

FACTORS INFLUENCING BACHELOR OF SCIENCE IN NURSING
STUDENTS' PERCEPTIONS OF ELDERCARE
CULTURAL SELF-EFFICACY

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Arlene H. Morris was born January 21, 1954 in Kansas City, Missouri, the only child of the late Arlin Henry Hughes and Lorene Crook Hughes. She grew up in Arkansas and graduated from Augusta High School in 1972. She graduated from Harding University with a Bachelor of Science in Nursing Degree in 1978. After working as a staff nurse and home health nurse in White County, AR and at the University of Mississippi, Oxford, MS, she began teaching in the School of Nursing at Auburn University Montgomery (AUM) in 1993. She received a Master of Science in Nursing from Troy University, Troy, AL in 1997. In the summer of 2003, she entered graduate school at Auburn University while continuing teaching nursing at AUM.

DISSERTATION ABSTRACT
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CULTURAL SELF-EFFICACY

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The theoretical framework for this study was provided by Bandura's (1986) conceptualization of self-efficacy for selecting behaviors perceived as effective in complex situations, and in motivation to perform the behaviors of caring for older adults, specifically older adults from various cultural backgrounds. The increasing number of culturally diverse older adults in the U.S. has prompted research on methods to adequately prepare a nursing workforce to provide quality care to these individuals. Identifying effective teaching-learning methods enables evidence-based teaching (Fineout-Overholt, Melnyk, & Schultz, 2005; Killeen & Barnfather, 2005).

Participants from two schools of nursing in the southeastern U.S. provided the sample. The Eldercare Cultural Self-Efficacy Scale (Shellman, 2003) and the Inventory for Assessing the Process of Cultural Competence-Revised (Campinha-Bacote, 2002c) were used to evaluate student self-efficacy. A pre-course demographic questionnaire provided insight to student characteristics and a post-course demographic questionnaire provided information regarding the clinical experiences during a senior level community health course and how these experiences impacted participant perception of self-efficacy.

Results of the research revealed few statistically significant changes over time or by school. Continued evaluation of nursing curricula and evidence-based teaching-learning strategies should be integrated into the Bachelor of Science in Nursing curriculum.

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This dissertation is dedicated to my husband, James Kelly Morris; son, Jared Hughes Morris; and daughter, Mary Lorie Morris. They have been patient in enduring the stresses of my educational process, and have brought much joy to my life. Additionally, this work is dedicated to my nursing students, with whom I learn and endeavor to provide the best of nursing care for the older population.

Style manual or journal used: Publication Manual of the American Psychological Association, 5th Edition.

Computer software used: SPSS 15, Windows XP, and Microsoft Word 2003

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I. INTRODUCTION

Nursing, as a discipline, requires an interaction, or transaction, between the nurse and the client. During this transaction, the client's goals are identified to enable collaboration between the nurse and client for determining the most effective individualized approach to attain the desired goals and outcomes of healthcare (Benner & Leonard, 2005; Husting, 1997; King, 1981; Parker, 2006). Client health outcomes have been linked to quality nursing care (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, 2004a, 2004b), and a shortage of nurses is prompting intensified attempts to plan strategies to meet the needs of the population, specifically within the United States (U.S.) (Aiken, 2006; American Association of Colleges of Nursing, 2007; American Nurses Association, 2001; American Nurses Foundation, 2002; Buerhaus, Auerback, & Staiger, 2007; University of Illinois, 2001; U.S. Department of Health and Human Services Health Resources and Services Administration, 2004; U.S. Government Accounting Office, 2007).

Two other factors relate to ensuring quality nursing care: the aging of the population and an increase in cultural diversity. The percent of older adults within the population of the U.S. continues to increase, yet gerontology has been the least selected practice area for graduate nurses (Happel & Brooker, 2001; Mackin, Kayser-Jones, Franklin, Evans, Sullivan-Marx, & Herr, 2006; Rieder, 2007). The U.S. population is

also increasing in racial/ethnic and cultural diversity (U.S. Census Bureau, 2002, 2004). Healthcare behaviors are influenced by cultural values (Giger & Davidhizar, 2004; Leininger, 1978, 1991a, 1991b, 1997a, 2002; Purnell & Paulanka, 2003). Language barriers and differing values may complicate nursing interactions. Cultural differences, ageism, and multiple complex health needs can diminish the effectiveness of nursing interactions (Bernal & Froman, 1993; Peterson & Smith, 1996). Nursing educators are challenged to incorporate the most effective educational strategies to enable graduates to provide quality care for an older, culturally diverse population.

Specifically, the number of the older adults in the U.S. continues to increase with the aging of the baby boomer generation, increasing the predicted proportion of the older population from approximately 12% in 2010 to 29% by 2020 (U. S. Census Bureau, 2004). Many older adults will have an essentially healthy life from practicing lifelong health promotion behaviors; however, periods of acute illnesses during the older years will require episodic healthcare. Older adults are the greatest consumers of healthcare, often presenting multiple chronic conditions (Ebersole, Hess, & Luggen, 2004). Chronic illnesses have unpredictable exacerbations, requiring more intensive periods of management and treatment (Ebersole, Hess, & Luggen, 2004; Miller, 2000; Strumpf, 2000). Episodes of acute illnesses can occur concurrently with chronic conditions, causing difficulty in accurate diagnosis and effective treatment management. Supportive nursing care is important throughout the healthcare system for prevention/health promotion, acute care, chronic care, and end-of-life care. The increasing number of older adults needing health promotion care, plus the expanding treatment options for both acute and chronic conditions, forecast an increased demand for greater numbers of nurses

prepared to effectively care for the special health needs of older adults throughout the healthcare continuum (Partnership for Solutions, 2004).

Older adults can be perceived as a sub-population that forms a cultural group by having experienced unique life events that lead to shared values, beliefs, and behaviors (Shellman, 2003). Generational differences in thinking and valuing (Bennis & Thomas, 2002; Lancaster & Stillman, 2002) impact the interaction of younger nurses caring for older adults (Ashmore & Banks, 1997; Auerback & Levenson, 1977). It has been suggested that stereotyping of older adults (ageism) may have an unintended influence on prognosis of illnesses, possibly through medical profiling or causing a declining interest in pursuing care of older adults as a practice area (Cohen, 2001; Palmore, 1998; Reyna, Goodwin, & Ferrari, 2007; Rodin & Langer, 1980). Declining interest of nursing students in the field of gerontology will further complicate the problem of meeting the healthcare needs of a greater number of older adults with more complex health issues (American Geriatrics Society, 2000; Lookinland & Anson, 1995).

In addition to aging, the population in the U.S. and within the state of Alabama is increasing in cultural and ethnic diversity (Bogie, 2007). These population shifts necessitate nurses who can deliver culturally competent care to an increasingly diverse elderly population (Ethnogeriatric Committee of the American Geriatric Society, 2004; Shellman, 2003). People within various cultures perceive health behaviors differently, and may practice various types of health promotion or healthcare activities (D'Avanzo, 2008; Leininger, 2002; Purnell & Paulanka, 2003). Understanding the client's healthcare beliefs is important in working with an individual to attain the desired health goal (Leininger, 1978). Nurses who do not demonstrate cultural awareness impair the

development of a trusting relationship with the client, prevent identification of client goals, and thus may thwart client adherence to the recommended treatment plan (Spector, 2004; Whitfield & Baker-Thomas, 1999).

Nurse educators must consider the anticipated older, diverse population in order to prepare nursing students to provide care for 1) health promotion, 2) treatment of acute illnesses episodes, 3) maintenance of chronic conditions through remissions and exacerbations, and 4) support through the end-of-life. Nurses must consider the individual older client's attitudes and values (which may vary considerably from the generational attitudes and values of the individual nurse). Additionally, the nurse must work with an individual client's cultural health beliefs and behaviors to present acceptable care options for attaining the client's desired health outcome. The challenge for nursing educators is to determine the most effective methods of teaching the ever-more complex discipline of nursing. Identifying effective teaching-learning methods leads to evidence-based teaching (Fineout-Overholt, Melnyk, & Schultz, 2005; Killeen & Barnfather, 2005).

The theoretical foundation for this study is Bandura's (1986) social cognitive theory, specifically the construct of self-efficacy. Self-efficacy impacts selection of behaviors perceived as effective in complex situations, and promotes motivation to perform the selected behaviors (e. g., caring for older adults). Bandura (1986) suggested that the influence of a person's self-evaluation of ability and of the effectiveness of an action occurs between the acquisition of knowledge and the performance of behaviors. A person's judgment of personal ability to perform an action affects both motivation and behavior. A person's "sense of personal efficacy to exercise some control over events that

affect their lives. . .involves organizing cognitive, social, and behavioral subskills into courses of action” (Bandura, 1986, p. 391). Developing the interrelationship between knowledge and action requires a person’s evaluation of ability to perform the action and the motivation to do so.

Bandura (1986) stated that competent performance requires use of multiple skills in differing circumstances, which includes “judgment of what one can do with whatever skills one possesses” (p. 391). This judgment involves a perception of the person’s ability to accomplish a certain level of performance (perceived self-efficacy), and the judgment of what consequence the behavior will cause (outcome expectation). “Efficacy and outcome judgments are differentiated because individuals can believe that a particular course of action will produce certain outcomes, but they do not act on that outcome belief because they question whether they can actually execute the necessary activities” (Bandura, 1986, p. 392).

Bandura’s concept of self-efficacy is important in this study to provide insight regarding nursing student’s perception of personal efficacy in providing care for older adults of varying cultural backgrounds. The determination of efficacy involves both the process of determining nursing care behaviors that will produce desired outcomes and if self-efficacy exists at a level that fosters a motivation to perform the behavior.

Instruments

Nursing students’ perceptions of cultural self-efficacy have been shown to increase during exposure to nursing curricula (Jeffreys & Smolaka, 1999). For the purpose of this study, the Eldercare Cultural Self-Efficacy Scale (ECSES) was used to

measure BSN student self-efficacy as it relates to the care of older adults of differing cultural backgrounds (Shellman, 2003). Additionally, Campinha-Bacote's (2002c), Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) was used to measure any statistically significant change in bachelor of science in nursing (BSN) students' self-rating of cultural competence that may have occurred during a senior level community health course.

Problem Statement

The U.S. is "facing a historic demographic change, and we do not have an adequate, well-trained work force—from doctors down to basic in-home caregivers—who know the details of aging" (Crary, 2007). Nursing educators must determine the best methods of educating student nurses to care for a diverse aging population when planning curricula. There is a lack of information regarding identifying factors that impact student perceptions of eldercare cultural self-efficacy. Identification of these factors can aid in planning nursing curricula that will more effectively develop nurses to care for older adults.

Purpose of the Study

The primary purpose of this study was to identify senior level BSN students' perceptions of Eldercare Cultural Self-Efficacy (ECSE) at the beginning and end of the senior level community health course to determine which factors may relate to a change in self-rating on the ECSES. Results from this study will help nursing educators in two schools of nursing in Alabama to more fully understand currently prevalent

characteristics of senior level baccalaureate nursing students, characteristics of clinical experiences, and how these characteristics may relate to students' self-rating of ECSE.

Research Questions

1. What effect, if any, do student demographic variables have on self-rating of Eldercare Cultural Self-Efficacy (ECSE) of senior level BSN students prior to a senior level community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES)?
2. What is the relationship between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course?
3. Are there difference in ECSES or IAPCC-R ratings pre and post a community health course?
4. If so, what factors of clinical experience may relate to a change in BSN students' self-reporting on the ECSES?

Significance of Study

There is considerable research on healthcare providers' cultural competency (American Nurses Foundation, 2002; Blackstock, 2003; Brathwaite, 2005, 2006; Cagle, 2006; Campinha-Bacote, 2002a, 2002b, 2002c, 2003, 2006; Chrisman & Schultz, 1997; Donini-Lenhoff & Hendrick, 2001; Drake, 2004; Dreachslin, Jacobs, Putsch, Weech-Maldonado & Welch, 2002; Gray & Thomas, 2005; Kelly & Fitzsimons, 2000; Kleiman, 2006). Findings from this study will add to the body of knowledge regarding BSN

students' self-rating on the ECSES and IAPCC-R. Results of data analysis will reveal factors that correlate with student self-efficacy ratings at the completion of a senior level community health course. Findings may provide insight to determine whether student self-efficacy ratings change for all older adults as a cultural sub-group, or for older adults of specific cultural backgrounds following senior level clinical experiences.

Identification of related factors may help educators recognize situations in which additional or varied clinical or classroom assignments or teaching-learning approaches may be helpful. Identification of factors that correlate positively will suggest curricula strategies that may promote eldercare self-efficacy. With the ever increasing amount of information to be included in nursing curricula, information that supports effective teaching-learning practices for eldercare cultural competence will support additional evidence-based teaching.

Assumptions of the Study

For the purpose of this study, the following assumptions were made:

1. Senior level BSN students cared for culturally diverse clients.
2. Eldercare cultural self-efficacy was identifiable through self-report on the ECSES.
3. Cultural competency constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire were identifiable through self-report on the IAPCC-R.
4. The students completing the instrument were honest and accurate in their responses.

5. The instruments were assessed for and produced appropriate measures of reliability and validity.

Limitations of the Study

For the purpose of this study, limitations included the following:

1. Use of self-report methods for conducting research involving issues such as attitudes and competence raises concern regarding accuracy of self-report measurements.
2. The two points of measurement at beginning and ending of the clinical experience of the community course may be an overly restricted point of time that does not accurately capture impact of the experiences in successive courses or post-graduation.
3. The specific type of experience with the older persons being cared for by BSN students during community health clinical experience could not be predicted or controlled.
4. The cultural background of the older persons being cared for by BSN students during the community health clinical experience could not be predicted or controlled.

Definitions of Terms

For the purpose of this study, the following operational definitions were used:

Ageism “reflects a deep-seated uneasiness on the part of young and middle-aged—a personal revulsion and distaste for growing old, disease, disability; and fear of powerlessness, ‘uselessness,’ and death; a process of systematically stereotyping of and discrimination against people because they are old, just as racism and sexism accomplishes this with skin color and gender” (Butler, 1993, p. 1).

Bachelor’s of Science in Nursing (BSN) degree—an undergraduate program of study leading to the baccalaureate degree in nursing which requires at least 120 semester credit hours in pre-requisite academic support courses and major nursing theory and concurrent clinical courses; awarded following Baccalaureate Nursing Education (Norman, 2006, p. 13).

Culture is “the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways” (Leininger & McFarland, 2006, p. 13).

Cultural assessment is “a systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being evaluated” (Leininger, 1978, p. 85).

Cultural awareness is “the process through which the nurse becomes respectful, appreciative, and sensitive to the values, beliefs, lifeways, practices and problem-solving strategies of a client’s culture” (Campinha-Bacote, 2002c, p. 55).

Cultural competence is “the ongoing process in which the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the client (individual, family, or community)” (Campinha-Bacote,

2002c, p. 14); and which “is composed of the five constructs of cultural awareness, cultural knowledge, cultural encounters, cultural skill, and cultural desire” (Campinha-Bacote, 2002c, p. 54).

Cultural encounters are “direct engagement in cross-cultural interactions with clients from culturally diverse backgrounds” (Campinha-Bacote, 2002c, p. 58).

Cultural knowledge “results from the process of seeking and obtaining a sound educational foundation about the worldviews of different cultures” (Campinha-Bacote, 2002c, p. 56).

Cultural skill is “the ability to collect relevant cultural data about the client’s health history and health problem, as well as to accurately perform a culturally-specific physical assessment” (Campinha-Bacote, 2002c, p. 58).

Cultural values are “values [that] give an individual a sense of direction as well as meaning to life [and are] held on an unconscious level” (Campinha-Bacote, 2002c, p. 7).

ECSE is the abbreviation for Eldercare Cultural Self-Efficacy.

ECSES is the abbreviation for the Eldercare Cultural Self-Efficacy Scale.

Elder is any individual aged 65 years or older.

Eldercare cultural self-efficacy (ECSE) is “the perceived self-efficacy or confidence for performing certain gerontological nursing skills to diverse populations” (Shellman, 2003, p. 16).

Eldercare cultural self-efficacy scale (ECSES) is “the operationalization of Eldercare Cultural Self-Efficacy for purposes of measurement” (Shellman, 2003, p. 16).

Ethnocentrism is “a person’s total unawareness that others do not share the same worldview that he or she has. One assumes that his or her values, beliefs, and practices are the only and the correct way to view the world” (Campinha-Bacote, 2002c, p. 55).

Evidence-based education is educational practice selected on the basis of prior use leading to expected learning outcomes.

Gerontology is the study and practice of working with older adults.

IAPCC-R is the abbreviation for the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised.

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) is a tool developed for assessing levels of cultural competence, ranging from cultural incompetence, culturally aware, or culturally competent, to culturally proficient (Campinha-Bacote, 2002c).

Outcome expectation is a “judgment of the likely consequence a behavior will produce. . . but not to be misconstrued as the effectiveness of a technique” (Bandura, 1986, p. 391).

Perceived self-efficacy is a “judgment of one’s capability to accomplish a certain level of performance” (Bandura, 1986, p. 391).

Senior nursing student is a student in a BSN program of study who has completed the junior level courses.

Organization of the Study

A higher percentage of the U.S. population is older and more culturally diverse than in previous years, leading to increased need for nurses’ competence in working with

these older clients throughout the spectrum of healthcare delivery. The specific problem investigated in this study is the relationship of student characteristics and experiences during a senior level community health course within two BSN programs on students' ratings of Eldercare Cultural Self-Efficacy (ECSE). Chapter II provides a review of related literature concerning anticipated demographic changes in the U.S., transcultural nursing care, and eldercare cultural self-efficacy. Additionally, issues such as the shortage and generational divisions in the U.S. nursing workforce and the need for gerontology content in the nursing curriculum are discussed. Chapter III presents the research design and data analysis. The results of the research study will be discussed in Chapter IV, followed by a summary, discussions, implications, recommendations, and conclusions based on the study findings in Chapter V.

II. REVIEW OF LITERATURE

Introduction

The specific problem investigated in this study was the impact of student variables and experiences during a senior level community health course on self-rating of perceived Elder Cultural Self-Efficacy (ECSE) as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES) (Shellman, 2003). The purpose of this chapter is to provide a review of related literature concerning predicted U.S. demographic changes in age and ethnic composition, cultural competence needed by healthcare professionals specifically regarding healthcare needs of older persons, and nursing workforce predictions.

A greater number of older adults in the U.S. is expected over the next four decades, with anticipation of a greater range of healthcare needs for this older population (American Geriatrics Society, 2000). Older adults can be “considered a cultural subgroup, based on life experiences that lead to formation of shared attitudes, values, and behaviors” (Shellman, 2003, p. 14), which can affect healthcare practices.

Additionally, demographic trends indicate an increase in individuals from diverse racial and ethnic backgrounds within the U.S. These culturally diverse people will comprise a greater proportion of the older U.S. population (U.S. Census Bureau, 2004). Research has shown that minorities experience health disparities related to access and utilization of care (Epstein & Ayanian, 2001; Fiscella, Franks, Gold, & Clancy, 2000; Hegyvary, 2006). Unless this situation is addressed, culturally diverse older adults will

be in jeopardy of diminished quality of healthcare. Leininger's (1978) Transcultural Care theory of nursing is presented as a proposed method to more effectively provide care across cultures. Campinha-Bacote's (2002c) Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) is reviewed as a suggested approach to assessing the cultural competence of senior level baccalaureate nursing students.

Furthermore, shortages in the nursing workforce exacerbate the need for nursing educators to develop curricula to prepare nurses knowledgeable of the specifics of caring for older adults from various cultural backgrounds. Bandura's theory of self-efficacy (1986) provided the theoretical foundation, applied through use of Shellman's (2003) Eldercare Cultural Self-Efficacy Scale (ECSES).

Purpose of the Study

The primary purpose of this study was to identify senior level BSN students' perceptions of Eldercare Cultural Self-Efficacy (ECSE) at the beginning and end of the senior level community health course to determine which factors may relate to a change in self-rating on the ECSES. Results from this study will help nursing educators in two schools of nursing in Alabama to more fully understand currently prevalent characteristics of senior level baccalaureate nursing students, characteristics of clinical experiences, and how these characteristics may relate to students' self-rating of ECSE.

