A CORRELATIONAL STUDY ON THE CULTURAL AWARENESS AMONG GRADUATING ASSOCIATE DEGREE NURSING STUDENTS

by

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A CORRELATIONAL STUDY ABOUT THE CULTURAL AWARENESS

AMONG

GRADUATING ASSOCIATE DEGREE NURSING STUDENTS

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Abstract

Researchers have developed strategies used in nursing programs to promote cultural awareness (Hunter & Krantz, 2010). Minimal research has focused on the graduating associate degree-nursing students to determine if a relationship existed between the use of an integrated cultural curriculum and the nursing student's level of cultural awareness (Kardong-Edgren & Campinha-Bacote, 2008, Sealey, Burnett, & Johnson, 2006). The associate degree-nursing program accreditation, statistical, and benchmark reports mandated the integration of diversity content, local, national, and worldwide perspectives in the curricula (NLN, 2008). Additionally societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). A correlational approach was implemented to determine if relationships existed between the integrated cultural curriculum and level of cultural awareness in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The Cultural Awareness Scale (CAS) was used to survey the participants. Based on the findings of the 51 participants surveyed in this study, the cultural awareness level may be attributed to several factors, including the integrated cultural curricula. The nursing student's learning style, perception of faculty, personal experiences, and cultural encounters may also contribute to the cultural awareness level. Analysis of variance results revealed no statistically significant difference on the CAS total or subscale scores based on gender, age, and ethnicity. The outcome of this study may encourage academic affairs leaders to emphasize cultural awareness as a significant student-learning outcome for nursing educational programs.

Dedication

I would like to thank my parents Edward J. Martin, III and Beatrice H. Martin, and husband Byron Dennis Almond, Jr., whose patience, encouragement, and never ending understanding helped support me through the many highs and lows of this journey over these past four years.

> Trust in the Lord with all your heart and lean not on your own understanding; in all your ways submit to him, and he will make your paths straights.
>
> Proverbs 3:5-6

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I would like to thank my parents Edward J. Martin, III and Beatrice H. Martin, and husband Byron Dennis Almond, Jr., whose patience, encouragement, and never ending understanding helped support me through the many highs and lows of this journey over these past four years.

My dissertation chair Dr. Shawn Boone, kept me on pathway, provided guidance, expertise and support while inspiring my performance and the elevating the quality of this document. My committee members, Dr. Mark Johnson, and Dr. Melissa Holmberg shared their collective knowledge and invaluable insight during the development of this document. I am grateful for the experiences, wisdom, guidance, feedback, and support each of you provided. I am eternally grateful to each of you.

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CHAPTER 1: INTRODUCTION

Researchers have developed strategies used in nursing programs to promote cultural awareness (Hunter & Krantz, 2010). However, minimal research has focused on the graduating associate degree-nursing students to determine if a relationship existed between the use of an integrated cultural curriculum and the nursing students level of cultural awareness (Kardong-Edgren & Campinha-Bacote, 2008, Sealey et al., 2006). The associate degree-nursing program accreditation, statistical, and benchmark reports have mandated the integration of diversity content, local, national, and worldwide perspectives in the curricula (NLN, 2008). Additionally societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). Hunter and Krantz (2012) stated nursing program leaders experience challenges when determining the curricula most effective in promoting cultural awareness.

A correlational approach was implemented to determine if a relationship existed between the integrated cultural curriculum and level of cultural awareness in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). In addition, the focus of the study was to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age). The Cultural Awareness Scale (CAS) was used as a data collection tool. The CAS is comprised of five subscales. In this study, the General Education subscale represents the integrated cultural curricula. Additionally, the

Behavior Comfort, Cognitive Awareness, Research Issues, and Patient Care subscales represented different elements of cultural awareness among nursing practice (Kranovich-Miller et al., 2008).

The student's participating in this study were enrolled in a nursing program using integrated cultural curricula. Cultural content was integrated throughout each course. Based on the constructivist theory, students will be able to capitalize on previous experiences and multiple perspectives gained from completing the integrated cultural curriculum. All graduating associate degree-nursing students were invited to participate in the study.

The findings of this study may be used to inform and guide nursing program administrators in curriculum development related to the integration of cultural content to promote cultural awareness. The results of this study may be used to inform nursing faculty members regarding the need for additional training related to transcultural nursing concepts. The outcome of this study may encourage academic affairs leaders to emphasize cultural awareness as a significant student-learning outcome for nursing educational programs.

Chapter 1 contains a summary of the background, the problem statement, and the purpose statement. The chapter also includes a discussion of the importance of the study, the description of the study, data collection procedures, the hypothesis, and research questions, the conceptual framework, and definition of terms. Also included in the chapter are the assumptions, scope, limitations, and delimitations in the study as well as a summary of the chapter.

Background

Nursing educational programs are designed to prepare nursing students to provide safe patient care in current health care environments (National League for Nurses, 2012). The Office of Minority Health (2012) mandated 14 principles to guarantee the appropriate standards for diverse individuals. These 14 principles must be adhered to by all of the caregivers, including nursing students (OMH, 2012). Current and future nursing professionals must be trained to provide appropriate services for all individuals (Carey, 2011; OMH, 2012).

Societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). One method of integrating cultural concepts throughout the entire curricula is called the integrated cultural curricula (BRN, 2012). An integrated cultural curriculum incorporates cultural content throughout the entire nursing program and uses no specific model (BRN, 2012). Integrated cultural curriculum may not use a freestanding cultural course, immersion, or an international experience to teach cultural content (Kardong-Edgren & Campinha-Bacote, 2008).

The most frequently cited curricula for promoting cultural awareness, as a nursing student-learning outcome, is the integration of culture across the curricula (Kardong-Edgren & Campinha-Bacote, 2008). Four researchers cited an increase in the cultural scores for 312 nursing students trained in programs using a curriculum with cultural content integrated throughout (Caffrey, Neander, Markle, & Stewart, 2005; Campbell-Heider, Rejman, Austin-Ketch, & Sackett, 2006; Hughes & Hood, 2007; & Smodlaka, 1999). The tools used to evaluate the cultural scores in these

four studies were as follows: Transcultural Self-Efficacy Tool (TSET), Caffrey Cultural Competence in Health care Scale (CCCHS), Cross Cultural World Mindedness (CCWM), and Cross-Cultural Evaluation Tool (CCET) (Caffrey et al., 2005; Campbell-Heider et al., 2006; Hughes & Hood, 2007; Jeffreys & Smodlaka, 1999).

Faculty members knowledgeable about strategies for teaching cultural concepts may prefer using the integrated cultural curriculum (Kardong-Edgren & Campinha-Bacote, 2008). Kardong-Edgren and Campinha-Bacote (2008) stated using the integrated cultural curriculum might be considered uncertain, questionable, or doubtful considering the often-cited concern of faculty members who may not be versed in strategies used to teach cultural content. Nursing faculty members preparing nursing students to provide care for a multicultural population must also be knowledgeable of strategies used when providing appropriate services to all patients (Hunter & Krantz, 2010; Sealey et al., 2006).

The associate degree-nursing program participating in this study wanted to determine if a relationship existed between the use of an integrated cultural curriculum and the level of cultural awareness among its graduating nursing students (Sealey et al., 2006). The associate degree-nursing program participating in this study was established in 1945. This community college has enrolled more than 20,000 diverse individual representing the surrounding community in Los Angeles. The curriculum used by this nursing program included an integrated cultural curriculum.

Demographics

Currently, the United States is made up of diverse individuals, who represent many races, ethnicities, religions, and cultures. By 2050, the amount of multicultural individuals in the United States is expected to increase (D'Amico & Barbarito, 2012). By 2050, D'Amico & Barbarito, (2012) predicted the Asian population will increase from 3% to 11%. Additionally, the African American population will increase from 12% to 16% and the Hispanic population will increase from 9% to 21%. D'Amico and Barbarito (2012) indicated the German, Brazilian, Greek, Egyptian, and Turkish population will increase by 2050.

U.S. Department of Health and Human Services (DHHS) (2010) acknowledged 83.2% of registered nurses (RN) are non-Hispanic Caucasians, 3.6% are Hispanic, and 5.4% are Black/African Americans. The Asian or Native Hawaiian/Pacific Islander, non-Hispanics population represents 5.8% of RNs, 0.3% of RNs are American Indians/Alaska Natives, and 1.7% of RNs non-Hispanic (U.S. DHHS, 2010). An additional 500,000 ethnically diverse nurses are needed to replicate the ratio of ethnically diverse individuals in the population (Lowe, 2009). The difference between the diversity of the patient population and the nursing population presents several challenges when providing cultural and linguistically appropriate services (D'Amico & Barbarito, 2012). Nursing personnel need to be culturally aware and trained to provide cultural and linguistically appropriate services (The American Nurses Association, 2012).

Cultural competence movement

Cultural awareness is an ongoing learning dynamic which includes aspects of cultural knowledge, cultural skill, and cultural competence (Campinha-Bacote, 2007; Rew, 2003). Cultural competence is expressed as an ability that enables the nursing student to work efficiently with diverse individuals (Hunter & Krantz, 2010; Sealey et al., 2006). Cultural skill combines health views, cultural ideals, illness occurrence, frequency, and treatment effectiveness (Hunter & Krantz, 2010). Cultural and linguistically appropriate care moves beyond biologic parameters to a more holistic approach and seeks to increase knowledge, change attitudes, and hone clinical skills (U.S. DHHS, 2012). Culture shapes the way in which individuals rationalize their world and provides a lens through which to create meaning (U.S. DHHS, 2012).

An examination of individual biases and effective cross-cultural communication skills are paramount to the elimination of intercultural barriers and the optimal provision of health care to a multicultural society (Chitty & Black, 2010). Health care organizations providing appropriate services to multicultural individuals understand the cultural and linguistic differences among nursing staff, nursing students, and patient populations (Chitty & Black, 2010). These health care organizations recognize differences can and do lead to obstacles during the delivery of excellence health care (Chitty & Black, 2010). Health care professionals providing appropriate services to multicultural individuals understand the interplay between policy and practice and are committed to policies, procedures, and programs enhancing services to diverse clientele (Bednarz, Schim, & Doorenbos,

2010). The Office of Minority Health Department (2012) developed a report with the 14 principles addressing the national standards for delivery of appropriate care to diverse individuals.

Cultural Competence in Nursing Education

The associate degree nursing statistical report mandated cultural content integration in nursing curricula (The NLN, 2008). The criteria and standards for accreditation of associate degree nursing programs mandated the integration of diversity content, local, national, and worldwide perspectives in the curricula (NLN, 2008). Additionally societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). Nursing program leaders experience challenges when determining the curricula most effective for promoting cultural awareness (Hunter & Krantz, 2010).

Various methods used by nursing programs to teach cultural content include freestanding courses on transcultural nursing or anthropology, cultural immersion, service-learning in a specific culture, simulation, focus groups, and the integrated cultural curriculum (Bednarz, Schim, & Doorenbos, 2010; Hunter & Krantz, 2010). Some nursing program curricula have been standardized but do not include components of cultural content (Kumas- Tan, Beagan, Lopie, MacLeod, & Frank, 2007). Nurse educators recognize the need to measure the cultural awareness level among nursing students (Kumas- Tan, Beagan, Lopie, MacLeod, & Frank, 2007). Four decades of research focused on determining strategies used to foster cultural awareness in nursing (Hunter & Krantz, 2010). Nursing programs have not

established a valid tool to gauge the level of cultural awareness among nurses and nursing students (Bednarz, Schim, & Doorenbos, 2010)

Carey (2011) stated some faculty members who teach transcultural-nursing concepts have not received any advance level preparation in transcultural nursing, therefore faculty members may teach from a common sense approach. It may be necessary for nursing faculty to receive training in transcultural nursing in order for nursing schools to comply with the recommendations of the Board of Registered Nursing (2012). Using the integrated cultural curriculum might be considered uncertain, questionable, or doubtful considering the often-cited concern, regarding faculty members not experienced in teaching cultural material (Carey, 2011; Kardong-Edgren & Campinha-Bacote, 2008).

Problem Statement

Four decades of research exists regarding curricula used in nursing programs to promote cultural awareness (Hunter & Krantz, 2010). The general problem is research studies have not focused on graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles, to determine if a relationship existed between the use of an integrated cultural curriculum and the level of cultural awareness (Carey, 2011; Kardong-Edgren & Campinha-Bacote, 2008; Sealey et al., 2006). The associate degree nursing statistical report mandates cultural content incorporation in nursing curricula (The NLN, 2008). The criteria and standards for accreditation of associate degree nursing programs mandate the integration of diversity content, local, national, and worldwide perspectives in the curricula (NLN, 2008). Additionally societal and cultural patterns must be integrated across the

entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7).

The specific problem is little research had focused on associate degree-nursing students to determine if a relationship existed between integrated cultural curriculum and the student's level of cultural awareness (Kardong-Edgren & Campinha-Bacote, 2008; Sealey et al., 2006). The curricula used by the associate degree-nursing program participating in this study included an integrated cultural curriculum. The intent of this correlational study was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). Additionally, the focus was to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

Purpose

The purpose of this quantitative correlational research was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The Cultural Awareness Scale (CAS) was used to collect data about the integrated cultural curriculum and the student's level of cultural awareness in a large metropolitan area, such as in Los Angeles. The CAS is comprised of five subscales. In this study, the General Education subscale represented the integrated cultural curricula. The

Behavior Comfort, Cognitive Awareness, Research Issues, and Patient Care subscales represented different elements of cultural awareness among nursing practice (Kranovich-Miller et al., 2008). The CAS was used to measure the student's awareness of differences in cultures, awareness of values, beliefs, and biases of others. The CAS was used to measure cultural knowledge and determine nursing program methods and techniques of addressing cultural diversity. The Pearson *r* was used to determine if differences existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students. The ANOVA test was used to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

Significance of the Study

The significance of the research was based on the thought that an integrated cultural curriculum was the most effective method for promoting cultural awareness among graduating associate degree-nursing students (Kardong-Edgren-Campinha-Bacote, 2008). Implementing the integrated cultural curriculum gives learners an opportunity to incorporate new information by building upon what they already know (Hunter & Krantz, 2010). The suggestion by the BRN (2012) is societal and cultural patterns must be integrated across the entire nursing school curricula to promote cultural awareness among graduating associate degree-nursing students.

Significance of the Study to Nursing Education

The intent of this research was meaningful because it determined if relationships existed between the integrated cultural curriculum and the student's

cultural awareness level in an associate degree-nursing program in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). Several nursing program leaders experience challenges when determining the curricula most effective in promoting cultural awareness (Hunter & Krantz, 2010). The BRN (2012) section 1426-e7 recommends the integration of interrelated developmental and societal disciplines with importance on shared and ethnic patterns, human maturity, and performance significant to health and illness through the nursing curricula.

Nursing educational programs are not mandated to use a specific teaching strategy to promote cultural awareness (BRN, 2012). "Developing cultural competence as a nursing student is a critical first step to providing culturally competent nursing care" (Carey, 2011, p. 258). A positive correlation between the curricula used at the participating associate degree-nursing program and the student's level of cultural awareness may be used to guide nursing program leaders in the selection of curricula. The findings of this study may be used to inform and guide the nursing program administrators in the development of the curricula related to the integration of cultural content to promote cultural awareness.

Significance of the Study to Higher Education Administrators

The research results may be useful to higher education (HE) administrators in nursing programs. Higher education administrators may decide to develop standardized curricula with cultural content integrated throughout to meet the need of nursing program leaders. Higher education administrators may choose to develop

transcultural nursing courses and programs to meet the training need of nursing program leaders and nursing faculty.

Nursing educational programs must prepare the nursing workforce effectively to meet cultural and linguistically appropriate service mandates (Waite, 2010). The results of this study may be valuable to higher education administrators in academic affairs departments as they make decisions regarding the importance of cultural awareness as a significant student-learning outcome for nursing educational programs. Higher education administrators may choose to use a validated tool to gauge the nursing student's cultural understanding (Waite, 2010).

Nature of the Study

The focus of this correlational research was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level of the graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The focus was also to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age). For the purposes of this study, the target population included all associate degree-nursing students in the graduating class, in a large metropolitan area such as in Los Angeles. The CAS was used to gather information about the curricula and the level of cultural awareness among graduating nursing students in Los Angeles (see Appendix A).

Overview of the Research Method

In this quantitative correlational study, the CAS tool, a paper and pencil survey was administered to 51 people to survey the attitudes, opinions, behaviors, or characteristics of the graduating associate degree-nursing population. Survey inquiry is widely accepted among researchers as an advantageous manner to retrieve data required to reveal the preferences and mindset of participants (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). This study included a focus on describing trends in a large sample of individuals (Burmeister & Aitken, 2012; Gogtay, 2010). The results of the CAS were analyzed and generalized from the sample to the population. A problem is appropriate for study using quantitative research methods if the focus is on measurement (assigning numbers to variables) and statistical analysis (Mertens & McLaughlin, 2013; Vogt, 2007). The Pearson *r* was used to test for a correlation between the integrated cultural curriculum and the student's level of cultural awareness. The ANOVA test was used to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

Overview of the Design Appropriateness

A survey or questionnaire tool permits a rapid analysis of data from a structured instrument to numbers (Fricker & Schonlau, 2002; Neman, 2006). The survey inquiry may be administered to a large sample using objective questions (Mertens & McLaughlin, 2013). When principal investigators conduct quantitative correlational studies using only a survey tool, they may not spend as much time interacting with participants as in qualitative research because there are no interviews

or observations needed (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013; Neman, 2006).

Some surveys describe what people say they think and do, but other survey studies attempt to find a relationship between the characteristic of the respondents and their reported behaviors and opinions (Fricker & Schonlau, 2002; Marczyk, DeMatteo, and Festinger, 2005; Mertens & McLaughlin, 2013). For the purposes of this study, a survey tool was used to allow participants to describe what they think and do (Fricker & Schonlau, 2002). Based on this information, the best survey to use was one that allowed participants to self-proclaim their level of cultural awareness.

Using a quantitative correlational design may also provide an opportunity for the collection of baseline data and presentation of the results using descriptive statistical analysis. The CAS tool was used to measure the student's awareness of differences in cultures, awareness of values, beliefs, and biases of others, and personal values, beliefs, and biases. The CAS tool was also used to measure the cultural knowledge and determine the nursing program methods and techniques of addressing cultural diversity.

Research Tool

A research tool is an instrument used to obtain data by the researcher. Survey inquiry is an advantageous manner to retrieve data required to show the preferences and mindset of participants (Mertens & McLaughlin, 2013; Salkind, 2003). Survey research assesses the incidence and associations among psychological and sociological variables and explores paradigms such as mindsets, attitudes, bias, partiality, and opinions (Salkind, 2003).

Survey research is efficient because the data gathering part of the study is completed after one contact with the participants (Mertens & McLaughlin, 2013; Salkind, 2003).

The CAS. The CAS was developed in 2003 for the specific purpose of measuring the outcome of a program designed to foster understanding of diverse individuals among faculty and students and its relationship to health care (Rew et al, 2003). Additionally, CAS was intended to survey the cultural knowledge among health care professionals and students and to determine an institute's methods and techniques of addressing cultural diversity. The CAS was developed based on a review of the literature on cultural consciousness, cultural proficiency, cultural understanding, and nursing education (Rew et al., 2003). Cultural awareness, cultural understanding, and cultural competence are concepts with definitions still progressing and the terms are used interchangeably to refer to the same concept (Rew et al., 2003). Rew (2003) mentioned the definition of cultural awareness, cultural understanding, and cultural competence are implied rather than clearly stated.

The CAS tool includes 36 questions with a Likert answer design. The CAS scores range from (7) strongly agree (1) to strongly disagree to measure the following five subscales: research issues, behavior comfort, general educational, cognitive awareness, and patient care (Krainovich-Miller et al., 2003). There is no correct or incorrect answer to the CAS survey because cultural awareness is an ongoing learning dynamic (Rew, 2003).

