A major driving force for preparing culturally competent health professionals is to meet the Healthy People 2010 goal of improving and increasing years of healthy life and eliminating disparities among culturally and ethnically diverse patient populations (U.S. Department of Health and Human Services, 2000). In 2000, an estimated 35 million, or 12.3%, of the U.S. population were African American; 12.5%, Hispanic; 3.6%, Asian; 0.9%, American Indian; and 9.1%, other, accounting for almost 25% of the population in the United States (U.S. Bureau of Census, 2001). In comparison, census data indicate that minorities will account for 47% of the U.S. population makeup by 2050.

Cultural competence in healthcare delivery has been given much attention during the past two decades (Betancourt, Green, Carrillo, & Naneh-Firempong, 2003; Kagawa-Singer & Kassim-Lakha, 2003; Xakellis et al., 2004). This interest stems from the fact that patients from different cultural and ethnic backgrounds hold distinct understandings of health and illness (Heikkila & Ekman, 2000; Lam & Fielding, 2003); have different disease incidence for a variety of health problems, such as hypertension, diabetes, and cancer (Brinton et al., 1997; Cappuccio, 1997; Newman et al., 2004); and reveal different cultural beliefs that affect their health outcomes (Choi, 2002; Kruger & Gericke, 2003; Lworth-Anderson, Goodwin, & Williams, 2004).

The purpose of this training program was to prepare nursing staff in family-centered geriatric care that emphasizes providing culturally competent care to hospitalized elders at two major tertiary hospitals in New York. This research report corresponds to the first phase of a 3-year project. In this research project, a descriptive exploratory design was used to identify the levels of cultural awareness and cultural competence of nursing staff who participated in a family-centered geriatric care training program.

Cultural Competence Among Staff Nurses Who Participated in a Family-Centered Geriatric Care Program

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However, there is much evidence to suggest that nurses lack the skills necessary to deliver culturally competent care (Rosenfeld, Bottrell, Fulmer, & Mezey, 1999; Smith et al., 2002).

The other rising challenge for healthcare providers is the fact that the U.S. population is aging. In 2000, more than 12% of the total U.S. population was 65 years or older. During the next decade, as the baby boomers age, that number is expected to increase significantly. It is projected that by 2050, older adults will comprise 20% of the U.S. population (U.S. Bureau of Census, 2004). It is well documented that advanced age is associated with increased incidence of acute and chronic diseases such as heart failure, hypertension, stroke, and diabetes. This increase in disease incidence has resulted in further use of healthcare services, as evidenced by the fact that elders have high discharge rates, 355.7 per 1,000 individuals, and a long average length of stay, 5.9 days (U.S. Department of Health and Human Services, 2000). Furthermore, the diversity of aging among different ethnic groups affects their health and well-being in a way that reflects their unique cultural beliefs (Helman, 2000; Hewner, 1997). Consequently, achieving cultural competence status has become one of the most central issues for healthcare providers to meet the needs of a growing multicultural and aging society.

As a result, training relevant to the provision of nursing services to members of ethnic-minority groups is becoming an integral part of the curricula for preparing healthcare providers (Kobylarz, Heath, & Like, 2002). The core curriculum of ethnogeriatric teaching includes aspects related to acquiring positive attitudes toward elders from different cultures, gaining knowledge related to addressing healthcare needs within its cultural context, and gaining necessary skills for providing culturally competent care (Xakellis et al., 2004). In response to these challenges, Mount Sinai NYU Health and North Shore-Long Island Jewish Health System launched the Nursing Care Quality Initiative (NCQI) to prepare nurses who could act as geriatric resource nurses on their units (Smith et al., 2002). The NCQI program consisted of both geriatric and family-centered care, a model that recognizes the need of patients and family to be actively involved in all aspects of the healthcare plan (Fitzpatrick, Salinas, et al., 2004; Fitzpatrick, Stier, et al., 2004; Salinas, O’Connor, Weinstein, Lee, & Fitzpatrick, 2002; Smith et al., 2002; Stier et al., 2004; White et al., 2002). After completion of the NCQI project, a second training program for staff nurses was initiated in two of the hospitals that participated in the NCQI project, adding a focus on cultural dimensions of aging to the geriatric and family care components. This article is a description of the cultural component of the follow-up project.