Research Questions

1. What effect, if any, do student demographic variables have on self-rating of Eldercare Cultural Self-Efficacy (ECSE) of senior level BSN students prior to a senior level

community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES)?

2. What is the relationship between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course?
3. Are there difference in ESCES or IAPCC-R ratings pre and post a community health course?
4. If so, what factors of clinical experience may relate to a change in BSN students' self-reporting on the ECSES?

Aging in America

According to the U.S. Department of Health and Human Services Administration on Aging (2005), about one in every eight Americans is over the age of 65. This age group has been projected to increase 15% from 35 million in 2000 to 40 million by 2010 (approximately 12% of the total population), with a subsequent 36% increase to 55 million by 2020 (approximately 20% of the total population), followed by an increase to 71.5 million by 2030. It is anticipated that “by the mid-twenty-first century, older people will outnumber younger people for the first time in history” (Meiner & Luckenotte, 2006, p. 7). The number of Americans considered the oldest old (over age 85) is projected to also increase to 6.1 million by 2010, and a subsequent 44% increase to 7.3 million by 2020 (U.S. Department of Health and Human Services Administration on Aging, 2005). Those Americans who reach age 65 can expect to live an average of 18.5 more years (U.S. Department of Health and Human Services Administration on Aging, 2005). It is

anticipated that approximately 80% of adults over age 65 will experience at least one chronic condition requiring healthcare services, and about 50% will have two or more chronic conditions (Lubkin & Larson, 2006; National Center for Chronic Disease Prevention and Health Promotion, 2004; U.S. Department of Health and Human Services Administration on Aging, 1996).

In the U.S., short stay hospitalizations occurred at three times the rate for those over the age of 65 than for persons of all other ages, and persons over the age of 65 experienced a longer length of stay (5.8 days as compared to 4.8 for persons of all ages) (National Center for Health Statistics, 2006; U.S. Department of Health and Human Services Administration on Aging, 2005). Additionally, the annual number of visits to physicians was higher for those over age 65 (U.S. Department of Health and Human Services Administration on Aging, 2005). Those in the oldest old age range are the greatest consumers of healthcare (Yali & Revenson, 2004). Approximately 95% of older adults live in the community, with “about 4% of persons between the age of 65 and 75 living in nursing facilities. . . [increasing to] 5% for persons ages 75 to 84, and 15% for persons ages 85 and older” (Meiner & Lueckenotte, 2006, p. 7).

Specifically, Alabama ranked fourteenth in the U.S. for population of older adults, with 12.9 percent of the total population aged 65 years and over during the year 2005 (U.S. Census Bureau, 2005). In Alabama, the average life expectancy for the total population born in the year 2005 is 74.7 years; life expectancy for white females is 78.4 years and 72.7 years for white males; females of all other ethnic groups in Alabama can expect to live an average of 75.9 years, while males of all other ethnic groups have an average life expectancy of 68.3 years (Bogie, 2007).

During the 1900's, life expectancy in the U.S. increased by approximately 25 years, due to antibiotics, improved maternal and child health, economic stability that allowed progress in nutrition and social conditions, and prevention and treatment of chronic diseases. Hormone, joint and organ replacement added years of increased functioning, such that:

with added understanding of the complex, multiple, interacting acute and chronic psychological and physical conditions attendant to an aging population, focus on the coping and adaptation mechanisms of our society is warranted. Science has moved from the narrow view of aging as a disease and biological inevitability to a broad view of healthy aging, and healthy living as a matrix of nutritional, physical, social, psychological/ emotional, and behavioral needs. (Fitzsimons, 2000)

One of the two major goals of *Healthy People 2010* was to “increase quality and years of life” (U.S. Department of Health and Human Services, 2000, p. 2), which addressed the increase in the aging of the U.S. population. As early as the 1920s, a body of knowledge and skills specifically focusing on the needs of older persons began to develop (Ebersole, Hess, & Luggen, 2004). Research for providing effective nursing care for older adults continued to develop, which included recommendations for gerontologic curricula and formation of competency guidelines for education and healthcare institutions (Lubkin & Larsen, 2006; Mauk, 2006; Pew Health Professions Commission, 1998).

“The expectation that older people have cognitive and physical defects can be debilitating to the older individual in terms of self-esteem and performance” (Nelson,

2005). Some research has indicated that many current healthcare providers have not demonstrated knowledge of the specific healthcare needs of older adults or appropriate ways to address these needs (Netting & Williams, 1999). For example:

...[healthcare providers] initially were not knowledgeable about or appreciative of the care needs of elders. Many felt they understood geriatrics, when it was clear they did not. Others did not believe there was anything special or different about caring for frail elderly persons. . . . [and healthcare staff] had to recognize that much of primary healthcare is shifting from acute to chronic care. Expanding the scope of practice, emphasizing the patient's psychosocial needs, developing a focus on care by helping patients adapt to their declining physical capabilities, and using an [interdisciplinary] team approach...became critical. (p. 225)

Older adults receive healthcare, throughout the healthcare delivery system, including health promotion and illness prevention, acute care, chronic care, rehabilitation, and end-of-life care. For an increased number of older adults with chronic, non-curable illnesses, psychosocial interventions for management of issues such as stress and pain must be included in primary prevention (Strumpf, 2000; Yali & Revenson, 2004). Additionally, evaluation of older adults' everyday functioning in out-patient and home settings led to development of specific interventions to promote increased time of independence in community settings (Diehl, Marsiske, Horgas, Rosenberg, Saczynski, & Willis, 2005).

Adults at age 65 may not be frail but, during the approximately 18 more years of expected life, most can anticipate experiencing health problems that lead to physical or

mental decrease in function (Lubkin & Larsen, 2006; Strumpf, 2000). Chronic illnesses often lead to dependence, powerlessness, uncertainty, role changes, and diminishing physical abilities (Miller, 2000). A challenge for nursing is improving care for the both healthy and frail elderly, with the desired outcomes of enhancing the quality of life, maximizing independence and well-being, and supporting family caregivers (Center for Advancement of Health, 1999a, 1999b; Luggen & Meiner, 2001; National Institute of Nursing Research, 1994; Strumpf, 2000). It is imperative to understand the coping strategies and daily decisions that older adults make about their health behaviors (Berg, Hedelin, & Sarvimaki, 2005; Berg, Saravimaki, & Hedelin, 2006; Loeb, 2006; Loeb, Penrod, Falkenstern, Gueldner, & Poon, 2003) in order to effectively provide nursing support.

Some healthcare planners have suggested rationing of health services for older adults (Howe & Lettieri, 2001). Marginalization of older people can be linked to Americans' equation of a person's worth with one's employment and earnings. The "national passion for independence does not compare well with the situation of most of the elderly, therefore attention turns away from them...the elderly come to represent those who need or will soon need care and who are dependent" (Culpepper, 1993, p. 193). However, celebration and sharing of strategies for survival, strength, and zest in aging can break through ageism, racial and ethnic barriers. Additionally, the burgeoning baby-boomer generation may provide power in numbers, education and wealth that may lead to a shift in attitudes of the younger generations' valuing of older adults (Culpepper, 1993).

Stereotyping of older adults can be termed ageism. Ageism occurs when older adults are viewed as having less responsibility, power, or dignity (Nelson, 2005). An individual may perceive personal mortality when providing service (such as healthcare) to any person or group (such as older adults) that serves as a reminder of personal mortality. This thinking can lead to intense anxiety, which can then lead to the avoidance of older adults (Nelson, 2005). Student nurses (as well as employed nurses) may develop negative attitudes about working with older people and become demoralized if the perception is that the nursing care does not make a difference in outcomes (Haight, Crist, & Dias, 1994; Reyna, Goodwin, & Ferrari, 2007; Watson, 1992). Additionally, Stevens (2006) notes:

For many clinicians, communicating with older adults can be anxiety producing and fraught with challenges. These challenges may be associated with our memories of past difficulties communicating with older adults, be they family members, clergy, teachers, or neighbors, or they may be related to the physiological or psychosocial characteristics associated with aging. (p. 122)

A shift from negative attitudes can occur by using evidence to support effective interpersonal and technical nursing practices with older adults, particularly those experiencing dementia, and can lead to client outcome attainment that encourages the nursing staff (Conn, Burks, Rantz, & Knudsen, 2002; Pryor, 2006; Tolson, Irene, Booth, Kelly, & James, 2006; Watson, 1992; Watson, 2002).

Student nurses' attitudes towards the care of elderly persons has been shown to be influenced by personal attitudes and values, such as that formed by prior experience with

an elderly family member (Kotzabassaki, Vardaki, Andera, & Parissopoulos, 2002; Kriseman, 2005). The site of student nurses' clinical practice can also impact attitudes toward older adults, necessitating careful selection of sites and placement of the clinical experiences within the nursing curriculum (Hoffman, Messmer, Hill-Rodriguez, & Vazquez, 2005; Markstrom, 1991).

Changing Cultural Demographics in the United States

The second of the two major goals of the U.S. *Healthy People 2010* was to “eliminate health disparities” (U.S. Department of Health and Human Services, 2000, p. 2), which related to inequalities in healthcare for diverse population groups in the U.S. Increases are predicted in the number of individuals belonging to minority groups within the U.S. (U.S. Census Bureau, 2002; U.S. Census Bureau, 2006; Yali & Revenson, 2004). Minority populations are projected to increase from 16.4% in 2000 to 23.6% of the total U.S. population in 2020. The Hispanic minority population is expected to increase at the greatest percentage (254%), followed by Asians and Pacific Islanders (208%), African-Americans (147%), American Indians, Eskimos, and Aleuts (143%), and whites (74%) (U.S. Census Bureau, 2004).

Much has been written concerning cultural impact on healthcare. The Institute of Medicine (IOM) (2002, 2004) ascertained that possible sources for healthcare disparities may occur from provider prejudice against minorities, uncertainties in communication with people of differing ethnic backgrounds, or stereotyping client behavior. Healthcare needs of specific cultural groups have been discussed. Tate (2003) discussed specific suggestions to approach increased intercultural understanding of Hispanic clients, while

Ekblad, Maraattila, & Emilsson (2000) reported use of focus groups to determine suggested themes to improve care for various cultural groups in Sweden. Reynolds (2004) proposed that healthcare providers with a U.S. background have conflict with culturally or linguistically diverse clients. DeRosa & Kochurka (2006) suggest U.S. healthcare providers need to develop core attitudes of caring, empathy, openness and flexibility, and develop awareness of clients' health beliefs and practices by performing a cultural assessment. Berlin & Fowkes (1983) developed a LEARN framework for understanding, teaching, and negotiating to promote health when working with culturally diverse clients.

The Transcultural Leadership Continuum (TLC), a four-year project funded by the Robert Wood Johnson Foundations, Inc. for nursing programs in New Jersey, led to increased discussion of concepts related to culture (Kelly & Fitzsimons, 2000). Sitelman and Sitelman (2000) considered "the ethical perspectives of human beings as persons... whose value may be measured by behavior relative to norms" (p. 13). However, the freedom of an individual to choose independent behaviors can impact adherence to cultural norms, as well as have an influence on personal foundations for ethical decision-making (Sitelman & Sitelman, 2000; White, 2000). Shared cultural values impact ways of relating to others and viewing activity and life (Bossman, 2000). Munhall (2000) suggested a fifth pattern of knowing (in response to Carper's [1978] four fundamental patterns of knowing in nursing), that of the process of unknowing, in order to understand meanings and perspectives of clients from a different culture. Salmond (2000) encouraged creating a climate of trust to promote paradigm shifts among those from different cultural backgrounds.

Fowler (2006) described the error of assumptions or conclusions being made about race. The terms race, ethnicity, and minority are not homogeneous categories, but rather are impacted by many individual influences (Ezenwa, Ameringer, Ward, & Serlin, 2006). Influences on healthcare may include such factors as religious practices and beliefs associated with such health promotion behaviors as not smoking and group exercise (Roff, Kelmmack, Parker, Koenig, Sawyer-Baker, & Allman, 2005).

Although sociodemographic factors such as income, education, and religious beliefs have been shown to correlate with health behaviors, these characteristics often have not been accurately documented in research design and data analysis (Hegyvary, 2006; NeSmith, 2006; Roff, Klemmack, Parker, Koenig, Sawyer-Baker, & Allman, 2005). Therefore, questions regarding the actual basis for reported health disparities persist due to mixed findings of many studies (Hegyvary, 2006; National Institute of Health, 2006). Fiscella, Franks, Gold, and Clancy (2000) reviewed socioeconomic and ethnic disparities in healthcare quality, specifically health prevention activities, within the national initiative to eliminate disparities in healthcare. These researchers found that factors impacting the access to care included “affordability, geographic access, transportation, education, knowledge, literacy, health beliefs, racial concordance between physician and patient, patient attitudes and preferences” (p. 2580).

Jett (2007) related that, although by the year 2050, minority elders may account for 50% of the elderly population, access to healthcare for minority elders is less than for whites. Not offering the same standard of care because of financial constraints was one type of disparity, and Jett recommended following standards for all persons “regardless of financial status, race, age, ethnicity, or type of (or lack of) insurance. . . and

understanding the minority elder community” (p. 1). The Institute of Medicine Committee on Quality of Health Care in America (2001) suggested a new paradigm of emphasizing quality care for an increasingly diverse U.S. population. Researchers emphasized communication with individual clients to determine what factors exerted the greatest influence on health behavior choices (Lookinland, Linton, Lavender, 2002; Majumdar, Browne, Roberts, & Carpio, 2004; Peterson, Whitman, & Smith, 1997; Schlenk, DunbarJacob, & Engberg, 2004; Shellman, 2004; Underwood, 2006).

Although inequities in insurance coverage affect access to healthcare services (Institute for the Future, 2000), health promotion activities have been associated with increased perceived self-efficacy, benefits, support and decreased barriers to the health promotion activities (Walker, Pullen, Hertzog, Boeckhner, & Hagemen, 2006). Peters (2006) discussed the impact of racism on chronic stress emotions and the use of emotion-focused coping strategies. Furthermore, Whitfield & Baker-Thomas (1999) proposed an approach to studying ethnic diversity of an aging population that considers individual differences within the ethnic groups rather than focusing on between-group differences. These authors contend that “race only implies a biological differentiation, yet a greater source of variability between Caucasians and African Americans comes from differences due to ethnicity such as lifestyle, language, and historical experiences” (p. 74). Each of these variables is influenced by the beliefs of the individual, which must be assessed through interpersonal interactions rather than overgeneralizing or stereotyping.

Epstein and Ayanian (2001) proposed that, although inaccuracies in administrative data may account for some of the reported racial disparities in health outcomes, changes in many aspects of healthcare provision may lead to cumulative

changes in health outcomes. For example, provision of healthcare services in a manner that is respectful of an individual's language and culture impacts the safety and quality of client care (U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, 2000). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2007) studied efforts of 60 hospitals to provide quality care for diverse populations, concluding that providing care with awareness of different beliefs, cultures and languages of patients is actually a preventative safety issue. Misdiagnosis and under- or over-utilization of healthcare services occurs with lack of effective communication. JCAHO (2007) recommendations included sensitizing staff regarding avoiding stereotyping and increasing discussion of issues related to culture and language that could impact client safety, such as appropriateness of healthcare education materials, including informed consent documents.

Transcultural Nursing Care

Nursing literature extensively asserts the need for culturally sensitive and competent care. Individuals with diverse cultural values and beliefs require use of different healthcare approaches (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995). Nurses have developed methods or theories of providing care for clients of differing cultures. Leininger (1969) discussed the impact of culture in nursing care, stating "it is important for the nurse to understand the patient's view of illness, [including] how the patient knows and understands his illness, how he desires to be helped, and the ways health personnel can help" (p. 12). This nurse researcher explained, "cultural differences are often the basis for poor communication, interpersonal tensions, and hesitation in

working effectively with others” (Leininger, 1969, p. 2), and that “culture clashes will [occur] among specific cultures and with health personnel of different cultural orientations” (Leininger, 1996, p. 30). Leininger’s model can “help nurses develop questions for the assessment of client cultural beliefs related to health and illness . . . [to] provide culturally competent care” (Reynolds & Leininger, 1993, p. 32). The model can also help prevent “. . . cultural imposition [of using] nursing practices when providing care to clients which may be offensive or in conflict with their lifeways” (Leininger & McFarland, 2006, p. 9). Imposition of offensive nursing practices can cause clients to perceive insult, embarrassment, or emotional pain (Leininger, 1997c; Smith, 1998).

Cultural values are transmitted through socialization practices, and nurses must apply knowledge of individuals’ cultural beliefs to plan care and facilitate changes in health attitudes and the resultant health behaviors (Bernal, 1998; Blackstock, 2003; Camphina-Bacote, 2002c; Leininger, 1970; Spector, 2004). The field of transcultural nursing provides a basis for study of “culture-specific and culture-universal nursing care practices” (Leininger, 1978, p. 8).

Leininger (1996) predicted that by the year 2010, culturally competent care will replace the healthcare delivery system’s focus on managed care, primary care, and case management, because consumers will desire care that fits individual cultural needs. Use of Leininger’s theoretical three modes of action and decision a) culture care preservation and maintenance, b) culture care accommodation and negotiation, and c) culture care repatterning and restructuring can provide a basis for health personnel to be responsive to clients and respect the client’s needs to actively participate in healthcare choices and decisions. By 1999, California’s Medicaid managed care organization, Medi-Cal,

required cultural competence to substantially impact health services and by 2001, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare were developed by the Office of Minority Health within the U.S. Department of Health and Human Services (2001).

Researchers have explored “the complex, multileveled experiences of health and illness and examined the assumptions concerning class, race, gender, and ethnicity that underlie . . . worldviews” (Evans, 2006, p. 275). Information regarding beliefs of groups of people from various cultures abounds in nursing literature (D’Avanzo, 2008; Ethnogeriatric Committee of the American Geriatric Society, 2004; Galanti, 2004; Giger & Davidhizar, 2004; Leininger & McFarland, 2002; Purnell & Paulanka, 2003; Spector, 2004). This information can provide a knowledge base for possible cultural values and beliefs and common attributes, yet stereotyping must be avoided. “Recipe-type approaches fail to fully account for the intracultural variation that exists within any ethnic group” (Bernal, 1998, p. 7). An existential view of culture may group facts in such a manner that an artificial, superficial (and perhaps assumed) view is created which limits the complexities at the level of the individual (Gray & Thomas, 2005).

Awareness of cultural differences is the initial step toward cultural competence (Campinha-Bacote, 1999). Awareness that individuals have particular cultural beliefs can promote the validation and respect of those beliefs. As Cagle (2006) ascertained,

Caring interactions that meet the ethical principle of beneficence (above all, do good) may be a challenge in cases where the client and nurse are from different ethnic or cultural backgrounds. This is particularly true when cultural values influence the interpretation of caring interactions of

both parties. (p. 308)

Quality holistic care encompasses the components of culturally competent care (Bernal, 1998). “Nurses can play a major role in improving the health status of culturally diverse groups by ensuring the promotion of health in a manner that respects, values, and furthers cultural diversity” (Wells, 2000, p. 197).

The International Council of Nurses’ definition of competence is “a level of performance, demonstrating effective application of knowledge, skills, attitudes, and judgments” (Jirwe, Gerrish, & Emami, 2006, p. 7). Therefore, cultural competence “refers to the knowledge, skills, attitudes, and judgments nurses need in order to care from people from diverse cultural backgrounds” (Jirwe, Gerrish, & Emami, 2006, p. 7). Kleiman (2006) discussed cultural impact on nurse-client relationships. For example, Johnson (2003) recounted the need for nurses to “value the client’s faith, put yourself in your patient’s place, [realize] you can’t change someone who doesn’t want to change, work within your patient’s beliefs, and accept each patient’s perspective” (p. 56).

The American Nurses Association (ANA) position statement (1998) and the American Academy of Nursing (2001) include cultural competence within the professional responsibility of nursing care. Efforts to enhance transcultural communication support the importance of cultural competence in the nurse-client relationship (Campinha-Bacote, 1999; Maltby, 1999; Munoz & Luckmann, 2005; Villarruel, Portillo, & Kane, 1999). The American Association of Colleges of Nursing (1998) included cultural competence as an essential component of baccalaureate education.

