare: how to provide care that is culturally sensitive and effective and why is it important to do so? The Capstone Project, Cultural Bias Education of Nursing Faculty, was an attempt to provide answers to these questions by measuring the cultural competence levels of nursing faculty prior to and after conducting a seminar on cultural competence. The IAPCC-R was utilized to measure the specific project question: What effect will a cultural bias seminar have on the cultural competence level of nursing faculty? The statistical findings illustrated an increase in total cultural competence from a pre-intervention mean of 67.5 to a post-intervention mean of 74.53 which proved to be statistically significant (level of significance $\alpha = 0.05$) with a p value of 0.01 (Table 4).

Implication of Findings

The nursing faculty self-reported a low previous experience (40%) with a cultural competence class. The low level of previous exposure to a cultural competence class or seminar may have contributed to the increase (in overall number) in cultural competence according to not only the total IAPCC-R scores but also within the categories. It is likely that the seminar was positioned to increase the level of cultural competence of the nursing faculty based upon their level of interest in the subject material (73%) and their level of prior exposure to a cultural competence class.

The IAPCC-R tool has been utilized in several studies and the Reliability Coefficient Cronbach's Alpha was cited as substantiation for the use of the tool. A Cronbach's Alpha greater than .7 is normally accepted as valid and reliable. The overall

internal consistency is high for this project (Cronbach's alpha=0.768 for pre and 0.854 for post evaluation). The overall Cronbach's Alpha score validated the use of the IAPCC-R, and the overall results were statistically significant with a p value of 0.01. The reliabilities are good for Knowledge and Desire categories however, the reliabilities on other categories were less robust (Table 3).

The results demonstrated that the participants perceived higher cultural competence in all the categories and for total mean scores at post intervention compared to pre-intervention (Table 4 and Figure 2). In particular, the post-scores for Skill (M=14.88, SD=2.39) were significantly higher at 0.10 level ($p = 0.080$) than pre scores (M=13.23, SD=2.55). The post scores for Desire (M=18.41, SD=1.70) were significantly higher at 0.10 level ($p = 0.096$) than pre scores (M=17.25, SD=1.91). The post scores for Encounters (M=14.88, SD=2.39) were significantly higher at 0.05 level ($p = 0.009$) than pre scores (M=12.36, SD=2.16).

The faculty's participation in the seminar seemed to increase the mean score for each category as measured by the IAPCC-R. The CENA's highest self-reported level of proficiency at 100% was Knowledge of other Cultures. This category showed the lowest overall mean and the least increase (Table 4). This may illustrate that an individual's self-perceived cultural competence level may not in fact match the research findings. The participants were masters and doctorate prepared faculty who perceived that they possessed a higher level of knowledge of other cultures. It is a difficult task to learn about every culture found in the U.S. It was the goal of the project administrator to increase the overall level of cultural competence. There was an overall increase from cultural

awareness to cultural competence, and therefore the general goal was achieved. Perhaps future seminars may include more specific information about other cultures.

Application to Theoretical/Conceptual Framework

Leininger's Cultural Care and Universality Theory employs the concepts of human care, caring, culture, emic, etic, health, and environmental context as a basis for the theory. The seminar was an attempt to integrate the concepts through classroom exercises, videos, and a didactic lecture and employ Campinha-Bacote's IAPCC-R (Appendix A) to measure the effectiveness of the seminar. The specific topic of cultural bias, though not included directly in Leininger's Sunrise Enabler (Appendix B), nor measured by the IAPCC-R, is by nature implicit or unconscious making it more difficult to label and measure. It is, however, interwoven in many of Leininger's concepts. It is also addressed indirectly through the measurement of self-awareness.

Implicit bias, as illustrated through numerous examples in the seminar, has been directly or indirectly responsible for an increase in health disparities. It was the intent of the seminar to increase the level of awareness of bias in healthcare to the participants, the nursing faculty. The faculty at this university educates nursing students pursuing associate, baccalaureate, masters and doctorate nursing degrees. There is currently no standard cultural competence curriculum for nursing students and no standard cultural competence training for nursing faculty. The seminar was an attempt to increase the general level of nursing faculty cultural competence, which it statistically accomplished, and to create awareness of implicit bias and its role in health disparities.

Limitations

The primary limitation of the project is the small sample size for both the pre-and post-intervention which might result in the insignificant results for the IAPCC-R measures of awareness and knowledge specifically. The low number of participants is also a direct result of the overall size of the program and the total potential for a seminar, which was limited to a maximum of 16. Although there was statistically significant increase in the overall level of cultural competence, the project results would be more robust if there were a greater number of participants. It is important to note that three non-nursing faculty participated in the seminar and completed the IAPCC-R, which may also represent part of the increase in cultural competence level. It is, therefore, difficult to generalize the results as typical among nursing faculty at larger institutions.