Rationale for Selecting the CAS. The emphasis of this research was to determine if a relationship existed between the integrated cultural curriculum and the level of cultural awareness of the graduating associate degree-nursing students in a

large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The CAS was designed to measure the outcome of a program aimed at increasing the student's mindfulness of multiethnic variety and its relationship to health care. This tool was determined to be the best tool to use for this study (Rew et al., 2003).

The CAS is comprised of five subscales. The General Education subscale has 14 questions representing the integrated cultural curriculum. The Behavior Comfort, Cognitive Awareness, Research Issues, and Patient Care subscales represented different elements of cultural awareness among nursing practice (Kranovich-Miller et al., 2008). The Cognitive Awareness subscale contains seven items pertaining to intellectual understanding. The Research Issues subscale contains four items pertaining to research concerns. The Behavior Comfort subscale contains six items pertaining to behavior and comfort with communications. The Patient Care subscale contains five items pertaining to patient care and clinical topics.

Target Population

For the purposes of this study, the target population included 55 associate degree-nursing students in the graduating class in a large metropolitan area such as in Los Angeles. The selected associate degree-nursing program uses an integrated cultural curriculum. Additionally, the program director of the associate degree-nursing program participating in the study stated, "They use an integrated cultural curriculum, however the degree to which it is done varies." Given a 95% level of confidence and the margin of 5% error, the goal was to select a minimum of 49 participants (Mertens & McLaughlin, 2013).

In this study, the purposive sample was the approach used because

participants were already enrolled and attending the associate degree-nursing program. The study sample was readily available and allowed for an adequate sample size. The purposive sample was a sampling method in which subjects for the study were in the right place at the right time (Burns, Grove, & Gray, 2012). The purposive sample provided valuable information about the relationship between the integrated cultural curriculum and the level of cultural awareness in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles. Provided the sample size and composition is fully representative of the population under study, generalizations relative to the population can be made (Burmeister & Aitken, 2012; Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013).

Research Questions

Research questions serve two purposes. The purpose of the research questions were to focus the study by restating the purpose of the study in more explicit terms and link the research purpose in the particular study (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). The research questions used to conduct the study are as follows:

RQ1: What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles?

RQ2: What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)?

Hypothesis

H10: There are no relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H1A: There are relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H20: There are no relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H2A: There are relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H30: There are no relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H3A: There are relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H40: There are no relationships existing between the General Education and Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H4A: There are relationships existing between the General Education and Cognitive

Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H50: There are no differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

H5A: There are significant differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

Theoretical Framework

Dr. Madeline Leininger's Theory

The theoretical framework guiding this research included two theorists from the transcultural-nursing arena Dr. Madeline Leininger and Dr. Josepha Campinha-Bacote, and the constructivist theory. The "Theory of Culture Care Diversity and Universality Theory" is a philosophy appropriate for guiding studies about cultural competency (Chitty & Black, 2010, p. 235). Dr. Leininger recognized numerous areas of similarity between nursing, anthropological knowledge, and theoretical research interests leading to the formulation of transcultural nursing philosophy and practice (Chitty & Black, 2010).

Dr. Lenininger theorized the importance of the culture, knowledge, and care as vital and obligatory to nursing education and practice (Chitty & Black, 2010). Dr. Leininger stated culturally appropriate care is the most comprehensive holistic nursing theory because it encompassed the total and holistic human and human group

lifespan perspective (Chitty & Black, 2010). Dr. Leininger also thought culturally appropriate care encompassed a consideration of social structure factors, worldview, cultural history, values, environmental context, language, and (basic, inherent) folk, and professional patterns (Chitty & Black, 2010).

A cultural assessment may be used to enhance the delivery of cultural and linguistically appropriate services (CLAS) and education as needed (Chitty & Black, 2010). Dr. Leininger's created a cultural assessment model focused on the following areas: learning, financial, family, and community, civil, spiritual, theoretical, folk values, attitudes, and practices. Dr. Leininger's model also considered how patients from diverse backgrounds view health and illness (Chitty & Black, 2010). In order for a nurse to become culturally aware, he or she needs to explore the perspectives, assumptions, or misconceptions he or she may have (Chitty & Black, 2010; Munoz & Hilgenberg, 2005).

Dr. Campinha-Bacote

Cultural awareness is an ongoing learning dynamic, which includes aspects of cultural knowledge, cultural skill, and cultural competence (Campinha-Bacote, 2007; Rew, 2003). Dr. Campinha-Bacote created the "Process of Cultural Competence in the Delivery of Health Care Services Model" (Campinha-Bacote, 2007, p. 15). Cultural competency was defined as the advancement of growth in which nurses build knowledge and skill related to diverse individuals, which includes consciousness, comprehension, accepting, compassion, and communication (Campinha-Bacote, 2007). A health care professional demonstrates cultural skill by blending the previously mentioned qualities in human interactions (Graham et al., 2008). This

standard summarized the components defined in the literature as critical factors of cultural competence (Graham et al., 2008).

Dr. Josepha Campinha-Bacote described her model for culturally competent care in 1991 and made revisions in 1998 and in 2002 (Campinha-Bacote, 2007). Dr. Josepha Campinha-Bacote (2007) explained cultural competence as a continual progression without an absolute endpoint. Dr. Josepha Campinha-Bacote (2007) called her model the "volcano model" because it is formed by five interdependent constructs representing a volcano (p. 19). The symbolic eruption of the "cultural desire" construct leads to gains in the other four constructs (Campinha-Bacote, 2007, p. 19). The "five constructs include (a) cultural awareness, (b) cultural knowledge, (c) cultural skill, (d) cultural encounters, and (e) cultural desire" (Campinha-Bacote, 2007, p. 19). By including each of these constructs in one's practice, Campinha-Bacote suggested the health care provider would be able to improve the effectiveness of medical, nursing, or other health care interventions to promote patient health (Campinha-Bacote, 2007).

Cultural awareness occurred when a health care provider was intentionally passionate and discerning about "the values, beliefs, practices, and problem solving strategies of the clients' culture" (Graham & Richardson, 2008, p. 39). Cultural awareness also involved self-analysis and investigation of one's own culture and method of discerning and performing (Sealey et al., 2006). Cultural skill is the capability of obtaining pertinent information concerning the patient's health record, and primary problem, "as well as accurately performing a physical assessment" (Sealey et al., 2006, p. 133). The relevant data gathered must include information

concerning the patient's opinions, practices, and values; helping the health care professional to intervene appropriately based on the patient distinct background (Sealey et al., 2006).

Constructivist Theory

The constructivist theory suggested students make sense of new material by building upon what they understood from previous life occurrences (Bulman, 2005). Constructivist instruction, therefore, seeks to incorporate the learners' previous experiences, various perceptions, and opportunities to entrench knowledge in pertinent social perspective (Hunter & Krantz, 2010). Constructivism recognizes value and principles can differ for each individual. Its methodology is explanatory and it comprises a continual assessment of divergent analysis (Hunter & Krantz, 2010). Developing an understanding of contradictory analysis among the participants in health care is a critical part of becoming culturally aware in a country with an increasingly diversified population (Hunter & Krantz, 2010). Based on constructivist theory, students participating in this research capitalize on previous experiences and multiple perspectives gained from completing the integrated cultural curriculum. The integrated cultural curriculum gives learners an opportunity to incorporate new information by building upon what they already know (Hunter & Krantz, 2010).

Definitions of Terms

The following terms and variables will be defined for operational use.

Cultural awareness

Conceptual definition: Based on Dr. Rew's (2003) definition, cultural

awareness is multidimensional, which includes five key classifications: didactic familiarities, mindfulness of feelings, laboratory, and scientific education, research concerns, and experimental practice. Cultural mindfulness, cultural understanding, and cultural proficiency are ideas with definitions still progressing (Rew et al., 2003). Additionally, the definition of cultural mindfulness, cultural understanding, and cultural proficiency are implied rather than plainly stated (Rew et al., 2003).

Operational definition: Cultural awareness happens when a nurse is purposely passionate and sensitive about "the ideals, views, theories, opinions, and practices of the clients' culture (Graham & Richardson, 2008). Cultural awareness involves reflection and analysis of one's personal culture and method of discerning and performing (Sealey et al., 2006).

Cultural Desire.

The passion a health care worker has which inspires them to provide appropriate care for diverse individuals (Campinha-Bacote, 2007).

Cultural Knowledge.

The technique of obtaining health information about a cultural group is defined as cultural knowledge (Sealey et al., 2006).

Cultural Skills.

The "ability to obtain pertinent information regarding the patient's health history, presenting problem, and performing a physical assessment is defined as cultural skill" (Sealey et al., 2006, p. 133).

Integrated Cultural Nursing Curricula

An integrated cultural curricula is one incorporating cultural concepts throughout the entire nursing program and uses no specific model (BRN, 2012). An integrated cultural curricula does not use a freestanding cultural course, immersion, or an international experience to teach cultural concepts.

Transcultural Nursing:

Transcultural nursing is also referred to as culturally skilled, culturally experienced, or culturally proficient nursing. Six factors included in the practice of transcultural nursing are awareness, skill, knowledge, encounters, desire, and assessment (Maier-Lorentz, 2008).

Assumptions

Three principal assumptions were anticipated during this study. One assumption was nursing students and practicing nurses will provide care routinely for patients of diverse age, gender, culture, racial, and ethnic backgrounds. An additional assumption was the associate degree-nursing program participating in this study used curricula incorporating cultural content throughout the entire nursing program (Kardong-Edgren & Campinha-Bacote, 2008; Kumas-Tan, Beagan, Lopie, MacLeod, & Frank, 2007). Nursing program curricula are expected to prepare the nursing workforce to meet the regulatory standards (OMH, 2012).

Scope

The correlational research purpose was to determine if relationships existed between the integrated cultural curriculum and the level of cultural awareness in graduating associate degree nursing students in a large metropolitan area, such as in

Los Angeles (Sealey et al., 2006). In addition, the focus of the study was to determine if differences existed in the level of cultural awareness (as measured by the CAS) for graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

The Cultural Awareness Scale (CAS) was used to collect information about the integrated cultural curriculum and the level of cultural awareness among graduating nursing students in Los Angeles. The sample was selected from the nursing program director's list of graduating students currently enrolled and attending the nursing program. The target sample included 51 graduating associate degree-nursing students.

Limitations and Delimitations

Correlational studies can suggest an association between two variables, but proving one variable caused a change in another variable may be difficult (Johnson & Christensen, 2008). Correlation does not equal causation. The emphasis of this study was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level among graduating associate degree-nursing students as measured by the CAS (Sealey et al., 2006).

Four limitations are associated with correlational studies. Correlational studies are non-experimental research methods which include "no manipulation of an independent variable by a researcher" (Johnson & Christensen, 2008, p. 43). The lack of manipulation and weaker techniques of controlling for extraneous variables will make it difficult to make a statement about cause and affect (Johnson & Christensen, 2008). The potential for participant self-reporting biases exist may

result in honesty issues (Johnson & Christensen, 2008). Researcher bias may influence the scrutiny of the statistics.

Summary

The intent of this correlational research was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The Cultural Awareness Scale (CAS) was used to collect information about the integrated cultural curriculum and level of cultural awareness among graduating nursing students in Los Angeles. The CAS is comprised of five subscales. In this study, the General Education subscale represented the integrated cultural curricula. The Cognitive Awareness, Research Issues, Behavior Comfort, and Patient Care subscales represented different elements of the cultural awareness among nursing practice (Rew et al., 2003). The Pearson *r* was used to test for a correlation between the integrated cultural curriculum and the student's level of cultural awareness as measured by the CAS tool. The ANOVA was used to determine if differences existed in the level of cultural awareness among graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

The background, problem statement, purpose, nature, and significance of the study presented introductory information regarding the need for a health care professional who is trained to provide appropriate services for diverse individuals. Appropriate services for multicultural individuals include the implementation of BRN (2012), Institute of Medicine (2012), and OMH (2012) principles as required

for the delivery of excellent care. A nursing student who is culturally aware ensures care is pertinent, appropriate for diverse individuals, and accepting to the views and ideals of patients, clients, or consumers (Graham & Richardson, 2008).

Chapter two encompasses a review of important studies, both historical and current. The focus of chapter two will include a methodical analysis of approximately 10 years of peer-reviewed literature focused on the most frequently used curricula to teach cultural content. The literature review will focus on the demand for all health care professionals to be educated regarding cultural concepts. Chapter two will focus on exploring several peer-reviewed studies relevant to the need for culturally aware health care professionals from a political, social, and transcultural aspect. The summary of peer-reviewed studies relevant to the development of cultural awareness provided a response to the question posed in the research and created a foundation for this study.

The research results may be used to inform and guide nursing program administrators in the improvement of the curricula related to the incorporation of cultural content to promote cultural awareness. The outcome of this study may reveal nursing faculty members need additional training related to transcultural nursing concepts. The findings of this study may encourage academic affairs leaders to emphasize cultural awareness as a significant student-learning outcome for nursing educational programs.

CHAPTER 2: LITERATURE REVIEW

The National League of Nursing associate degree nursing statistical report mandates cultural content incorporation in nursing curricula (The National League for Nursing, 2008). Additionally societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). The most frequently cited curricula for promoting cultural awareness as a student learning outcome was the integration of culture across the curricula (Kardong-Edgren & Campinha-Bacote, 2008).

The purpose of this correlational research was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level of the graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The emphasis of chapter 2 includes an analysis of literature associated with the research question. The focus of chapter 2 is to discuss the historical and current findings related to the topic and gaps in the literature.

Title Searches, Articles, Research Documents, and Journals

Researchers have developed strategies used in nursing programs to promote cultural awareness (Hunter & Krantz, 2010). However, minimal research has focused on graduating associate degree-nursing students to determine if a relationship existed between the use of an integrated cultural curriculum and the level of cultural awareness (Kardong-Edgren & Campinha-Bacote, 2008; Sealey et al., 2006). No studies were found concentrating on graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles to determine if a relationship existed

between the use of an integrated cultural curriculum and the student level of cultural awareness (Sealey et al., 2006).

The literature review includes peer-reviewed journals, dissertations, publications, Gale, EBSCOhost ProQuest, and ERIC. The literature reviewed included several printed books, many online digital books (audio), various online journals, and publications. The keyword searches and phrases included cultural awareness, nursing education, cultural competence, registered nurses, cultural competence, health care disparity, cultural awareness in the health care work environment, and cultural competence assessment measurement tools. Table 1 includes the keywords and search results.

Table 1

Key word search

Key Words	Dissertations	Policy Statements	Books	Journals
Cultural awareness	5	1	2	11
Nursing education and cultural competency	5		5	18
Registered nurses and cultural competency	10	3		4
Health care Disparity	3	4	2	6
Cultural competence in the health care work environment	3	6	1	4
Cultural competence assessment measurement tools	5		2	5

The Multicultural United States

Cultural awareness combines cultural values, disease prevalence, health beliefs, incidence, and treatment efficacy (Chitty & Black, 2010). Nurses require

substantial expertise and proficiencies to function in a multicultural environment. The knowledge base required is the ability to be culturally aware. More important is the need for nurses to recognize or acknowledge they have the requisite skills to provide CLAS to all patients. The provision of CLAS is the standard for delivery of health care for diverse individuals (OMH, 2012).

The population of diverse individuals is increasing (U.S. DHHS, 2010). Based on this information the nursing population does not reflect the same level of diversity (Sanner et al., 2010; U.S. DHHS, 2010). The United States is made up of diverse people, who represent many races, ethnicities, religions, and cultures (U.S. DHHS, 2010). By 2050, D'Amico and Barbarito, (2012) predicts the Asian population will increase from 3% to 11%, African Americans population will increase from 12% to 16%, and the Hispanic population will increase from 9% to 21%. Additionally, there will be increases in the percentages of the following populations: German, Brazilian, Greek, Egyptian, and Turkish (D'Amico & Barbarito, 2012).

U.S. DHHS (2010) acknowledged more than 82% of Registered Nurses (RN) are White non-Hispanic, 3.6% of RN's are Hispanic, 5.4% of RN's are Black/African Americans, 5.8% of RN's are Pacific Islander/Native Hawaiian or Asian, less than 0.5% of RN's are American Indians/Alaska Natives, and 1.7% of RN's are two or more races, non-Hispanic (Cherry & Jacob, 2014; U.S.DHHS, 2010). This trend contributes significantly to the challenges the nursing professional experiences when endeavoring to provide appropriate services to diverse patients (Lowe, 2009). An

additional 500,000 ethnically diverse nurses are needed to replicate the ratio of ethnically diverse individuals in the population (Lowe, 2009).

Cultural Competence Theorist and Theories

Dr. Madeline Leininger's Theory

There are two main theorists who have been influential in the cultural competence arena, Dr. Madeline Leininger and Dr. Josepha Campinha-Bacote. The "Theory of Culture Care Diversity and Universality Theory" is a philosophy appropriate for guiding studies about cultural competency (Chitty & Black, 2010, p. 235). Dr. Leininger's background is a unique match for theorizing appropriate care for diverse individuals. Dr. Leininger is the first professional nurse to obtain a Ph.D. in cultural and social anthropology (Chitty & Black, 2010). Dr. Leininger recognized numerous areas of similarity between nursing, anthropological knowledge, and theoretical research interests leading to her formulation of transcultural nursing philosophy and practice (Chitty & Black, 2010).

Dr. Leninger's book, "Transcultural Nursing: Concepts, Theories, and Practice" was the first authoritative text on transcultural nursing practice positioning the framework for her cultural care diversity and universality theory (Chitty & Black, 2010, p. 234). Dr. Leininger initiated the "National Transcultural Nursing Society and the Journal of Transcultural Nursing" is the only publication focusing exclusively on transcultural nursing phenomena (Chitty & Black, 2010, p. 235). For the 21st century, Dr. Leininger expressed an interest in establishing transcultural-nursing institutes to educate and research transcultural nursing and health phenomena (Tomey & Alligood, 2002).

Dr. Lenininger theorized the importance of the culture, knowledge, and care as vital and obligatory to nursing education and practice (Chitty & Black, 2010). Dr. Leininger stated culture care is the most comprehensive holistic nursing theory because it encompasses the total and holistic human and human group lifespan perspective (Chitty & Black, 2010). Dr. Leininger also thought culturally appropriate care encompassed a consideration of social structure factors, worldview, cultural history, values, environmental context, language, and (basic, inherent) folk, and professional patterns (Chitty & Black, 2010).

Several cultural assessment tools may be used during patient care. However, Dr. Leininger's cultural assessment model focused on the following areas: learning, financial, family, and community, civil, spiritual, theoretical, folk values, attitudes, and practices. Dr. Leininger's model also considered how patients from diverse backgrounds view health and illness (Chitty & Black, 2010; Munoz & Hilgenberg, 2005). The benefit of using a cultural assessment is to enhance the delivery of CLAS and education as needed. In order for a nurse to become culturally aware, he or she needs to explore the perspectives, assumptions, or misconceptions he or she may have (Chitty & Black, 2010; Munoz & Hilgenberg, 2005).

One challenge of the 21st century is for nursing educational institutions to meet the needs of different ethnic groups by educating nurses to provide appropriate services (BRN, 2012; The Office of Minority Health, 2012). Developing skills to communicate with various patients is essential for nursing professionals (The Office of Minority Health, 2012). Chitty and Black (2010), highlighted the significance of reflecting on diversity when evaluating and instructing patients and families. There

are two useful, basic questions to ask all patients. The first question is: "In your opinion, what do you think caused your health problem (Chitty & Black, 2010, p. 235; Munoz & Hilgenberg, 2005)?" The second question is: "in your opinion, what treatment do you think will help you (Chitty & Black, 2010, p. 236; Munoz & Hilgenberg, 2005)?" A cultural assessment can reveal nutritional preferences and customs.