St. Clair and McKenry (1999) studied effects of international student experiences on students' ethnocentrism, cultural sensitivity, and cultural self-efficacy. These researchers concluded that there is a difference in achievement of cultural self-efficacy and cultural competence, specifying five levels of cultural transformation: 1) Honeymoon state (beginning of the cultural journey); 2) Ethnocentrism (placing one's own beliefs and practices above anyone else's, not recognizing the value of the practices, beliefs, traditions of another culture); 3) Cultural relativism (awareness, sensitivity, appreciation for, and acceptance of new culture); 4) Ethnorelativism (assimilation, adaptation, integration of the cultural lifeways, beliefs, and practices into one's own nursing practice); 5) Perspective transformation (refining the cultural integration skills and moving toward cultural competence).

Bernal (1998) considered culturally competent care to be a developmental process based on assumption of the following culturally competent skills: "a) increasing one's own knowledge about the beliefs, values and norms of different ethnic groups; b) becoming aware of one's own biases; c) developing relationships with individuals and communities; d) increasing one's second language capabilities or learning how to effectively use an interpreter; e) conducting assessments of important background information on the population; f) negotiating plans of care that consider the need for adaptation" (p. 7).

Campinha-Bacote (1999) also considered cultural competence to be a process in which a nurse caring for a client (individual, family, or community) continuously attempts to provide culturally competent care. The Process of Cultural Competence Model includes five components in the delivery of healthcare services: a) cultural

awareness, b) cultural knowledge, c) cultural skill, d) cultural encounter, and e) cultural desire, and is considered an ongoing process of development (Campinha-Bacote, 1999, 2002c; Campinha-Bacote & Munoz, 2001; Munoz & Luckmann, 2005). Campinha-Bacote (2002c) developed an Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) that has been useful for determining healthcare professionals' progress in the five components and overall cultural competence.

Campinha-Bacote (2002c, 2003) considered the component of cultural desire to be the basis for developing cultural competence. Dean's (2001) work supported this proposition, using four different perspectives (modernist, postmodern, intersubjective, and sociopolitical) for healthcare providers to question their own personal beliefs, values, and biases, and to actually determine what is not known (or lack of competence) in order to more effectively build "self- and other-understanding" (p. 628). The clinical skills and attitudes "fundamental to all good clinical work—introspection, self-awareness, respectful questioning, attentive listening, curiosity, interest, and caring. . . are the elements of relationship building that lead to mutual respect and help find similarities as well as differences" (Dean, 2001, p. 629).

Furthermore, individuals and groups of people experiencing physical or mental disabilities, cultural or other barriers to access to the healthcare delivery system may be considered vulnerable (Zoucha, 2005). Zoucha (2005) recommended using Leininger's cultural care nursing theory to enable:

the nurse to view the individual, family, and community from the perspective of the seven cultural factors identified in the Sunrise Model:

religion, kinship, technology, educational, economic, political and legal, and cultural lifeways. By using this view, nurses and other healthcare professionals can decrease the vulnerability of the individual, family, and community by uncovering the concern of cultural difference and promoting ethical practice that is congruent with the cultural beliefs of those in the caring relationship with nurses and other healthcare professionals. (Zoucha, 2005, p. 84)

Whitfield and Baker-Thomas (1999) discuss the importance of considering individual differences within groups of aging minorities rather than limiting studies to differences between ethnic, racial, and cultural groups in relation to the aging process. They propose that studying different minority groups without comparison to the majority group will provide more accurate analysis of genetic and environmental influence on aging of group being studied, and will lead to more effective policies and practices based on the information obtained.

Blackstock (2003) evaluated nursing student's perceptions of cultural self-efficacy, using Jeffreys and Smodlaka's (1999) 83-item Transcultural Self-Efficacy Tool (TSET), finding higher student confidence in the affective items than the cognitive or skill items. Blackstock (2003) also concluded that BSN students did request more culturally diverse client assignments to provide for more cultural encounters, and in the event that "client care required extra time and effort from the nurse, there must be an internal desire to want to learn about others" (Blackstock, 2003, p. 87). The TSET was also used to evaluate Australian nursing students' transcultural self-efficacy, with results

indicating progressive development of transcultural self-efficacy through the nursing curriculum (Lim, Downie, & Nathan, 2004).

Bernal and Froman (1993) developed the Cultural Self-Efficacy Scale (CSES) for assessing nurses' perceptions of self-efficacy in caring for clients from various cultural backgrounds. Coffman, Shellman, & Bernal (2004) reviewed American nurses' perceived cultural self-efficacy between the years 1987 and 2002 as measured by the CSES, and found that "American nurses and student nurses reported the highest degree of self-efficacy with African-American and Hispanic patients, and the lowest with Asian American patients" (Coffman, Shellman & Bernal, 2004, p. 180). However, the results indicated a general lack of confidence (self-efficacy) in caring for clients from all ethnic groups. Another study of licensed registered nurses in the state of New Mexico using the CSES revealed that "licensed registered nurses in New Mexico were moderately efficacious in caring for clients patients of five cultural/ethnic groups" (Hagman, 2006). Additionally, preliminary studies revealed a lower cultural self-efficacy of U.S. nurses as compared to nurses in Spain (Jimenez, Contreras, Shellman, Gonzalez & Bernal, 2006).

Eldercare Cultural Self-Efficacy

Shellman (2003) continued the study of culturally competent nursing care with older adults, and developed the Eldercare Cultural Self-Efficacy Scale (ECSES). This scale, adapted from the Cultural Self-Efficacy Scale (CSES) published by Bernal and Froman (1993) was used to assess the perceived self-efficacy of student nurses in caring for culturally diverse older clients in community settings (Neafsey & Shellman, 2002; Shellman, 2003, 2004). Shellman (2007) found a statistically significant increase in

American student nurses' self-efficacy on the ECSES following a education program in a BSN curriculum using reminiscence therapy. Recommendations included nursing school evaluation of "elder cultural self-efficacy and subsequent use of this information to develop cultural and gerontological programs and integrate them into clinical experiences" (Shellman, 2007, p. 50). This study was undertaken to add to the knowledge needed to address that recommendation. Evaluation of nursing student ECSE can provide insight into areas of the nursing curriculum that need to be included or enhanced.

Nursing Workforce

Culturally competent care for all clients, including older adults, requires time for communication and building rapport. Research has shown that quality nursing care decreased length of hospital stays, and prevented incidences of urinary tract infections, pneumonia, shock, and upper gastrointestinal bleeding; effective nursing also prolonged time between hospitalizations or long-term care placements due to chronic illnesses (Aiken, 2006; Aiken, Clarke, Cheung, Sloane, & Silber, 2003; American Nurses Association, 2002; Joint Commission for Accreditation of Healthcare Organizations, 2002; U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, 2004a, 2004b; Williams, 2007). As the baby boomer generation ages, an increased demand for caregivers will be required to care for anticipated physical and mental needs of this generation (Crary, 2007). Increased need for acute and chronic illness care can be expected, as well as a greater focus on healthy aging, prevention and health promotion. More intensive services are anticipated during shorter hospitalizations,

and as many of the older adults will want to live at home instead of institutions, a home-care crisis may ensue (Crary, 2007).

Although the number of registered nurses (RNs) licensed in the U.S. increased to 2.9 million in 2004 (U.S. Department of Health and Human Services Health Resources and Services Administration, 2004), this is not enough to meet the anticipated needs of the projected increase in the older population (American Association of Colleges of Nursing, 2007; American Nurses Association, 2001). The U.S. Department of Labor Bureau of Labor Statistics (2005) projected a need for more than one million new and replacement nurses by 2012 to provide care across a spectrum of settings ranging from health promotion and primary care in public health settings to home, hospital, long-term, and hospice care. By the year 2020, nurses are expected to be in short supply in 44 states and the District of Columbia (U.S. Department of Health and Human Services Health Resources and Services Administration, 2004), with the demand for nurses exceeding the supply (American Association of Colleges of Nursing, 2007).

Multiple factors have contributed to the nursing shortage. Fewer students have enrolled in nursing programs, in part due to a shortage of nursing faculty (Aiken, 2006; Southern Regional Education Board, 2002). Additionally, research revealed that nurses were dissatisfied with salaries, benefits, and working environments (Buerhaus, Auerback, & Staiger, 2007; Curran, 2007). These trends resulted in an average age of 43.3 years for working registered nurses in the year 2000, while those under the age of 30 accounted for only 9.1% of nurses, and RNs over the age of 50 years were predicted to account for 40% of all RNs by the year 2010 (U. S. Government Accounting Office, 2007).

Generational Issues

Actually, the nursing workforce is composed of nurses from four different generations (Sherman, 2006). These multiple generations of nurses within the workforce each have differences in attitudes and values, causing challenges for teamwork among the age-diverse staff and nursing leaders. Zemke, Raines and Filipczak (2000) described defining experiences of those born during the eras of 1922-1943 (the Veterans or Traditionalists), 1943-1960 (the Boomers), 1961-1980 (the Xers or Generation X), and 1980-2000 (the Nexters, Millennials, or Generation Y), resulting in different core values and attitudes regarding life and work. Lancaster and Stillman (2002) continued the discussion of these value conflicts and suggested methods for building on strengths of each generation in the work place. Bennis and Thomas (2002) related the intense significance of the differences in those born in the 1920s to 1940s (Veterans) from those born in the 1960s to 1980s (Xers). A dicotomy in communication (both verbal and non-verbal), work ethic, and expectations for respect has been shown to result in tremendous misunderstandings. Interestingly, Margaret Mead (1978) reflected on the vast differences in values between generations in America of such great significance that sub-cultures were formed.

Generational issues can be anticipated to influence the nursing workforce itself as nurses from each of the different generations are employed in various healthcare settings. Additionally, generational issues can be anticipated to impact the cross-generational care provided by younger nurses caring for older adults. Therefore, nursing faculty face the challenges of 1) preparing nursing students to work with a multi-generational nursing staff during the stress of a nursing shortage; 2) to be aware of intense generational

differences in attitudes, values, and behaviors when providing care for an increased older population; 3) to be prepared to provide culturally competent care for a more culturally diverse aging population; and 4) to provide nursing care that includes specific recommendations for evidence-based quality care of older adults' needs throughout the spectrum of healthcare.

Gerontology in the Nursing Curriculum

As an accrediting body for baccalaureate and graduate nursing programs, the American Association of Colleges of Nursing (1998) included cultural competency as essential for baccalaureate education. Additionally, ten of the 30 competencies developed by the American Association of Colleges of Nursing and the John A. Hartford Foundation (2000) as necessary for baccalaureate nurses to provide high quality care to older adults and their families related to culturally diverse older adults:

- 1) Recognize one's own and others' attitudes, values, and expectations about aging and their impact on care of older adults and their families.
- 2) Adopt the concept of individualized care as the standard of practice with older adults.
- 3) Communicate effectively, respectfully, and compassionately with older adults and their families.
- 4) Incorporate in to daily practice valid and reliable tools to assess the functional, physical, cognitive, psychological, social, and spiritual status of older adults.
- 5) Analyze the effectiveness of community resources in assisting older adults and their families to retain personal goals, maximize function,

maintain independence, and live in the least restrictive environment.

- 6) Prevent or reduce common risk factors that contribute to functional decline, impaired quality of life, and excess disability in older adults.
- 7) Appreciate the influence of attitudes, roles, language, culture, race, religion, gender, and lifestyle on how families and assistive personnel provide long-term care to older adults.
- 8) Evaluate differing international models of geriatric care.
- 9) Evaluate the utility of complementary and integrative healthcare practices on health promotion and symptom management for older adults.
- 10) Facilitate older adults' active participation in all aspects of their own healthcare. (American Association of Colleges of Nursing and The John A. Hartford Foundation, 2000, p. 3)

Grant (1996) discussed the effects of ageism on healthcare providers' responses to aging. Ryan and McCauley (2004) investigated the student attitudes associated with a lack of interest in a baccalaureate capstone clinical experience designed to have time with mentors in state-of-the-art geriatric care in New York State. These researchers utilized Kogan's (1961) Attitudes Toward Old People Scale (KOP) and Palmore's revised version (1998) of The Facts on Aging Quiz (FAQI), to discover "nursing students lack knowledge about the elderly and often do not have positive attitudes toward them" (Ryan & McCauley, 2004, p. 8). These researchers pointed out that identification of BSN students' knowledge base and attitudes toward the elderly should influence curricular planning for clinical experiences. Ryan and McCauley (2004) further proposed developing strategies to promote BSN graduates' selection of nursing for the elderly as

sites for employment, such as seeking clinical opportunities in the nursing curriculum that would help develop positive attitudes toward older adults and providing nursing care for the older population.

Ryan and McCauley's findings regarding student's attitudes toward older adults were similar to those of many other international researchers over the past few decades (Galbraith & Suttie, 1987; Happell & Brooker, 2001 [in Australia]; Markstrom, 1991 [in Michigan]; Oglesby, 1992 [in Texas]; Reyna, Goodwin, & Ferrari, 2007; Rodin & Langer, 1980; Sheffler, 1995; Slevin, 1991; Soderhamn, Lindencrona & Gustavsson, 2001 [in Sweden]; Zakari, 2005 [in Saudi Arabia]; Zuckerberg, 1991). Additionally, Zakari's (2005) study revealed that Saudi students were reluctant to choose a career in gerontology due to "a self-assessed lack of knowledge on aging, a lack of confidence in their ability to care for the elderly, and a lack of experience" (p. 138).

Oglesby (1992) suggested research replication at schools with diverse nursing student ethnicity, including evaluation of faculty and nursing staff attitudes toward older adults and the effect of those attitudes on nursing students' attitudes. Additionally, evaluation of the level of client care needed and the staff's attitudes at the clinical sites in which nursing students provide care for older adults was recommended by several researchers (Kotzabassaki, Vardaki, & Parissopoulos, 2002; Markstrom, 1991; Murray, 2002; Oglesby, 1992; Samborski, 1990; Scheffler, 1995; Schneiderman, Jordan-Marsh, & Bates-Jenson, 1998; Skarupski, 2003; Zembrzuski, 2000). Not all older adults are economically disadvantaged or from cultural backgrounds different from those of the nursing students, prompting proposal that influence of the quality of care provided in clinical settings on student attitudes be evaluated (Murray, 2002; Smith-Campbell, 2005).

Happell and Brooker (2001) reported the unpopularity of gerontology among Australian nursing students. “The reasons given by students for their lack of interest in this area of nursing practice reflected negative attitudes toward older adults, the type of work involved, the effect on their own self-esteem, and the impact on their career path” (p. 13). Two of the six themes extracted from this research were a) “fear or discomfort with the elderly and b) lack of necessary personal characteristics or ability to cope with this area of practice” (p. 15).

As the previously cited studies over the past thirty years have revealed, negative views regarding care of older adults persist in multiple areas of the U.S. and around the world. Various suggestions for incorporating gerontologic content in the nursing curricula have been presented to address the impact of student and nurse reluctance to care for the elderly. For example, Happell and Brooker (2001) observed that the negative views and misconceptions of nursing students regarding care of older adults have a great impact on healthcare: “In addition to finding staff to work in elder care, the issue of quality is a concern. Attracting nurses with a genuine interest in and commitment to working with the elderly population is of paramount importance” (Happell & Brooker, 2001, p. 16). These researchers presented the following four suggestions: a) “the nursing profession as a whole [must] address this negativity to produce a more accurate and positive representation of gerontology” (p. 16); b) “presentation of gerontology content within nursing curricula must be examined; c) educators with a passion for this specialty [must] continue to challenge students’ attitudes to encourage a more positive view; and d) examples of best practice in education must be disseminated” (p. 17).

An obvious need is to identify and test ways to change students' attitudes toward the aging population (Ryan & McCauley, 2004). Other authors have suggested "one apparent strategy to ensure a workforce adequately prepared to care for the elderly is to give every nursing student adequate knowledge and skills in geriatric nursing" (Mezey & Fulmer, 1999, p. 118).

Initiatives in nursing education have included graduate recruitment strategies for students interested in geriatric nursing (Mackin, Kayser-Jones, Franklin, Evans, Sullivan-Marx, Herr, et al., 2006), establishing Hartford Centers of Geriatric Nursing Excellence (HCGNEs) (Harvath, Beck, Flaherty-Robb, Hartz, Specht, Sullivan-Marx, et al., 2006), and linking the HCGNEs to other schools in neighboring states to promote geriatric nursing curricular reforms (Souder, Kagan, Hansen, Macera, Mobily, & White, 2006). Development of geriatric nursing leaders through both conferences (McBride, Fagin, Franklin, Huba, & Le Quach, 2006) and partnerships (Young, Swanson, Richards, Wallhagen, Archbold, et al., 2006) have proved successful. Additionally, modifications in health policy for older adults have been influential in impacting preparation of a nursing workforce to meet the needs of the increasing older population (Harrington, Beverly, Maas, Buckwalter, Bennett, Young, et al., 2006).

Summary

Anticipated demographic changes have forecast that the U.S. population will rapidly increase in both percent of older adults and percent of different cultures. As the studies cited have described, various issues influence the attitude of nurses and students toward providing care for older adults from diverse cultures. Healthcare can be

impacted by ageism, stereotyping, lack of communication skill between generations or cultures, and lack of cultural awareness or desire for cultural competency. These issues can lead to health outcome disparities in older clients or those from differing cultural backgrounds than the healthcare provider. Nursing educators must prepare a workforce to address the healthcare needs of the expected consumers. Suggestions have been presented in nursing literature of various ways to include aging issues and increase cultural content in the healthcare curricula.

The specific problem investigated in this study is the impact of student variables and experiences during a senior level community health course on self-rating of perceived Elder Cultural Self-Efficacy (ECSE). Chapter III will present the research design and data analysis. The results of the research study will be discussed in Chapter IV, followed by a summary, discussions, implications, recommendations, and conclusion based on the study findings in Chapter V.

III. METHODS

Introduction

The purpose of this research was to identify senior level BSN students' perceptions of Eldercare Cultural Self-Efficacy (ECSE) at the beginning and end of the senior level community health course to determine which factors may correlate to a change in self-rating on the Eldercare Cultural Self-Efficacy Scale (ECSES) regarding care of older adults from four ethnic backgrounds. This study identified demographic characteristics of senior level BSN students, pre-course self-ratings on the ECSES, on the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R), and various clinical experiences to determine any correlation with student perceptions of ECSES at the completion of the senior level community health course.

Purpose

This study was instigated to assist nursing educators in two schools of nursing in the southeast U.S. to more fully understand currently prevalent characteristics of senior level baccalaureate nursing students, and how these characteristics may relate to students' self-rating of Eldercare Cultural Self-Efficacy. These findings may be beneficial for curricular planning in these and other schools of nursing. This chapter describes participants of the study, variables that were investigated, research design, sampling

methods, data collection instruments, procedures, and the types of analyses that were conducted.

Research Questions

1. What effect, if any, do student demographic variables (age, race, number of locations of residence within the state, outside the state, outside the U. S., the personal rating of desire for cultural competence, and the rating of personal value of caring) have on self-rating of Eldercare Cultural Self-Efficacy (ECSE) of senior level BSN students prior to a senior level community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES).
2. What is the relationship between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course?
3. Is there a difference in ECSES or IAPCC-R ratings pre and post a senior level community health course?
4. If so, what factors of clinical experience correlate to a change in BSN students' self-reporting on the ECSES at statistically significant levels?

Participants

The target population for this study was BSN students in two schools of nursing enrolled in a senior level community health course. No other special criteria were set for participants. The pool of potential participants totaled 123 students, between the ages of 19 and 53 years of age.

The universities chosen for this study were public, state supported institutions that shared the same appointed Board of Trustees, President, and Dean of Nursing. One university, begun in 1856, was located in the rural southeastern U.S., and offered undergraduate, graduate, and professional degrees through thirteen schools and colleges. In fall 2006, enrollment was over 22,000. The other university, established in 1967, was located on a 500-acre campus seven miles east of a metropolitan area. This university offered graduate and undergraduate degrees through the schools of Business, Education, Liberal Arts, Nursing, and Sciences. During fall 2006, enrollment was approximately 5,500. Both universities were accredited by the Commission on Colleges of the Southern Association of Colleges and Schools (SACS). Both schools of nursing were approved by the state board of nursing and by the American Association of Colleges of Nursing (AACN) through the Commission on Collegiate Nursing Education (CCNE).