To evaluate the educational program, the following question was addressed: What are the levels of cultural awareness and cultural competence among staff nurses who participated in a continuing education program focused on increasing knowledge of culturally competent geriatric care?

**EDUCATIONAL PROTOCOL**

The educational training program consisted of one cultural workshop (CW) and five sessions of the basic curriculum in ethnogeriatric care. The main focus of the CW was on understanding the components of cultural competence and its relevance to healthcare delivery. Ethnogeriatric education was aimed at introducing basic elements of culturally competent care of elders, information on the risk of health conditions and death among elders from different ethnic backgrounds, basic skills needed for a culturally competent geriatric assessment, and healthcare intervention related to the geriatric population. The ethnogeriatric curriculum was developed by experts of ethnogeriatric healthcare (Yeo, 2001). Since its development, it has been used in a number of geriatric curricula; the content is included in Appendix A. The content for the CW was adapted by project staff (see Appendix B).

**SETTING UNITS AND REGISTERED NURSE STAFF**

This study was conducted in two major tertiary hospitals in New York: Mount Sinai Hospital, located in Manhattan, and Long Island Jewish Medical Center, located in New Hyde Park. Both institutions combined employ over 3,000 professional nurses; 343 registered nurses (RNs) encompass the nursing staff on the 13 targeted medical surgical units. The majority are from ethnic minority groups, where African American, Asian, and Hispanic RNs account for 53.1% and 67.4% of nursing staff on the 13 targeted units at Long Island Jewish Medical Center and Mount Sinai Hospital, respectively. Nursing staff at these two key facilities provide healthcare to a diverse population from various ethnic and cultural backgrounds.

The sample consisted of 207 RNs who participated in the educational training program and completed the research questionnaires in Phases 1 and 2 of the current project. In the first phase, 65 unmatched pairs of RNs were enrolled in pretest and posttest groups. In the second phase, equal and matched pairs of 142 RNs were recruited for both pretest and posttest groups.

**QUESTIONNAIRES**

Two questionnaires were used in this study: Cultural Awareness Scale (CAS), adapted from Rew, Becker,
Cookston, Khosropour, and Martinez (2003), and the Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals-Revised (IAPCC-R) Scale (Campinha-Bacote, 2003).

The CAS was developed by adapting the items on the scale developed by Rew and colleagues (2003) for nursing students so that it could be used for assessment of cultural awareness among staff nurses. The CAS was used to measure the level of nurses' cultural awareness after introducing the educational program. The CAS consists of 13 items, where every item has values ranging from 1 (strongly agree) to 7 (strongly disagree). The total score ranges from 13 to 91, with a higher score reflecting less cultural awareness. Based on the obtained scores, respondents are divided into three categories: high, medium, and low cultural awareness levels. The Cronbach's alpha reliability coefficient was established using the sample of this study. Cronbach's alpha coefficient for internal consistency of instruments was conducted for the CAS and IAPCC-R using the total sample of the pretest and posttest groups. Cronbach's alpha for the CAS was .68 for pretest assessment and .73 for posttest assessment, demonstrating acceptable internal consistency. The standardized alpha for the IAPCC-R was .74 for pretest assessment and .83 for the posttest assessment (see Table 1).

Cultural competency was measured by the IAPCC-R Scale developed by Campinha-Bacote (2003). The IAPCC-R contains 25 items in five subscales representing five dimensions. The five subscales assess the cultural constructs of desire, knowledge, awareness, skills, and encounters. Responses to these items were rated using a 4-point Likert scale. To avoid response bias, some of the items are negatively expressed and the others are positively expressed. Scores on each item are summed for a total score after reverse scoring for negative items. Higher scores indicate more cultural competence. On the basis of the score, the IAPCC-R divides respondents into four categories: culturally incompetent, culturally aware, culturally competent, and culturally proficient.