Implications for Nursing

The lack of a standardized cultural competence curriculum for nursing programs has not aided the profession in meeting the needs of the changing U. S. demographics. The nursing profession needs to develop a uniform curriculum or standards in order to provide more competent care and to aid in decreasing health disparities. The CLAS standards are an attempt by the federal government to help address the changing demographics and create a guideline and specific mandates to aid agencies to give culturally appropriate care.

The seminar was an attempt to model exercises and provide faculty with a starting point of resources to improve their own cultural competence. The participants were exposed to a variety of exercises and examples of how to teach cultural competence. Implicit bias is a complicated topic and the participants were receptive and open to

learning new concepts. In order to appropriately instruct faculty on cultural competence, a more comprehensive and extensive curriculum should be developed with specific measurable outcomes. Implicit bias may be added to such a curriculum once a base of cultural competence knowledge is achieved.

Nursing students will ultimately benefit from increased cultural competence levels of nursing faculty. The nurse of tomorrow will be responsible for providing culturally competent care amid a complicated and demanding healthcare system. Progressive nursing programs have initiated cultural competence classes that have been woven into curricula and have supported faculty development for cultural competence classes.

Recommendations

The two-hour seminar was an introductory class to cultural competence. The exercises, videos, and activities can be expanded to include many facets of cultural competence. Cultural bias education requires thoughtful planning and execution in order to successfully conduct this type of education. The participants each received a copy of the presentation, the CLAS Standards and numerous resources on a flash drive so as to be able to refer to the seminar and integrate pertinent aspects into their teaching.

The results of this project did support the concept of increasing cultural competence through a seminar-type model. However, further research/projects are recommended with more participants in order to be able to better assess and measure interventions and outcomes. In nursing, competence is often measured by skill acquisition. Cultural competence is a skill that may be measured, as the IAPCC-R demonstrated, but one that is complex and is not terminal. It will never be possible to

teach about every culture in order to provide culturally competent care but nurses should always strive to learn and practice this to the full extent of their abilities.

Conclusion

The Capstone Project, Cultural Bias Education of Nursing Faculty, increased the level of awareness of cultural competence of nursing faculty in a private university in Western North Carolina. The findings were statistically significant and will add to the very limited amount of existing research on cultural bias education of nursing faculty. It is also the first project that measured cultural competence levels of nursing faculty following a cultural bias seminar. This project will also add to the very limited body of knowledge on cultural bias education for nursing faculty.

The world is shrinking. Nurses will be caring for more diverse patient populations. Nursing faculty must prepare our future nurses. The nursing profession has the potential to create a standard cultural competence curriculum to better prepare nurses. Therefore, it is imperative that nursing faculties also receive appropriate cultural competence training. This project was an attempt to do so.

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Appendix A

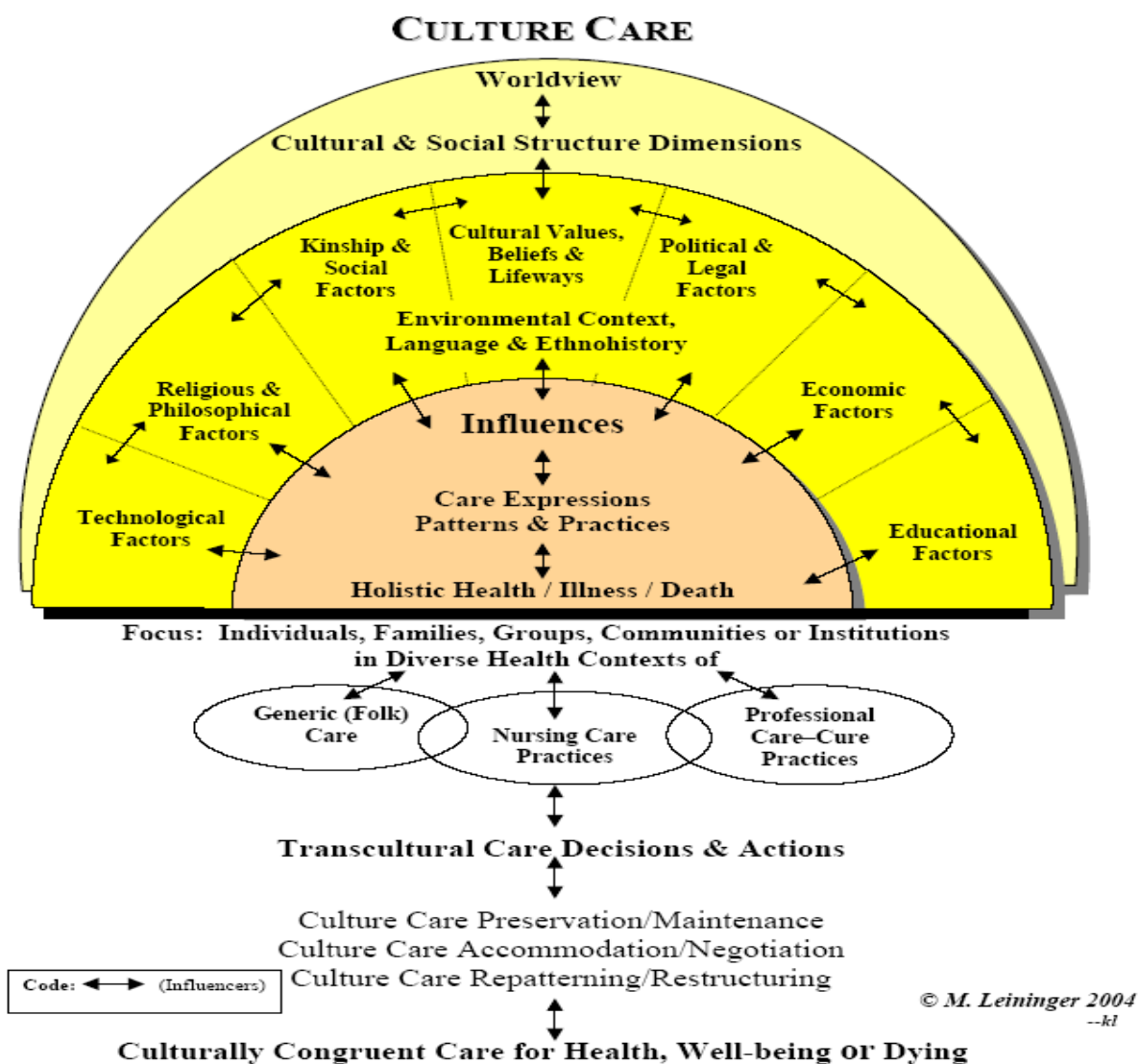
Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) ©

