A Comparison of Self-Reported Cultural Competency Skills Among Two Groups of Nursing Students: Implications for Nursing Education

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ABSTRACT
This study was designed to examine self-reported cultural competency skills of second-semester junior-level nursing students toward clients from culturally diverse backgrounds. The purpose of this study was to ascertain if the addition of an innovative cultural sensitivity intervention facilitated greater self-perceived cultural competency skills when compared with the traditional method of incorporating cultural diversity into a junior-level clinical course. The Ethnic Competency Skills Assessment Inventory was used to collect data from participants attending a university in an urban midwestern county. Significant differences were noted between the pretest scores and posttest scores. Pretest scores were significantly lower than posttest scores for both groups. Nurse educators must examine further the differences in learning experiences related to cultural diversity that may account for these differences.

The quality of the services provided to culturally diverse clients is affected by the extent to which student nurses respond to the interactions between culture and health care. Yet, many students lack the basic understanding of cultural pluralism needed to maximize competency with ethnically and racially diverse clients (Varricchio, 1987). To continue to ignore this fundamental relationship in the basic education of nurses can restrict the quality of nursing performance, as well as client satisfaction (Roada, 1993; Rothenburger, 1987). The development of culturally competent care is essential because of increasing diversity, increasing disclosure of identities, care delivery moving to homes, and increasing inequity in access to health care (Meleis, 1996). Providing such care requires a knowledge base that can guide the processes used to provide culturally competent care (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).

Purpose
The purpose of this study was to ascertain if the addition of an innovative cultural sensitivity intervention (three onsite consultations by an expert in cultural nursing) facilitated greater self-reported cultural competency skills when compared with the traditional method of incorporating cultural diversity into a clinical course. The Ethnic Competency Skills Assessment (ECSA), a self-report instrument, was used to collect data from participants. The focus of this research was to determine whether a statistically significant difference existed on cultural competency skills scores between two groups of second-semester junior-level nursing students—one group received an innovative treatment and the other group received the standard or traditional treatment. The expectation was that an answer to this question would provide direction for further development of multicultural nursing education curricula.

Method
Sample. The sample consisted of junior-level nursing students from two campuses. Convenience sampling was used. Due to funding constraints, the consultant was hired for 50 hours of onsite consultation, including preparation time. From this, two clinical groups were selected to receive the consultation. Both clinical experiences occurred in the same facility. The traditional group (Treatment Group 1) consisted of 49 participants from six clinical groups. The innovative treatment group (Treatment Group 2) consisted of 17 participants from two clinical groups.

Instrument Materials. The ECSA (Ho, 1992), a self-report instrument, was used to measure self-perceived cultural competency skills when providing nursing care with culturally different clients. This is a 23-item Likert-type questionnaire with five response options (ranging from
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<th>Pretest</th>
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<tr>
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<tr>
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<td>Treatment Group 2</td>
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<td>9.69</td>
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never to always). The coefficient alpha on the pretest was .9444. This instrument was modified to include the word “nursing” for one item. That item read “Am able to objectify and make use of my own culture/ethnicity and professional culture (nursing) which may be different than the client’s own culture and ethnicity.” The higher the score, the greater the cultural competency. It took approximately 5 to 10 minutes to complete the instrument.

**Collection of Data.** A list of second-semester junior-level nursing students was obtained from the undergraduate dean’s office. This list was used to divide the students into two groups, those who would receive consultation from a cultural expert and those who would not. Written permission to conduct the study was obtained from the nursing students at the first clinical meeting. Institutional Review Board approval also was obtained. After written permission was obtained, the ECSA was administered prior to attending the clinical experience. Treatment Group 1 was to receive the traditional approach to learning and applying cultural diversity concepts in a clinical setting, and Treatment Group 2 was to receive onsite consultation from a cultural diversity expert in addition to the traditional approach.

Both groups received the traditional approach to integrating cultural diversity into the course by regular course faculty. The traditional approach included the following exercises:

- Completion of a cultural self-assessment exercise.
- Incorporation of sociocultural course objective concepts into weekly anecdotal records (e.g., identify the major social, cultural, economic, education, ethical, ethnic, legal, political, and religious factors that impact on client care).
- Documentation of culturally sensitive care in charting and care plan formulation.
- Demonstration of an understanding of the cultural uniqueness of clients in the application of the nursing process within the clinical papers.