The schools of nursing shared a common curriculum, with course numbers, names, and description listed identically in each university catalogue. Both universities required five semesters of upper division nursing content for the baccalaureate degree. Upon completion of the lower division pre-nursing requirements, students were admitted to the BSN program once a year in the fall semester of the junior year. During the junior fall semester, one of the required nursing courses was NURS 3610, Physical Assessment, which included content regarding assessment strategies throughout the lifespan, and specific strategies for cultural assessment. Another course offered during the fall of the junior year, NURS 3710, Professional Concepts I, presented concepts including cultural impact on individual's and groups' health beliefs and behaviors, along with the role of the nurse in the healthcare delivery system. During fall 2005 (the year that the

participants in this study completed these courses), different faculty members taught NURS 3610 and 3710 on each campus. In the spring semester of the junior year, NURS 3720, Professional Nursing Concepts II was taught. This course includes medical-surgical content with application across the lifespan, taught by several different faculty members on each campus. Faculty with specific expertise presented content related to pediatric and gerontology concepts. The specific gerontology content was taught by the same faculty member on both campuses during spring 2006, during which the participants of this study were enrolled. Additionally, on one of the campuses, during the spring and summer semesters of 2006, the nursing students were required to complete four service hours in discussions with international students taking an English as a Second Language (ESL) course. On the other campus, ten of the senior level students were enrolled in the course “Cultural Expeditions in Healthcare” offered as an elective during fall 2006 concurrently with the senior level community health course.

Variables of Interest

The dependent or criterion variable in this research study is the BSN students’ self-rating of Eldercare Cultural Self-Efficacy (ECSE) at the end of the senior level community health course (post-course), for each of four cultural groups (African-American, Asian-American, Latino-Hispanic, and White). This dependent variable is an interval measurement of individual attitude (Creswell, 2005) using an affective 5-point Likert type scale for 28 items developed by Shellman (2003). Additionally, a total score (interval scale) was calculated for students’ self-rating for each of the four ethnic groups.

A treatment group was not used because all of the senior level BSN students on both campuses would experience the community health clinical rotation.

One of the independent or predictor variables considered in this study were the BSN students' rating on the ECSES at the beginning of the senior level community health course (pre-course ECSES). The ratings were measured on a five-point interval scale of a Likert type for each of the 28 items with a total score calculated for each of the four ethnic groups. The maximum score possible for each of the four ethnic groups considered in the ECSES was 140.

Additional independent variables recognized in this study from the pre-course demographic survey include age (an interval scale); gender (measured as a nominal, dichotomous scale: 01) male; 02) female); race (measured on a nominal/categorical scale) as: 01) African-American, 02) Mexican American, 03) White, 04) Southeast Asian, 05) Other Hispanic, 06) Native American, 07) Puerto Rican, 08) Japanese, 09) Filipino, 10) Other (specify); and the number of past geographic residences within the state, outside the state, and outside the U.S. Another independent variable from the pre-course demographic survey was the individual respondents' rating of caring within a personal value system using a 4-point interval scale of 01) no value, 02) slight value, 03) moderate value, and 04) great value. Participants' rating of personal desire for cultural competence using a 4-point Likert type interval scale of 01) no desire, 02) slight desire, 03) moderate desire, and 04) great desire provided one other independent variable from the pre-course demographic survey (see Appendix A).

The IAPCC-R used a 4-point Likert type scale for each of the 25 items, with a maximum possible score of 100. Individual items on the pre-course IAPCC-R were

measured on an interval scale from which sub-scale and overall totals were calculated. The same measurement techniques were used to calculate each student's response to the post-course IAPCC-R.

Post-course demographic data included the number of student experiences providing nursing care to older adults of four ethnic backgrounds. For each of the ethnic backgrounds, respondents were asked to indicate the number of clients for whom care was provided at various levels of acuity (as designated by characteristic of client encounter), and rate the experience as (-1) not promoting self-efficacy, (0) having no effect, or (+1) promoting self-efficacy. Furthermore, for each of the ethnic backgrounds, the number of clients for whom care was provided at various clinical site environments was requested, with a self-rating of the experience as (-1) not promoting self-efficacy, (0) having no effect, or (+1) promoting self-efficacy (see Appendix B).

Research Design

The impetus for this study was the query regarding what factor(s) influenced senior level BSN student's perception of effectiveness in providing care for older adults. Literature had revealed that nursing students were reluctant to choose employment in the area of gerontology. Bandura's (1986) theory of self-efficacy suggested a person was reluctant to engage in situations in which there was a lack of perceived self-efficacy. The path of inquiry developed as follows: If student self-efficacy could be measured, were there specific demographic characteristics of students who perceived lower self-efficacy in caring for older adults (for example, age, gender, race, number of residence locations, etc)? Were the students' perceptions of self-efficacy in caring for older adults influenced

by a generalized difficulty in relating to clients from an older generation (Bennis & Thomas, 2002; Shellman, 2003)? Were the students' perceptions of self-efficacy influenced by caring for clients from different ethnic backgrounds than their own? Did students' perceptions of cultural competence in general have any statistically significant relationship with students' perception of self-efficacy in caring for older adults of various ethnic backgrounds? Were there student clinical experiences in the BSN program that correlated at statistically significant levels with student perception of effectiveness in care of the older adults? Particularly, were the students' perceptions of self-efficacy in providing nursing care correlated at a statistically significant level with the acuity level of client care or the locations of the clinical experiences? Identification of factors that correlated with student perceptions of eldercare cultural self-efficacy would provide insight for nursing educators planning theory and clinical curricula. These thoughts were formed into the research questions listed previously in this chapter.

Specifically, this study is conceptualized as the interactions of BSN students with older clients from various cultural backgrounds. However, the correlation of the nursing curriculum on the students' interactions with older, diverse clients is the area being studied in order to determine any factors that may impact eldercare cultural self-efficacy. Possible correlation between the variables of student demographics, pre-course scoring on the IAPCC-R and ECSES with post-course scoring on the IAPCC-R and ECSES, as possibly influenced by the type of nurse-client interactions and the environment of the interactions during the semester, will be investigated. Figure 1 shows the central area as the conceptualized area of interest.

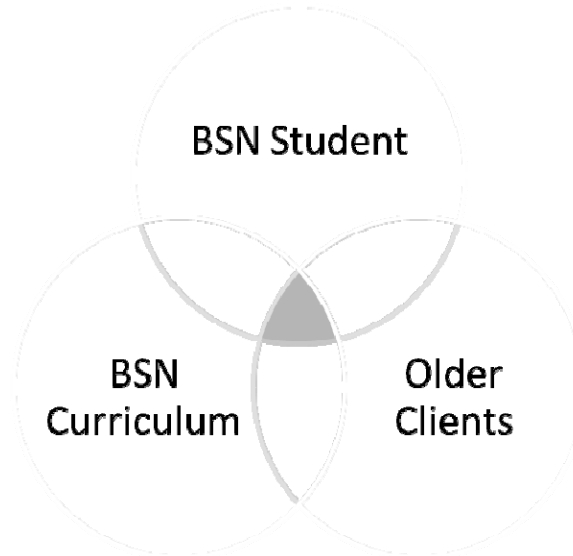


Figure 1. Conceptualization of area of interest

This study was designed using a prospective correlational approach.

Correlational studies may be relationship studies or prediction studies. Relationship studies are used to determine if, and to what degree, a set of variables are related (Gay & Airasian, 2000), but do not establish cause and effect (Polit & Beck, 2004). “With the availability of software packages for analyzing multivariable studies, researchers are designing studies in ways that allow for deeper understanding of the complex relations among sets of variables” (Grimm & Yarnold, 1995, p. 1).

This research study was a prospective correlational, causal comparative survey using a pre and post-course questionnaire. Descriptive statistics were analyzed to reveal demographic characteristics and initial pre-course self-rating on the IAPCC-R and on the ECSES of senior level BSN students. An explanatory prospective quantitative correlational design attempted to describe the effect of the course, including specific experiences within the course, on the post-course ESCES outcomes. Specifically, the

study was conducted to determine the extent to which one or more independent variables on the pre-course demographic survey and/or the pre-course IAPCC-R may provide additional explanations for the pre-course ECSES, and on the dependent variable of the ECSES post-test. Furthermore, assessment of perceived efficacy in providing nursing care in differing types of nurse-client interactions and in varying clinical locations were measured by participant responses on the post-course demographic survey and then correlated with the post-course ECSES.

Sample

The tangible population (Huck, 2004) for this proposed study was all senior level BSN students within two schools of nursing in the southeast U.S. during fall semester 2006. All students enrolled in NURS 4740 comprised the pool from which voluntary participants were drawn. No other specific criteria were required for participants. Students were between the ages of 19 and 55 years, and demographics of the sample were expected to reflect those of the universities. The minimum number of participants needed to validate the study was set by the researcher at 90; the maximum number of participants possible for this study was 123. "Power becomes acceptable at sample sizes of 100 or more in situations with a moderate effect size at both alpha levels" (Hair, Black, Babin, Anderson, & Tatham, 2006, p. 11).

The sampling procedure involved the researcher's attendance during the final portion of a NURS 4740 class meeting on each campus during the first month of the course. The initial response rate was 82%. Sampling for the post-course questionnaire followed the same procedure, with the researcher attending the final portion of a NURS

4740 class during the last month of the course. The final response rate was 71%. The researcher, but not the course instructor, was present during voluntary participation for the pre-course and post-course surveys.

Instruments

Eldercare Cultural Self-Efficacy Scale (ECSES) Validity and Reliability

The Eldercare Cultural Self-Efficacy Scale (ECSES) developed by Shellman (2003) was selected to assess the student nurses' perceived self-efficacy in caring for older adults from the four largest ethnic groups based on U.S. census data (African American, Asian American, Latino-Hispanic, and White). This questionnaire, used in both the pre-course and post-course surveys for the current research, was a modified version of the Cultural Self-Efficacy Scale (CSES) developed by Bernal and Froman (1993). The CSES was used to measure community health nurses' perception of self-efficacy in providing culturally competent care the four ethnic groups. Shellman modified the CSES to include items from nursing literature and experienced gerontological nurses' input regarding care of older adults to develop the ECSES to form a survey tool for self-evaluation, using a five-point interval scale ranging from 1) very little confidence to 5) quite a lot of confidence for each of 28 items related to care of older adults. The same 28 items were repeated for each of the four ethnic backgrounds (African American, Asian American, Latino-Hispanic, and White). The maximum total score possible for any of the ECSES scales was 140 (Shellman, 2006).

Content validity was determined by experts agreeing the questions were representative of the area of interest (Shellman, 2007). Shellman discussed the reliability of the ECSES:

The purpose of the ECSES is to measure nursing students' levels of self-efficacy towards caring for older adults of four distinct ethnic groups. The overall internal consistency estimate of the 28-item scale was .95 with the four-subscale alpha scores ranging from 0.83 to 0.92, thus indicating that the scale is internally consistent and measures the students' perceptions of cultural self-efficacy in caring for elders of four ethnic groups. . . Reliability coefficients of the ECSES for another study ranged from 0.96 to 0.98 across each testing point (2007, p. 46).

The Cronbach's alpha coefficient provides an estimate of reliability. More specifically, it provides an estimate of internal consistency by determining how all items on a test relate to all the other items on the test and to the total test. Cronbach's alpha results range from 0 to 1, varying with the type of items on a test. Higher internal consistency reliability is shown by results closer to 1 (Gay & Airasian, 2000). Assumptions for Cronbach's alpha are that all the items in the scale are measured using an interval or ratio scale and that each item should be normally distributed (Cronk, 2006).

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

The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) (Campinha-Bacote, 2002c) is a revision of

Campinha-Bacote's (1999) Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC). The copyrighted IAPCC-R is a 25-item instrument for self-rating of cultural competence based on the subscale constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The IAPCC-R was designed for self-evaluation of cultural competence using a four-point scale to answer each of the 25 items, with a maximum total score possible of 100. Levels of cultural competence were calculated as culturally proficient for scores of 91-100, culturally competent for scores of 75 to 90, culturally aware for scores of 51 to 74, and culturally incompetent for scores of 25 to 50 (Campinha-Bacote, 2002c, 2007). The subscale for cultural awareness included items 1, 2, 3, 15, and 18; the subscale for cultural knowledge included items 6, 8, 10, 11, and 12; the subscale for cultural skill included items 5, 9, 20, 21, and 22; the subscale for cultural encounters included items 14, 16, 17, 23, and 25; and the subscale for cultural desire included items 4, 7, 13, 19, and 24 (Campinha-Bacote, 2007).

The reliability of the IAPCC-R had been demonstrated in a study of 275 certified nurse practitioners resulting in a Cronbach's alpha of .85 (Koempel, 2003). McCoy (2005) reported IAPCC-R reliability with a Cronbach's alpha of .81 in a study of 111 nursing students and faculty. Another study of 313 nursing faculty in the U.S. using the IAPCC-R produced a Cronbach's alpha of .869 (Kardong-Edgren, 2004). A study with 238 physical therapy students yielded a Cronbach's alpha of .78 and a Guttman Split Half of .77 (Gulas, 2005). Split-half reliability entails splitting a single test into two comparable halves, or subtests, computing each subjects' score on the two halves, correlating the two set of scores and applying the Spearman-Brown correction formula to

measure internal consistency as an assessment of reliability (Gay & Airasian, 2000). Content validity of the IAPCC-R was established by transcultural healthcare expert reviews (Campinha-Bacote, 2007).

Pre-course and Post-course Demographic Questionnaires

The pre-course demographic questionnaire was designed by the researcher to obtain background information regarding the individual participants that might correlate to the dependent variable of eldercare cultural self-efficacy (see Appendix A). The post-course demographic questionnaire was designed by the researcher to obtain information regarding clinical experiences of the individual participants that might correlate to the dependent variable of eldercare cultural self-efficacy (see Appendix B).

Procedures

Research methods included a prospective data collection using a pre-course and post-course survey. The researcher obtained permission from the authors of the ECSES and IAPCCC-R (see Appendix C). The dean of the two schools of nursing granted permission to conduct the study at both of the schools. The researcher obtained Institutional Review Board (IRB) permission from each of the universities (see Appendices D and E). The researcher contacted the faculty of NURS 4740 Professional Nursing Concepts III (the same faculty taught the content on both campuses during fall 2006), explained the study (see Appendix F), received permission to collect the data, and set data collection dates.

The researcher visited a class meeting of NURS 4740 on both campuses within the first month of fall semester 2006. Details of the study were explained to the students enrolled in the class, using a script (see Appendix G). Informed consent forms (see Appendix H) and the pre-course survey questionnaire packets were distributed to all students present at that time. Students volunteering to participate were asked to complete the questionnaire packet and return it in an unmarked sealed manila envelope to a sealed box at the back of the room following completion. The researcher again visited a class meeting of NURS 4740 on both campuses within the last month of fall semester 2006 to distribute the post-course survey questionnaire packets to students volunteering to participate. Again, students were asked to complete the questionnaire packet and return it in an unmarked sealed manila envelope to a sealed box at the back of the room following completion. At the end of the fall 2006 semester all students enrolled in NURS 4740 were offered a free pizza lunch as a gesture of appreciation from the researcher for the time required to complete the questionnaire packets.

There were no known anticipated risks or discomforts associated with participation. All participants were informed of their right to voluntary participation and the right to terminate the study at any time for any reason. To protect confidentiality of participants and prevent possible breaches, all identifying information was numerically coded. Data were recorded so that participants could not be directly identified. Specifically, each participant self-coded the survey using the last three digits of their phone number and street address digits from the previous spring. This code, and not the participant's actual name, was placed by the participant on the title page of all data collection packets. Therefore, no code list existed. Data was recorded and analyzed as

anonymous. Hard paper copies of data collection forms were stored in a locked filing cabinet at one of the Schools of Nursing. All data were entered on an Excel spreadsheet by the researcher. Electronic copies of aggregate data were stored in a filing cabinet in a room locked in the researcher's absence. Only the researcher and faculty sponsor had access to the data and coding sheets used to match participants' pre- and post-course survey questionnaires. The pre- and post-course survey questionnaire packets will be destroyed one year following completion of the research using the School of Nursing paper shredder.

The only anticipated benefits of participation in the study for the students was that exposure to the pre-course survey questionnaire could serve as a reminder of concepts potentially encountered in the NURS 4740 clinical experiences with older adults. Students were able to consider and possibly self-reflect on personal perceptions of eldercare cultural self-efficacy prior to and following the clinical component of NURS 4740. An anticipated benefit for the general population generated from this study is that this research could help identify factors that effect baccalaureate nursing student perceptions of eldercare cultural self-efficacy for use in curricular planning, thus potentially promoting an increase in the cultural sensitivity of baccalaureate nursing students and graduates who will be providing nursing care to older adults.

Statistical Analyses

Research question one was: What effect, if any, do student demographic variables have on self-rating of eldercare cultural self-efficacy (ECSE) of senior level BSN students prior to a senior level community health course as measured by the Eldercare

Cultural Self-Efficacy Scale (ECSES)? Data were collected for this question using the pre-course demographic questionnaire and the pre-course ECSES. The data collected from this study were analyzed by using multiple methods, using the Statistical Package for the Social Sciences version 15.0 (SPSS) software.

Analysis included descriptive statistics that indicate the general tendencies in the data (mean) and the spread of the scores (variance, standard deviation, and range) for each of the demographic characteristics. In order to determine any statistically significant relationships among the variables, Pearson correlation, analysis of variance (ANOVA), and backward multiple regression correlations were used to determine which factors contributed most to the pre-course ECSES rating.

From the seventeen possible demographic questions, information from seven were selected to analyze as independent variables using bivariate correlation with the pre-course ECSES for each ethnic group (African-American, Asian-American, Latino-Hispanic and White). Items were analyzed to determine any that revealed statistically significant levels of correlation. Pearson's product-moment correlation is one of the most frequently used bivariate correlational procedures in situations in which "1) each of the two variables is quantitative in nature and 2) each variable is measured so as to produce raw scores" (Huck, 2004, p. 62). Analyses were computed using a one-tailed test for statistical significance, with the p -value at the <0.05 level.

Research question two asked: What relationship, if any, exists between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course. Data were collected for this question using the pre-course IAPCC-R and the pre-course ECSES. Descriptive statistics

included the mean and standard deviations for responses on each of the pre-course assessment tools, including the subgroups of the IAPCC-R (cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire).

Multiple regression was again used to analyze the data to determine the strength of relationship between pre-course survey results for any of the five IAPCC-R subgroups with ratings on any of the pre-course ECSES for the four ethnic groups. Correlation coefficients range between -1.0 and +1.0, with those close to 0.0 representing weak relationships, and those close to 1.0 or -1.0 representing strong relationships. Significant correlations indicate reliable relationships, not necessarily strong correlations (Cronk, 2006).

Research question three asked: Did a difference occur in self-rating on the ECSES or IAPCC-R pre and post a community health course? Data were collected for this question using the pre-course course IAPCC-R, the pre-course ECSES, the post-course IAPCC-R, and the post-course ECSES. Descriptive statistics were used to report results of the subscales of each of the tools. The ECSES has four sections, one for each of four ethnic groups (African-American, Asian-American, Latino-Hispanic, and White). The IAPCC-R has five subscales (cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire). Descriptive statistics were used to determine the mean and standard deviations for the pre and post-course survey results for the total sample and by school one and school two. Analysis of variance (ANOVA) was used to compare the pre-course IAPCC-R, with the post-course IAPCC-R, the pre-course ECSES, with the post-course ECSES for each of the four ethnic groups. Further analyses using a mixed model repeated measures ANOVA provided information regarding change

in pre and post-course scores over the time of the course and by school, as well as the interaction of effects of time and school, using a one-tailed test for statistical significance. A two-way mixed ANOVA allows examination of the sample means to see if the differences in participant responses over the time of the course and between the participants from each school are further apart than would be expected by chance.