The Statistical Package for the Social Science program was used for data analysis. For descriptive purposes, data analysis included means, median, standard deviation, and ranges to describe the levels of cultural awareness and cultural competence of the participants. The data were examined for abnormal distributions. The IAPCC-R scores were categorized into four levels of cultural competence to reflect the scale's category ranges.

FINDINGS

In the pretest group, 202 participants completed the CAS and 198 participants completed the IAPCC-R. The number of RNs who completed the CAS and the IAPCC-R in the posttest group was 199 and 197, respectively.

Cultural Awareness

Cultural awareness was measured using the CAS. The mean score for the pretest group was 31.26 (SD = 8.95), with scores ranging from 13 to 68 points. The posttest group mean was 28.52 (SD = 8.49), with a range of 13 to 57 points (see Table 2). In the pretest group, majority (171, 83.8%) of the participants think that their beliefs and attitudes are influenced by their cultures, and 165 (80.9%) think that their behaviors are influenced by their cultures. In contrast, 178 (89%) participants in the posttest group hold the same thoughts. In addition, 156 (75.7%) participants in the...
pretest group believe that their culture influences their care decisions. In comparison, 174 (87%) participants in the posttest group share the same beliefs. The majority of nursing staff had high cultural awareness level in both the pretest (83.2%) and posttest (89.4%) groups (see Table 3).

Measuring cultural competence by IAPCC-R revealed that the mean scores for the nursing staff of the pretest group was 67.30 (SD = 7.36), with scores ranging from 39 to 88. The mean for cultural competence of the posttest group was 70.60 (SD = 8.45). The minimum score for this group was 47; the maximum score was 90 (see Table 2). In the pretest group, 36 (17.6%) participants disagreed or strongly disagreed that there is a relationship between culture and health; however, this number was lower in the posttest group: 22 (11.1%) participants. In addition, 63 (30.4%) participants reported that they were not comfortable or somewhat not comfortable in asking questions that relate to the patients’ ethnic/cultural backgrounds. However, this number was lower in the posttest group: 40 (20.3%) participants. The majority of participants were culturally aware: 82.3% and 65.5% of participants in the pretest and posttest groups, respectively. The proportion of culturally competent nursing staff was 16.7% in the pretest group but was much higher in the posttest group, 28.9%; however, none of the participants was culturally proficient (see Table 4).

In addition to the scores on these two questionnaires, the project staff received a number of comments from staff nurses who participated in the educational program. Overall, the responses were very positive, both regarding the content and the expert speakers. One participant remarked that ethnogeriatrics should be incorporated into all divisions of healthcare, not only in geriatrics. Another staff nurse indicated that it was sometimes hard to accept cultural differences (from your own) regarding end-of-life care. However, another staff nurse indicated that it was important to remember the cultural needs of the patient, as nurses often get caught up in the tasks that have to be done rather than focusing on the patients and their families.

**DISCUSSION**

The majority of RNs had low scores on the CAS and high scores on the IAPCC-R, indicating relatively high cultural awareness levels. Given the fact that most RNs in both institutions are prepared at the bachelor of science in nursing level, and they provide nursing care to a multicultural community, it is not surprising that most participants had a high level of cultural awareness.

There are no published research reports that used the IAPCC-R in assessing the cultural competency level among RNs. In this study, the educational intervention led to higher levels of cultural competence among the nurses. Given the espoused goal of both nursing educational institutions and healthcare delivery facilities, this is an important finding, particularly for staff development programs. In this study, continuing education for RNs led to increased cultural competence. This finding has implications for staff development programs at all levels, particularly for staff nurses in acute care facilities. Cultural awareness education, such as the one implemented in this study, could be incorporated into staff development programs at all levels.