Dr. Josepha Campinha-Bacote's Theory

Dr. Josepha Campinha-Bacote (2007) described her model for culturally competent care in 1991 and made revisions in 1998 and 2002. Cultural ability occurs when the nurse increases the familiarity related to the elements of cultural consciousness, understanding, sensitivity, interaction, and skill (Campinha-Bacote, 2007). A health care professional demonstrates proficiency when interacting with diverse persons by blending understanding, sensitivity, and skill (Graham et al., 2008). The emphasis of the volcano model was on the specific critical factors of cultural expertise, which are consciousness, expertise, ability, encounter, and aspiration (Camphinha-Bacote, 2007).

Campinha-Bacote (2007) called her model the "volcano model" because it is formed by five interdependent constructs representing a volcano (p. 19). The symbolic eruption of the "cultural desire" construct leads to gains in the other four constructs (Campinha-Bacote, 2007, p. 19). The "five constructs include (a) cultural awareness, (b) cultural knowledge, (c) cultural skill, (d) cultural encounters, and (e) cultural desire" (Campinha-Bacote, 2007, p. 19). By including each of these constructs in one's practice, Campinha-Bacote suggested the health care provider will

improve the effectiveness of medical, nursing, or other health care interventions to promote patient health (Campinha-Bacote, 2007).

Cultural awareness occurs when a health care provider is intentionally passionate and discerning about "the values, beliefs, practices, and problem solving strategies of the clients' culture" (Graham & Richardson, 2008, p. 39). Developing cultural awareness includes self-analysis and consideration of one's own philosophy and its impact on their way of discerning and acting (Sealey et al., 2006). In addition, cultural understanding is the deliberate rational practice in which health care workers respect the views of the patient's cultures (Graham & Richardson, 2008).

One of the most serious barriers to cultural and linguistically appropriate services is not the lack of comprehension of the particulars of any specified cultural orientation, but the health care providers' lack of self-awareness and careless approach with diverse individuals (Campinha-Bacote, 2010). Cultural awareness occurs along a continuum ranging from unaware ineffectiveness to unaware expertise. Campinha-Bacote (2010) indicated cultural competence consisted of four distinct levels: unaware ineffectiveness, aware ineffectiveness, aware expertise, and unaware expertise. Unaware ineffectiveness is being oblivious to the fact one is lacking cultural knowledge or the health care provider is unaware cultural variances exist between themselves and the patient (Campinha-Bacote, 2010).

Aware ineffectiveness occurs when a person is deficient in the knowledge concerning another cultural group. This occurs when the health care provider knows culture plays a key role in the interactions with others, but they do not know how successfully to communicate with clients from different cultural backgrounds

(Campinha-Bacote, 2010). Aware expertise occurs when a health professional makes an effort to learn about the health beliefs of diverse individuals (Campinha-Bacote, 2010). This health care professional personally experiences cross-cultural connections and is particularly sensitive to cultural differences appreciated and understood to have successful and effective cross-cultural connections (Campinha-Bacote, 2010).

Unaware expertise is the capability of the health care professional instinctively to provide quality health care services to diverse individuals (Campinha-Bacote, 2010). This occurs when the health care professional has experienced many encounters with culturally diverse clients and has developed an intuitive grasp to easily and effectively communicate in cross-cultural encounters (Campinha-Bacote, 2010).

A patient's thoughts and beliefs determine how he or she will interpret illnesses and the causes attributed to the illness (Campinha-Bacote, 2010; Sealey et al., 2006). In addition, knowing the degree of acculturation of the patient is imperative. The health care professional must be familiar with the disorders prevalent to diverse groups of people (Campinha-Bacote, 2010; Sealey et al., 2006). Nursing professionals must be familiar with genetic distinctions, signs of diseases and possible variances in medication metabolism among diverse ethnic groups (Campinha-Bacote, 2010; Sealey et al., 2006).

The ability to interview a patient and ascertain an accurate diagnosis demonstrates cultural skill (OMH, 2012; Sealey et al., 2006). Communication with a patient in his or her preferred language, including the use of interpreter services is

crucial (OMH, 2012). Using the patient's language of preference will guarantee accuracy of the message, preventing mistakes caused by confusion, preventing incorrect diagnosis, management, and poor or non-compliance of the patient (OMH, 2012; Sealey et al., 2006).

A cultural encounter occurs when the practitioner interacts with a diverse individual in the health care setting (Campinha-Bacote, 2010). A cultural encounter may increase the health care provider's range of verbal and non-verbal responses, and the accuracy when communicating with patients of diverse cultures. In addition, learning the usual non-verbal communication to prevent mistakes or offensive gestures with diverse individuals is crucial (The Office of Minority Health, 2012; Sealey et al., 2006).

Campinha-Bacote (2010) defined cultural awareness as the passion exhibited when nursing employees are motivated to deliver appropriate care for diverse patients. Health care providers must believe care is vital to good health care and their dealings should be congruent with their thoughts (The Office of Minority Health, 2012; Sealey et al., 2006). Cultural expertise is based on a duty to social justice (Campinha-Bacote, 2010). In addition, culturally adept individuals have the essential skills to break down systems of practice responsible for inequities (Campinha-Bacote, 2007).

Campinha-Bacote (2010) explained cultural ability as a continuing activity not a final goal. There are six assumptions in the Campinha-Bacote Model. The first assumption is cultural competence is not an endpoint, but a progression, or experience (Campinha-Bacote, 2010). The second assumption is the process of cultural

awareness includes the five interdependent constructs: aspiration, consciousness, comprehension, ability, and confrontation (Campinha-Bacote, 2007). The third assumption is cultural awareness is the central fundamental construct of the model (Campinha-Bacote, 2010). The fourth assumption is variations exist within ethnic groups as well as across ethnic groups (Campinha-Bacote, 2010). The fifth assumption is cultural awareness is a critical element in delivering appropriate care to diverse individuals (Campinha-Bacote, 2010). The sixth assumption is all meetings are considered to be cultural encounters (Campinha-Bacote, 2007).

Educational Theories

Constructivist Theory

Theories from the educational arena, Kelly (1991) and Piaget (1977), were utilized to create the constructivist learning theory (Hunter & Krantz, 2010). The constructivist theory proposes students make sense of new material by building upon what they previously understood from past life occurrences (Brooks, 1984; Bulman, 2005). Constructivist instruction, therefore, seeks to incorporate the learners' prior experiences, various perceptions, and opportunities to entrench experience in pertinent social perspective (Bulman, 2005; Hunter & Krantz, 2010).

Constructivism acknowledges value and principles can differ for each. Its methodology is explanatory and it comprises a continual assessment of divergent analysis (Hunter & Krantz, 2010). Developing an understanding of differences among the participants in health care is a critical part of becoming culturally aware in a country with an increasingly diversified population (Hunter & Krantz, 2010).

Integrated Curricula

Although the integrated curriculum approach is not a theory as such, the use of this approach is founded on the constructivist theory. The integrated curriculum gives learners the opportunity to incorporate new information and build upon the data from past life experiences. The suggestion by the BRN (2012) is societal and cultural patterns must be incorporated thorough the nursing school curricula. An integrated cultural curriculum incorporates cultural content throughout the entire nursing program while possibly using no specific model (BRN, 2012).

The benefit of using the integrated curricula is the elimination of a freestanding cultural course, cultural immersion, or an international experience to teach cultural content (Kardong-Edgren & Campinha-Bacote, 2008). The most frequently mentioned curriculum implemented to achieve cultural awareness is the incorporation of cultural content throughout the entire curricula (Kardong-Edgren & Campinha-Bacote, 2008). When faculty members are knowledgeable about cultural concepts using the integrated curricula may be an advantageous strategy to meet accreditation requirements (Kardong-Edgren & Campinha-Bacote, 2008).

Health Care Regulations

U.S. DHHS created the Healthy People 2020 initiative (2010). The Healthy People 2020 initiative sets goals and objectives with a 10-year target for completion (U.S. DHHS, 2010). The goals and objectives are planned to monitor public health and disease prevention to increase the wellbeing of all individuals in the United States (U.S. DHHS, 2010). U.S. DHHS 2020 initiative is a mechanism for deliberate

supervision by the federal government, states, communities, and many other community and private sector partners (U.S. DHHS, 2010).

The Healthy People 2020 initiative has four overarching goals (2010). The first goal is to advance the health of the public; the second goal is to attain health equity, eradicate health inconsistencies, and increase the health of all individuals (U.S. DHHS, 2010). The third goal is to design environments promoting health for all. The fourth goal is to improve behaviors, development, and value of life (U.S. DHHS, 2010).

There are a total of 400 measurable objectives monitored to determine the public health (U.S. DHHS, 2010). The objectives influence the public and require health agencies to evaluate the progress toward achieving the objective (U.S. DHHS, 2010). The objectives are written with a statement of intent, a baseline value for measuring, and a target for the year. There are 28 focus areas, for example, access to quality health services, diabetes, nutrition, obesity, sexually transmitted disease, and tobacco use (U.S. DHHS, 2010).

All of the U.S. DHHS 2020 goals are important; however the pertinent goal for this study is the one focusing on the health care delivery to various individuals (2010). This goal is gauged by assessing racial and ethnic background and cultural needs (U.S. DHHS, 2010). U.S. DHHS 2020 ambitions guide nationwide health promotion (2010). The California Department of Public Health (CDPH) guides state health promotion (2010). The CDPH is a performance-based company, which focuses on optimizing the health and wellbeing of the individuals in California, mainly through population-based programs, policies, and proposals (2011).

The CDPH fiscal year 2011-2012 budget highlights included the goal to achieve health equities and eliminate health disparities. In addition, the first goal of the CDPH is to address issues identified by U.S. DHHS (2010) objectives. Health care leaders who are culturally aware recognized cultural and linguistic differences exist among staff and patient populations and these differences may lead to barriers in the delivery of health care to diverse individuals (Chitty & Black, 2010; Hunter & Krantz, 2010). Campinha-Bacote (2007) stated health care organizations must seek intimate knowledge of the communities they serve.

As health care business become cognizant of the communities they serve, they will be better able to increase the level of culturally and linguistically sensitive care (Maier-Lorentz, 2008). Health care leaders must also be knowledgeable of the policies, procedures, and programs enhancing services to diverse clientele (Campinha-Bacote, 2007; Sealey et al., 2006). A health care report by the OMH (2012) mandated 14 principles regarding the appropriate health care for various individuals. These 14 principles are listed in selected textbooks and some faculty members may discuss them, however, the nursing program curricula may not specifically mention these mandates. For example, the integrated cultural curriculum may suggest cultural aspects of nursing defined or discussed, but does not specifically list the mandates. The integrated cultural curriculum may be written to allow academic freedom.

Challenges for Health care Professionals

The difference between the diversity of the patient population and the nursing population may present several challenges when providing culturally and

linguistically appropriate services (D'Amico & Barbarito, 2012). The primary challenge is the increased incidence of health disparity. The Centers for Disease Control (2011) defines health disparity as the variance of the incident, frequency, and mortality.

The first challenge addresses how care is provided to various individuals (The Office of Minority Health, 2012). A possible reason for this challenge is some health care professionals are not as versed or need education regarding diverse cultures. In addition, some practicing nurses lack the experience needed to provide cultural and linguistically appropriate services to all patients (Campinha-Bacote 2002; Satcher & Pamies, 2006). The second challenge is racial and ethnic difference in health result from variation in an individual's exposures or vulnerability and is a reflection of issues related to the health care system (U.S. DHHS, 2012). Thus, nursing personnel should be knowledgeable about methods used to provide appropriate services for all patients (Chitty & Black, 2010). The third challenge is the acknowledgement of ethnic and racial differences existing in health status as a result of the imbalances in income, education, environmental, specific health behaviors, and the ability to obtain quality health services (Centers for Disease Control, 2011). To alleviate these challenges, transcultural education must be incorporated into the curricula for health professionals (Institute of Medicine, 2012; OMH, 2012).

Learning to communicate with people from a variety of different cultures is fundamental. The nursing professional must consider the different ethnic background of the patient (The Office of Minority Health, 2012). Methods for providing appropriate care to diverse individuals involved showing genuine interest in people,

researching a group's background, communicating with patients, and facilitating communication (Campinha-Bacote, 2010).

Other strategies used when providing culturally and linguistically appropriate care include using competent interpreters, identifying and addressing barriers to health care with goal-directed and practical solutions. These strategies may be practical when providing appropriate care to any diverse patient (Maier-Lorentz, 2008; The Office of Minority Health, 2012). Additionally, when nurses are providing care for patients, they should be empathetic and unbiased (BRN, 2012; The Office of Minority Health, 2012). Furthermore, some people in the nursing profession have not been trained to communicate with various individuals in the health care setting (Maier-Lorentz, 2008).

Medical schools provide little education regarding the care of culturally diverse patients (Abrums, Resnick, & Irving, 2010). Only a third of the U.S. medical schools provide information about how to address the ethnic issues (Abrums et al., 2010). Most nurses received training regarding ethnic and racial beliefs and ideals, but continue to be ineffectively prepared to communicate or provide care for various individuals including patients or other health care professionals (Abrums et al., 2010).

Given these challenges training all nursing students to provide CLAS to all patients is significant (Poon et al., 2003; The Office of Minority Health, 2012). Nurses and nursing students should be thoroughly trained to provide CLAS (Carey, 2011). Nurses must somehow adapt to these challenges and obtain the information needed to provide transcultural, holistic, and excellent care to all patients (Maier-Lorentz, 2008). Ultimately, education and training in CLAS is a requirement for all

health care professionals (Campinha-Bacote, 2007; Carey, 2011, The Office of Minority Health, 2012). What educational strategy or curricula will strengthen the cultural diversity programs in nursing schools and increase the level of cultural understanding or knowledge in nursing students?

Nursing Education Programs

Nursing educational institutions must meet the needs of different ethnic groups by preparing nurses to provide quality care to various individuals (BRN, 2012; Soroff, Rich, Rubin, Strickland, & Plotnick, 2002). Nursing programs must prepare the future workforce effectively to communicate and care for all patients (BRN, 2012; The Office of Minority Health, 2012). All academic institutions need to recruit, encourage, and retain qualified diverse students and faculty (Campinha-Bacote, 2007; The Office of Minority Health, 2012). Nursing programs are expected to accept the learner as a human being and recognize students differ in learning needs related to age, sex, cultural/ethnicity, socioeconomic background, and educational training (BRN, 2012). Faculty preparing future nurses to provide care to a diverse population must also improve the abilities and expertise needed to provide CLAS (BRN, 2012; Sealey et al., 2006; The Office of Minority Health, 2012).

There are many challenges experienced by nursing program administrators and nursing educators. Meeting the health care workforce goals presents a challenge to the health care education sector (BRN, 2012; NLN, 2012). The nursing school curricula need standardization for teaching, evaluating, and measuring the level of cultural awareness among nursing students (Hunter & Kratz, 2010; Musolino, Burkhalter, Crookston, Ward, Harris, Chase-Cantarini, & Babitz, 2010).

Nurse administrators and educators must select an effective and trustworthy assessment tool adequately to measure the level of cultural awareness among nursing students (Kumas-Tan et al., 2007). Waite (2010) proposed a correlation between patient outcomes and cultural competence training. The expectation is a nursing student will develop cultural awareness and provide cultural and linguistically appropriate services to all people (Carey, 2011).

The development of ethnic diversity is the purpose and mission of the American Nurses Association (ANA) (Lowe, 2009). The ANA has incorporated ethnic diversity into the strategic plan and commitment to improve the health care service to all people (Lowe, 2009). Future nurses need to be well-informed regarding the delivery of appropriate services in a clinical setting (Lowe, 2009).

Nursing students may help each other learn about similarities and differences between cultural groups. Nursing faculty members may achieve various teaching strategies to increase the cultural awareness of students (Carey, 2011). The faculty member may perform the following teaching strategies: focus groups, discussions, sharing, role-playing, and simulation exercises (Carey, 2011; Lowe, 2009).

The critical shortage of cultural and racial diversity among nursing faculty members must be addressed by nursing academia (Lowe, 2009). Additionally, the nursing curricula must be written to reflect the needs of the nursing student with culturally diverse learning styles (Lowe, 2009). More cultural diversity content must be integrated in the nursing curricula (Lowe, 2009).

Nursing program administrators must determine the impact of curricula used to educate current and future nurses (U.S. DHHS, 2012; NLN, 2012). The current

recommendation of the California Board of Registered Nursing (Section 1426-d & e7), states instructions must include the incorporation of legal, social, and moral aspects of nursing, and ethnic diversity throughout the entire nursing curricula (BRN, 2012). For this reason, a number of nursing programs use the integrated cultural curriculum because it satisfies the accreditation requirements although it may not be the most effective method for promoting cultural awareness among nursing students (BRN, 2012; NLN, 2012).

The Associate Degree Nursing Statistical Review mandates cultural content incorporation in nursing curricula (The NLN, 2008). The NLN (2012) and the BRN (2012) stated nursing education must include transcultural-nursing content in the curricula. As a result, nursing education must integrate cultural content throughout the entire nursing curricula (BRN, 2012; NLN, 2012).

There have been years of investigation related to the provision of appropriate services for various individuals, however, nursing programs administrators have not determined how appropriately to teach or gauge the impact of using curricula designed to increase the cultural understanding among nursing students (Kumas-Tan et al., 2007). Nursing students must comply with regulations and successful function in a multicultural health service delivery system (Carey, 2011). Selecting a valid and reliable assessment tool to evaluate the depth of cultural understanding among nursing students is mandatory (Carey, 2011). The current literature provided little guidance, documented a lack of standardization and consistency in the choice of tools used to evaluate cultural awareness and understanding (Kumas-Tan et al., 2007).

Gozu et al. (2007) reviewed and evaluated 45 data collection tools used to assess cultural competence and found 15 of the studies documented reliability or validity of the tools. Only six of the measurement tools in the study documented both psychometric properties. The evaluation goals of cultural competence training was to ascertain if the student has gained the attitude, knowledge, behavior, and skills to care for various patients (Gozu et al., 2007). Additionally, the goal was to determine if the training had an impact on the care given to various individuals (Gozu et al., 2007).

Based on the analysis, nurse administrators and educators have limited access to reliable and validated standardized tools used to measure or evaluate the impact of training related to cultural content (Carey, 2011). Sealey et al. (2006) revealed nurses in the 21st century required substantial knowledge and skills to function in a multicultural world. In addition, nurses must realize the amount of agreement among patients and the response to treatment will correspond with the services receive and the expectations (OMH 2012; Sealey et al., 2006).

Nurses must be equipped to deliver appropriate services to all patients (The Office of Minority Health, 2012). More important, faculty who teach nursing students to care for various groups of people must also possess the abilities and understanding to accomplish this undertaking (The Office of Minority Health, 2012). The study by Sealey et al. (2006) analyzed the degree of cultural proficiency among baccalaureate nursing faculty in Louisiana. The outcome of this study revealed nursing faculty were challenged when teaching the topic of cultural competence and may need preparation (Sealey et al., 2006).

Methods Used to Teach Cultural Competence

Sanner, Baldwin, Cannella, Charles, and Parke's (2010) research determined an interactive meeting was a successful approach to increase cultural awareness among students in nursing programs. The emphasis of this research centered on the impact of multicultural awareness meeting on 47 nursing students in a southeastern public university (Sanner et al., 2010).

The meeting included an interactive presentation, small group activity, and pre and posttest to evaluate the depth of cultural awareness (Sanner et al., 2010). The Openness to Diversity/Challenge Scale is a pre and post-test (Sanner et al., 2010). The findings of the study suggested an educational design using a cultural diversity forum might increase cultural awareness among nursing students (Sanner et al., 2010).

The purpose of Graham and Richardson's research (2008) was to foster cultural awareness in nursing students by using games and simulation. The researcher defined the term game as involving competition and rules. The facilitators were trained to manage the classroom using games and simulations. The useful finding from this research was when the games or simulations are performed efficiently application to real life is clear. In addition, the success of this research has led to the examination of practical training in nurse education (Graham et al., 2008).

Yarbrough and Klotz (2007) revealed participation in experiential or service-learning intervention increased the level of cultural competency. In addition, Nokes, Nickitas, Keida, and Neville (2005) researched the influence of service learning on the level of cultural competency among nursing students. The problem in Nokes,

Nickitas, Keida, and Neville's (2005) study was even though nursing students were trained to function in leadership roles in the community, they may lack cultural competency.