Research question four asked: What factors of clinical experience correlate to a change in BSN students' self-reporting on the post-course ECSES at a statistically significant level? Data were collected for this question using the post-course demographic survey, the post-course IAPCC-R, and the post-course ECSES. Descriptive statistics were used to report results of the total score of numbers of clients from the four ethnic backgrounds that received care from the sample of participants. Analyses of possible relationship(s) of the characteristics of nurse-client interactions were facilitated by collapsing data from the post-course survey related to characteristics of the nurse-client encounter into the two categories: collaborative or challenging. These categories were correlated with the participants' rating of effect on perception of efficacy in caring for older persons as negative effect (-1), no effect (0), or positive effect (+1). Additionally, data regarding the environmental setting of the nurse-client interaction were collapsed into community or institutional categories, which reflected the acuity level of client care (more skilled nursing care required in institutional settings). These community or institutional categories were also correlated with the participants' rating of effect on perception of efficacy in caring for older persons as negative effect (-1), no effect (0), or positive effect (+1). This descriptive research study is an attempt to identify which

factor(s), if any are correlated with a change in the post-course ECSES at a statistically significant level.

Backward multiple regression was also used for research question four in an attempt to explain which factors related most statistically significantly with the post-course ECSES. Multiple regression was used to understand the relationships by determining how much influence a variable had on the dependent variable of post-course ECSES scores. Although correlation does not mean causation, “one can gain a better understanding of the nature of a phenomenon by identifying those factors with which it co-occurs. . . Information of co-occurrence helps to define the theoretical constructs involved in the phenomenon under study” (Grimm & Yarnold, 2001, p. 33).

An analysis of variance (ANOVA) was used for statistical analysis of the relationship between the demographic data and the pre-course ECSES. “Instead of using a series of individual *t*- test comparisons, the difference among the groups are examined through analysis of variance that considers the variation across all groups at once. . . The question answered by the ANOVA test is whether group means differ from each other” (Munro, 2005, p. 152). The ANOVA test examines the variation and tests whether the between-group variation exceeds the within-group variation (Munro, 2005).

ANOVA has been shown to be fairly robust, meaning that even if the researchers do not rigidly adhere to the assumptions, the results may still be close to the truth. The assumptions for ANOVA are the same as those for the *t* test; that is, the dependent variable should be a continuous variable that is normally distributed, the groups should be mutually exclusive (independent of each other), and the groups should have equal

variances (homogeneity of variance requirement). (p. 153)

Regression analyses were then conducted to determine relationship of the demographic data with the pre-course ECSES. “Multiple regression can be used with data representing any scale of measurement to analyze the results of causal-comparative, as well as correlational, studies to determine the degree to which variables are related” (Gay & Airasian, 2000, p. 501). Results were reported for the full model and the restricted model (after variables were eliminated through backward elimination). “Multiple regression correlation provides powerful tools for analyzing the combined and independent contributions of multiple potential determinants, particularly when experimental control is not possible” (Grimm & Yarnold, 2001, p. 56).

The multiple correlation coefficient (R) indicated the degree of relationship between a linear combination of the scores, ranging from 0 to -1 or +1, with 0 indicating no relationship between the scores, -1 indicating a perfect inverse relationship, and +1 indicating a perfect relationship. “In multiple regression correlation, the overall R must be statistically significant before comparing the statistical significance of partial coefficients or contributions of specific variables” (Grimm & Yarnold, 2001, p. 54). The multiple coefficient of determination (R^2) indicated the percentage of variance explained from the combination of the variables. R^2 is actually computed as $1 - R^2$ to determine the proportion of variance that is not shared by the weighted combination of variables (Grimm & Yarnold, 2001, p. 48). Effect size for regression is reported as R^2 and means that percent of the variability in the dependent variable is accounted for by the relationship between the dependent and independent variables (Cronk, 2006). In backward elimination, the first analysis of the series includes all of the predictors. Then

each successive analysis involves fewer predictors with the order of elimination based on the removal of the variable that produces the smallest decrement in the R^2 at that step (Cronk, 2006).

Summary

This chapter included an overview of the research, a description of the participants in the study, and the procedures for obtaining the data. The dependent or criterion variable of the students' self-rating of eldercare cultural self-efficacy as measured by Sehlman's eldercare cultural self-efficacy scale (ECSES) was discussed. The independent variables considered in the study were described. These independent variables include items on the pre-course demographic survey, the pre-course Inventory to Assess the Process of Cultural Competence Among Healthcare Providers (IAPCC-R), the post-course demographic survey, and the post-course IAPCC-R. The types of descriptive and analytical statistics were presented for consideration. Results of this research will be presented in Chapter 4. Summary, discussion, implications, recommendations, and conclusions will be presented in Chapter 5.

IV. RESULTS

Introduction

The purpose of this research was to examine factors that may impact BSN students' perception of eldercare cultural self-efficacy as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES) at the completion of a senior level community health course. This study examined data collected at the beginning (or pre-course) of the community health course regarding student demographic characteristics, self-assessment of cultural competence as measured by the Instrument to Assess the Process of Cultural Competence among Healthcare Providers-Revised (IAPCC-R), and a self-rating on the ECSES for four ethnic groups (African American, Asian American, Latino Hispanic, and White). At the completion of the course (or post-course), data collection included information regarding students' clinical experiences during the course, a self-assessment on the IAPCC-R, and on the ECSES for the same four ethnic groups as in the pre-course ECSES.

Research Questions

1. What effect, if any, do student demographic variables (age, race, number of locations of residence within the state, outside the state, outside the U. S., the personal rating of desire for cultural competence, and the rating of personal value of caring) have on self-rating of Eldercare Cultural Self-Efficacy (ECSE) of senior level BSN students prior to a

senior level community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES).

2. What is the relationship between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course?
3. Is there a difference in ECSES or IAPCC-R ratings pre and post a senior level community health course?
4. If so, what factors of clinical experience correlate to a change in BSN students' self-reporting on the ECSES at statistically significant levels?

Although the IAPCC-R had been used in previous studies (Brathwaite, 2005; Brathwaite, 2006; Brathwaite & Majumdar, 2006; Campinha-Bacote & Munoz, 2001), as had the ECSES (Coffman, Shellman, & Bernal, 2004; Shellman, 2003), the current research is the only study found that seeks to determine if there is any statistically significant relationship between these two tools. Also, the data were examined to determine any relationship among the additional independent variables of student demographics or course clinical experiences with the end of course students' self-rating on the ECSES. Quantitative methods were used to analyze data to determine any factors that had a statistically significant relationship with the end of course ECSES. The findings are presented with an overview of the participants, discussion of the four research questions related to the problem, and a summary.

Participants

The sample was comprised of 102 senior level BSN students of the 125 students enrolled in a community health course in two schools of nursing who volunteered to

participate in the study. Pre-course survey questionnaires were coded by the participants, and matched for comparison with post-course survey questionnaires, which were also coded by the participants according to the same coding criteria.

Demographic characteristics of the sample included age, gender, race, number of previous locations of residence within the state, number of locations of residence outside of the state, and number of residence locations outside of the U. S. Additionally, participants were asked to specify skill in speaking another language, using an interpreter, and what (if any) previous cultural courses had been taken. The demographic survey also requested the number of clients for whom the participant had provided care from an African American background, from an Asian American background, from a Latino Hispanic background, and from a White background prior to the community health course. Furthermore, participants were asked to rate (by selecting one of four options) a personal desire for cultural competence, and to what extent caring was personally valued (by selecting one of four options presented).

Descriptive analysis of the data revealed a mean age ($n = 102$) of 24.62 years ($SD=6.274$), with a range of 34 years from age 19 to age 53 for the total sample. The first school of nursing (SON) surveyed ($n = 48$) presented a mean age of 27.42 years ($SD=7.579$) with a range of 32 years from age 21 to age 53. Students at the second SON surveyed were slightly younger ($n = 54$; 22.13 years; $SD=3.268$), ranging from 19 to 38 years of age (range of 19 years). The sample was predominantly female ($n = 96$; 94.1%). Ethnic backgrounds of the participants were predominantly Caucasian ($n = 87$; 85.3%), followed by African American ($n = 9$; 8.8%). Four participants were from Latino

Hispanic background (3.9%), and two participants (2%) indicated other as the ethnic background.

Ten of the participants (9.8%) could speak a language in addition to English, and only seven (6.9%) had experienced working with an interpreter. Forty-one (40.2%) of the participants had resided in only one location within the state, and 38.2% of the sample had lived in two locations within the state. One-half (n = 51; 50%) of the participants had lived outside of the state. Participants who had lived in a different country than the U. S. represented 12 % (n = 12) of the sample.

Responses to questions about providing nursing care for older adults of various ethnicities during either previous courses or employment revealed that 100% of the sample had cared for older adults from both African American and White backgrounds. Forty-two participants (41.2%) had previously cared for older adults from Latino Hispanic backgrounds, and eighteen participants (17.6%) had cared for clients from Asian American backgrounds. Cultural competence was desired by most participants, by selection of the rating of moderate desire (42.4%) or great desire (46.1%). The majority of participants also greatly valued caring (93.1%), one of the foundational constructs of the nursing profession. Table 1 represents the demographic characteristics of the sample.

The pre-course and post-course surveys included two additional tools. The IAPCC-R is a 25-item tool designed for self-evaluation of cultural competence, which uses a four-point Likert-type scale to allow a maximum score of 100. The ECSES is a 28-item tool that provides for self-evaluation related to care of older adults from four ethnic backgrounds, The ECSES has a five-point Likert-type scale, with a maximum score of 140. Each of the instruments used for data collection demonstrated internal

Table 1

Demographic Characteristics of the Sample

Characteristic	Total n = 102	SON 1 n = 48 (47.1%)	SON 2 n = 54 (52.9%)
Age	<i>M</i> = 24.62 (<i>SD</i> = 6.274) Range = 19-53	<i>M</i> = 27.42 (<i>SD</i> = 7.579) Range = 21-53	<i>M</i> = 22.13 (<i>SD</i> = 3.268) Range = 19-38
Gender:			
Male	n = 6 (5.9%)	5 (10.4%)	1 (1.9%)
Female	n = 96 (94.1%)	43 (89.6%)	53 (98.1%)
Race:			
White	n = 87 (85.3%)	38 (79.2%)	49 (90.7%)
African- American	n = 9 (8.8%)	7 (14.6%)	2 (3.7%)
Latino-Hispanic	n = 4 (3.9%)	1 (2.1%)	2 (3.7%)
Other	n = 2 (2.0%)	1 (2.1%)	1 (1.9%)
Prior culture course:			
Yes	n = 50 (49.0%)	34 (70.8%)	16 (29.6%)
No	n = 52 (51.0%)	14 (29.2%)	38 (70.4%)
Specific course:			
Cultural expeditions	n = 14 (13.7%)	1 (2.1%)	13 (24.1%)
ESL	n = 39 (38.2%)	36 (75%)	3 (5.6%)
Speaks language other than English	n = 10 (9.8%)	2 (4.2%)	8 (14.8%)
Interpreter skills	n = 7 (6.9%)	5 (10.4%)	2 (3.7%)

(table continues)

Table 1 (continued)

Characteristic	Total n = 102	SON 1 n = 48 (47.1%)	SON 2 n = 54 (52.9%)
# living locations within the state:		<i>M</i> = 2.00 (<i>SD</i> = 1.130) Range = 0-5	<i>M</i> = 1.75 (<i>SD</i> = .853) Range = 1-5
1 location	n = 41 (40.2%)	18 (37.5%)	23 (42.6%)
2 locations	n = 39 (38.2%)	16 (33.3%)	23 (42.6%)
3 locations	n = 13 (12.7%)	8 (16.6%)	5 (9.3%)
4 locations	n = 4 (3.9%)	3 (6.3%)	1 (1.9%)
5 locations	n = 3 (2.9%)	2 (4.2%)	1(1.9%)
Lived outside of state	n = 51 (50%)	25 (52.1%)	26 (48.1%)
# other states:			
1 other state	n = 24 (23.5%)	8 (16.7%)	16 (29.6%)
2 other states	n = 15 (14.7%)	10 (20.8%)	5 (9.3%)
3 other states	n = 3 (2.9%)	1 (2.1%)	2 (3.7%)
4 other states	n = 3 (2.9%)	2 (4.2%)	1 (1.9%)
5 other states	n = 3 (2.9%)	2 (4.2%)	1 (1.9%)
7 other states	n = 2 (2.0%)	1 (2.1%)	1 (1.9%)
11 other states	n = 1 (1.0%)	1 (2.1%)	0 (0%)
Lived outside of U. S.	n = 12 (11.8%)	5 (10.4%)	7 (13.0%)

(table continues)

Table 1 (continued)

Characteristic	Total n = 102	SON 1 n = 48 (47.1%)	SON 2 n = 54 (52.9%)
# of students with previous African-American client care experience	n = 102 (100%)	n = 48 (100%)	n = 54 (100%)
# of African-American clients		<i>M</i> = 8.21 (<i>SD</i> = 11.371) Range = 1-47	<i>M</i> = 16.65 (<i>SD</i> = 18.332) Range = 1-100
# of students with previous Asian-American client care experience	n = 18 (17.6%)	n = 7 (14.6%)	n = 11 (20.4%)
# of Asian-American clients		<i>M</i> = 1.71 (<i>SD</i> = 1.113) Range = 1-4	<i>M</i> = 3.11 (<i>SD</i> = 3.180) Range = 1-10
# of students with previous Latino Hispanic client care experience	n = 42 (41.2%)	n = 15 (31.3%)	n = 27 (50%)
# of Latino-Hispanic clients		<i>M</i> = 2.36 (<i>SD</i> = 2.061) Range = 1-8	<i>M</i> = 4.08 (<i>SD</i> = 4.680) Range = 1-20

(table continues)

Table 1 (continued)

Characteristic	Total n = 102	SON 1 n = 48 (47.1%)	SON 2 n = 54 (52.9%)
# of students with previous White client care experience	n = 102 (100%)	n = 48 (100%)	n = 54 (100%)
# of White clients		<i>M</i> = 11.32 (<i>SD</i> = 17.204) Range = 1-100	<i>M</i> = 24.56 (<i>SD</i> = 24.958) Range = 5-150
Pre-course rating of desire for cultural competence:		n = 48 <i>M</i> = 3.29 (<i>SD</i> = .713) Range = 2-4	n = 54 <i>M</i> = 3.37 (<i>SD</i> = .708) Range = 1-4
No desire (1)	n = 1 (1.0%)	0 (0%)	1 (1.9%)
Slight desire (2)	n = 11 (10.8%)	7 (14.6%)	4 (7.4%)
Moderate desire (3)	n = 43 (42.2%)	20 (41.7%)	23 (42.6%)
Great desire (4)	n = 47 (46.1%)	21 (43.8%)	26 (48.1%)
Pre-course rating of personal valuing of caring:		<i>M</i> = 3.92 (<i>SD</i> = .347) Range = 2-4	<i>M</i> = 3.93 (<i>SD</i> = .264) Range = 3-4
Not valued (1)	n = 0 (0%)	0 (0%)	0 (0%)
Slightly valued (2)	n = 1 (1.0%)	1 (2.1%)	0 (0%)
Moderately valued (3)	n = 6 (5.9%)	2 (4.2%)	4 (7.4%)
Greatly valued (4)	n = 95 (93.1%)	45 (93.8%)	50 (92.6%)

consistency reliability with Cronbach's alphas ranging from .766 to .981. Table 2 summarizes the calculated Cronbach's alpha for the pre-course and post-course IAPCC-R (25 items) and the pre-course and post-course ECSES for the four ethnic groups (28 items each).

Research Questions Results

Data were analyzed to address the four research questions considered in this study. The research questions focus on determining the relationship between the independent variables (demographic data, pre-course IAPCC-R responses, pre-course ECSES responses, and post-course demographic data) and the dependent variable (post-course ECSES) during the senior BSN community nursing course.

Research Question One

Results of data analysis addressed Research Question 1: What effect, if any, do student demographic variables have on self-rating of eldercare cultural self efficacy (ECSE) of senior level BSN students prior to a senior level community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES)? Two different assessments (the demographic survey and the pre-course ECSES) were used to assess different characteristics of the sample.

A one-tailed Pearson Correlation was used to analyze data to determine any statistically significant relationships between each of seven selected demographic characteristics (independent variables) with the pre-course ECSES for the four ethnic categories (dependent variables). The original 17 demographic variables were decreased to seven to minimize inflation of Type I error. Gender was not analyzed as an independent variable since males comprised only 5.9% of the sample. Race was

Table 2

Summary of Measurement Scales

Scale	N	Mean (SD)	Items	Cronbach's Alpha
Pre-course IAPCC-R	101	71.41 (6.46)	25	.766
Post-course IAPCC-R	82	71.77 (7.54)	25	.830
Pre-course ECSES (African American)	94	99.26 (18.57)	28	.958
Post- course ECSES (African American)	86	104.31 (15.94)	28	.949
Pre-course ECSES (Asian-American)	95	90.22 (23.48)	28	.977
Post-course ECSES (Asian American)	81	92.79 (21.80)	28	.976
Pre-course ECSES (Latino-Hispanic)	96	95.73 (22.01)	28	.956
Post-course ECSES (Latino-Hispanic)	79	94.39 (24.20)	28	.981
Pre-course ECSES (White)	100	110.51 (18.35)	28	.967
Post-course ECSES (White)	88	114.02 (16.83)	28	.962

analyzed using only the two ethnic categories with the greatest percentage of respondents in the sample: White (85.3%) and African American (8.8%). Participant age, number of locations of residence within the state, outside the state, outside the U.S., the participants'

personal rating of a desire for cultural competence, and the participants' personal rating of valuing caring comprised the seven demographic independent variables.

One variable, desire for cultural competency, correlated with each of the five dependent variables. More specifically, those individuals rating a desire for cultural competence higher also tended to express higher levels of pre-course cultural competence on the IAPCC-R ($r = .469, p \leq .001$), and higher participant rating of desire for cultural competence also correlated with higher scores on the ECSES for Asian-American clients ($r = .290, p \leq .01$), for African-American clients ($r = .277, p \leq .01$), for Latino Hispanic clients ($r = .244, p \leq .01$), and for White clients ($r = .182, p \leq .05$). Data revealed a statistically significant correlation between participants of African-American backgrounds and the pre-course IAPCC-R ($r = .329, p \leq .001$), as well as weak statistically significant correlations with the pre-ECSES for Latino-Hispanic clients ($r = .216, p \leq .05$), for African-American clients ($r = .177, p \leq .05$), and for Asian-American clients ($r = .173, p \leq .05$). Participants specifying more locations of residence within the state correlated at the $p \leq .01$ level with the ECSES for Latino Hispanic clients ($r = .266$) and at the $p \leq .05$ level with the each of the ECSES for Asian-American clients ($r = .210$), for African-American clients ($r = .192$), and with the pre-course IAPCC-R ($r = .170$). Higher personal caring ratings on the pre-course demographic questionnaire correlated at a $p \leq .05$ level with higher pre-course ECSES scores for Asian-American clients ($r = .199$), and equally for both African-American and Latino Hispanic clients ($r = .175$), but did not correlate with White clients. Interestingly, participants' rating of residing outside the U.S. correlated at a $p \leq .01$ level with the pre-course ECSES for White clients ($r = .248$), and with the pre-course IAPCC-R ($r = .254$). A summary of the

correlations between each demographic item and the pre-test ECSES scores for each ethnic group is presented in Table 3.

Table 3

Summary of Pre-Course Bivariate Correlations

	Pre IAPCC- R (n=99)	Pre- ECES African - American (n=99)	Pre- ECES Asian- American (n=97)	Pre- ECES Latino- Hispanic (n=97)	Pre- ECES White (n=99)
Race	.329***	.177*	.173*	.216*	.123
Age	.228*	.137	.158	.122	.081
# locations in AL	.170*	.192*	.210*	.266**	.023
Lived outside AL	.062	.090	.035	.048	.003
Lived outside US	.254**	.051	.051	.108	.248**
Desire for cultural competence	.469***	.277**	.290**	.244**	.182*
Personal caring rating	.128	.175*	.199*	.175*	.147

Sig. (1-tailed) * $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Backward multiple regression was used to analyze the strength of the relationships between seven of the demographic factors with each of the ECSES ethnic groups. The overall full regression models resulted in R^2 values ranging from .096 for the ECSES for White clients to R^2 of .280 for the pre-course IAPCC-R. Four of the five regression models also resulted in statistical significance ($p \leq .05$). The backward elimination process reduced each full model to one or two variables that most significantly contributed to the prediction of the dependent variables. Each of these restricted models will be discussed. A summary of the pre-course regressions with full and final restricted models is presented in Table 4.