These findings must be interpreted within the limitations of the study. Given the nature of the study design and the convenience sample, the study has limited generalizability. It was not possible to determine the effect of nurses’ educational background, years of nursing-work experience, age, and ethnicity on cultural awareness and cultural competence levels. Moreover, some nurses who completed the questionnaires in the pretest group participated in the posttest group for Phase 1 of this study. Without knowing the extent of the overlap between the two groups, beyond

<table>
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<th>Cultural competence in Pretest and Posttest Groups</th>
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<tr>
<td>Pretest group (n = 147)</td>
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<td>Posttest group (n = 145)</td>
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<td>N</td>
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<td>---------------------------------------------</td>
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<tr>
<td>Culturally incompetent</td>
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<td>Culturally proficient</td>
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<th>Frequencies of Cultural Awareness in Pretest and Posttest Groups</th>
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<td>Cultural awareness</td>
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<tr>
<td>Pretest group (n = 152)</td>
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<tr>
<td>Posttest group (n = 149)</td>
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the use of descriptive statistics, it was not possible to make comparisons between groups. However, in Phase 2, this issue was addressed by matching participants in pretest and posttest groups. Consequently, the paired t test for Phase 2 of this study revealed a significant difference in nurses’ cultural awareness levels (t = 3.95, p < .001, n = 133) and cultural competence levels (t = −8.13, p < .001, n = 134) among RNs who received the educational program and those who did not. This indicates that the cultural training program was an effective measure in increasing nurses’ cultural awareness and cultural competence levels.

This study aimed to provide the basic elements toward preparing culturally competent nursing staff who could deliver culturally tailored care. There is still much to understand and to learn about how to integrate the cultural component of healthcare into nursing practice. Future studies should evaluate culturally designed training programs for effectiveness and, in a further step, assess the effect of delivering culturally competent care on nursing-sensitive outcomes. Studies should include RNs with different educational preparations.

CONCLUSION

Developing an understanding of the cultural dimension of care is a challenging task given the complexity and interrelationship of patients’ cultural background and healthcare providers’ cultural beliefs. Determining the levels of cultural awareness and cultural competence is an essential step for preparing nursing staff equipped with the necessary knowledge, attitude, and skills to provide culturally competent care. Moreover, culturally focused training programs are an effective means for preparing nurses to deliver culturally sensitive care.

REFERENCES


**ADDRESS FOR REPRINTS.** Joyce J. Fitzpatrick, PhD, RN, FAAN, Frances Payne Bolton School of Nursing, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106 (e-mail: joyce.fitzpatrick@case.edu).
APPENDIX A. Ethnogeriatrics Core Curriculum*

Module 1: Introduction and overview
Introduces basic concepts in culturally competent care of elders and summarizes sources and patterns of demographic data on the ethnic diversity of elders in the United States.

Content outline

1. Ethnogeriatrics as a field
   A. Healthcare for elders from diverse ethnic backgrounds
   B. Intersection of the studies of aging, ethnicity, and health
   C. Importance of ethnogeriatrics

II. Impact of cultural factors on geriatric care
   A. Culture works to create differences in explanations of disease and treatment
   B. Effects of ethnocentrism.

III. Demographic data on elders from diverse ethnic populations
   A. Sources of U.S. data and their limitations
   B. Most recent numbers and percentages of older Americans in major ethnic populations from census data
   C. Past trends and future projections of changes in sizes
   D. Heterogeneity within ethnic populations

IV. Theories used in ethnogeriatrics
   A. Dearth of theoretical bases
   B. Explanatory models of health and illness
   C. History of double and triple jeopardy hypotheses of minorities, aging, and health
   D. Ecological approach: a contextual approach that identifies systems within which individuals act, presented as a series of concentric circles.

V. Intercultural dynamics
   A. Importance of cultural factors in healthcare encounters and settings
   B. Acculturation continuum
   C. Levels of culture and their expression in a healthcare encounter

VI. Policy affecting healthcare for ethnic elders
   A. Major implications of federal, state, and local policies on healthcare and support for older adults from diverse ethnic backgrounds (e.g., lack of access to Supplemental Security Income and Medicaid by noncitizen immigrants).
   B. Policies of health settings that differentially affect ethnic elders (e.g., lack of interpreters or written health education materials in elder’s language)

VII. Cultural competence in ethnogeriatric care
   A. A continuum based on degree of effectiveness of skills and service delivery in caring for elders from diverse ethnic backgrounds
   B. System- or institutional-level components
   C. Individual provider level
   D. Ethnic-specific versus multiethnic models of healthcare

VIII. Principles of geriatric care

(continues)
Module 2: Patterns of health risk.
Overview of the available information on the risk of health conditions and death among elders from diverse ethnic backgrounds.