Treatment Group 2 received three 2-hour onsite consultations from an expert in cultural nursing, in addition to the traditional approach to incorporation of cultural diversity into the course by regular course faculty. The consultant, who is a Black bachelor’s prepared female nurse with 10 years of nursing experience, has regularly taught practicum nursing students at one of the University’s community-based nursing center programs housed in a health care facility. This consultant provides health care services to an ethnically diverse population. Her research expertise is in the area of feeding practices among Black women. She was selected as a consultant because of her practice expertise with diverse populations, research involvement with Black women, and teaching experience.

The three onsite consultations included collaboration with students in a group setting during clinical time and postconference. These collaborations were conducted to help students realize the clients’ ethnic minority reality; discuss openly racial and ethnic differences; adapt to the clients’ interactive style and language; and apply change strategies consistent with the clients’ needs and problems, degree of acculturation, and motivation for change. The consultant also assisted students to formulate culturally relevant care plans. The consultant was available for consultation with course faculty as well as hospital staff and attended several course meetings. Having a consultant who was a member of a minority culture seemed to add face validity, depth, and meaning to information the students had previously learned regarding racial and ethnic differences in their cultural sensitivity lecture course. In addition, the open and frank sharing of the consultant’s own experiences facilitated greater realization and sensitivity of the clients’ ethnic minority reality.

**Results**

To determine if differences existed in student nurses’ attitudes toward culturally different clients, one-way ANOVAs were used to determine if mean attitude scores were higher among the group who received the onsite consultations (Treatment Group 2). The Table shows the means and the standard deviation of the pre- and posttest scores. There was a significant difference between pretest scores (mean = 86.6, SD = 13.87, n = 65) and posttest scores (mean = 93.97, SD = 12.22, n = 57). Pretest scores were significantly lower than the posttest scores (F[1,118] = 11.53, p < .001). There also was a significant difference between Treatment Group 1 (mean = 88.53, SD = 11.87, n = 49) and Treatment Group 2 (mean = 79.88, SD = 17.61, n = 16). Treatment Group 1 had significantly higher scores than Treatment Group 2 (F[1,118] = 5.53, p < .05). Among Treatment Group 2, posttest scores were significantly higher than the pretest scores (F[1,61] = 5.19, p < .05). Among Treatment Group 1, the posttest scores also were significantly higher than the pretest scores (F[1,67] = 6.36, p < .05).

Before the treatment (pretest), Treatment Group 1 was significantly higher than Treatment Group 2 (F[1,63] = 4.99, p < .05). After the treatment (posttest), there were no significant differences between Treatment Group 1 and Treatment Group 2. This means the scores of Treatment Group 2 increased much higher than scores of Treatment Group 1. In other words, the treatment had an effect. The .05 level of confidence was used.

**Discussion**

There were several threats to internal validity which may have accounted for the
initial pretest mean score differences. Significant differences resulting from this study could be the consequence of non-equivalent groups rather than the treatment or independent variable. Unfortunately, the consultant was contracted for approximately 50 hours, which included attendance at course meetings, preparation time, and site visits. This limited the number of clinical groups that would receive the innovative treatment (Treatment Group 2, n = 16). The sample sizes were unequal, which affects the comparison (Treatment Group 1, n = 40; Treatment Group 2, n = 16). History and maturation also are possible sources of invalidity because it is uncertain whether the groups were exposed to the same events and whether they have the same maturational processes. The scores of Treatment Group 2 increased much higher than scores of Treatment Group 1. In other words, the treatment had an effect. Because both groups knew they were in a study, Treatment Group 1 could have manipulated the scores through their responses. Both groups had highly positive attitudes in the pretest, which may be because of either the effects of cultural course content present in their earlier curricula or they may be giving socially acceptable answers.

The findings obtained from this research were more instructive than conclusive. From this study, the researcher has developed a psychosocial skills module from which students are required to watch a videotape on clinical nursing and culture. To assess learning, students complete a computerized posttest. The incorporation of the significant social factors, which includes culture, is performed regularly in the students' anecdotals records as well as during preconference and postconference discussions.

The results of this investigation suggest that nurse educators need to examine the differences in learning experiences related to cultural diversity that may account for differences in attitudes of student nurses. Such an examination is needed to prepare student nurses to practice in a multicultural society. Student nurses who are cognizant of the effects of their cultural values, beliefs, and attitudes are capable of establishing more empathic and culturally relevant care plans. The nursing faculty assist, monitor, and consult with students during the stages of the nursing process as related to assessment, analysis, implementation, and evaluation of culturally competent care. The goal is to focus on how different aspects of diverse cultures are employed to facilitate or block culturally competent client care. The ability to identify, analyze, and evaluate the impact of culture on the delivery of care is a critical skill for nurses (Mansour, 1994). If nurse educators are to meet the challenges and opportunities of the years that lie ahead, cultural sensitivity and culturally competent care is necessary.

References