Effect sizes provide a way to judge the relative importance of differences, by telling the size of the difference or relationship and are used to estimate necessary sample sizes and conduct power analysis (Cronk, 2006). Correlation and regression effect sizes should be determined by squaring the correlation coefficient to obtain a coefficient of determination (R^2). “The coefficient of determination, R^2 , often is used as a measure of the meaningfulness of r . This is a measure of the amount of variance the two variables share” (Munro, 2005, p. 250).

The largest effect size was reported for the pre-course IAPCC-R results, with an R^2 of .252 on the restricted model. Two variables were retained in this restricted model. The variable that exhibited the greatest statistical significance was the demographic rating of desire for cultural competence ($\beta = .404, p \leq .001$) indicating that those participants rating a greater desire for cultural competence also had higher levels on the pre-course IAPCC-R. The other contributing variable was race ($\beta = .192, p \leq .05$) indicating that non-White participants responded at higher levels on the pre-course IAPCC-R. The findings of the regression models are presented in Table 4.

Research Question Two

Data were also analyzed to answer Research Question 2: What is the relationship between the Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and the ECSES prior to a senior level community health course? Descriptive statistics revealed the mean of each of the subscales for the IAPCC-R and the ECSES for each ethnic group. Multiple regression was used to analyze correlations between the pre-course scores on each of the subscales of the IAPCC-R with scores on the pre-course ECSES for each ethnic group. Participants that self-rated higher cultural skills had a

higher self-rating for all four ethnicities of the pre-course ECSES. Higher rating of cultural skill correlated at the highest level with each of the ECSES ethnic groups: for Latino Hispanic clients ($r = .417, p \leq .001$), followed by the ECSES for White clients ($r = .369, p \leq .001$), then African-American clients ($r = .327, p \leq .01$), and Asian-American clients ($r = .247, p \leq .01$). Cultural knowledge was the second highest correlating factor, statistically significant at $p \leq .01$ for African-American clients ($r = .252$), for Asian-American clients ($r = .243$) and for Latino Hispanic clients ($r = .243$). However, cultural knowledge demonstrated a weaker statistically significant relationship ($p \leq .05$) for the ECSES for White clients ($r = .231$) as did rating of cultural awareness with the ECSES for White clients ($r = .220$), and rating of cultural desire with the ECSES for White clients ($r = .175$). These are presented in Table 5.

Analysis using backward multiple regression then allowed the identification of which IAPCC-R subgroup ratings most strongly correlated with ratings for self-efficacy for each of the four ECSES ethnicities. The restricted model revealed statistically significant relationships with ratings of ECSES at the $p \leq .001$ level for both Latino Hispanic clients ($F = 19.574$) and for White clients ($F = 15.337$), at the $p \leq .01$ level for African-American clients ($F = 10.899$), and at the $p \leq .05$ level for Asian-American clients ($F = 5.998$). Furthermore, the IAPCC-R subscale with the most statistically significant relationship was shown by correlation of cultural skills with ratings for all four ECSES ethnicities: highest for Latino Hispanic clients ($\beta = .417, p \leq .001$), followed the ECSES responses for White clients ($\beta = .369, p \leq .001$), then for African-American clients ($\beta = .327, p \leq .01$), and rating for Asian-American clients ($\beta = .247, p \leq .05$). The findings are presented in Table 6.

Table 4

Pre-Course Regressions with Full and Final Restricted Models

	PreIAPCC- R (n=99)	Pre-ECES African American (n=99)	Pre-ECES Asian American (n=97)	Pre-ECES Latino- Hispanic (n=97)	Pre- ECES White (n=99)
<u>Full Model</u>					
R Square	.280	.143	.153	.161	.096
Standard Error of Estimate	.226	.644	.815	.750	.740
F	5.067***	2.176*	2.301*	2.432*	1.386
<u>Restricted Model</u>					
R Square	.252	.077	.114	.144	.061
Standard Error of Estimate	.224	.647	.811	.741	.731
F	16.198***	8.059**	6.033**	5.227**	6.341*
<u>Beta Coefficients (β)</u>					
Race	-.192*			-.194*	
Age					
# locations in AL			.173	.274**	
Lived outside AL					
Lived outside US					-.248*
Desire for cultural competence	.404***	.277**	.267**		
Personal caring rating				.170	

Sig. * $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Research Question Three

Measures of central tendency provided a general overview of sample results for Research Question 3: Is there a difference in IAPCC-R or ECSES ratings pre and post a

Table 5

Bivariate Correlation of Pre-Ccourse IAPCC-R and Pre-Course ECSES

	Pre-ECES African- American (n=93)	Pre-ECES Asian- American (n=94)	Pre-ECES Latino- Hispanic (n=95)	Pre- ECES White (n=99)
Cultural awareness	.133	.122	.107	.220*
Cultural knowledge	.252**	.243**	.243**	.231*
Cultural skills	.327**	.247**	.417***	.369***
Cultural encounter	.042	.073	.081	.094
Cultural desire	.111	.081	.174*	.175*

* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Table 6

Multiple Regression Correlations for Pre-Course IAPCC-R and ECSES

	Pre-ECES- African- American (n=93)	Pre-ECES Asian- American (n=94)	Pre-ECES Latino- Hispanic (n=95)	Pre-ECES White (n=99)
<u>Full Model</u>				
R Square	.134	.088	.181	.167
Standard Error of Estimate	17.86	23.10	20.55	17.18
F	2.695*	1.696	3.939**	3.718**
<u>Restricted Model</u>				
R Square	.107	.061	.174	.137
Standard Error of Estimate	17.74	22.92	20.19	17.12
F	10.899**	5.998*	19.574***	15.337***
<u>Beta Coefficients</u>				
Cultural awareness				
Cultural knowledge				
Cultural skills	.327**	.247*	.417***	.369***
Cultural encounter				
Cultural desire				

* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

senior level community health course? The scores for the pre-course IAPCC-R were nearly identical at both SONs (SON 1 $M = 2.85$, $SD = .260$; SON 2 $M = 2.86$, $SD = .261$). The scores for the pre-course ECSES for African-American clients was slightly higher at SON 1 ($M = 3.66$, $SD = .637$) than at the SON 2 ($M = 3.49$, $SD = .606$). Additionally, SON 1 had slightly higher scores for the Asian-American ECSES ($M = 3.40$, $SD = .682$) than did SON 2 ($M = 3.10$, $SD = .916$). Table 7 presents summaries of scale means and standard deviations of the results of each of the instruments used to collect data. Means and standard deviations are presented for the total sample as well as a breakdown between School of Nursing 1 and School of Nursing 2.

Table 7

Pre- and Post-Course Survey Means for Each Scale and Group

	IAPCCC-R	ECES – African American	ECES – Asian American	ECES – Latino-Hispanic	ECES – White
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
<u>School One</u>	(n = 41)	(n = 41)	(n = 40)	(n = 39)	(n = 41)
Pre	2.85(.260)	3.66 (.637)	3.40 (.682)	3.54 (.732)	3.98 (.618)
Post	2.86 (.313)	3.70 (.673)	3.36 (.976)	3.40 (1.120)	4.04 (.670)
<u>School Two</u>	(n = 48)	(n = 48)	(n = 43)	(n = 43)	(n = 48)
Pre	2.85 (.261)	3.49 (.606)	3.10 (.916)	3.34 (.743)	3.98 (.887)
Post	2.89 (.297)	3.87 (.574)	3.39 (.817)	3.50 (.798)	4.12 (.530)

With the exception of the ECES scale pertaining to African-American clients, differences between schools of nursing groups and over the time of the course failed to reach statistical significance. When examining the change in cultural self-efficacy

pertaining to African-American clients, a statistically significant effect was found pertaining to time ($F = 11.58, p \leq .001$), indicating that all students changed during the course. However, an interaction effect was also found ($F = 7.481, p = .008$), which indicated that school two changed more than school one. Survey responses from school two were slightly lower on the pre-course ECSES for African-American clients, and were slightly higher on the post-course ECSES for African-American clients than were survey responses from school one. Survey responses from school one were initially slightly higher on the pre-course ECSES and increased only slightly during the course. Results are summarized in table 8. The plot in Figure 2 displays the increased ECSES scores for African-American clients that occurred by school over the course of the semester.

Research Question Four

Research Question 4: What factors of clinical experience may correlate to a change in BSN students' self-reporting on the ECSES at statistically significant levels? was addressed using bivariate correlation and multiple regression analyses. The small sample size of post-course respondents who provided nursing care for clients from Asian-American ($n = 8$) and Latino Hispanic ($n = 12$) ethnic backgrounds make correlation less reliable for those ethnic groups. Therefore, the discussion is limited to the correlations between the pre-course demographics and the pre-course ECSES for clients of African-American and White ethnicities.

The scale for student rating effectiveness in providing care was limited by the forced choice of the client characteristic having negative impact, no impact, or positive impact. Characteristics of clients were collapsed into groupings of collaborative type interactions and more challenging interactions of client care. The only correlation

occurred between participant rating of collaborative type of interactions with clients and a positive impact on perception of efficacy ($r = .214, p \leq .05$). The information is presented in Table 9.

Additionally, the participants' ratings regarding the environment of care correlated most strongly with negative impact on perceived effectiveness correlated at statistically significant levels for White clients in institutional settings of care ($r = .289, p \leq .01$). Ratings of positive impact on perceived effectiveness in community settings of care demonstrated a weak relationship for White clients ($r = .269, p \leq .05$). Participants

Table 8

Summary of Mixed-Model ANOVAs

Dependent variable	School	Time	School X Time Interaction
	F (Sig.)	F (Sig.)	F. (Sig.)
IAPCC-R	$F = .130 (p = .719)$	$F = 1.27 (p = .263)$	$F = .315 (p = .576)$
ECSES African American	$F = .000 (p = .987)$	$F = 11.58 (p = .001)$	$F = 7.481 (p = .008)$
ECSES Asian American	$F = .767 (p = .384)$	$F = 1.558 (p = .216)$	$F = 2.597 (p = .111)$
ECSES Latino Hispanic	$F = .081 (p = .776)$	$F = .020 (p = .888)$	$F = 2.86 (p = .095)$
ECSES White	$F = .094 (p = .760)$	$F = 1.53 (p = .219)$	$F = .279 (p = .598)$

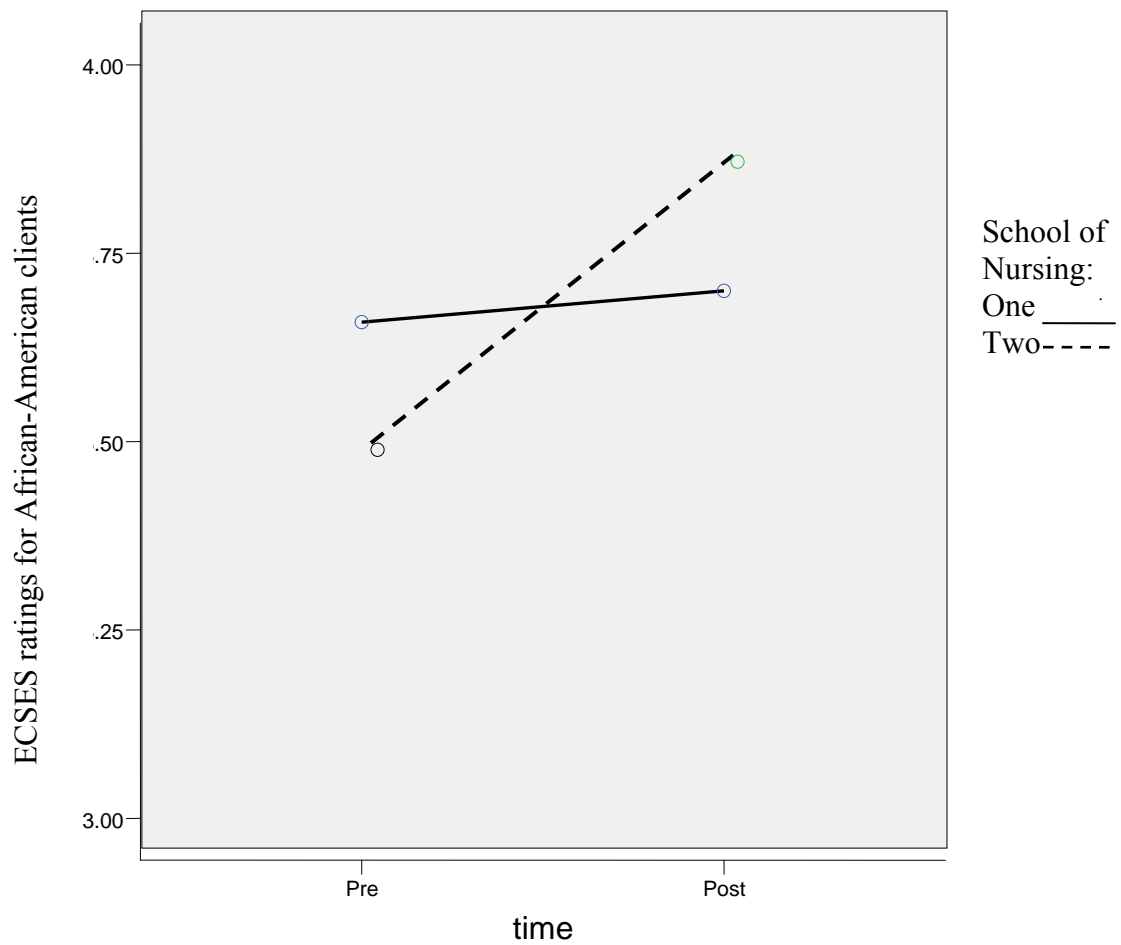


Figure 2. Interaction Between School and Time

rated a negative impact on perceived efficacy for African-American clients in institutional settings of care ($r = .225, p \leq .05$). These findings are summarized in Table 10.

Summary

Data were analyzed to answer each of the four research questions. Research Questions 1, 2, and 4 were addressed by using descriptions of the central tendencies of the sample, bivariate correlation analyses, and backward multiple regression. Research

Table 9

Correlation of Characteristic of Client Interaction in Clinical Experiences with Post-Course Perceived Effectiveness

Characteristics of client care interactions		Perceived Effectiveness	Change in Efficacy
Collaborative interaction in care of African-American clients	Pearson Correlation	.214*	.100
	Sig. (2-tailed)	.047	.355
	N	(n = 87)	(n = 87)
Challenging type care interaction with African-American clients	Pearson Correlation	.025	.140
	Sig. (2-tailed)	.819	.193
	N	(n = 87)	(n = 88)
Collaborative Interaction in care of White clients	Pearson Correlation	.205	.033
	Sig. (2-tailed)	.059	.758
	N	(n = 86)	(n = 87)
Challenging type care interaction with White clients	Pearson Correlation	.026	.088
	Sig. (2-tailed)	.814	.417
	N	(n = 86)	(n = 88)

* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Question 3 was addressed using descriptive analysis and a mixed model ANOVA to determine effect of school location and time, as well as interaction between school and location.

Research Question 1 results disclosed the demographic variable of cultural desire correlated with higher pre-course IAPCC-R scores and higher pre-course ECSES scores for each of the four ethnic groups. The most statistically significant relationship occurred between participants indicating an African-American background on the pre-course

Table 10

Correlation of Client Interaction Environment in Clinical Experiences with Post-Course Perceived Effectiveness

Characteristics of client care environments		Perceived Effectiveness	Change in Efficacy
Community setting of care for African-American clients	Pearson Correlation	.161	.148
	Sig. (2-tailed)	.138	.172
	N	(n = 86)	(n = 87)
Institutional setting of care for African-American clients	Pearson Correlation	.225*	.204
	Sig. (2-tailed)	.035	.057
	N	(n = 88)	(n = 88)
Community setting of care for White clients	Pearson Correlation	.269*	.166
	Sig. (2-tailed)	.015	.126
	N	(n = 82)	(n = 86)
Institutional setting of care for White clients	Pearson Correlation	.289**	.133
	Sig. (2-tailed)	.007	.216
	N	(n = 86)	(n = 88)

* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

demographic survey and those participants scoring higher on the pre-course IAPCC-R. A higher personal caring rating on the pre-course demographic survey correlated with higher pre-course ECSES scores for Asian-American, African-American, and Latino-Hispanic clients. Additionally, more locations of residence within the state correlated at statistically significant levels with higher scores on the pre-course IAPCC-R and each ECSES except for White clients, while more locations of residence outside the U.S. correlated at a statistically significant level with scores on the pre-course ECSES for White clients.

Research Question 2 results indicated participants scoring higher on the pre-course IAPCC-R cultural skills subscale correlated at the highest statistically significant

levels with pre-course scores for each of the ECSES ethnic groups. The IAPCC-R subscale of cultural knowledge correlated at the second highest statistically significant level for each of the ECSES ethnic groups.

Research Question 3 response analysis revealed minimal changes in pre- and post-course mean scores on the IAPCC-R at either school. Minimal pre-post changes occurred for each of the ECSES client groups, with the only statistically significant effect occurring for the ECSES for African American clients over the time of the course, with more change at school two.

A low number of post-course respondents for care of clients from Asian-American or Latino-Hispanic backgrounds limited analysis to respondents for care of African-American and White clients for Research Question 4. Results of analysis showed a correlation occurred between collaborative client clinical interactions and positive impact on perception of self-efficacy. Interestingly, challenging client clinical interactions did not correlate with either positive or negative impact on self-efficacy. Institutional settings of care for White and African-American clients correlated at statistically significant levels with a negative impact on perceived self-efficacy, while community settings of care for White clients only correlated weakly with positive impact on self-efficacy. Summary, discussion, implications and conclusions will be presented in Chapter 5.

V. SUMMARY, DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

Purpose of the Study

The purpose of this study was to identify senior level BSN students' perceptions of eldercare cultural self-efficacy (ECSE) at the beginning and end of the senior level community health course to determine which factors related to a change in self-rating on the ECSES. The findings of this study will assist nursing educators in two schools of nursing from which the sample was drawn to more fully understand current characteristics of senior level baccalaureate nursing students, and how these characteristics may relate to students' self-rating of ECSE. Educators in other schools of nursing may be interested in considering the findings of this study when planning curricula to meet the needs of the increasing number of older adults in the U.S.

Summary

The participants included BSN students in two schools of nursing enrolled in a senior level community health course during fall 2006. A total of 102 students volunteered for participation in the study (48 out of 53 on one campus; 54 out of 70 on the other). Descriptive statistics revealed that the participants were predominantly female (94.1%). Caucasians represented 85.3%, African-Americans represented 8.8%, Latino

Hispanics represented 3.9%, and other ethnic minorities accounted for 2% of the sample. The mean age of participants in the study was 24.62 years, ranging from 19 to 53 years.

The study was designed using a prospective, correlational, causal comparative survey using a pre- and post-course questionnaire. In addition to the demographic questions, Campinha-Bacote's (2002c) Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R) and Shellman's (2003) Eldercare Cultural Self-Efficacy Scale were assessed at both pre- and post-course times. The post-course survey also included questions related to the type and location of clinical experiences with each of the four ethnic groups specified in the ECSES.

Descriptive statistics, Pearson's product moment correlations, analysis of variance (ANOVA), and backward multiple regressions were used to determine statistically significant relationships based on the following research questions:

1. What effect, if any, do student demographic variables, (age, race, number of locations of residence within the state, outside the state, outside the U.S., the personal rating of desire for cultural competence and the rating of personal value of caring) have on self-rating of eldercare cultural self-efficacy (ECSES) of senior level BSN students prior to a senior level community health course as measured by the Eldercare Cultural Self-Efficacy Scale (ECSES)?
2. What is the relationship between the Inventory of Assessing the Process of Cultural Competenc-Revised (IAPCC-R) and the ECSES prior to a senior level community health course?
3. Is there a difference in the ECSES or IAPCC-R ratings pre and post a senior level community health course?