Content outline
I. Mortality
II. Morbidity
III. Functional status
IV. Social support
V. Statistical differences are not always meaningful differences
VI. Variations by education and income level, access to care, and lifestyle, and sometimes, in general, although elders from ethnic populations other than White receive higher levels of support from members of their immediate families, within each ethnic group, there are isolated elders with weak or no family ties.

Module 3: Culturally appropriate geriatric care: Fund of knowledge
Background information that geriatric providers should have to provide effective care to elders from diverse cultural backgrounds, including the importance of knowledge of (a) major systems of health beliefs, including the use of complementary/alternative medicine and issues in end-of-life care; and (2) major historical events experienced by cohorts of elders in the United States from diverse ethnic backgrounds.

Content outline
I. Systems of culturally based health beliefs, use of complementary/alternative medicine, and issues in end-of-life care
II. Historical experiences of cohorts of older ethnic populations
   A. Cohort analysis is a tool to understand the impact of historical experiences of various ethnic cohorts on the lives of elders. It includes major influences on the ethnic group during the lifetime of the current population of elders, such as periods of higher discrimination or immigration.
   B. Use of cohort analysis in clinical care

Module 4: Culturally Appropriate Geriatric Care: Assessment
Basic background and skills needed to provide a culturally competent geriatric assessment. Targeted areas within the module include strategies for effective communication, guidelines for use of standardized assessment instruments, and the five domains of ethnogeriatric assessment (client background, clinical domains, problem-specific information, intervention-specific data, and outcome criteria).

Content outline
I. Preparatory considerations
   A. Demonstrating respect to older patients in culturally appropriate ways to establish a trusting relationship.
   B. Communication issues
II. Ethnogeriatric assessment
   A. Background/contextual topics
   B. Clinical assessment domains
   C. Use of standardized assessment instruments (e.g., cognitive status, depression, and functional status).
   D. Intervention-specific data
   E. Outcomes-specific data: negotiating therapeutic outcome criteria with older adults/family members
   C. Problem-specific data: Elicit explanatory models of illness from patient and relevant family members

Module 5: Culturally appropriate geriatric care: Healthcare Interventions. Access and utilization
Presentation of cultural issues in the delivery of geriatric healthcare after assessments are completed, including health promotion, informed consent, medications, dementia and care giving, long-term care, surgery, and working with families. Patterns of utilization of healthcare services by elders from different ethnic populations and barriers to that utilization are also presented.

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### APPENDIX A (CONTINUED)

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<td>I. Ethnic issues in healthcare interventions for older patients</td>
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<td>A. Health promotion strategies recommended for ethnic elders</td>
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<td>B. Issues in treatment and response to treatment</td>
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<td>II. Access and utilization</td>
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### APPENDIX B. Cultural Workshop*

**Objectives**

By the completion of this seminar, the learner will be able to

1. Discuss an overview of cultural competency in healthcare delivery
2. Define cultural competence in healthcare delivery
3. Discuss the five components of cultural competence in healthcare delivery
4. Develop awareness of own cultural understandings

**Content outline**

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<th>I. Introduction</th>
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<td>A. Overview of the presentation</td>
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<td>II. Cultural awareness</td>
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<td>A. Definitions</td>
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<td>B. Current federal and national standards/guidelines</td>
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<td>III. Campinha-Bacote’s model and application of cultural competence</td>
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<td>A. Cultural awareness</td>
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<td>IV. Conclusion</td>
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<td>A. Summary</td>
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<td>B. Questions/answers</td>
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<td>C. Evaluations</td>
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