A study by Nokes et al. (2005) determined participation in a service-learning intervention increased the level of cultural expertise and analytical thinking among nursing students. Opportunities exist for nursing students to collaborate with other stakeholders to elevate the health of the people living in various communities (Nokes et al., 2005). Therefore, nursing students need to comprehend the value of service learning (Nokes et al., 2005).

Sullivan (2009) discovered a cultural immersion strategy influence the level of cultural awareness in nursing students. Sullivan (2009) studied nursing students who provided health care services to immigrant-refugees. Evaluation techniques included focus groups, cross-cultural interactions, or reflective journals (Sullivan, 2009). Sullivan (2009) reported an increasing amount of a cultural mindfulness among nursing students participating in a cultural immersion approach.

The results of Hunter and Krantz's (2010) investigation confirmed educational experiences transformed student's opinions, thoughts, comprehension, and proficiencies regarding cultural expertise. Hunter and Krantz (2010) indicated the constructivist learning theory acknowledged multiple socially constructed realities rather than a single reality. Constructivism assumes significance and principles can vary for different individuals. Constructivism is informational and it includes a continual evaluation of opposing explanations (Hunter & Krantz, 2010).

The theories from Kelly (1991), Piaget (1977), and the educational area were utilized to create the constructivist learning theory (Hunter and Krantz, 2010). Constructivists suggested learners understand new information and build upon what they know from life experiences (Brooks, 1984; Bulman, 2005). Hunter and Krantz (2010) compared the level of cultural awareness among nursing students in an online or traditional classroom venue. The graduate level program was based on the Campinha-Bacote model (Hunter & Krantz, 2010). The results of the study revealed significant changes in cultural awareness scores for all of the members regardless of the teaching modalities (Hunter & Krantz, 2010).

The study by Kardong-Edgren and Campinha-Bacote's (2008) evaluated the curricula and cultural expertise of the graduating nursing students in four bachelors of nursing programs. The students were surveyed at the end of the nursing education program. A variety of teaching strategies were implemented to teach cultural ideas. Two of the programs used multicultural theories. One program used a freestanding cultural course taught by nursing faculty with a strong cultural educational background. One program used an integrated cultural curriculum approach.

All of the participants in this study were deemed culturally aware irrespective of the nursing program curricula (Kardong-Edgren & Campinha-Bacote, 2008). The expectation was nursing students in the integrated cultural curriculum group would score higher than students in the groups using other curricula. The results of this study may be quite alarming because the most frequently cited method for teaching is to incorporate cultural awareness throughout the entire curricula (Kardong-Edgren & Campinha-Bacote, 2008).

When faculty members are knowledgeable about strategies for teaching cultural ideas, using the integrated cultural curriculum may be an advantageous (Kardong-Edgren & Campinha-Bacote, 2008). Using the integrated cultural curriculum may help nursing programs avoid the problems associated with the addition of cultural content often experienced by the many as soft science in a biomedically laden curricula (Kardong-Edgren & Campinha-Bacote, 2008). Kardong-Edgren & Campinha-Bacote (2008) said using the integrated cultural curriculum might be considered uncertain, questionable, or doubtful considering the often-cited concern of faculty members not versed in strategies used to teach cultural content.

Slade, Thomas-Connor, and Tsao (2008) described a collaborative effort between the nursing and English faculty to pilot a process promoting cultural competence among nursing students by using a pathography. The students were challenged critically to read difficult transcultural exchanges and apply pertinent nursing views to explore the health care situation (Slade et al., 2008). After reading the case study the, students were expected to create study questions and were assigned to small groups to discuss the study questions. After the individual discussions were completed the entire class participated in a class discussion.

At the completion of the class discussion the students were asked to write an analytical composition (Slade et al., 2008). The results revealed the use of a pathography was successful in fostering the cultural awareness of nursing students (Slade et al., 2008). In addition, using the pathography was more effective than the

previous strategies for promoting cultural awareness in nursing students (Slade et al., 2008).

Slade's (2008) research confirmed graduating nursing students lacked cultural expertise, which may prevent them from working efficiently with various individuals. In addition, an analysis of several studies revealed graduating nursing students were only culturally aware regardless of their race, ethnicity, or the nursing program (Kardong-Edgren & Campinha-Bacote, 2008).

Integrated Cultural Nursing Curricula

Societal and cultural patterns must be integrated across the entire nursing school curricula (Board of Registered Nursing, 2012, section 1426-e7). An integrated cultural curriculum incorporates cultural content throughout the entire nursing program and uses no specific design (BRN, 2012). An integrated cultural curriculum may not use a freestanding cultural course, cultural immersion, or an international experience to teach cultural concepts (Kardong-Edgren & Campinha-Bacote, 2008). Using the integrated cultural curriculum might be considered uncertain, questionable, or doubtful considering the often-cited faculty unprepared to teach cultural content (Kardong-Edgren & Campinha-Bacote, 2008).

When faculty members are knowledgeable about cultural content the integrated cultural curriculum may be a useful approach to meet accreditation requirements (Kardong-Edgren & Campinha-Bacote, 2008). When faculty members are not knowledgeable about cultural content, it may be helpful to implement another approach to meet accreditation requirements. The use of the integrated cultural curriculum or no specific approach may mean the cultural content is implemented by

a few of the faculty members comfortable with the topic (Kardong-Edgren & Campinha-Bacote, 2008). As a result, the ability of nursing faculty to integrate cultural content across the entire curricula is still a concern.

For the purposes of this study, an integrated cultural curriculum is a one incorporating cultural concepts throughout the entire nursing program and uses no specific design or program to teach cultural concepts (BRN, 2012). Sealey et al. (2006), said those faculties who teach multicultural nursing may not have received any graduate level training in multicultural nursing, therefore, the faculty members may teach from a common sense approach. In order for nursing schools to comply with the recommendations of the BRN (2012) the nursing programs evaluate the impact of the curricula on nursing students and ensure the nursing faculty received training in transcultural nursing.

Gaps in the Research Literature

There are no published studies focused on graduating associate degree-nursing students in a large, diverse metropolitan area, such as in Los Angeles, to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level among students in nursing programs (Sealey et al., 2006). Many studies focused on small rural areas and reported the result of using integrated curricula to teach cultural content as being an effective method to increase the cultural awareness of nursing students (Hughes & Hood, 2007; Hunter & Krantz, 2010; Kumas-Tan et al., 2007; Sanner et al., 2010; Slade, Thomas-Connor, & Tsao, 2008; Yarbrough & Klotz, 2007). Therefore, in response to the BRN (2012), The

Office of Minority Health (2012) regulatory mandates, and the gap in the research literature the need for this quantitative correlational study is significant.

Research Methodology

The correlational design was the best choice for this study for several reasons. The focus of this study was not to perform a treatment or use a control group, which eliminated the choice of experimental design (Azarian, 2011; Johnson & Christensen, 2008; Mertens & McLaughlin, 2013). The focus of this study was not to include an exploration of one locale, environment, setting, a single theme, a single document, or one particular incident, which eliminated the choice of a case study (Bogdan & Biklen, 2007).

The CAS, a discrete answers Likert-type tool, was used rather than participant observation or participant interviews. The purpose of this study was not to focus on what the cultural awareness lived experience meant to the nursing students, which eliminated the choice of a phenomenological study (Schram, 2005). Using a correlational design was the best method to use when the purpose of the study is to describe or analyze relationships between variables.

Correlational study provides suggestions on how variables are associated or how variables are related; in contrast to descriptive research or comparative research (Bogdan & Biklen, 2007; Mertens & McLaughlin, 2013; Salkind, 2003). The intent of this correlational study was to determine the extent to which the integrated cultural curriculum and level of cultural awareness (as measured by the CAS tool) among nursing students were related and if changes in one were reflected or relative to changes in another. Additionally, using a correlational design may permit the

opportunity to study the trend and level of relationship between integrated cultural curriculum and the levels of cultural awareness among nursing students as measured by the CAS.

This correlational study was intended to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). The purpose of using a quantitative correlational design was to determine if an association or relationship existed between variables in a predictable pattern for one group of individuals (Johnson& Christensen, 2008; Mertens & McLaughlin, 2013). Based on this information, a correlational design was the best method to use when answering the research questions of this particular study. Using a correlational design was the best method because the purpose was to determine if an association or relationships existed between variables in a predictable pattern for one group of individuals (Johnson & Christensen, 2008; Mertens & McLaughlin, 2013).

Conclusion

In conclusion, education and training in cultural awareness is a requirement for all health care workers (Carey, 2011). Many studies focused on geographical areas not large metropolitan areas, such as Los Angeles, and indicated nursing students in various nursing programs were not culturally adept, but were only culturally aware regardless of their race, ethnicity, or type of nursing curricula (Kardong-Edgren & Campinha-Bacote, 2008; Sanner et al., 2010.

Based on the current literature, no published research focused on the graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles to determine if a relationship existed between the use of an integrated cultural curriculum and the student's level of cultural awareness (Sealey et al., 2006). Therefore, in response to the regulatory mandates and the gap in the research the need for this quantitative correlational study is significant.

Summary

The focus of this chapter was to review the theorist specializing in cultural content, health care regulations, nursing education programs, challenges for health care professionals, research methodology, and research tool. Additionally, the focus of this chapter was on the general methods used to teach cultural concepts, including using an integrated cultural curriculum. The emphasis of this correlational research was on the graduating registered nursing students in a large metropolitan area, such as Los Angeles to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level of the student (as measured by the CAS results) (Sealey et al., 2006).

Thorough analysis of the literature revealed nursing students were not culturally experienced or proficient but were culturally aware regardless of their race, ethnicity, or type of nursing program (Kardong-Edgren & Campinha-Bacote, 2008). Practically every transcultural researcher concurs cultural competence is an important factor of best nursing practice and a significant student-learning outcome for nursing programs (Riley, 2012). A minimal amount was known about the results of using integrated cultural curriculum to teach cultural concepts at a nursing program

in a large metropolitan area, such as in Los Angeles. As a result, this correlational study was crucial.

The outcome of this research may be utilized to support the incorporation of cultural content in nursing program curricula. The study may inform nursing faculty members regarding the need for additional training related to transcultural nursing concepts. The study may encourage academic affairs leaders to emphasize cultural awareness as a significant student-learning outcome for nursing educational programs.

Chapter 3: METHODS

Minimal research has been focused on the graduating associate degree-nursing students to determine if a relationship existed between the integrated cultural curriculum and the students cultural awareness level (Kardong-Edgren & Campinha-Bacote, 2008; Sealey et al., 2006). This correlational study was designed to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level of the graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006).

The Cultural Awareness Scale (CAS) is a 36 Likert-type questionnaire utilized to analyze the level of cultural awareness and determine the organization's methods and techniques of addressing cultural diversity (see Appendix A). Additionally, the intent of this study was to determine if differences existed in the level of cultural awareness among the graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

The Pearson *r* was used to test for a correlation between the integrated curricula and the student's level of cultural awareness as measured by the CAS. An ANOVA test was used to determine if differences existed in the level of cultural awareness among graduating associate degree-nursing students based on demographic factors (gender, ethnicity, and age).

Chapter 3 focuses on the methodology of the study and explains the data collection process. The focus of Chapter 3 is to explain the research participants, the choice, and suitability of the research design, data collection and analysis, validity, and reliability. Minimal research findings existed regarding cultural awareness levels

among associate degree nursing students in large metropolitan areas, such as in Los Angeles. This study may be a starting point for forthcoming explorations.

Research Method and Design Appropriateness

Research design

A quantitative correlational design was used to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level of graduating associate degree student nurses in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). Implementing an experimental treatment or control group was not the emphasis of this study. The motivation of this correlational design was to provide an opportunity to collect baseline data and determine relationships between the integrated cultural curriculum and the levels of cultural awareness as measured by the CAS results (Mertens & McLaughlin, 2013).

Design appropriateness

Quantitative methods are used when the researcher wants to use a more structured and controlled approach with a formal instrument obtaining the same information from each subject (Mertens & McLaughlin, 2013). The focus of this study was to use a correlational design to determine if a relationship existed between the integrated cultural curriculum and cultural awareness levels among graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006).

Several designs were explored prior to finalizing a decision to use a correlational design. The focus of this study was to determine if an association or relationship existed between variables in a predictable pattern for one group of

individuals (Mertens & McLaughlin, 2013). A correlational design was used to determine if relationships existed between the variables (Mertens & McLaughlin, 2013). The three likely results of a correlational study are zero correlation, negative correlation, or positive correlation (Johnson & Christensen, 2008; Mertens & McLaughlin, 2013). Additionally, the findings from this study may show the integrated cultural curriculum and the cultural awareness level as measured by the CAS results are positively correlated, negatively correlated, or not correlated (Mertens & McLaughlin, 2013).

The correlational design was the best choice because the focus of this study was not on implementing a treatment, randomizing the sample, or using a control group, which eliminated the choice of experimental design (Azarian, 2011; Johnson & Christensen, 2008; Mertens & McLaughlin, 2013). The focus of this study did not include an exploration of one locale, environment, setting, a single theme, a single document, or one particular incident, which eliminated the choice of a case study (Bogdan & Biklen, 2007). This study did not focus on what the cultural awareness lived experience meant to the nursing students, which eliminated the choice of a phenomenological study (Schram, 2005). The CAS, a discrete answers Likert-type tool, was used rather than participant observation or participant interviews.

The emphasis of this correlational study was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles (Sealey et al., 2006). Based on this information a correlational study was the best method to use to answer the research questions because it intended to

determine if associations or relationships existed between variables in a predictable pattern for one group of individuals (Johnson & Christensen, 2008; Mertens & McLaughlin, 2013)

Method Appropriateness

A problem is appropriate for study using quantitative research methods if the focus is on measurement (assigning numbers to variables) and statistical analysis (Azarian, 2011; Frankfort-Nachmias & Leon-Guerrero, 2006; Trochim, 2006; Vogt, 2007). When a researcher decides to assign numbers to an observation, it can be expressed in the following level of measurements (nominal, ordinal, interval, or ratio). Nominal measures will name or categorize data, ordinal measures will rank data, interval measures will state data in equal distance from each other, and ratio will measures data with equal intervals and a true zero.

The three main categories of statistics are descriptive, associational, and inferential (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). One problem best studied using quantitative approaches are those determining how variables are associated or related with each other or drawing a conclusion from the population (inferential)(Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). The most appropriate research method was the quantitative correlational design. The intent was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as Los Angeles (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013; Sealey et al., 2006). The chosen method was appropriate because it provided for the use of descriptive statistics to describe the results of the CAS

(Mertens & McLaughlin, 2013; Salkind, 2003).

Descriptive statistics will be used to describe and present the data in a manageable format (Azarian, 2011; Frankfort-Nachmias & Leon-Guerrero, 2006; Trochim, 2006). Using a quantitative correlational methodology provided for the collection of data, comparison of the results, determination if the results were correlated, and presentation of the results by using numbers or statistics (Mertens & McLaughlin, 2013). The quantitative method was best suited to the purpose of this study.

Consequently, using a qualitative method was inappropriate for this study for several reasons. First, the purpose of the study was not to focus on exploring the knowledge, meaning, attitudes, and view of the participants; the purpose of this study was to provide quantifiable answers to the research question (Mertens & McLaughlin, 2013). Additionally, the purpose of this study was not to focus on investigating an issue from a new approach or perspective; instead the intent of this study was to focus on previous literature or other research studies related to the variable (Fricker & Schonlau, 2002; Hesse-Biber & Leavy, 2011; Mertens & McLaughlin, 2013).

The qualitative method does not use a linear approach or statistical analysis, which is necessary to determine the correlation between independent and dependent variables. A general criticism of qualitative research is the lack of scientific rigor and the ability to reproduce and generalize on a larger scale (Mertens & McLaughlin, 2013). Quantitative research may be best used to provide a general picture of trends, association, or relationships (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013).

One survey research tool was used to collect data. The research tool used during this study was the CAS, which is a seven-point discrete answer Likert-type survey. Permission was granted for the use of the CAS (see Appendix B). Survey inquiry is an advantageous manner to retrieve data required to show the preferences and mindset of participants (Mertens & McLaughlin, 2013; Salkind, 2003). Salkind (2003) stated survey research assesses the incidence and associations among psychological and sociological variables and explores paradigms such as mindsets, attitudes, bias, partiality, and opinions.

Survey research has many advantages. An advantage of using survey research is an opportunity to obtain an extensive representation (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013; Salkind, 2003). Survey research is effectual because the data compilation part of the study is completed after one interaction with the participants (Mertens & McLaughlin, 2013; Salkind, 2003). Survey research reveals minimal sampling error and can generate precise results (Salkind, 2003).

Survey research has two disadvantages. A disadvantage of using survey research includes interviewer bias, which may occur when the researcher encourages approval or disapproval of a response. An additional disadvantage to using survey research occurs when the participant responds to survey questions with a bias because he or she wants to answer the questions with a socially acceptable answer (Salkind, 2003).

Azarian (2011) indicated survey inquiry allows a researcher to survey a large sample, using objective questions taking little time to administer. In addition, when conducting quantitative research, the researcher may not spend as much time

interacting with the participants as in qualitative research because there are no interviews or observations needed (Azarian, 2011). The focus was on describing trends in a large sample of individuals rather than intervening or relating variables. The results were analyzed and generalized from the sample to the population. Quantitative research design may be best used to provide a general picture of trends, association, or relationships (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). The quantitative method was best suited to the purpose of this research.

Research Questions

Research questions serve two purposes. The first purpose of the research question is to focus the study by restating the intent of the study in more explicit terms (Fricker & Schonlau, 2002; Mertens & McLaughlin). The second purpose of the research question is to link to the research purpose in a particular study (Fricker & Schonlau, 2002; Mertens & McLaughlin). The research questions (RQ) used to conduct this study are as follows:

RQ1: What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles?

RQ2: What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)?

Hypothesis

H10: There are no relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H1A: There are relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H20: There are no relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H2A: There are relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H30: There are no relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H3A: There are relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H40: There are no relationships existing between the General Education and Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H4A: There are relationships existing between the General Education and

Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles

H50: There are no differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

H5A: There are significant differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

Population

When a study involves gathering data from people it is imperative to include a specific description of who the people are in an attempt to determine the possibility of generalizing the research findings (Krathwohl & Smith, 2005). The target population included all graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles, which uses an integrated cultural curriculum. The sample included all graduating associate degree-nursing students who volunteered.

The college participating in this study is in a large metropolitan area, such as in Los Angeles. Currently, 700 international students from more than 30 different countries are enrolled in classes at this college. These international students have transferred to impressive universities throughout the United States. There are two sessions in the college year, during the fall and spring. The summer and winter sessions are optional.

These participants specifically represent graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles, which used an integrated cultural curriculum approach to teaching cultural content. Additionally, the sample was selected from the program director's list of graduating associate degree nursing students currently enrolled and attending the nursing program.

The associate degree-nursing program philosophy is founded on the following two statements: (a) Learning experiences are most effective when content is arranged in a simple to a complex manner. (b) Education is a continual process of developing a body of knowledge, skills, and attitudes. The associate degree-nursing program's conceptual framework was intended to meet the necessities of non-native English speaking students. As a result, the college has implemented an integrated cultural curriculum encouraging sensitivity to diverse cultures and languages in order to serve the student nurses and the clients they will serve as registered nurses, primarily in California (see Appendix C).

Sampling Frame

The Raosoft (2013) online power analysis software was used to calculate the sample size. To determine the minimum sample, 95% level of certainty or confidence and 5% margin of error were used. (Burmeister & Aitken, 2012; Gogtay, 2010). Prior to Institutional Review Board (IRB) approval, the target population included 60 graduating nursing students who would be invited to participate in the study. The goal was to select a minimum sample of 53 participants. At the time of the IRB approval, the originally proposed target population graduated from the program. In March 2014, the nursing program director's list of graduating students

consisted of 55 students. The goal was to select a minimum sample of 49 participants.