4. If so, what factors of clinical experience correlate to a change in BSN students' self-reporting on the ECSES at statistically significant levels?

Discussion

The answer for Research Question One was determined to be the variable, desire for cultural competence, which correlated with higher scores on the pre-course ECSES for each of the four ethnic groups and with higher scores on the pre-course IAPCC-R. African-American ethnicity of participants correlated with higher pre-course ECSES scores for Latino Hispanic, African-American, and Asian-American clients. Participants who had resided in more locations within the state correlated with higher pre-course ECSES for Latino Hispanic, Asian American and African American clients; those who had resided outside the U.S. correlated with higher pre-course ECSES scores for White clients.

The importance of cultural desire had been discussed by other researchers. Campinha-Bacote (2002c) developed a model for the process of competence, using a volcano to symbolically represent that it is cultural desire that evokes the process of cultural competence. When the volcano erupts (desire), it brings forth the desire to enter into the process of becoming culturally competent by seeking cultural encounters, obtaining cultural knowledge, conducting culturally-sensitive assessments and being humble to the process of cultural awareness. (p. 10)

The relationship of the pre-course IAPCC-R and the pre-course ECSES as posed by Research Question Two was addressed using descriptive statistics and bivariate correlation. Participants who self-rated the IAPCC-R cultural skill subscale higher also had a higher self-rating for all for ethnicities of the pre-course ECSES. Cultural knowledge was the second highest correlating factor. Backward multiple regression also revealed higher cultural skill ratings as most highly correlated with all four ethnicities, at the $p \leq .001$ level of significance for Latino Hispanic clients and White clients, and at the $p \leq .01$ level of significance for African-American and Asian-American clients.

Analysis for Research Question Three involved measures of central tendency, 1-tailed Pearson correlations, mixed-model ANOVAs, and backward regression. Descriptive statistics revealed a pre-course mean score of 99.24 (out of 140 possible score; $n = 93$, $SD = 18.67$) for the eldercare cultural self-efficacy (ECSE) with African-American clients. For Asian-American clients, the pre-course ECSES revealed a mean score of 90.41 ($n = 94$, $SD = 23.53$). The ECSES pre-course mean score for working with Latino Hispanic clients was 95.84 ($n = 95$, $SD = 22.1$), while the ECSES pre-course results were highest for White clients with a mean of 110.31 ($n = 99$, $SD = 18.32$). Although 85% of the participants were Caucasian, this result revealed areas in which students did not perceive self-efficacy for caring for older adults. The post-course ECSES mean score increased for caring for African-American clients by 5.05 points, and for caring for White clients by 3.51 points. The post-course mean ECSES score for caring for Asian-American clients increased by only 2.57 points, while the mean ECSES for caring for Latino Hispanic clients decreased 1.34 points. The limited number of experiences during the course with Asian-American and Latino Hispanic clients may

contribute to the slight increase in these scales. Participants' self-rating on the IAPCC-R remained at 71 for both the pre- and post-course evaluation.

When considering data for Research Question Four, only a small number of participants reported opportunities for clinical care of clients from Asian-American or Latino Hispanic ethnicities during the course; thus, only data from participants related to change in self-efficacy for African-American or White older adults were analyzed using two-tailed bivariate correlation. Relationships between types of client care interactions (collapsed into collaborative or challenging categories of interactions) and effect on perceived effectiveness in care (negative impact, no impact, or positive impact) as rated by respondents on the post-course demographic questionnaire were found at statistically significant levels for only collaborative interactions with African-American clients ($n = 87, r = .214, p \leq .05$). Additionally, data from the post-course demographic questionnaire regarding the type of environment in which care was provided were collapsed into the two categories of community environment or institutional environment. Care of older White clients in institutional settings related most strongly to increased perceived effectiveness ($n = 86, r = .289, p \leq .01$), followed by a community environment of care for older White clients ($n = 82, r = .269, p \leq .05$) and an institutional environment for care of older African-American clients ($n = 88, r = .225, p \leq .05$).

Limitations

The small size and limited geographic area of the sample limit the applicability to other schools of nursing. Use of self-report methods for conducting research involving issues such as attitudes and competence raises concern regarding accuracy of self-report

measurements. The two points of measurement at beginning and ending of the clinical experience may not reflect continued impact of the experiences. The specific type of experience with the older persons being cared for by BSN students during community health clinical experience could not be predicted or controlled. The cultural background of the older persons being cared for by BSN students during the community health clinical experience could not be predicted or controlled.

Implications

This exploratory study was conducted to obtain baseline descriptive information regarding students in two baccalaureate schools of nursing and any changes that occurred in the perceptions of eldercare cultural self-efficacy (ECSE) during a senior level community health course. Factors that may have impacted any change were analyzed for statistical significance. Bandura (1986) proposed that areas in which students perceived a greater self-efficacy “foster active engagement in activities and contribute to the growth of competencies” (p. 393). The findings may be useful in planning nursing curricula to maximize content that relate to increased participant perception of increased efficacy.

This research has been an attempt to address recommendations that:

Researchers in aging need to sit back, take a break from empirical research and devote more effort to integrating the knowledge base. . . where seemingly disparate theories, concepts, and findings are combined in ways that break new conceptual ground or provide a provocative slant to an issue. (Grant, 1996, p. S2)

Although the participants of this research study have completed the nursing degree requirements, insight may be gained from considering the relationship of some of the factors found to correlate at statistically significant levels with increased eldercare cultural self-efficacy for future students. Those factors include both community and institutional environments of care during the clinical component of the senior level community course. Interestingly, no statistically significant relationship was revealed between challenging characteristic of care and change in self-efficacy. Evaluation of teaching-learning strategies used for the theory component regarding aging and diversity issues should be assessed throughout the curriculum (Sargent, Sedlak, & Martsolf, 2005; Trossman, 2003; Warren, 2002).

Ways to promote opportunities for collaboration with older clients and their families in all care settings should be emphasized. Presentation of content should be planned in such a manner to allow increased awareness of cultural and generational factors that may impact care, such as by using actual case studies. Caution should be considered that stereotyping is not promoted with the case study presentation.

Ryan, Hodson-Carlton, and Ali (2000) recommend an immersion experience for teaching transcultural nursing. Koskinen and Jokinen (2007) and Walsh (2003) also discussed international exchange experiences. However, not all nursing students may have the time or financial resources to allow the immersion in a different culture. Other logistic issues may arise when planning intercultural experiences (Koskinen & Tossavainen, 2003). Furthermore, students may be able to have an intercultural experience in geographically close areas, because many different ethnic backgrounds can be found in the same geographical region. The differing age of the students and older clients

creates the differing generational backgrounds. Therefore, promoting clinical experiences with older clients of various socio-economic and ethnic backgrounds within a community course, in both rural and urban community or institutional environments, can provide opportunities for cross-cultural encounters and collaboration in ways to attain the clients' desired health goals (Like, Steiner, & Rubel, n.d.). Promoting the students' ability to determine the clients' health goals provide insight into the clients' cultural values and beliefs, and thus can enhance the collaboration in the nurse-client interaction.

The most statistically significant relationship between the pre-course demographic survey and the pre-course IAPCC-R and pre-course ECSES was the students' rating of desire for cultural competence. Reinforcement of students' desire for cultural competence as well as desire for caring for older adults should be emphasized by all nursing faculty. Mezirow's (1990) Perspective Transformation adult learning theory may provide insight in helping students consider dilemmas, experience cognitive dissonance, and promote transformative learning in the affective domain. "The distinction is between a transmissionist style, in which the pupil accepts whatever the teacher says, and a transformationist style in which the pupil is encouraged to question and to criticize" (McGee, 1992, p. 19).

This research revealed little change during the semester of community health experiences, although higher demographic survey ratings of cultural desire and personal valuing of caring correlated with slightly higher scores on the IAPCC-R and ECSES. Campinha-Bacote (2006) suggested that "cultural curricular content should focus on attitudes, skills, and knowledge" (p. 243). Teaching learning strategies for all three domains should be incorporated into the nursing curriculum.

Affective, cognitive and psychomotor learning domains are influenced by modeling of faculty. Preparation of nursing faculty should be considered when determining faculty qualifications for role modeling. Campinha-Bacote stated “fewer than 75 nurses currently certified in transcultural nursing by the Transcultural Nursing Society” (Campinha-Bacote, 2006, p. 243). Campinha-Bacote (2006) further suggested a need to assess and improve the institutional climate for diversity, and to have a clearly defined, valid and reliable tool to evaluate cultural competence training, such as the Tool for Assessing Cultural Competence Training developed by the Association of American Medical Colleges (, p. 243).

Jeffreys (2006) also considers learning process involving cognitive, practical, and affective domains needed for development of nursing cultural competence. A self-perception of competence is included in the Cultural Competence and Confidence model, and a ‘self-efficacy appraisal of inefficacious, efficacious, and supremely efficacious’ is included in the Transcultural Self-Efficacy Pathway (Jeffreys, 2006, p. 27).

Additional suggestions for instilling desire for culturally diverse populations were discussed by Cagle (2006). In a pre-nursing course focusing on cultural competence and ethical decision making, the pedagogical approach of knowing and connecting practice was used to value each learner’s experience. This approach was previously discussed by Diekelmann & Micol (2003) to encourage understanding and application of nursing content. Cagle also piloted a decision-making model and provided nursing students opportunity to evaluate personal values as basis for choosing nursing actions. Furthermore, Ott, Doyle, and Tarantino (2004) found that cultural competence and client

advocacy increased following opportunities for interaction with culturally diverse clients and time for reflection.

Gray and Thomas (2005) explored two frameworks in nursing literature for viewing culture. The essentialist approach viewed facts in such a way as to narrowly or superficially limit the focus to a group with assumed common features, such as with race or ethnicities, and may actually promote stereotyping. The critical constructivist view considered culture as a socially constructed system in which differences are created or sustained among people, and may lead to power and vulnerability (through determining valuing or stigmatizing). These authors suggest nursing education focus on development of critical analysis skills in both educators and students, specifically:

rather than develop culturally competent nurses who serve mainly in the role of cultural broker in the service of the healthcare system, consider strategies needed to develop nurses who are simultaneously culturally conscious (from a critical perspective), cultural mediators (the essentialist role, cultural allies (a bridging role between essentialists and constructivist roles), and cultural activists (the critical constructivist role). (p. 268)

Therefore, nursing educators should consider methods to increase student and faculty desire for cultural competence by promoting critical consideration of the interactions with individual clients. Patient-centered communication can provide focus on individual clients and increase comfort of the healthcare provider (Kriesman, 2005; Kulwicki, 1996; Leininger, 1997b; Moral, Alamo, Jurado, Torres, 2001; Shellman, 2006).

As stated by McGee (1992):

It is neither practical nor desirable to attempt to teach students about many different cultures; the aims should rather be on developing a set of principles that equip the nurse to care for people not just of one culture but of many different ones. (p. 18)

This may involve faculty and student self-evaluation of attitudes and values as well as evaluation of any changes in behavior that occur (Law, 2006; Lenburg, Lipson, Demi, Blaney, Stern, Schultz, et al., 1995; Leonard, 2006; Martin, Yarbrough, & Alfred, 2004; Rew, Becker, Cookstone, Khosropour, & Martinez, 2003; Sealey, 2006).

Although the participants in this study are no longer in the schools of nursing, learning may continue to occur as reflection of experiences during nursing education, or during future interactions with various cultural and aged individuals. Gibilisco (2004) stated:

We can never know all the consequences of any particular event. History happens once and only once. We can't make repeated trips back in time and let fate unravel itself multiple times, after tweaking this or that little detail. But events can conspire, or have causative effects over time and space, in such a manner as to magnify the significance of tiny events in some circumstances. In some case, certain variables have threshold points where a tiny change will dramatically effect the distant future. (p. 223)

Further data analyses may reveal specific areas within the IAPCC-R and ECSES in which students rated lowest self-efficacy. These areas can provide a point of reference

for curricular evaluation of placement and teaching methods for these content areas. Faculty orientation to the curriculum should include how the cultural and geriatric content is integrated into all courses and clinical experiences. Integrating educational strategies that have resulted in increased student learning outcomes can provide a basis for evidence-based teaching.

Recommendations for Further Research

This study was conceptualized as the interactions of BSN nursing students with older clients from various cultural backgrounds and requiring differing acuties of nursing care. The impact of nursing curriculum on the students' self-efficacy was the point of concern, and how a greater influence on quality of care can be achieved through a greater self-efficacy.

Cagle (2006) pointed out, "It is incumbent on nurse educators to strengthen the ethical commitment of students and their understanding of effective ways to provide healthcare to diverse populations" (p. 313). Further research is recommended in the affective domain of learning to identify factors impacting the valuing of desire for cultural competence and caring for older adults. Shulman's (2002) table of learning could provide a guide for researching levels of student learning outcome attainment, progressing from 1) Engagement and Motivation to 2) Knowledge and Understanding to 3) Performance and Action to 4) Reflection and Critique to 5) Judgment and Design

to the level of 6) Commitment and Identity (p. 37). Krathwohl, Bloom, and Masia's (1964) taxonomy of educational objectives in the affective domain could also provide a guide for researching level of student learning regarding eldercare cultural self-efficacy.

Based on the findings of this study, a comparison can possibly be made with the results from Shellman's (2003) study of Connecticut senior level BSN students' rating of ECSE. Further study of additional cohorts of students in Alabama will provide additional data. Further study of this cohort of students (May 2007 graduates) at six months or one year following graduation would help determine not only ECSE perceptions, but also what post-graduation eldercare culturally competent behaviors have been demonstrated in the students' nursing practice. Additional study of nursing faculty within the state of Alabama would provide information regarding the faculty ECSE self-rating, especially as the demographics of older adults within the state of Alabama continue to become more diverse.

The post-course survey section for participant responses regarding client characteristics and environments of care should be revised for future studies. The scale for participant responses regarding effect of the client characteristics or care environment should be increased from negative impact, no effect, or positive impact to a Likert-type scale that would allow more sensitive measurement of the impact of the clinical experiences. Other questions not addressed in this study were if the students' perceptions influenced by perceptions of interpersonal skills (Ashmore & Banks, 1997). Whether attitudes of low self-efficacy are impacted by the student's self-efficacy or hesitancy for the cultural encounter, the encounter with older clients, or the need for more complex nursing knowledge and skill concurrent with the older individual, the culture difference,

or the increased nursing knowledge and skill, and potential for increased experience with death and dying issues should be researched.

Further assessment of student perceptions regarding experiences through the nursing curriculum, the undergraduate curriculum, and life experiences (Reeves, 2006) could provide insight into types of experiences that promote cultural self-efficacy. Additionally, assessment of students, faculty and client perceptions of barriers to cultural competence, and recommendations to overcome the barriers would provide insight for curricular planning (Shapiro, 2002).

Just as immersion experiences have been used for teaching transcultural care, these could be applied to immersion experiences with the older adult culture. Research could be conducted regarding changes eldercare self-efficacy following increased time throughout the curriculum for encounters with older adults from various cultural backgrounds. Future research should measure ECSES at the beginning and end of the BSN curriculum and six to 12 months post-graduation.

Research in the area of eldercare self-efficacy should be continued to determine specific teaching/learning methods that impact higher responses on post-course ECSES. For example, Cagle (2006) recommended

An integrative response, with a consistent focus on theory (cognitive learning), and practice (affective and psychomotor learning) of culture and ethics, and further attention to the Code of Ethics for Nurses, might encourage students to their future professional role as social change agents—healthcare professionals who speak with a collective voice for the improvement of healthcare overall, balancing technology

with moral care and a focus on individual values and the needs of a diverse population of healthcare recipients. (p. 313)

Further research could also involve client responses to care provided, and areas of satisfaction or improvement in health outcomes. As stated by Netting and Williams (1999):

Determining what outcomes are important to measure is a value-based process. The outcomes that are important to healthcare administrators (such as reduced utilization) are often organizational, not clinical outcomes. Clinicians, on the other hand, view outcomes as quality-of-life changes for patients and focus on whether the intervention worked for the person served, even if that intervention placed the person in the hospital for an expensive stay. In other words, it is important to distinguish between organizational and client-centered outcomes since they are not always the same. (p.231)

Conclusions

The theoretical framework for this study was provided by Bandura's conceptualization of self-efficacy for selecting behaviors perceived as effective in complex situations, and in motivation to perform the behaviors of caring for older adults, specifically older adults from various cultural backgrounds. The increasing percent of culturally diverse older adults in the U.S. led to research on methods to adequately prepare a nursing workforce to provide quality care to the individuals. Identifying effective teaching-learning methods enables evidence-based teaching (Fineout-Overholt, Melnyk, & Schultz, 2005; Killeen & Barnfather, 2005).

Participants from two schools of nursing in the southeastern U.S. provided the sample. The IAPCC-R and ECSES were used to evaluate student self-efficacy. A pre-course demographic questionnaire provided insight to student characteristics and a post-course demographic questionnaire provided information regarding the clinical experiences during a senior level community health course and how these experiences impacted participant perception of self-efficacy.

Results of the research showed few statistically significant changes over time or by school. Continued evaluation of nursing curricula and evidence-based teaching-learning strategies should be integrated into the BSN curriculum.

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APPENDICES

APPENDIX A

PRE-COURSE DEMOGRAPHIC SURVEY

Following the demographic survey, two other questionnaires are attached. The Eldercare Cultural Self-Efficacy Scale is a modified version of the Cultural Self Efficacy developed by Bernal and Froman (1993). This scale has been developed to measure levels of confidence in providing culturally competent care to elders of four ethnic groups (African-American, Latino/Hispanic, Asian-American, and White). The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (Campinha-Bacote, 2002) is a scale that has been developed to measure the level of cultural competence among healthcare professionals.

Please do not write your name on the paper as all information is confidential. I ask that you do provide the last two numbers of your telephone number and street address so the data can be coded and entered properly.

Thank you for taking the time to fill this questionnaire out. I sincerely appreciate your participation in this research.

Please use the phone numbers/street addresses that you used LAST MAY

LAST TWO NUMBERS OF YOUR PHONE NUMBER _____

LAST TWO NUMBERS OF STREET ADDRESS _____

Demographic Information

Directions: Your responses are confidential. Please answer all of the questions by checking the appropriate category or by filling in the information about your background.

Age in years _____ Sex: 01 Male _____ 02 Female _____

Race/Ethnicity:-

01 African-American _____ 02 Mexican American _____ 03 White _____

04 South Asian _____ 05 Other Hispanic _____ 06 Native American _____

07 Puerto Rican _____ 08 Japanese _____ 09 Filipino _____

10 Other _____

In which community health clinical section are you currently enrolled?

(1) AU _____ (2) AUM _____

Have you ever had a course in providing culturally competent nursing care?

(01) Yes _____ (02) No _____

If yes, mark the kind of coursework you have had:

(01) Cultural Expeditions in Nursing _____

(02) English Second Language interactions _____

(03) Other _____

Do you speak a language other than English? (01) Yes _____ (02) No _____

If yes, what language other than English can you speak?

Have you learned how to work with an interpreter? (01) Yes _____ (02) No _____

For how many generations has your family lived in the United States?

(01) I am the first _____ (02) my parents were the first _____

(03) my grandparents were first _____ (04) before my grandparents _____

How many different geographic locations with the state of Alabama have you lived? _____

Have you lived outside of the state of Alabama (01) Yes _____ (02) No _____

If yes, how many different states? _____

Have you lived outside of the continental USA (not including Alaska and Hawaii)?
(01) Yes _____ (02) No _____; If yes, please specify the
locations _____

Have you cared for African-American elders in community health?
(01) Yes _____ How many clients _____ (02) No _____

Have you cared for Latino/Hispanic elders in community health?
(01) Yes _____ How many clients _____ (02) No _____

Have you cared for Asian-American elders in community health?
(01) Yes _____ How many clients _____ (02) No _____

Have you care for White elders in community health:
(01) Yes _____ How many clients _____ (02) No _____

Sites of experiences: (01) such as home health with elders _____

(02) nutrition sites _____, (03) elder care sites _____

APPENDIX B

POST-COURSE COURSE ASSESSMENT SCALES

Following the demographic survey, two other questionnaires are attached. The Eldercare Cultural Self-Efficacy Scale is a modified version of the Cultural Self Efficacy developed by Bernal and Froman (1993). This scale has been developed to measure levels of confidence in providing culturally competent care to elders of four ethnic groups (African-American, Latino/Hispanic, Asian-American, and White). The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (Campinha-Bacote, 2002) is a scale that has been developed to measure the level of cultural competence among healthcare professionals.