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Due to limitations of copyright laws the actual questionnaire is not available but can be referenced in Dr. Campinha-Bacote's book *The Process of Cultural Competence in the Delivery of Healthcare Services – The Journey Continues* (2007).

Appendix B

Leininger's Sunrise Enabler to Discover Culture Care

Appendix C

Continuing Education Needs Assessment

In order to ascertain and design a cultural competence seminar to fit the needs of the faculty please take a few minutes to complete this survey.

Are you employed - ☐ Part-time or ☐ Full time?

What is your highest level of education attained?

☐ LPN ☐ RN-Diploma ☐ RN-ADN ☐ BSN ☐ MSN ☐ PHD ☐ DNP ☐ Other _____

How many times have participated in a Cultural Competence CE event? _____

Please indicate level of proficiency under each area:

	VERY	SOMEWHAT	NOT AT ALL
CLAS Standards			
Health Disparities			
Knowledge of other Cultures			
US Demographics			

Please indicate which areas are of greatest interest to you within Cultural Competence:

	VERY	SOMEWHAT	NOT AT ALL
Self-Awareness			
Educational Resources			
Cultural Bias			
Knowledge & Skills			

Please indicate what topics you would like to see covered in a seminar:

1.

2.

3.

Thank you for your time.

Please return completed form to Lugene Moore in the GWU School of Nursing.

Appendix D



Clinical, Administrative, Research
& Educational Consultation
in Transcultural Health Care

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Date: November 2, 2012
To: Mr. Frank Castelblanco
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates
RE: Letter of Permission for Use of the IAPCC-R

This letter grants permission Mr. Frank Castelblanco to use the "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised" (IAPCC-R) to assess the level of cultural competence of 16 faculty at [redacted] University in the project entitled, "Cultural Bias Education in Nursing Faculty." I have received payment of \$256 for 32 tools to be used in this pre/post test project.

TIME FRAME: Permission to use the IAPCC-R in this project is limited to be used from January 1, 2013 through February 28, 2013. **Upon March 1, 2013 all unused tools must be destroyed.**

ADMINISTRATION: This permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in which Mr. Frank Castelblanco hand-distributes the tool to the participants and then collects the tool immediately following its completion. Mr. Frank Castelblanco agrees that the IAPCC-R cannot be administered in any other offsite format such as in an online course, internal or external mailings, or via an Internet website offering.

RESTRICTIONS OF COPYING: **Mr. Frank Castelblanco agrees that the IAPCC-R cannot be copied or reproduced in its entirety nor can any of the 25 items of this tool be copied for any reason. This includes**, but not limited to, being copied in formal or informal publications/ presentations, **in his DNP project paper** or in any academic papers in hard copy or electronic format, as handouts for presentations, PowerPoint presentations, and/or Poster presentations. The IAPCC-R is only to be used for the above purpose of onsite administration for 16 participants. Please reference, "www.transculturalcare.net/iapcc-r.htm or contact Dr. Campinha-Bacote at meddir@aol.com," in lieu of copying the IAPCC-R.

PUBLICATIONS: Mr. Frank Castelblanco agrees that any publications (formal or informal) or presentations of the findings of this study using the IAPCC-R will be shared with me.

Thank you for complying with the requests of using this copyrighted tool. Please contact me if you have any questions.