The population included a total of fifty-five graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles. A purposive sample was a sampling method in which subjects for the study were in the right place at the right time (Burns, Grove, & Gray, 2012). Sampling is a suitable mean of data collection using quantitative research designs. Provided the sample size and composition is fully representative of the population under study, generalizations relative to the population can be made (Burmeister & Aitken, 2012; Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013).

In this study, the purposive sample was the approach used because participants were already enrolled and attending the associate degree-nursing program. The study sample was readily available and allowed for an adequate sample size. The purposive sample provided valuable information about the relationship between the integrated cultural curriculum and the level of cultural awareness in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles. The sampling process limited the generalizability of the results (Leedy & Ormrod, 2010).

Probability samples are not based on a random selection in which every person in the population has an equal probability of being selected for the sample (Burmeister & Aitken, 2012). Selection of the sample in this study did not include any number table or computer to randomly select the sample. Probability samplings are used to select a sample based on the subjective judgment of the researcher, rather

than random selection. Using probability sampling may be viewed as inferior during quantitative study, because the results are not generalizable to a larger population. However, for studies using small populations, such as this study of 55 participants, probability samplings were most appropriate to use.

Since the population included 55 students on the director's list, a purposive sampling technique called total population sampling was used. The goal of purposive sampling was not to randomly select from the population but to create a sample with the intention of making generalizations to the larger population. The goal of using a purposive sample was to focus on a particular characteristic of a population in order to answer the research question.

The entire population of 55 students was chosen because it met the criteria of interest. To choose the total population sample three steps were followed. The population criterion was defined. The target population included all graduating associate degree-nursing students in a large metropolitan area, such as in Los Angeles, which used an integrated cultural curriculum. To ensure the participants met the criteria the sample was selected from the program director's list of graduating associate degree nursing students currently enrolled and attending the nursing program.

The statistical power of the design will not be able to refute the null hypothesis if the sample size is not large enough (Burmeister & Aitken, 2012; Gogtay, 2010). A small sample will increase the risk of false negatives (Type II error) (Burmeister & Aitken, 2012; Gogtay, 2010). The power and p-value are inversely related; it may be safe to say a small sample will increase the probability of

the H01 is true, given the statistics and the sample size (Hayat, 2013; Burmeister & Aitken, 2012;). A small sample increases the margin of error and widens the confidence interval (Hayat, 2013; Gogtay, 2010). The risk is the level of confidence in the conclusion will be low (Hayat, 2013; Gogtay, 2010).

A large sample decreases the risk of false negative (Type II error) and increases the statistical power of the design, decreasing the (Type I error) probability of the H01 being true, given the statistics (Burmeister & Aitken, 2012; Gogtay, 2010). The margin of error will be decreased, which will narrow the confidence interval (Burmeister & Aitken, 2012; Hayat, 2013). In addition, the level of confidence in the conclusion of the study will be increased (Hayat, 2013). If there are resources to increase the size of the sample, it may be worth it to achieve a higher level of confidence (Burmeister & Aitken, 2012; Hayat, 2013).

Researcher's Role

The role of the researcher was to function in the observer-as-participant role. The observer-as-participant role "requires the researcher to reveal their researcher identity in the setting, but the extent to which they actively engage with the members of the setting is limited" (Creswell, 2007, p. 205).

The researcher role involved observing the environment, participants, and surrounding when informed consent forms were discussed and surveys were distributed (Salkind, 2003). Observing how his or her body was positioned (open or closed posture) the use of hands and eye contact with the participants is also vital (Salkind, 2003). In the researcher role, it is crucial to note the inner (subjective) thoughts and feelings arising as the participants submit the completed surveys.

Observing the interactions between the participants before, during, and after the data collection was necessary. The researcher remained in the classroom while the participants completed the survey. It was especially important to be cognizant when certain judgments arise (during the survey) and to set aside time critically to reflect on the meaning and thoughts reinforcing any judgments.

Permission

The Dean of Institutional Effectiveness and the Chairperson/Director of Associate Degree Nursing Program gave written approval for the commencement of the study (see Appendix D). The memorandum of understanding (see Appendix E) includes a collaborative effort. The final results of the study will be given to the college in order to be kept on file at the Office of Institutional Effectiveness and college library. The college will be provided with a summary of results of the data collected from participants. In addition, a brief presentation may be offered to the campus to summarize the implications of the study results. Participation is purely at the discretion of individuals who volunteer and the college will not be actively involved in helping to secure participants.

Informed Consent

The associate degree-nursing students in the graduating class were contacted to inform them of opportunity to participate in the study. All participants were provided with a written document informing them of the procedure, intent of the study, and potential risks. On the day of the data collection, the students were given an oral introduction including information, intent of the study, and potential risks (see Appendix F).

The participants were volunteers from the associate degree-nursing program. The participants were instructed and informed regarding the confidentiality of data, demographics, and the role of the research and eventual publication of results. The human subjects were provided with all of the necessary information regarding the research prior to the selection process.

There were no identified risks to the subject's participating, provided there was anonymity. The participants were informed of the option to withdraw their consent even after the survey was over and the data had been collected and analyzed. Email or telephone contact information was provided to all participants. The participants were encouraged to contact the student researcher if they had reservations about joining the research.

Study codes

The use of study codes is an efficient technique for protecting the privacy of research participants. Study codes were used on data collection tools instead of documenting the participants' personal information. This encryption method is intended to safeguard the participants' responses and data when surveys are saved or out in the open. In the event, a data file is misplaced, stolen, or the participant chooses to withdraw from the study, having the data safeguarded by a study identification (ID) will inhibit anyone who may view the data from determining the participant's identity.

Each participant was assigned a study ID prior to data collection. The participant's name along with their unique study ID was typed on a separate document. This document was stored separately from data documents. In the data

collection process, all participants distinctive study ID were written onto their survey, or the participant were provided with his or her unique study ID and was instructed to write the study ID on his or her survey. Demographic data was obtained through a study code process. The participants were instructed to write the following on a 3x5 card: name initials, gender, age, and ethnicity. The study codes were created from the letters of the college, cultural class initial, gender, age, and ethnicity.

Confidentiality

The participants were given all of the selected questions from the CAS. The results of the survey were anonymous and the participants were instructed only to write their specific study ID on the survey. The participants were instructed to place the completed survey into the ballot-type box and step out of the room. The survey was submitted in an unmarked envelope and placed in a locked-box.

Any demographic information (with specific code identifiers) obtained was stored separately from the survey or other personal identifiers. Any information with participant identifiers will be maintained in a confidential manner. The information obtained during the study will be included in the dissertation study and may be published in scientific journals, but the subject's identity will be kept strictly confidential. The data was downloaded to another secured, password-protected computer in a home office.

Data will be kept on file for a period of 5 years after the conclusion of the dissertation. The data will be permanently destroyed at the end of the 5-year period. Any paper copy of data and informed consent forms will be shredded. Computer files related to the study will be permanently deleted from the computer.

Geographical Location

The target population was selected from the associate degree-nursing program in a large metropolitan area, such as in Los Angeles. The community college participating in the study had an international, multicultural student body of over 20,000 students. Additionally, the racial makeup in Los Angeles County is 47.7% Hispanic or Latin of any race, 28.7% Non-Hispanic White, 13.5% Asian, 8.3% Black, 0.2% American Indian, and 2.5% Non-Hispanic all others, which is more culturally diverse than the national demographics (SCAG Regional Council, 2011).

Data Collection

Once authorization to conduct the study was received from University of Phoenix-School of Advanced Studies Institutional Review Board (IRB), the potential participants were approached. Permission to collect data for this study was granted by the Dean of Institutional Effectiveness and the Chairperson/Director of Associate Degree Nursing Program (see Appendices D and F). The Chairperson/Director of Associate Degree Nursing Program and a Senior Faculty member announced the survey purpose, time, and location to the students on February 18, 2014.

The data collection process occurred in a selected classroom at two different times to accommodate the participants. The first data collection period included 30 students and the second data collection period included 21 students. During both data collection periods, the students were given the informed consent documents, the CAS survey, and a 3x5 card to complete demographic data. The participants were informed that the nursing program, all participant information, and the results of the survey would be anonymous. The participants were instructed not to write any

identifying data on the CAS survey.

The time allotted to complete the survey was 45 minutes; all students completed the survey within 30 minutes. The subjects did not encounter the possibility of anxiety, emotional, social, physical, or legal threats greater than those typically faced in everyday life or during the performance of usual physical or psychological examinations or tests.

At the completion of the survey, the participants were instructed to place the completed survey into a sealed envelope, and then the surveys were placed in a locked container. The study's purpose and procedures were shared with nursing faculty members during a faculty meeting on March 3, 14 at 1:45PM. All nursing faculty were apprised of the study's findings.

Research Tool

A research tool is an instrument used to obtain data by the researcher. To select the most reliable and validated tool to use for this proposal, many commercially used tools were explored. A discrete answer Likert-type research tool was used during this study. Survey inquiry is an advantageous manner to retrieve data required to show the preferences and mindset of participants (Mertens & McLaughlin, 2013; Salkind, 2003). Survey research is efficient because the data gathering part of the study is completed after one contact with the participants (Mertens & McLaughlin, 2013; Salkind, 2003).

Instrument

Cultural awareness scale. The CAS data collection tool was created in response to the desire to measure cultural awareness (Rew et al., 2003). Approval to

utilize the CAS tool was obtained from Dr. Lynn Rew. The CAS tool is located in the public domain and written permission to use the tool was not required (see Appendix B). The CAS was used to measure the result of a program intended to promote understanding of the student regarding multiethnic diversity and its association to health care (Rew et al., 2003). The CAS was intended to evaluate cultural awareness and determine an institute's methods and techniques of addressing cultural diversity.

The CAS tool included 36 questions with a Likert answer design. The CAS scores range from strongly agree (7) to strongly disagree (1) to measure the following five subscales: "general educational familiarity, intellectual understanding, research interests, conduct/demeanor with communications, and patient care/clinical topics" (Rew, 2003, p. 251). There is no correct or incorrect answer to the survey as cultural capability is an ongoing learning dynamic.

The instrument was developed based on an analysis of the information on cultural understanding, cultural proficiency, cultural compassion, and nursing education (Rew et al., 2003). Cultural understanding, sensitivity, and competence are concepts with definitions still developing and used to refer to the same concept (Rew et al., 2003). As stated by Rew et al. (2003), cultural awareness consists of a combination of cultural understanding (the emotional dimension), cultural compassion (the attitudinal dimension), cultural expertise (the intellectual dimension), and cultural abilities (the social dimension). All four of these components must be addressed in the classroom, clinical practice, and research. Rew et al. (2003) indicated the multidimensional aspects of cultural awareness include understanding of

attitudes, research interests, classroom, and clinical training. As a person continues to cultivate cultural awareness, they move on the continuum towards cultural proficiency. Cultural awareness is the broadest concept.

Reliability

Reliability explains the research instrument's dependability of evaluating data (Riley, 2012). The CAS was created in response to a need for a valid and reliable research tool to measure the level of cultural awareness in faculty and students (Riley, 2012). A correlation coefficient, such as Cronbach's alpha, is often used to evaluate reliability by examining the amount of random error of the tool. A coefficient of 1.00 represents perfect reliability, with most investigators considering a coefficient of 0.80 as the lowest acceptable measure for established research instruments, while new tools are considered reliable when Cronbach's $\alpha \geq 0.70$ (Riley, 2012). The CAS was created in 2003 and used in three studies to measure the cultural awareness level of faculty and students (Rew et al., 2014).

The initial CAS included 37 Likert-type questions (Rew et al., 2003). Reliability estimations revealed internal consistency findings for the five key categories identified as follows: "general educational experiences (0.83); awareness of attitudes (0.66); classroom and clinical instruction (0.81); research issues (0.88); and clinical practice (0.88). A total scale reliability estimation of 0.91 for students and 0.82 for faculty was revealed" (Rew et al., 2003, p. 254).

Rew et al. (2003) said an average item score and Cronbach's alpha reliability for the five key categories identified are as follows: "general educational experiences (0.85); awareness of attitudes (0.79); classroom and clinical instruction (0.94);

research issues (0.71); and clinical practice (0.77)" (p. 255). Additionally, a total scale reliability estimate of 0.82 was also found. A reliability coefficient of 0.91 resulted after the analysis of nursing students from various academic levels (Rew et al., 2003). Of the 72 students, 26 were Bachelor of Science (BSN) in nursing, 26 were Masters of Science (MSN) in nursing, 13 were in the Doctorate program, and seven were in the RN to BSN program (Rew et al., 2003).

Krainovich-Miller et al. (2008) reported a Cronbach's alpha for the CAS total instrument of 0.869, with subscale scores ranging from 0.687 to 0.902. These results indicated the questions correlated appropriately within each subscale and were consistent with the findings of Rew et al. (2003). This data contributed to the dependability and supported the reliability of the CAS (Krainovich-Miller et al., 2008). The statistical data from the previous research and the CAS total instrument reliability of ≥ 0.70, led to the conclusion the instrument was suitable for this study.

Validity: Internal

A valid research design will be able to tell the researchers what they want to know about the subjects (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013). The design must reveal consistent results regardless of the subjects being studied. The most common threat to statistical validity includes participants' characteristics, unreliability of measures, multiple comparisons, and error rates (Fricker & Schonlau, 2002; Mertens & McLaughlin, 2013).

Validity is an important concept in research referring to the theoretical and scientific reliability of a research study (Marczyk, DeMatteo, & Festinger, 2005; Fricker & Schonlau, 2002; Mertens & McLaughlin, 2007). The internal validity is

the ability of a research design to rule alternative explanation of the results (Marczyk et al., 2005). The statistical validity refers to the quantitative evaluation affecting the accuracy of the conclusions drawn from the results of a study (Marczyk et al., 2005).

The construct validity is the congruence between the study's results and the theoretical foundation (Marczyk et al., 2005). The CAS went through a content validity study whereby educators and other experts in the teaching of cultural diversity were asked to review each item to assess if it measured the construct (Rew et al., 2003). This process for establishing content validity is a necessary beginning for other steps in the process.

The CAS had a content validity index of .88 (Rew et al., 2003). The total number of items for the scale was then condensed from 37 to 36. This 36-item CAS was then administered to 118 nursing students. The Cronbach's alpha score of .82 was achieved from the phase 1 (37-item scale) and 2 (36-item scale) data which is consistent with the reported construct validity.

Validity: External

The CAS tool is strong enough to gauge a nursing student's level of cultural awareness; the weakness is its inability to show how specific program components led to outcomes (Rew et al., 2003). A higher mean score denotes a higher level of cultural awareness, however no distinct acceptable level exists. The discoveries from Rew's (2003) analysis were not generalizable to all student nurses as a result of the small quantity of participants from one geographical area, a small sample used for the factor investigation, and all participants attended the same university. Despite the

limitation of the CAS, the tool does deliver valid and reliable scores regarding the cultural awareness in nursing students (Rew et al., 2003). This instrument is intended to gauge the cultural awareness among health professionals and students and determine an institute's methods and techniques of addressing cultural diversity (Rew et al., 2003).

Rationale for Selecting the CAS

The intent of this correlational research was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles, as measured by the CAS tool (Rew et al., 2003). The CAS was designed to measure the outcome of a program aimed at increasing the student's mindfulness of multiethnic variety and its relationship to health care. This tool was determined to be the best tool to use for this study (Rew et al, 2003). The CAS is comprised of five subscales. The General Education subscale has 14 questions representing the integrated cultural curriculum. The Patient Care, Behavior Comfort, Research Issues, and Cognitive Awareness subscales include 22 questions representing different elements of cultural awareness in nursing practice.

CAS Subscale Meanings

The CAS has five subscales. The General Education subscale represented the integrated cultural curricula. The Cognitive Awareness, Research Issues, Behavior/Comfort, and Patient Care subscales represented different elements of cultural awareness in nursing practice. Table 2 displays the Cultural Awareness subscales, meaning of each subscale, and corresponding questions.

Table 2
Cultural Awareness Subscale Meanings

Cultural Awareness Subscale	Meaning	Question
General Education	The integrated cultural curricula element, which included the institute's methods and techniques of addressing cultural diversity (Rew et al., 2003).	Question 1-4, 14, 16, 18-22, 24-27
Cognitive Awareness	Self-analysis and consideration of one's own philosophy and its impact on their way of discerning and acting (Rew et al., 2003).	Question 5-7, 11, 15, 17 & 20
Research Issues	The level of exposure to research concerns related to the cultural awareness (Rew et al., 2003).	Questions 28-31
Behavior Comfort	The level of comfort experienced when providing CLAS to cultural diverse individuals (Rew et al., 2003).	Question 8-10, 12-13, 36
Patient Care	The level of skill used when providing CLAS to cultural diverse individuals (Rew et al., 2003).	Question 23, 32-35

Note. The General Education subscale represented the integrated cultural curricula. The Cognitive Awareness, Behavior Comfort, and Patient Care, and Research Issues subscales represented different elements of cultural awareness.

General educational subscale. The General Education subscale described the integrated cultural curricula element, which included the institute's methods and techniques of addressing cultural diversity (Rew et al., 2003). The General Educational experience subscale asks participants to respond to statements about the nursing program related to cultural content (Rew et al., 2003). This subscale represents the significance and importance of nursing faculty who model behaviors and conduct that are insightful and sensitive to multicultural issues (Rew et al., 2003).

Patient care subscale. The Patient Care subscale indicates the level of skill used when providing CLAS to culturally diverse individuals (Rew et al., 2003). These results may occur when students have cultural skill and frequent cultural encounters with diverse individuals. A nurse with cultural skill will be able to interview and ascertain accurate information from a culturally diverse person (Campinha-Bacote, 2007). A cultural encounter occurs when the practitioner interacts with a culturally diverse person in the health care setting (Campinha-Bacote, 2010). A cultural encounter may increase the health care provider's range of verbal and non-verbal responses, and the accuracy when communicating with patients of various cultures (Rew et al., 2003).

Behavior comfort subscale. The Behavior Comfort subscale indicates the level of comfort experienced when providing CLAS to culturally diverse individuals (Rew et al., 2003). Behavior and comfort subscale incorporates the consciousness, comprehension, acceptance, compassion, and communication (Rew et al., 2003). The statements in this subscale asked the participant to acknowledge if they interact with a culturally diverse patient without being judgmental regarding their health practices (Rew et al., 2003).

Cognitive awareness subscale. The Cognitive Awareness subscale described the ability to self-analyze and reflects on one's own philosophy and its impact on ways of discerning and acting (Rew et al., 2003). The Cognitive Awareness subscale results may be attributed to the differences in student learning styles and how the student perceived and assimilated experiences in the classroom and clinical environment.

Research issues subscale. The Research Issues subscale indicates the level of exposure to research interests related to the cultural awareness (Rew et al., 2003). The Research Issues subscale contained items relative to how students, faculty, and researchers, at the nursing school addressed cultural content.

Data Analysis

Data from the CAS was analyzed using the IBM ® Statistical Package for the Social Sciences (SPSS) statistical software version 21. Once the data from the CAS was collected the statistical analysis was conducted. A statistical analysis included percentages, ranges, means, and standard deviations. All data conversions were reviewed for errors by at least two people. Missing data may present an issue when analyzing data. The participant's responses to the CAS were examined to determine if items were missing. If a missing value was of a numeric type, the mean of the non-missing values for the same attribute was used as an estimate; if it was categorical, the mode (most frequent) value was used.

Analysis of the CAS Survey

The Cultural Awareness Scale (CAS) was used to collect information about the integrated cultural curriculum and level of cultural awareness among graduating nursing students in Los Angeles. The Cultural Awareness Scale consists of 36 Likert-type questions (see Appendix A. The CAS is comprised of five subscales. The General Education subscale has 14 questions representing the integrated cultural curricula. The Behavior Comfort, Patient Care, Cognitive Awareness, Research Issues subscales include 22 questions representing the level of cultural awareness of among nursing practices. The Cognitive Awareness subscale consists of seven

questions. The Research Issues subscale consists of four questions. The Behavior Comfort subscale consists of six questions. The Patient Care subscale consists of five questions.