Please do not write your name on the paper as all information is confidential. I ask that you do provide the last three numbers of your telephone number and street address so the data can be coded and entered properly.

Thank you for taking the time to fill this questionnaire out. I sincerely appreciate your participation in this research.

Please use the phone numbers/street addresses that you used MAY 2006

LAST THREE NUMBERS OF YOUR PHONE NUMBER _____

LAST THREE NUMBERS OF STREET ADDRESS _____

Post-Course Demographic Information Sheet

Directions: Your responses are confidential. Please answer all of the questions by checking the appropriate category or by filling in the information about your background.

A. During fall semester have you had any additional courses/experiences in improving your cultural competence other than Professional Nursing Concepts III?

(01) Yes _____ (02) No _____

If yes, mark the kind of coursework you have had:

(01) Cultural Expeditions in Nursing _____

(02) English Second Language interactions _____

(03) Learned how to work with an interpreter _____

(04) Other _____; please specify _____

B. During your Professional Nursing Concepts III clinical experiences:

- Have you cared for African-American elders? (01) Yes _____ (02) No _____

If yes, how many clients _____ ;

List locations _____

Describe your interaction:

- Have you cared for Asian-American elders? (01) Yes _____ (02) No _____

If yes, how many clients _____ ;

List locations _____

Describe your interaction:

- Have you cared for Latino-Hispanic elders? (01) Yes _____ (02) No _____

If yes, how many clients _____ ;

List locations _____

Describe your interaction:

- Have you cared for White elders? (01) Yes _____ (02) No _____

If yes, how many clients _____ ;

List locations _____

Describe your interaction:

C. How do you rate your desire for cultural competence in healthcare provision?

(01) no desire ____ (02) slight desire ____ (03) moderate desire ____ (04) great desire _____

D. How would you rate caring in your personal value system?

(01) not valued _____ (02) slightly valued _____ (03) moderate value _____ (04) great value _____

E. What factor(s) do you identify within this semester as having the greatest effect on your confidence in providing care to older adults from various cultural backgrounds?

During your Professional Nursing Concepts III clinical experiences have you cared for **African-American elders?** (01) Yes ___ (02) ___ : If yes, how many clients _____

Please select the following situations that apply to YOUR experience in NURS 4741. Place an approximate **number of times** you encountered the **following situation in caring for African-American older adults** during NURS 4741. Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the African-American background, using the scale negative impact, no impact, (neutral), positive impact.

Possible characteristics of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Very cooperative		Negative	No Impact	Positive
Recounted personal experiences (reminiscence)		Negative	No Impact	Positive
Appreciative of interaction with student nurse		Negative	No Impact	Positive
Discussed personal goals for health care		Negative	No Impact	Positive
Complex wound care		Negative	No Impact	Positive
Pain		Negative	No Impact	Positive
Memory problems		Negative	No Impact	Positive
Confusion		Negative	No Impact	Positive
Incontinent of bladder		Negative	No Impact	Positive
Incontinent of bowels		Negative	No Impact	Positive
Terminal diagnosis		Negative	No Impact	Positive
Agitation		Negative	No Impact	Positive
Combative		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

Place an approximate **number of times** you provided care for **African-American older adults** in each of the following **environments** during NURS Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the African-American background, using the scale negative impact, no impact, (neutral), positive impact.

Possible environments for nursing care of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Older person's private home		Negative	No Impact	Positive
Assisted living facility		Negative	No Impact	Positive
Elderly apartment of independent living units		Negative	No Impact	Positive
Senior nutrition center		Negative	No Impact	Positive
Adult day center		Negative	No Impact	Positive
Community clinics		Negative	No Impact	Positive
Hospice		Negative	No Impact	Positive
Hospital (specify unit: _____)		Negative	No Impact	Positive
Medical/surgical intensive care unit (ICU)		Negative	No Impact	Positive
Cardiac Intensive Care unit (CCU)		Negative	No Impact	Positive
CardioVascular Intensive Care unit (CVICU)		Negative	No Impact	Positive
Emergency room (ER)		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

During your Professional Nursing Concepts III clinical experiences have you cared for **Asian-American elders?** (01) Yes ___ (02) ___: If yes, how many clients _____

Please select the following situations that apply to YOUR experience in NURS 4741. Place an approximate **number of times** you encountered the **following situation in caring for Asian-American older adults** during NURS 4741. Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the Asian-American background, using the scale negative impact, no impact, (neutral), positive impact.

Possible characteristics of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Very cooperative		Negative	No Impact	Positive
Recounted personal experiences (reminiscence)		Negative	No Impact	Positive
Appreciative of interaction with student nurse		Negative	No Impact	Positive
Discussed personal goals for health care		Negative	No Impact	Positive
Complex wound care		Negative	No Impact	Positive
Pain		Negative	No Impact	Positive
Memory problems		Negative	No Impact	Positive
Confusion		Negative	No Impact	Positive
Incontinent of bladder		Negative	No Impact	Positive
Incontinent of bowels		Negative	No Impact	Positive
Terminal diagnosis		Negative	No Impact	Positive
Agitation		Negative	No Impact	Positive
Combative		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

Place an approximate **number of times** you provided care for **Asian-American older adults** in each of the following environments during NURS Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the Asian-American background, using the scale negative impact, no impact, (neutral), positive impact.

Possible environments for nursing care of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Older person's private home		Negative	No Impact	Positive
Assisted living facility		Negative	No Impact	Positive
Elderly apartment of independent living units		Negative	No Impact	Positive
Senior nutrition center		Negative	No Impact	Positive
Adult day center		Negative	No Impact	Positive
Community clinics		Negative	No Impact	Positive
Hospice		Negative	No Impact	Positive
Hospital (specify unit: _____)		Negative	No Impact	Positive
Medical/surgical intensive care unit (ICU)		Negative	No Impact	Positive
Cardiac Intensive Care unit (CCU)		Negative	No Impact	Positive
CardioVascular Intensive Care unit (CVICU)		Negative	No Impact	Positive
Emergency room (ER)		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

During your Professional Nursing Concepts III clinical experiences have you cared for **Latino-Hispanic elders?** (01) Yes ___ (02) ___: If yes, how many clients _____

Please select the following situations that apply to YOUR experience in NURS 4741. Place an approximate **number of times** you encountered the **following situation in caring for Latino-Hispanic older adults** during NURS 4741. Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the **Latino-Hispanic** background, using the scale negative impact, no impact, (neutral), positive impact.

Possible characteristics of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Very cooperative		Negative	No Impact	Positive
Recounted personal experiences (reminiscence)		Negative	No Impact	Positive
Appreciative of interaction with student nurse		Negative	No Impact	Positive
Discussed personal goals for health care		Negative	No Impact	Positive
Complex wound care		Negative	No Impact	Positive
Pain		Negative	No Impact	Positive
Memory problems		Negative	No Impact	Positive
Confusion		Negative	No Impact	Positive
Incontinent of bladder		Negative	No Impact	Positive
Incontinent of bowels		Negative	No Impact	Positive
Terminal diagnosis		Negative	No Impact	Positive
Agitation		Negative	No Impact	Positive
Combative		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

Place an approximate **number of times** you provided care for **Latino-Hispanic older adults** in each of the following environments during NURS Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the **Latino-Hispanic** background, using the scale negative impact, no impact, (neutral), positive impact.

Possible environments for nursing care of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
Older person's private home		Negative	No Impact	Positive
Assisted living facility		Negative	No Impact	Positive
Elderly apartment of independent living units		Negative	No Impact	Positive
Senior nutrition center		Negative	No Impact	Positive
Adult day center		Negative	No Impact	Positive
Community clinics		Negative	No Impact	Positive
Hospice		Negative	No Impact	Positive
Hospital (specify unit: _____)		Negative	No Impact	Positive
Medical/surgical intensive care unit (ICU)		Negative	No Impact	Positive
Cardiac Intensive Care unit (CCU)		Negative	No Impact	Positive
CardioVascular Intensive Care unit (CVICU)		Negative	No Impact	Positive
Emergency room (ER)		Negative	No Impact	Positive
Other (please specify: _____)		Negative	No Impact	Positive

During your Professional Nursing Concepts III clinical experiences have you cared for **White elders?** (01) Yes ___ (02) ___ : If yes, how many clients _____

Please select the following situations that apply to YOUR experience in NURS 4741. Place an approximate **number of times** you encountered the **following situation in caring for White older adults** during NURS 4741. Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the White background, using the scale negative impact, no impact, (neutral), positive impact.

Possible characteristics of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
		Negative	No Impact	Positive
Very cooperative				
Recounted personal experiences (reminiscence)				
Appreciative of interaction with student nurse				
Discussed personal goals for health care				
Complex wound care				
Pain				
Memory problems				
Confusion				
Incontinent of bladder				
Incontinent of bowels				
Terminal diagnosis				
Agitation				
Combative				
Other (please specify: _____)				

Place an approximate **number of times** you provided care for **White older adults** in **each of the following environments** during NURS Rate the impact of each experience on **your perception of your own effectiveness** in providing care to older adults from the White background, using the scale negative impact, no impact, (neutral), positive impact.

Possible environments for nursing care of elder clients	Estimate the number of times you encountered the situation in Nursing Concepts III.	Circle the impact of interaction(s) with older adult(s) with specific characteristics on your perception of your own effectiveness in providing client care:		
		Negative	No Impact	Positive
Older person's private home				
Assisted living facility				
Elderly apartment of independent living units				
Senior nutrition center				
Adult day center				
Community clinics				
Hospice				
Hospital (specify unit: _____)				
Medical/surgical intensive care unit (ICU)				
Cardiac Intensive Care unit (CCU)				
CardioVascular Intensive Care unit (CVICU)				
Emergency room (ER)				
Other (please specify: _____)				

APPENDIX C

LETTER OF PERMISSION TO USE IAPCC-R



J. Campinha-Bacote,
PhD., RN, CS, CNS, CTN, FAAN
Transcultural Consultant

Date: August 16, 2006

To: Ms. Arlene Morris
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates
RE: Letter of Permission For a Limited Use of the IAPCC-R

This letter grants permission to Ms. Arlene Morris to use my tool, "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised," on pages 109 & 110 of the book, *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care* (2003) 4th edition, for her dissertational work in assessing senior level BSN students. **Permission is only granted from August 2006 through May 2007.** Ms. Arlene Morris must again request permission to use the IAPCC-R for any extensions or further use of the IAPCC-R beyond this permission date.

Ms. Arlene Morris agrees that the IAPCC-R can only be administered in a pencil/paper format in which the IAPCC-R is personally distributed to each student and personally collected after its completion by Ms. Arlene Morris. The IAPCC-R cannot be used in any mailings/surveys or in an online course or Internet website. In addition, the IAPCC-R cannot be copied for any formal or informal publications, nor can it be copied for a presentation as a handout, PowerPoint slide or overhead transparency. **The IAPCC-R is only to be copied as a research tool in which it is personally distributed and collected by Ms. Arlene Morris.**

As part of this permission agreement, it is required that Ms. Arlene Morris mail to me a narrative summary of the findings (not mere raw data) of the study using my tool as well as mail to me any reliability or validity measures that were conducted on the IAPCC-R. In addition, any publication of the findings of the study using my tool must be shared with me. Ms. Arlene Morris will use the following citation when citing my tool:

Copyrighted by Campinha-Bacote (2002)
Printed with Permission from
Transcultural C.A.R.E. Associates

Thank you for complying with the requests of using this copyrighted tool and I look forward to hearing from you as soon as the study is completed.

(513) 469-1664

www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

APPENDIX D

INSTITUTIONAL REVIEW BOARD FROM AUBURN

Auburn University

Auburn University, Alabama 36849



Office of Human Subjects Research
307 Samford Hall

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

August 23, 2006

MEMORANDUM TO: Ms. Arlene Morris
Educational Foundations, Leadership and Technology

PROTOCOL TITLE: "Factors Influencing BSN Students' Perceptions of Eldercare Cultural Self-Efficacy"

IRB FILE: 06-143 EP 0608

APPROVAL DATE: August 23, 2006
EXPIRATION DATE: August 22, 2007

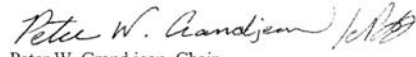
The above referenced protocol was approved by IRB Expedited procedure under Expedited Category #7 on August 23, 2006. You should report to the IRB any proposed changes in the protocol or procedures and any unanticipated problems involving risk to subjects or others. Please reference the above authorization number in any future correspondence regarding this project.

If you will be unable to file a Final Report on your project before August 22, 2007, you must submit a request for an extension of approval to the IRB no later than August 8, 2007. If your IRB authorization expires and/or you have not received written notice that a request for an extension has been approved prior to August 22, 2007, you must suspend the project immediately and contact the Office of Human Subjects Research for assistance.

A Final Report will be required to close your IRB project file.

If you have any questions concerning this Board action, please contact the Office of Human Subjects Research at 844-5966.

Sincerely,


Peter W. Grandjean, Chair
Institutional Review Board for the Use of Human
Subjects in Research

cc: Dr. William Spencer
Dr. James Witte

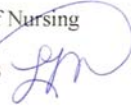
APPENDIX E

INSTITUTIONAL REVIEW BOARD FROM AUM



MEMORANDUM

TO: Ms. Arlene Morris, AUM School of Nursing

FROM: Dr. Lola McCord, Chair, AUM IRB 

DATE: August 24, 2006

RE: Your proposal for research, "Factors Influencing BSN Students' Perceptions of Eldercare Cultural Efficacy," *IRB file #2006-16*

Thank you for submitting the aforementioned research proposal to the AUM IRB for review. Given the nature of your protocols and the fact that your study already has been reviewed and approved by the AU IRB, we have elected to grant **concurrent approval**. The contingencies associated with your project review and status at AU will be in effect at AUM as well, and your review period will run through August 22, 2007, as stipulated in Dr. Peter W. Grandjean's August 23, 2006, memo of approval. We have documented the progress and status of your review at AU and will keep those recommendations and decisions on file as a record of your review status here.

Should you encounter unanticipated problems or find that you need to alter your protocols, please contact us (in addition to the AU IRB) as soon as possible so that we can discuss your situation. When contacting us, please reference the AUM file number indicated above. In the meantime, please retain this memo as a record of your IRB review status.

I wish you the best of luck with your study!

APPENDIX F

RECRUITMENT SCRIPT FOR COURSE FACULTY

Hello Mrs. Coker (instructor for community health course at both AU and AUM fall 2006),

I am a graduate student at Auburn University in the Department of Educational Foundations, Leadership and Technology. I am interested in baccalaureate nursing students' perceptions of confidence in caring for older adults, and more specifically older adults of various cultural backgrounds. I would like for you to provide students in NURS 4740 Professional Nursing Concepts III with the opportunity to participate in a research project designed to assess perceptions of confidence (self-efficacy) of senior level nursing students in a community health course in caring for older adults with various cultural backgrounds. Students who choose to participate will be asked to complete a series of questionnaires that will take approximately 45 minutes to one hour of their time, at two points in the semester, within the first and last months of the fall semester 2006. At the end of one of your regularly scheduled classes I will explain the research and ask for volunteers to participate in the research. I will deliver the information sheets and questionnaire packets to the students who choose to participate and ask them to complete the forms, place them in a blank envelope, and return the envelope to a sealed box at the back of the classroom. I will provide a free lunch (pizza) at the end of the semester following collection of all data for all senior nursing students whether they participated or not in the research, similar to the lunches provided by other guests to the class. I will read the following script to students when I come to the class (show instructor the following script). Do you have any questions? (Answer any questions the instructor may have). With all of this in mind, would you be willing to let me come to your class and tell your students about the project and to allow time at the end of one of your classes for students to complete the questionnaires?

Thank you for your time.

APPENDIX G

RECRUITMENT SCRIPT FOR PARTICIPANTS

Hello, my name is Arlene Morris and I am a graduate student at Auburn University in the Department of Educational Foundations, Leadership and Technology. I am interested in baccalaureate nursing students' perceptions of confidence in caring for older adults, and more specifically older adults of various cultural backgrounds. I am here today because your instructor, Mrs. Coker, has provided time opportunity at the end of this community health class meeting for you to participate in a research project designed to assess your perceptions of confidence in caring for older adults from various cultural backgrounds. This study will involve completing questionnaires now (prior to your clinical experiences) and then again at the completion of NURS 4740 Professional Nursing Concepts III. You must be over the age of 19 to participate. If you decide that you may be willing to participate, I ask that you read the information sheet that states specific details of this study. You may keep the information sheet for future reference. Please complete the attached questionnaires, place them in the attached blank envelope and return them to the box at the back of the room. Are there any questions? (Answer any questions the students may have). I will now distribute the questionnaire packets, and those who wish to complete them may do so. Thanks for your time. At the end of the semester, following all data collection, all senior nursing students will be invited to a free pizza lunch.

APPENDIX H

INFORMED CONSENT LETTER

Auburn University

Auburn University, Alabama 36849-5221

Educational Foundations
Leadership and Technology
4036 Haley Center

Telephone: (334) 844-4460
Fax: (334) 844-3072

INFORMATION SHEET for a Research Study Entitled Factors Affecting BSN Students' Perceptions of Eldercare Cultural Self-Efficacy

You are invited to participate in a research study to determine baccalaureate nursing students' perceptions of confidence in caring for older adults from various cultural backgrounds. This study is being conducted by Arlene H. Morris, MSN, RN under the supervision of Dr. James E. Witte, Associate Professor of Educational Foundations, Leadership, and Technology at Auburn University. I hope to learn about baccalaureate nursing students' perceptions of confidence in caring for older adults from various cultural backgrounds at the beginning and end of a senior level community health course. You were selected as a possible participant because you are a baccalaureate nursing student enrolled in NURS 4740 Professional Nursing Concepts III, and you are age 19 or older.

If you decide to participate, please complete the questionnaire packet that will take approximately 45 minutes to one hour. You will be given time following this regularly scheduled class for completion of the questionnaire, and you may place the completed questionnaires at the back of the room when you are finished in the sealed box. During the final month of NURS 4740, I will bring a follow-up questionnaire packet that will also take approximately 45 minutes to one hour which you may complete following a regularly scheduled class.

There are no known anticipated risks or discomforts associated with questionnaire completion. There is a slight risk of breach of confidentiality and feeling of coercion to participate in the research. Any information obtained in connection with this study and that can be identified with you will remain confidential. To protect your confidentiality and prevent possible breaches, all identifying information will be numerically coded. This code, and not your actual name, will be placed by you on all data collection packets. All information will be protected by being kept in locked storage. Information collected through your participation may be used to fulfill an educational requirement (dissertation), published in a professional journal, and/or presented at a professional meeting. If so, all data will be presented in aggregate form.

Your participation is voluntary, and you may withdraw from participation at any time, without penalty, and you may withdraw any data which has been collected about you, as long as that data is identifiable to you through your code. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, Auburn University Montgomery, or the School of Nursing.

Page 1 of 2

HUMAN SUBJECTS
OFFICE OF RESEARCH
PROJECT # 06-143 EP 0608
APPROVED 8-23-06 TO 8-22-07

No direct benefits are promised to you. If you desire feedback regarding changes in your personal results on the ECSES or IAPCC-R, these will be made available upon request before February 2007. This research could help identify factors that affect baccalaureate nursing student perceptions of confidence in caring for older adults with various cultural backgrounds, thus enabling greater information in planning baccalaureate curricula. I cannot promise that you will receive any or all of the benefits described.

If you have any questions, I invite you to ask them now. If you have any questions later, you may contact Arlene H. Morris, 334-244-3785, amorris@mail.aum.edu or James E. Witte, 334-844-3054, witteje@auburn.edu and we will be happy to answer them. You may keep this letter for your information.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone 334-844-5966 or email at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Arlene H. Morris 8/22/06
Investigator's signature Date

Arlene H. Morris
Printed name

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HUMAN SUBJECTS
OFFICE OF RESEARCH
PROJECT # 06-143 EP 0608
APPROVED 8-23-06 TO 8-22-07