Pearson's r correlation

Pearson's r correlations were used to determine if a relationship existed between the integrated cultural curriculum and cultural awareness among nursing students as measured by the CAS results (Fraenkel & Wallen, 2009; Sealey et al., 2006). Johnson and Christensen (2008) stated the Pearson Product-Moment Coefficient is one of the most frequently used correlation coefficient. The Pearson's r correlation can be used when both variables are expressed in terms of quantitative scores (Fraenkel & Wallen, 2009).

The correlation factor ranges from –1.00 to +1.00 and is a measurement of correlation power (Fraenkel & Wallen, 2009). A correlation is considered to be positive when the variables increase or decrease at the same time (Fraenkel & Wallen, 2009). When one of the variable increases and the other variable decreases the correlation is said to be negative (and vice versa) (Fraenkel & Wallen, 2009; Johnson & Christensen, 2008).

If the coefficient is close to +1.00 strong positive correlation exists (Johnson & Christensen, 2008). However, if the coefficient is close to -1.00 strong negative correlation exist (Fraenkel & Wallen, 2009). When no relationship or association exists between the variables no correlation exists (Johnson & Christensen, 2008). A factor of zero delineates a no relationship, association, or correlation (Fraenkel & Wallen, 2009; Johnson & Christensen, 2008).

The ANOVA test

An ANOVA analysis was used to compare the sample variances with one another to see if they were statistically different from one another (Steinberg, 2008). When testing the differences between three or more groups the F test is used. The F test will test the differences between group variances rather than the differences between group means (Steinberg, 2008).

In ANOVA (analysis of the variance) the F statistic is determined. The benefit of the ANOVA is it tests the significance of the differences between all groups simultaneously while not increasing the Type 1 error (Steinberg, 2008). An ANOVA was utilized to test the hypotheses and determine if differences existed on the cultural awareness levels of the graduating nursing students based on demographic data (age, gender, and ethnicity) (Steinberg, 2008).

Summary

In summary, the focus of chapter three was on the quantitative methodology with a correlational research design and its appropriateness to efficiently answer the research questions. The hypotheses and research questions were presented. The data collection and analysis included the use of the CAS. Since, the CAS survey tool is reliable and valid it was used during this study. Chapter three included a discussion regarding the population, a sampling frame, researcher role, informed consent, confidentiality, and geographical location.

CHAPTER 4: RESULTS

The purpose of this correlational study was to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles, as measured by the CAS tool (Sealey et al., 2006). Dr. Lynn Rew created the CAS tool in 2003, in response to the desire to measure cultural awareness. The CAS, a 7-point Likert survey, was used during this study to measure the outcome of a program intended to promote student understanding of multiethnic diversity and its association to health care (Rew et al., 2003). The CAS was the best tool to use because it intended to survey the cultural knowledge among health care professionals and students and determine an institute's methods and techniques of addressing cultural diversity (Rew et al., 2003).

Chapter 1 revealed nursing program curricula are expected to prepare the nursing workforce to meet the regulatory standards (OMH, 2012). The associate degree-nursing program participating in this study strived to encourage cultural awareness among faculty and students by incorporating cultural content throughout the integrated cultural curricula (Kardong-Edgren & Campinha-Bacote, 2008; Kumas-Tan et al., 2007). Chapter 2 included an integrative review of the research literature. The research literature revealed no published studies focused on graduating associate degree-nursing students in a large diverse metropolitan area, such as in Los Angeles, to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level among students in nursing programs (Sealey et al., 2006). Chapter 3 described the methodology used during the

study, delineated the research questions, and identified the hypothesis guiding the study.

The research questions guiding this study were:

RQ1: What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles?

RQ2: What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)?

The hypotheses tested are as follows:

H10: There are no relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H1A: There are relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H20: There are no relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H2A: There are relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H30: There are no relationships existing between the General Education and Research

Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H3A: There are relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H40: There are no relationships existing between the General Education and Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H4A: There are relationships existing between the General Education and Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H50: There are no differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

H5A: There are significant differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

The CAS total and subscale scores of the participants were analyzed using Pearson *r* correlation coefficient and the ANOVA. The Pearson *r* correlation coefficient was used to test for relationships between the CAS subscale scores. An ANOVA was used to test differences in the mean CAS scores for the demographic categories.

Data Collection Procedure

Prior to receiving Institutional Review Board (IRB) approval from the University of Phoenix, the target population consisted of 60 graduating nursing students who would be invited to participate in the study. The goal was to select a minimum sample of 53 participants. Upon approval from the University of Phoenix Institutional Review Board, on February 13, 2014, the Chairperson/Director of Associate Degree Nursing Program and Senior Faculty member were notified. By February 18, 2014, the proposed target population of 60 participants had already graduated from the program and the nursing program director's list of graduating students now consisted of 55 participants. The goal was to select a minimum sample of 49 participants.

After authorization to conduct the study was received from the University of Phoenix-School of Advanced Studies Institutional Review Board (IRB), the potential participants were approached. Permission to collect data for this study was granted by the Dean of Institutional Effectiveness and the Chairperson/Director of Associate Degree Nursing Program (see Appendices C and F). The Chairperson/Director of Associate Degree Nursing Program and Senior Faculty member announced the survey purpose, time, and location to the students on February 18, 2014.

Data collection occurred in a selected classroom at two different times to accommodate participants. The first data collection period included 30 participants and the second data collection period included 21 participants. The students were advised that the person conducting the study was a doctoral student with the University of Phoenix. The students were given the informed consent documents, the

CAS survey, and 3x5 card to complete demographic data.

The students were instructed that the research study was being conducted to measure the level of cultural awareness of graduating associate degree nursing students currently enrolled in the program using integrated cultural curricula. The participants were informed that the nursing program, all participant information, and the results of the survey would be anonymous. The participants were instructed not to write any identifying data on the CAS survey. Additionally, participants were advised that to ensure confidentiality, no names would be placed on the CAS, only the student identification number.

A minimal level of risk/stress was expected (physical, psychological, emotional, legal, financial) to human subjects because of their participation in this study. The participants were instructed to circle their honest response to the 36-Likert type questions. The students were instructed that if statements made them feel uncomfortable, they were to skip the statements and they may discontinue the CAS at any time without penalty. The CAS took approximately 30 minutes to complete. At the completion of the survey, participants were instructed to place the completed survey into a sealed envelope, and then the surveys were placed in a locked container. The 51 completed CAS surveys exceeded the anticipated amount of 49 participants. Responses remained confidential and no personal identification was used in the findings.

Demographic Data

A total of 51 associated-degree graduating nursing students participated in this study. Table 3 contains the descriptive statistics for participant gender characteristics

of 38 females (74.5%) and 13 males (25.5%).

Table 3

Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	13	25.5	25.5	25.5
Female	38	74.5	74.5	100.0
Total	51	100.0	100.0	

Table 4 contains the descriptive statistics for participant age ranges. The majority of the sample 23 participants (45.1%) were in the 29-39 year old age range, 20 participants (39.2%) were in the 18-28 year old age range, and eight participants (15.7%) were in the 40-50 year old age range.

Table 4

Age

	Frequency	Valid Percent	Cumulative Percent
18-28 years old	20	39.2	39.2
29-39 years old	23	45.1	84.3
40-50 years old	8	15.7	100.0
Total	51	100.0	100.0

Table 5 contains the descriptive statistics for participant ethnicity categories. The majority of the sample 29 (56.9%) identified themselves as Latino/Hispanic. Ten (19.6%), participants, identified themselves as Asian, two (3.9%) of the participants were African American, and two participants were multiracial. Four (7.8%), participants, identified themselves as Caucasian. One (2.0%) participant was Russian/Armenian, one (2.0%) participant was Cambodian, one (2.0%) participant was Pacific Islander, and one (2.0%) identified as being Other.

Table 5

Ethnicity

Ethnicity	Frequency	Valid Percent	Cumulative Percent
Caucasian	4	7.8	7.8
African American	2	3.9	11.8
Hispanic/Latino	29	56.9	68.6
Asian	10	19.6	88.2
Multi-racial	2	3.9	92.2
Other	1	2.0	94.1
Russian/Armenian	1	2.0	96.1
Cambodian	1	2.0	98.0
Pacific Islander	1	2.0	100.0
Total	51	100.0	

Data Analysis

Once data from the CAS was collected the statistical analysis was conducted. Data from the CAS was analyzed using IBM Statistical Package for the Social Sciences (SPSS) statistical software version 21. A statistical analysis included percentages, ranges, means, and standard deviations. All data conversions were reviewed for errors by at least two people. The participant's responses to the CAS were examined to determine if items were missing. The sample size varied across the subscale because individuals with missing data for an item were eliminated from the calculation of that subscale.

The participants were asked to complete the CAS tool, which included 36 questions with a Likert answer design. The CAS scales ranged from (7) strongly agree to (1) strongly disagree (Rew et al., 2003). However, seven items (question 8,

9, 12, 13,16, 22, and 36) were negatively worded and were to be reverse coded for data analysis (Rew et al., 2003). Therefore the scoring on the seven reverse coded items was as follows: 7 = Strongly Disagree, 6 = Moderately Disagree, 5 = Disagree, 4 = No Opinion, 3 = Agree, 2 = Moderately Agree, and 1 = Strongly Agree. Thus, higher mean scores denoted a higher level of cultural awareness (Rew et al., 2003).

The total and subscale scores on the CAS were determined for the entire sample (N = 51). The CAS total and subscale scores of participants were analyzed using Pearson *r* correlation coefficient and the ANOVA. The Pearson *r* correlation coefficient was used to test for relationships between the CAS subscale scores. An ANOVA was used to test differences in the mean CAS scores for the demographic categories. The CAS total scores were divided into two groups. The total scores ranging from 189 to 252 were placed in one category and scores of 188 to 1 were placed in another category.

Based on Dr. Rew's (2003) definition, cultural awareness is multidimensional, which includes five subscales: General Education, Patient Care, Behavior Comfort, Research Issues, and Cognitive Awareness. Cultural awareness, cultural knowledge, and cultural competence are ideas with definitions still progressing (Rew et al., 2003). Additionally, the definition of the cultural mindfulness, cultural understanding, and cultural proficiency are implied rather than plainly stated (Rew et al., 2003). Based on the operational definition cultural awareness happens when a nurse is purposely passionate and sensitive about the ideals, views, opinions, and practices of the clients' culture (Graham & Richardson, 2008). Cultural awareness involves reflection and analysis of one's own culture and method of discerning and performing (Sealey et al.,

2006).

Findings for the Research Question

CAS Subscale Scores

The research questions guiding this study were:

RQ1: What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles?

RQ2: What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)?

The Cultural Awareness Scale consisted of 36 Likert-type questions (see Appendix A) (Rew et al., 2003). The descriptive statistics was obtained on each question to determine the mean score and standard deviation (see Appendix G). The total score on the CAS was a minimum of 171.00, a maximum of 237.00, and a mean of 200.6667 (SD=16.00208). The higher mean scores imply a higher level of cultural awareness and lower mean scores imply a lower level of cultural awareness (Rew et al., 2003). The CAS scores were divided into five subscales, General Education experiences, Cognitive Awareness, Behavior Comfort, Research Issues, and Patient Care (Krainovich-Miller et al., 2008).

Table 6 shows the breakdown of the mean scores and standard deviations of the CAS total and subscales score. The total General Education (G.E.) experience

subscale score included 14 questions (numbers1-4, 14, 16, 18, 19, 21, 22, and 24-27) about the General Education experiences related to cultural awareness. The General Education subscale (N=46) obtained a mean score of 83.4783, a minimum score of 66.00, and a maximum score of 97.00 (SD=8.32063). The total Cognitive Awareness (C.A.) subscale score included 7 questions (numbers 5-7, 11,15, 17, and 20) addressing beliefs or viewpoints related to cultural awareness. The Cognitive Awareness subscale (N=48) obtained a mean score of 33.8958, a minimum score of 15.00, and a maximum score 0f 49.00 (7.58846). The total Research Issues (R.I.) subscale score included 4 questions (numbers 28-31) related to research and analytical concerns. The Research Issues subscale (N=43) obtained a mean score of 19.7907, a minimum score of 11.00, and a maximum score of 28.00 (SD=4.02112). The total Behaviors Comfort subscale score included 6 questions (number 8-10, 12, 13, and 36) pertaining to interactions with various individuals. The Behaviors Comfort subscale (N=46) received a mean score of 36.1087, a minimum score of 18.00, and a maximum score of 42.00 (SD=586223). The total Patient Care (P.C.) subscale score included 5 questions (number 23, 32-35) related to clinical and patient care issues. The Patient Care subscale (N=51) obtained a mean score of 31.5294, the maximum score of 35.00, and a minimum score of 22.00 (SD=3.45458).

Table 6

Cultural Awareness Subscales and Total Mean Scores

Variable Domain	*n*	Minimum	Maximum	*M*	SD
General Education	46	66.00	97.00	83.4783	8.32063
Cognitive Awareness	48	15	49.00	33.8958	7.58846
Research Issues	43	11.00	28.00	19.7907	4.02112
Behavior Comfort	46	18.00	42.00	36.1087	5.86223
Patient Care	51	22.00	35.00	31.5294	3.45458
Total Score	51	171.00	237.00	200.6667	16.00208

Note. The total CAS mean score was 200.6667, the minimum CAS mean score was 171.00, and the maximum CAS mean score was 237.00.

Pearson *r* Correlation Results

The first research question was tested to determine if relationships existed between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as Los Angeles. The Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students.

The correlation factor ranges from –1.00 to +1.00 and is a measurement of correlation power (Fraenkel & Wallen, 2009). A correlation is considered to be positive when the variables increase or decrease at the same time (Fraenkel & Wallen,

2009). When one of the variable increases and the other variable decreases the correlation is said to be negative (Fraenkel & Wallen, 2009; Johnson & Christensen, 2008). If the coefficient is close to +1.00, a strong positive correlation exists (Johnson & Christensen, 2008). However, if the coefficient is close to -1.00, a strong negative correlation exist (Fraenkel & Wallen, 2009). Table 7 shows the intercorrelations among the CAS subscales.

Table 7
Intercorrelations Among CAS Subscales

Subscale	C.A.	R.I.	B.C.	P.C.
G.E.	-.119	.456**	.517**	.435**
C.A.	-	.014	-.326*	-.318*
R.I.	-	-	.174	.303
B.C.	-	-	-	.235

Note. G.E.= General Education; C.A.= Cognitive Awareness; R.I.= Research Issues; B.C.= Behavior Comfort; P.C.=Patient Care . ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 at the 0.05 level (2-tailed).

Statistically significant correlations

When the General Education and Behavior Comfort subscales were compared using the Pearson *r* correlation the result was $r = .517$, $n = 44$, $p = 0.01$. The General Education subscale influenced the behavior/comfort subscale, resulting in a positive relationship. The Pearson *r* correlation results for the General Education subscale and Patient Care subscale scores was $r = .435$, $n = 46$, $p = 0.01$. The significance was established with a p-value of 0.01 two-tailed. The General Education subscale influenced the Patient Care subscale, resulting in a positive relationship. The General Education subscale influenced the Research Issues subscale, resulting in a positive relationship. The Pearson *r* correlation results for the General Education subscale and

the Research Issues subscale scores was *r* =. 456, *n* = 39, p = 0.01. The significance was established with a p-value of 0.01 two-tailed. The Pearson *r* correlation result for the Cognitive Awareness and the Behavior Comfort subscale was *r* = -.326, *n* = 46, p = 0.05. The significance was established with a p-value of 0.05 two-tailed. As the Cognitive Awareness subscale increased the Behavior Comfort subscale decreased, resulting in a negative relationship. The Cognitive Awareness subscale and the Patient Care subscale scores were r = -.318, *n* = 48, p= 0.05. The significance was established with a p-value of 0.05 two-tailed. As the Cognitive Awareness subscale increased Patient Care subscale decreased, resulting in a negative relationship. Based on relationships revealed, sufficient evidence exists to reject the null hypothesis in favor of the alternative hypothesis.

Non-statistically significant correlations

The Pearson *r* correlation results for the General Education subscale and Cognitive Awareness subscale scores was *r* = -.119, *n* = 45, p >0.05. As the General Education subscale increased Cognitive Awareness subscale decreased, resulting in a negative relationship. The Pearson r correlation results for the Cognitive Awareness subscale and the Research Issues subscale score *r* =.014, *n* = 42, p=0.05. The Cognitive Awareness subscale influenced the Research Issues subscale, resulting in a positive relationship. The Pearson *r* correlation result for the Behavior Comfort and the Patient Care subscale score was r = .235, *n* = 46, p > 0.05. The Behavior Comfort subscale influenced the Patient Care subscale, resulting in a positive relationship. When the Research Issues and Behavior Comfort subscale was compared using

Pearson *r* correlation the results was *r* =.174, *n* = 40, p = > .05. The Research Issues subscale influenced the Behavior Comfort subscale, resulting in a positive relationship. The Pearson *r* correlation for the Research Issues and the Patient Care subscale was *r* =.303, *n* = 43, p > 0.05.

ANOVA on CAS Level and Ethnicity

The one-way ANOVA was run to test for differences between the mean scores of the ethnic groups on the CAS score. Ten participants identified themselves as Asian, two participants were African American, and two participants were multiracial. Four participants identified themselves as Caucasian. One participant was Russian/Armenian, one participant was Cambodian, one participant was Pacific Islander, and one participant identified as being other. The race categories Pacific Islander, Cambodian, Russian/Armenian and Multi-racial were combined to create more meaningful results. The one-way ANOVA was run on the 5-ethnicity categories. Table 8a, 8b, and 8c display the results of the one-way ANOVA.

The one-way ANOVA on the ethnicity category yielded no statistically significant differences between groups on the CAS score, F (4, 46) = .933, ns.

Table 8a
ANOVA between CAS Score and Ethnicity

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Caucasian	4	1.2500	.50000	.25000	.4544	2.0456	1.00	2.00
African American	2	1.5000	.70711	.50000	-4.8531	7.8531	1.00	2.00
Hispanic/Latino	29	1.1724	.38443	.07139	1.0262	1.3186	1.00	2.00
Asian	10	1.2000	.42164	.13333	.8984	1.5016	1.00	2.00
Other	6	1.5000	.54772	.22361	.9252	2.0748	1.00	2.00
Total	51	1.2353	.42840	.05999	1.1148	1.3558	1.00	2.00

Table 8b
Test of Homogeneity of Variances on CAS Score and Ethnicity

Levene Statistic	df1	df2	Sig.
1.348	4	46	.267

Table 8c
ANOVA for CAS Score and Ethnicity

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.689	4	.172	.933	.453
Within Groups	8.488	46	.185		
Total	9.176	50			

ANOVA on CAS Level and Age

Table 9a, 9b, and 9c display the results of the one-way ANOVA on CAS Level and age. Twenty of the participants were 18-28 years old, 23 of the participants were 29-39 years old, and 8 participants were in the 40-50 years old category. The one-way ANOVA on the age category yielded no statistically significant differences on the CAS Level, F (1, 49) = .007.

Table 9a
ANOVA on CAS Level and Age

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
CAS level (189-252)	39	1.7692	.74203	.11882	1.5287	2.0098	1.00	3.00
CAS level (1-188)	12	1.7500	.62158	.17944	1.3551	2.1449	1.00	3.00
Total	51	1.7647	.70960	.09936	1.5651	1.9643	1.00	3.00

Table 9b
Test of Homogeneity of Variances on CAS Level and Age

Levene Statistic	df1	df2	Sig.
1.166	1	49	.286

Table 9c
ANOVA on CAS Level and Age

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.003	1	.003	.007	.936
Within Groups	25.173	49	.514		
Total	25.176	50			

ANOVA on CAS Level and Gender

Table 10a, 10b, and 10c display the results of the one-way ANOVA on CAS Level and gender. There were 13 males and 38 were females. The one-way ANOVA on the gender category yielded no statistically significant differences between groups on the CAS score, F (1, 49) = .002, ns.

Table 10a

ANOVA on CAS Level and Gender

CAS Level	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
189-252	39	1.7436	.44236	.07083	1.6002	1.8870	1.00	2.00
1-188	12	1.7500	.45227	.13056	1.4626	2.0374	1.00	2.00
Total	51	1.7451	.44014	.06163	1.6213	1.8689	1.00	2.00

Table 10b

Test of Homogeneity of Variances on CAS Level and Gender

Levene Statistic	df1	df2	Sig.
.008	1	49	.930

Table 10c

ANOVA on CAS Level and Gender

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.000	1	.000	.002	.965
Within Groups	9.686	49	.198		
Total	9.686	50			

Summary

The CAS tool was offered to a total of 51 graduating associate degree nursing students to answer two research questions. What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles? What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)? A total of 51 students participated in the research, with 51 providing usable data.

The Pearson *r* correlation coefficient revealed statistically significant

relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. The result revealed the integrated cultural curricula might influence the level of cultural awareness. ANOVA results revealed no statistically significant difference on the CAS total or subscale scores based on gender, age, and ethnicity. Additionally, these results support rejecting the null hypotheses in favor of the alternative hypotheses.

Conclusion

The purpose of this correlational study was to determine if relationships existed between the integrated cultural curriculum and the cultural awareness level of the graduating associate degree-nursing student. The data was collected using the CAS tool and four demographic questions (gender, age, ethnicity, and cultural class completed). The statistical program SPSS version 21 was used to analyze the data. Descriptive and inferential statistics was used to report the findings. The two research questions were tested using the Pearson *r* correlation and the ANOVA. The findings for the Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. The findings for the ANOVA revealed no statistically significant differences on the CAS total and subscale scores based on demographic data. The findings for the Pearson *r* correlation and ANOVA provided sufficient evidence to support rejecting the null hypothesis in favor of the alternative hypothesis.

Chapter 4 described the data collection, demographic data, and the data analysis of the relationship between the integrated cultural curriculum and the cultural

awareness levels. The methodology described in Chapter 3 was applied and the results were presented in narrative and table format. Chapter 5 included a discussion of the data, implication of from the results, summary of the findings, and conclusions of the study. Chapter 5 explains the limitation of the study and recommendations for future research.

CHAPTER 5: Summary, Conclusions, and Recommendations

The purpose of this correlational study was to determine if relationships existed between the integrated cultural curricula and the cultural awareness level in graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles, as measured by the Cultural Awareness Scale (CAS). The criteria and standards for accreditation of associate degree nursing programs mandated the integration of diversity content, local, national, and worldwide perspectives in the curricula (NLN, 2008). The Board of Registered Nursing (2012) recommended societal and cultural content be integrated across the entire nursing school curricula (section 1426-e7). The integrated cultural curricula were defined as one incorporating cultural concepts throughout the entire nursing program and use no specific model (BRN, 2012). The integrated cultural curricula do not use a freestanding cultural course, immersion, or an international experience to teach cultural concepts. The most frequently cited curricula for promoting cultural awareness, as a nursing student-learning outcome, is the integration of culture across the curriculum (Kardong-Edgren & Campinha-Bacote, 2008).

No research study focused on graduating associate degree-nursing students in a large, diverse metropolitan area, such as in Los Angeles, to determine if a relationship existed between the integrated cultural curriculum and the cultural awareness level among students in nursing programs (Sealey et al., 2006). Several studies focused on small rural areas and reported the impact of using integrated cultural curricula as an effective method to increase the cultural awareness of nursing students (Hughes & Hood, 2007; Hunter & Krantz, 2010; Kumas-Tan et al.,

2007; Sanner et al., 2010; Slade, Thomas-Connor, & Tsao, 2008; Yarbrough & Klotz, 2007). Although the studies cited focused on nursing programs in small rural areas, they did recommend the need for further research in large metropolitan areas (Krainovich-Miller et al., 2008; Rew et al., 2003; Rew, Becker, Chontichachalalauk, & Lee, 2014). Therefore, this study adds to the body of knowledge by focusing on a nursing program in a large metropolitan area. In response to the Board of Registered Nursing (2012), Office of Minority Health (2012) regulatory mandates, and the gap in the research, the need for this quantitative correlational study was critical.

This correlational study focused on one associate degree-nursing program using integrated cultural curricula, in a large metropolitan area, such as Los Angeles. The theoretical framework guiding this research included two theorists from the transcultural-nursing arena Dr. Madeline Leininger, Dr. Josepha Campinha-Bacote, and the constructivist theory. Lenininger theorized the importance of culture, knowledge, and care as vital and obligatory to nursing education and practice (Chitty & Black, 2010). Dr. Josepha Campinha-Bacote theorized cultural awareness occurred when a health care provider was intentionally passionate and discerning about "the values, beliefs, practices, and problem solving strategies of the clients' culture" (Graham & Richardson, 2008, p. 39).

The study sought to answer the following research questions:

RQ1: What relationship exists between the integrated cultural curriculum and the level of cultural awareness as measured by the CAS results of graduating associate degree nursing students in a large metropolitan area, such as in Los Angeles?

RQ2: What difference exists in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age)?

The hypotheses tested are as follows:

H10: There are no relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H1A: There are relationships existing between the General Education and Behavior Comfort Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H20: There are no relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H2A: There are relationships existing between the General Education and Patient Care Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H30: There are no relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H3A: There are relationships existing between the General Education and Research Issues Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H40: There are no relationships existing between the General Education and

Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H4A: There are relationships existing between the General Education and Cognitive Awareness Subscales for the graduating associate degree-nursing students in a large metropolitan area, such as Los Angeles.

H50: There are no differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

H5A: There are significant differences in the level of cultural awareness (as measured by the CAS) among graduating associate degree nursing students in a large metropolitan area, such as Los Angeles, based on demographic factors (gender, ethnicity, and age).

The CAS measured five subscales of cultural awareness. The CAS subscale scores were analyzed using the Pearson *r* correlation and the ANOVA. The Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. The ANOVA results indicated gender, age, and ethnicity had no statistically significant difference on the CAS total or subscale scores. These results support rejecting the null hypothesis in favor of the alternative hypothesis.

The focus of Chapter 5 is to provide a summary, analysis, and discussion of the findings from this study. Chapter 5 includes an analysis of the findings, conclusions, implications for higher education administration, and recommendations

for future research. The chapter concludes with a discussion regarding the limitations of the study.

Research Question Findings

Pearson *r* Correlation Results

Statistically significant correlations. The Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. Table 11 displays five statistically significant CAS subscale correlations were revealed.

The General Education subscale influenced the Behavior Comfort subscale, resulting in a positive relationship. The General Education subscale influenced the Research Issues subscale, resulting in a positive relationship. The General Education subscale influenced the Patient Care subscale, resulting in a positive relationship. As the Cognitive Awareness subscale increased the Behavior Comfort subscale decreased, resulting in a negative relationship. As the Cognitive Awareness subscale increased Patient Care subscale decreased, resulting in a negative relationship.

Table 11
Significant CAS Subscale Correlations

Correlation	Meaning	CAS Questions
General Education and Research Issues	Participants who expressed positive experiences with the integrated cultural curriculum also experienced a high level of exposure to research issues related to culturally diverse individuals.	Questions 1-4, 14, 16, 18-22, 24-31
General Education and Patient Care	Participants who expressed positive experiences with the integrated cultural curriculum also expressed a high level of skill used when providing CLAS to culturally diverse individuals.	Questions 1-4, 14, 16, 18-22-27, and 32-35
General Education and Behavior Comfort	Participants who expressed positive experiences with the integrated cultural curriculum also expressed a high level of comfort when providing CLAS to culturally diverse individuals.	Questions 1-4, 14, 16, 18-22, and 24-27
Cognitive Awareness and Behavior Comfort	Participant with higher levels of understanding and sensitivity expressed a lower level of comfort when providing CLAS to cultural diverse individuals.	Questions 5-7, 8-13, 15, 17, 20, and 36
Cognitive Awareness and Patient Care	Participant with higher levels of understanding and sensitivity expressed a lower level of skills when providing CLAS to cultural diverse individuals.	Questions 5-7, 11, 15, 17, 20, 23, and 32-35

Note. The Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students.

The CAS measured five distinct components of cultural awareness. Table 12 displays the Cultural Awareness subscales, meaning of each subscale, and corresponding questions. The General Education subscale represented the

integrated cultural curricula. The Behavior Comfort, Cognitive Awareness, Research Issues, and Patient Care subscales represented different elements of cultural awareness among nursing practices (Kranovich-Miller et al., 2008).

Table 12
Cultural Awareness Subscale Meanings

Cultural Awareness Subscale	Meaning	Question
General Education	The integrated cultural curricula element, which included the institute's methods and techniques of addressing cultural diversity (Rew et al., 2003).	Question 1-4, 14, 16, 18-22, 24-27
Cognitive Awareness	Self-analysis and consideration of one's own philosophy and its impact on their way of discerning and acting (Rew et al., 2003).	Question 5-7, 11, 15, 17 & 20
Research Issues	The level of exposure to research concerns related to the cultural awareness (Rew et al., 2003).	Questions 28-31
Behavior Comfort	The level of comfort experienced when providing CLAS to cultural diverse individuals (Rew et al., 2003).	Question 8-10, 12-13, 36
Patient Care	The level of skill used when providing CLAS to cultural diverse individuals (Rew et al., 2003).	Question 23, 32-35

Note. The General Education subscale represented the integrated cultural curricula. The Behavior Comfort, Cognitive Awareness, Research Issues, and Patient Care subscales represented different elements of cultural awareness (Rew et al., 2003).

General education and behavior comfort. A strong positive relationship was revealed between the General Education and the Behavior Comfort subscale. The null hypothesis in this study was rejected based on a statistically significant correlation revealed between the General Education and Behavior Comfort subscale. The nursing students in this study received high mean scores above 6.0 on 9

questions in the General Education subscale. These results mean participants who expressed a positive experience with the integrated cultural curricula also expressed a high level of comfort when providing cultural and linguistically appropriate services to culturally diverse individuals. These results indicated the participants agreed the nursing instructors adequately addressed multicultural issues in nursing and health care. Also, the participants expressed an increased understanding of multicultural issues since entering the nursing school. The high mean scores above 6.0 indicated the participants agreed the instructors were comfortable discussing multicultural issues and including all students in group discussions and exercises. This finding was consistent with the findings by Kardong-Edgren and Campinha-Bacote (2007) who determined the integration of cultural content across the nursing program curriculum promoted cultural awareness in nursing students.

The participants received a mean score of 5.4 to 6.0826 on questions indicating they disagreed that the instructors' behaviors made students from certain cultural backgrounds feel excluded or alienated (Rew et al., 2003). Similarly, the participants disagreed that the instructors called on students from minority cultural groups when issues related to their group came up in class (Rew et al., 2003). Conversely, the participants gave a low mean score of 4.4082 on the question denoting "nursing instructors seem interested in learning how their classroom behaviors may discourage students from particular cultural or ethnic groups" (Rew et al., 2003, p. 254). These results highlight the significance and importance of the nursing faculty who model behaviors and conducts that are insightful and sensitive

to multicultural issues. These results also exemplify how students perceived nursing faculty members in the classroom or clinical environment.

The Behavior Comfort subscale consisted of 7 questions; five of these questions were negatively worded and were reverse coded for data analysis. The Behavior Comfort mean scores ranged from 5.8 to 6.4, indicating the participants were comfortable assisting and providing care to patients and family members of all ethnic groups. These results are consistent with Rew et al., (2003), who denote behavior and comfort incorporate consciousness, comprehension, acceptance, compassion, and communication. Additionally, the literature by Campinha-Bacote (2007) and Rew et al., (2003) converge on the belief that nursing students with cultural skills and frequent cultural encounters also have increased comfort levels.

These results may be attributed to differences in student's language skills, background, home environment, or frequency of interaction with cultural diverse individuals. It is essential for faculty members to appreciate the student's perception of the learning environment, which may be influenced by different learning styles, previous learning experiences, and home environment. Therefore, administrators and faculty must create inclusive, sensitive, and insightful learning environments.

General education and research issues. A strong positive relationship was revealed between the General Education subscale and Research Issues subscales. The null hypothesis in this study was rejected based on a statistically significant correlation revealed between the General Education and the Research Issues subscale. This correlation suggests an integrated cultural curriculum may be an

effective method for incorporating research issues about cultural awareness into the learning environment. In this study, the link between the General Education and the Research Issues subscale highlighted the significance of the nursing faculty and students who explore and analyze research regarding multicultural aspects in health care.

In this study, the four questions in the Research Issues subscale received mean scores of 4.7 to 5.1. These scores may indicate how students perceived nursing faculty involvement in research regarding cultural issues. Also, these results may be attributed to the student's lack of exposure to evidence-based studies regarding cultural issues at this nursing school. The Research Issues subscale mean score for the participants in this study was 19.7907. These scores were similar to the results from a study completed by Krainovich-Miller et al., (2008), using the CAS tool at a research-intensive university. The New York University College of Nursing study participant's mean Research Issues subscale scores ranged from 19.12 to 20.29 (Krainovich-Miller et al., (2008).

These issues are important for administrators and faculty members who design learning experiences for nursing programs at community colleges. Community college nursing faculty may incorporate research into the classroom by considering the cultural differences related to health issues. According to Campinha-Bacote, providing appropriate care to diverse individuals includes showing genuine interest in people and researching a group's background (Campinha-Bacote, 2010). Additionally, Maier-Lorentz (2008) asserted exposure to research issues regarding transcultural nursing must include analysis and reflection

on cultural awareness, skill, encounters, desire, and assessment (Maier-Lorentz, 2008).

General education and patient care. A strong positive relationship was revealed between the General Education and the Patient Care subscales. The null hypothesis in this study was rejected based on a statistically significant correlation revealed between the General Education and the Patient Care subscale. The participants in this study received high mean scores on the five questions in the Patient Care subscale. The mean scores on the Patient Care subscale ranged from 6.0 to 6.6. The high mean scores may indicate participants who expressed positive experiences with the integrated cultural curriculum also expressed using a high level of cultural skill during cultural encounters with culturally diverse individuals.

These results are consistent with Campinha-Bacote (2007) who denotes a nurse with cultural skill will be able to gather accurate information when interviewing a culturally diverse patient (OMH, 2012). A cultural encounter occurs when the practitioner interacts with a culturally diverse individual in the health care setting (Campinha-Bacote, 2010). A cultural encounter may increase the health care provider's range of verbal and non-verbal responses, and the accuracy when communicating with patients of diverse cultures. In addition, learning the usual non-verbal communication to prevent mistakes or offensive gestures with culturally diverse individuals is vital (The Office of Minority Health, 2012; Sealey et al., 2006).

These issues are important to administrators and nursing faculty who design strategies for teaching in the clinical environment. Nursing faculty members must model appropriate behavior and conduct when interacting with diverse persons by

blending understanding, sensitivity, and skill (Graham et al., 2008). Ultimately, the nursing student's self-awareness and careful approach will improve the delivery of cultural and linguistically appropriate service with culturally diverse individuals (Campinha-Bacote, 2010).

Cognitive awareness and behavior comfort. Table 11 displayed a negative relationship existing between the Cognitive Awareness and the Behavior Comfort subscales. The null hypothesis in this study was rejected based on a statistically significant correlation revealed between the Cognitive Awareness and the Behavior Comfort subscale. A negative relationship existed between the Cognitive Awareness and Behavior Comfort subscale because participants were conscious of their own philosophy about culture and stated their beliefs, attitudes, and, behaviors were not influenced by their culture. Additionally, the participants did not agree a nurse's cultural beliefs influenced their nursing care decisions. Therefore, the participants in this study were comfortable assisting and providing care to cultural diverse patients and family members, regardless of their own cultural beliefs and attitudes.

The participants in this study received mean scores below 5.0 on 5 of the 7 questions on the Cognitive Awareness subscale. These results are consistent with Krainovich-Miller et al., (2008) who cited low Cognitive Awareness scores ranging from 28.67 to 39.82. The negative relationship between the Cognitive Awareness and Behavior Comfort subscale was in discord with the findings of Campinha-Bacote, (2007). Campinha-Bacote believed cultural consciousness included self-analysis and consideration of one's owns philosophy and its impact on their way of

discerning and acting (2007). This negative relationship may be attributed to the differences in student learning styles and how the student perceived and assimilated experiences in the classroom and clinical site (Campinha-Bacote, 2007). These results may indicate a variation in student reflective opportunities or cultural encounters with diverse individuals in a clinical environment. These results highlight the importance of nursing faculty providing additional clinical opportunities for student's to interact with culturally diverse individuals.

Cognitive awareness and patient care. Table 10 displays a relationship existing between the Cognitive Awareness and the Patient Care subscales. The null hypothesis in this study was rejected based on a statistically significant correlation revealed between the Cognitive Awareness and the Patient Care subscale. A negative relationship existed between the Cognitive Awareness and the Patient Care subscale. The negative relationship indicated the participants expressed the level of cultural skill used to provide patient care was not influenced by their own cultural philosophy. However, the expectation is cultural ability and proficiency occurs when the nurse is familiar with the elements of cultural consciousness, understanding, sensitivity, interaction, and skill (Campinha-Bacote, 2007).

Additionally, the participants may not be demonstrating proficiency when interacting with diverse persons if they are not efficiently blending understanding, sensitivity, and skill (Graham et al., 2008). Faculty may assist the students in blending understanding, sensitivity, and skill by modeling the appropriate behavior or skills in the classroom, clinical lab, or clinical environment. Also, Sullivan (2009) recommended faculty must use evaluation techniques such as focus groups,

cross-cultural interactions, or reflective journals to increase the amount of the cultural mindfulness among nursing students.

Non-significant correlations. The Pearson *r* correlation coefficient revealed relationships existed between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. Table 18 displays CAS subscale correlations considered to be key findings, though not statistically significant. A negative correlation existed between the Cognitive Awareness and Research Issues subscale. Positive correlations existed between the General Education and Cognitive Awareness subscale, the Patient Care and Behavior Comfort subscales, Research Issues and Behavior Comfort subscales, and the Research Issues and Patient Care subscale.

Table 13
Non Statistically Significant CAS Subscale Correlations

Correlation	Meaning	CAS Questions
Cognitive Awareness and Research Issues	Participant expressed high levels of understanding and low levels of exposure to research issues regarding culturally diverse individuals	Questions 5-7, 11, 15, 17, 20, 28-31
General Education and Cognitive Awareness	Participants expressed a positive experience with the integrated cultural curriculum and a level of sensitivity when providing CLAS	Questions 1-7, 11, 14-22, 24-27
Patient Care and Behavior Comfort	Participants expressed a level of skill and comfort when providing CLAS to cultural diverse individuals.	Questions 8-10, 12-13, 23, 32-36
Research Issues and Behavior Comfort	Participants with exposure to research issues expressed a level of comfort when providing CLAS to cultural diverse individuals.	Questions 8-10, 12-13, 23, 28-36
Research Issues and Patient Care	Participants with exposure to research issues expressed a level of skill when providing CLAS to cultural diverse individuals.	Questions 23, 28-35

Note. CAS subscale correlations considered to be key findings, though not statistically significant.

Cognitive awareness and research issues. A weak positive relationship existed between the Cognitive Awareness subscale mean score of 33.8958 and the Research issues subscale mean score of 19.7907. Some participants in this study were conscious of their own view, ideas, and philosophy regarding cultural diverse individuals. However, these same participants expressed limited exposure to research issues regarding cultural diverse individuals. These results highlighted the

significance of nursing faculty engaging in discussions regarding research in the classroom. Additionally, faculty must provided opportunities for student's to reflect on cultural encounters with diverse individuals in a clinical environment. Thus, the participant's views, ideas, and philosophy were not based on research issues presented in the classroom or clinical environment. Additionally, the Research Issues subscale mean scores indicated participants received limited exposure to evidence-based practice regarding multicultural concerns at this nursing school. This negative relationship may also be attributed to the variances in student learning styles, how the student perceived, and assimilated experiences in the classroom and clinical site (Campinha-Bacote, 2007).

General education and cognitive awareness. A weak negative relationship existed between the General Education and Cognitive Awareness subscale. These results indicated some participants in this study, who expressed positive experiences with institute's methods and techniques of addressing cultural diversity, also developed their own views, opinions, and philosophy regarding culturally diverse individuals. These results are consistent with Campinha-Bacote (2007) study. Campinha-Bacote denotes when a health care professional makes an effort to learn about the health beliefs of diverse individuals they experience cross-cultural connections and are particularly sensitive to cultural differences. These results are also consistent with Carey (2011) who denotes nursing students may help each other learn about similarities and differences between cultural groups.

Patient care and behavior comfort. A weak positive relationship existed between the Patient Care and Behavior Comfort subscales. This result is consistent

with Campinha-Bacote (2007) who indicated cultural ability and proficiency occurred when the nurse was familiar with the elements of cultural consciousness, understanding, sensitivity, interaction, and skill. Additionally, the participants are demonstrating proficiency when interacting with diverse persons because they are efficiently blending understanding, sensitivity, and skill (Graham et al., 2008). These results highlight the importance of faculty providing opportunities for student's to reflect on cultural encounters with diverse individuals in the simulated lab setting and the patient care environment.

Research issues and behavior comfort. A weak positive relationship existed between the Research Issues and Behavior Comfort subscales. These results indicated the participant exposure to research concerns influenced their comfort level when interacting with diverse individuals. These results are consistent with Yarbrough and Klotz (2007), who report participation in experiential or service-learning interventions increase the level of cultural awareness. These results may be attributed to differences in student learning styles in the classroom and clinical site (Campinha-Bacote, 2007). These results highlight the significance of faculty being familiar with the diverse student development and learning styles.

Research issues and patient care. A weak positive relationship existed between the Research Issues and Patient Care subscales. These results mean the participant's exposure to research findings influenced their level of cultural skill when providing CLAS to diverse individuals. These students experienced limited exposure to research regarding cultural diversity. These results are consistent with Campinha-Bacote (2007) who denotes a nurse with cultural skill will be able to

dialogue and discover an accurate diagnosis from a culturally diverse individual. These results highlight the need for faculty to model appropriate cultural skills when interacting with diverse persons.

ANOVA Results

The one-way ANOVA was run to test for differences between the CAS total and subscale mean scores based on ethnicity, gender, and age categories. In this study, the result of the ANOVA test revealed no statistically significant differences on the CAS total and subscale mean scores based on ethnicity, gender, and age categories. These results are consistent with Kardong-Edgren and Campinha-Bacote (2008), who revealed graduating nursing students were culturally aware regardless of their race, ethnicity, or a nursing program. These results may be attributed to student's learning styles, background, home environment, or frequency of interaction with cultural diverse individuals. Essential for faculty members is the need to appreciate the student's perception of the learning environment, different learning styles, previous learning experiences, and home environment. Therefore, administrators and faculty must create inclusive, sensitive, and insightful learning environments.

Implications for Higher Education Administration

Integrated Cultural Curricula

The integrated cultural curricula at the study site may have contributed to the statistically significant relationships revealed by the Pearson *r* correlation coefficient. However, other factors may have contributed such as student's learning

style, student's perception of faculty, student's personal experiences, and cultural encounters. Therefore, additional study is warranted to determine if the cause and effect relationship between the integrated cultural curricula and the cultural awareness levels.

The nursing program in this study uses the integrated cultural curriculum because it satisfies the accreditation requirements although it may not be the most effective method for promoting cultural awareness among nursing students (BRN, 2012; NLN, 2012). Additionally, the Associate Degree Nursing Statistical Review mandated cultural content incorporation in nursing curricula (The NLN, 2008). The NLN (2012) and the BRN (2012) stated nursing education must include transcultural-nursing content in the curricula. As a result, nursing education must integrate cultural content throughout the entire nursing curricula (BRN, 2012; NLN, 2012).

Program Evaluation

There are several challenges experienced by nursing program administrators and nursing educators. The nursing school method used to measure the level of cultural awareness among nursing students is ineffective (Hunter & Kratz, 2010; Musolino, Burkhalter, Crookston, Ward, Harris, Chase-Cantarini, & Babitz, 2010). Nursing program administrators must determine the impact of curricula used to educate current and future nurses (U.S. DHHS, 2012; NLN, 2012). Nurse administrators and educators must select an effective assessment tool to measure the level of cultural awareness among nursing students (Kumas-Tan et al., 2007; Waite, 2010). Nursing students need to comply with regulations and effectively function in a

multicultural health service delivery system (Carey, 2011).

Health care leaders must also be knowledgeable of the policies, procedures, and programs enhancing services to diverse clientele (Campinha-Bacote, 2007; Sealey et al., 2006). A health care report by the OMH (2012) mandated 14 principles regarding the appropriate health care for various individuals. These 14 principles must be included in selected textbooks and nursing program curricula. For example, the integrated cultural curriculum of the study site suggested cultural aspects of nursing defined or discussed, but does not specifically list the 14 mandates.

The associate degree-nursing program philosophy at the study site was founded on the following two statements: (a) Learning experiences are most effective when content is arranged in a simple to a complex manner. (b) Education is a continual process of developing a body of knowledge, skills, and attitudes. The associate degree-nursing program's conceptual framework was intended to meet the necessities of non-native English speaking students. The CAS mean total score of 200.6667 (SD = 16.00208), for the study participants in this correlational study substantiated the college has successfully implemented an integrated cultural curriculum (see Appendix C).

Faculty Training

In order for nursing schools to comply with the recommendations of the BRN (2012) the nursing programs must evaluate the impact of the curricula on nursing students and ensure the nursing faculty received training in transcultural nursing. Sealey et al., (2006), stated those faculties who teach multicultural nursing may not have received any graduate level training in multicultural nursing. Higher education

administrators may choose to develop transcultural nursing courses and programs to meet the training need of nursing program leaders and nursing faculty.

Recommendation for Future Research

The integrated cultural curricula used by the study site may have contributed to the statistically significant relationships revealed by the Pearson *r* correlation coefficient. However, other factors may have contributed such as student's learning style, student's perception of faculty, student's personal experiences, and cultural encounters. Therefore, additional study is warranted to determine if the cause and effect relationship between the integrated cultural curricula and the cultural awareness levels.

Further study using a pre/posttest design, a randomized sample, and the CAS tool is warranted. A pretest will provide baseline data on the CAS level prior to beginning the nursing program. At the end of the nursing program, the student will complete the posttest to determine the CAS level. Additionally, a pretest/posttest design with an intervention may be conducted (Sanner et al., 2010). The instrument and method used in this study would be a pre-intervention questionnaire, a qualitative intervention (six-hour classroom introduction seminar, seven hour internet, and blackboard 5.0 interactive program, and a 2-hour summary/evaluation classroom seminar), and post-intervention questionnaire.

The advantages of conducting qualitative research are the opportunity to explore the experience, meaning, attitudes, and view of the participants rather than providing quantifiable answers to the research question (Meadows, 2003). Using a qualitative method will allow the researcher to investigate the issue from a new

approach or perspective rather than only focusing on causal theories, previous literature, or other research studies (Hesse-Biber & Leavy, 2011). In addition, it would be beneficial to expand the recruitment sample to other nursing programs within the United States to explore statistically significant differences based on geographical areas (Kardong-Edgren & Campinha-Bacote, 2008).

Limitations of the Study

This correlational study has offered a perspective on the relationships between the integrated cultural curricula and cultural awareness level as measured by the CAS. As a direct consequence of this methodology, the study encountered a number of limitations, which need to be considered. Correlational studies are non-experimental methods, with "no manipulation of the independent variable by a researcher" (Johnson & Christensen, 2008, p. 43). The integrated cultural curricula used by the study site may have contributed to the relationships revealed. The lack of manipulation and weaker techniques of controlling for extraneous variables make it difficult to assert a claim about cause and effect (Johnson & Christensen, 2008). However, the relationships revealed may be attributed to the integrated cultural curricula or the specific study site.

As with any self-report measure, there are some concerns with social acceptability and students anticipating the responses they should choose on the instrument. The participants may have responded to survey questions with a bias. These results are consistent with Salkind (2003) who indicated participants respond to survey questions with a bias because he or she wants to answer the questions with a socially acceptable response. It could be argued nursing students are aware of the

expectations for their developing cultural awareness, therefore, the student would choose certain replies in an effort to appear to be culturally aware.

A limitation was encountered during the data analysis. The CAS tool had been used in three studies with nursing students, however, the tool had not been used in a dissertation. Additionally, the author of the CAS tool had not delineated which score corresponded to the level of cultural awareness. Rew et al., (2003) and Krainovich-Miller et al., (2008) provided no guidance for handling missing data on this instrument, however, missing data was eliminated from the calculation. Rew et al. (2003) and Krainovich-Miller et al. (2008) denoted further psychometric testing of the CAS tool with nursing students is warranted to determine the validity and reliability as a measure of cultural awareness.

A limitation was encountered with the small sample. The sample included a single community college, in one geographical area in Southern California. Therefore, the findings in this study are not generalizable to all nursing students. Different results may be attained in other regions of the country or with larger groups of nursing students.

Conclusion

This correlational study focused on determining if relationships existed between the integrated cultural curricula and the graduating associate degree-nursing student's level of cultural awareness. The focus of the theoretical framework highlighted the importance of culture, knowledge, and care as vital and obligatory to nursing education and practice (Chitty & Black, 2010). The literature implied integrated cultural curricula increased the level of cultural awareness (BRN, 2012;

NLN, 2008). In this study, the Pearson *r* correlation coefficient revealed statistically significant relationships exist between the integrated cultural curricula and the level of cultural awareness among graduating associate degree nursing students. Based on the results of the 51 participants surveyed in this study, the cultural awareness level may be attributed to several factors, including the integrated cultural curricula. Student's learning style, student's perception of faculty, student's personal experiences, and cultural encounters contributed to the cultural awareness level. Additionally, the ANOVA results revealed no statistically significant differences on the CAS total or subscale scores based on gender, age, and ethnicity.

Chapter 5 concludes this study. The findings revealed five statistically significant relationships exist between the integrated cultural curricula and the graduating associate degree-nursing student's level of cultural awareness. The result of this research may be utilized to support the selection of effective assessment tool to measure the level of cultural awareness among nursing students. The study may encourage academic affairs leaders to emphasize cultural awareness as a significant student-learning outcome for nursing educational programs.

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Appendix A: Copy of the Survey—CAS Tool

Data Collection Tool(s)/Survey

The University of Texas at Austin
School of Nursing
Cultural Awareness Student survey
Shirin Catterson, Jeff Cookston, Stephanie Martinez, Lynn Rew

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

Please note that the questionnaire is only about your experiences at this school of nursing, not the entire University.

		General Experiences at this School of Nursing	Does Not Apply	Strongly Disagree			No Opinion			Strongly Agree
1	1.	The instructors at this nursing school adequately address multicultural issues in nursing	☐	1	2	3	4	5	6	7
1	2.	This nursing school provides opportunities for activities related to multicultural issues.	☐	1	2	3	4	5	6	7
1	3.	Since entering this school of nursing my understanding of multicultural issues has increased.	☐	1	2	3	4	5	6	7
1	4.	My experiences at this nursing school have helped me become knowledgeable about the health problems associated with various racial and cultural groups.	☐	1	2	3	4	5	6	7
		General Awareness and Attitudes								
2	5.	I think my *beliefs and attitudes* are influenced by my culture.	☐	1	2	3	4	5	6	7
2	6.	I think my *behaviors* are influenced by my culture.	☐	1	2	3	4	5	6	7
2	7.	I often reflect on how culture affects beliefs, attitudes, and behaviors.	☐	1	2	3	4	5	6	7
4 RC	8.	When I have an opportunity to help someone, I offer assistance less frequently to individuals of certain cultural backgrounds.	☐	1	2	3	4	5	6	7
4 RC	9.	I am less patient with individuals of certain cultural backgrounds.	☐	1	2	3	4	5	6	7
4	10.	I feel comfortable working with patients of all ethnic groups.	☐	1	2	3	4	5	6	7
2	11.	I believe nurses' own cultural beliefs	☐	1	2	3	4	5	6	7

		influence their nursing care decisions.								
4 RC	12.	I typically feel somewhat uncomfortable when I am in the company of people from cultural or ethnic backgrounds different from my own.	☐	1	2	3	4	5	6	7
		Nursing Classes/Clinicals								
4 RC	13.	I have noticed that the instructors at this nursing school call on students from minority cultural groups when issues related to their group come up in class.	☐	1	2	3	4	5	6	7
1	14.	During group discussions or exercises, I have noticed the nursing instructors make efforts to ensure that no student is excluded.	☐	1	2	3	4	5	6	7
2	15.	I think that students' cultural values influence their classroom behaviors (for example, asking questions, participating in groups, or offering comments.)	☐	1	2	3	4	5	6	7
1 RC	16.	In my nursing classes, my instructors have engaged in behaviors that may have made students from certain cultural backgrounds feel excluded.	☐	1	2	3	4	5	6	7
2	17.	I think it is the nursing instructor's responsibility to accommodate the diverse learning needs of students.	☐	1	2	3	4	5	6	7
1	18.	My instructors at this nursing school seem comfortable discussing cultural issues in the classroom.	☐	1	2	3	4	5	6	7
1	19.	My nursing instructors seem interested in learning how their classroom behaviors may discourage students from certain cultural or ethnic groups.	☐	1	2	3	4	5	6	7
2	20.	I think the cultural values of the nursing instructors influence their behaviors in the clinical setting.	☐	1	2	3	4	5	6	7
1	21.	I believe the classroom experiences at this nursing school help our students become more comfortable interacting with people from different	☐	1	2	3	4	5	6	7

		cultures.								
1 RC	22.	I believe that some aspects of the classroom environment at this nursing school may alienate students from some cultural backgrounds.	☐	1	2	3	4	5	6	7
5	23.	I feel comfortable discussing cultural issues in the classroom	☐	1	2	3	4	5	6	7
1	24.	My clinical courses at this nursing school have helped me become more comfortable interacting with people from different cultures.	☐	1	2	3	4	5	6	7
1	25.	I feel that this nursing school's instructors respect differences in individuals from diverse cultural backgrounds.	☐	1	2	3	4	5	6	7
1	26.	The instructors at this nursing school model behaviors that are sensitive to multicultural issues.	☐	1	2	3	4	5	6	7
1	27.	The instructors at this nursing school use examples and/or case studies that incorporate information from various cultural and ethnic groups.	☐	1	2	3	4	5	6	7
		Research Issues								
3	28.	The faculty at this school of nursing conducts research that considers multicultural aspects of health-related issues.	☐	1	2	3	4	5	6	7
3	29.	The students at this school of nursing have completed theses and dissertation studies that considered cultural differences related to health issues.	☐	1	2	3	4	5	6	7
3	30.	The researchers at this school of nursing consider relevance of data collection measures for the cultural groups they are studying.	☐	1	2	3	4	5	6	7
3	31.	The researchers at this school of nursing consider cultural issues when interpreting findings in their studies.	☐	1	2	3	4	5	6	7
		Clinical Practice								
5	32.	I respect the decisions of my patients when they are influenced by their	☐	1	2	3	4	5	6	7

		culture, even if I disagree.								
5	33.	If I need more information about a patient's culture, I would use resources available on site (for example, books, videos, etc.).	☐	1	2	3	4	5	6	7
5	34.	If I need more information about a patient's culture, I would feel comfortable asking people I work with.	☐	1	2	3	4	5	6	7
5	35.	If I need more information about a patient's culture, I would feel comfortable asking the patient or a family member.	☐	1	2	3	4	5	6	7
4 RC	36.	I feel somewhat uncomfortable working with the families of patients from cultural backgrounds different than my own.	☐	1	2	3	4	5	6	7

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Appendix B: Permission to Use Existing Survey

On Tue, Mar 26, 2013 at 7:55 PM, Renee Martin-Thornton wrote:

Hello Ms. Lynn Rew,

I appreciate your permission to use this tool!! However, in order, to use this for my dissertation I would need an official survey permission form. Would you be willing to sign the attached "survey permission" form, giving me official permission to use the scale? I will wait to hear further from you.

Thanks in advance.

Renee Martin-Thornton

From: Lynn Rew <ellerew@mail.utexas.edu>
To: Renee Martin-Thornton
Sent: Mon, January 21, 2013 8:58:08 AM
Subject: Re: Cultural Awareness Scale

I've attached the scale. You are permitted to use it.

On Sun, Jan 20, 2013 at 6:35 PM, Renee Martin-Thornton wrote:

Hello Ms. Lynn Rew,

I located your information and this reference:

- Krainovich-Miller, B., Yost, J., Norman, R., Auerhahn, C., Dobal, M., Rosedale, M., Lowry, M., Moffa, C. (2008). Measuring Cultural Awareness of Nursing Students: A First Step Toward Cultural Competency. Journal of Transcultural Nursing 19, 250-258.

Appendix C: Analysis of the College studied

College Mission:

The mission of the college empowers students to achieve their educational goals, to expand their individual potential, and to successfully pursue their aspirations for a better future for themselves, their community, and the world.

College Goals:

The college has developed four goals. These goals serve as the broad planning objectives through which all other college planning documents and departmental plans will be based. Together these goals provide a foundation for building a true agenda of student success.

Goal 1: Increasing student success and academic excellence through student-centered instruction, student-centered support services, and dynamic technologies.

Goal 2: Increasing equity in successful outcomes by analyzing gaps in student achievement and using this to identify and implement effective models and programming to remedy these gaps.

Goal 3: Sustaining community-centered access, participation, and preparation improves the college's presence in the community, maximizes access to higher education and provides outlets for artistic, civic, cultural, scientific, and social expression as well as environmental awareness.

Goal 4: Ensuring institutional effectiveness and accountability through data-driven decision-making as well as evaluation and improvement of all college programs and governance structures.

College Vision:

Through our emerging focus on student-centered instruction, student-centered services, and integrated learning, East Los Angeles College will be an exemplary model for student academic achievement, skill development, and artistic expression.

Nursing Program-Requirements/Prerequisites:

A. High School graduate, or equivalent (GED or California High School Proficiency Test or United States College Degree).

B. GPA of 2.0 demonstrating Satisfactory Academic Progress.

C. Completion of TEAS test (Version 5) with a cut score of 62%

Registered Nurse Curriculum

First Semester
Nursing 265 Fundamentals of Nursing
Nursing 276 Introduction to the Nursing Process
Nursing 275A Pharmacology I
Nursing 266 Nursing Process & Practice in the Care of the Adult Client I
Nursing 277 Health Assessment
Physical Education
Second Semester
Nursing 267 Nursing Process & Practice in the Care of the Adult Client II
Nursing 268 Nursing Process & Practice in the Care of Clients with Alterations in Mental Health
Nursing 273 Role Transition
Nursing 275B Pharmacology II
Humanities
Third Semester
Nursing 269 Nursing Process & Practice in the Care of the Adult Client III
Nursing 271 Nursing Process & Practice in the Care of Women and the Newborn
Speech 101
Sociology 1 or 11/or Anthropology 102
Fourth Semester
Nursing 270 Nursing Process & Practice in the Care of Children
Nursing 272 Nursing Process & Practice in the Care of the Adult Client IV
American Institutions or U.S. History requirements

Appendix D: Permission to Use Premises

Premises, Recruitment, and Name (PRN) Permission form

University of Phoenix®

PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

OF

East Los Angeles College

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☒ I hereby authorize Renee Martin-Thornton, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled A Correlational Study About the Cultural Awareness Among Nursing Students

☒ I hereby authorize Renee Martin-Thornton, a student of University of Phoenix, to recruit subjects for participation in a study entitled A Correlational Study About the Cultural Awareness Among Nursing Students

☒ I hereby authorize Renee Martin-Thornton, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled A Correlational Study About the Cultural Awareness Among Nursing Students

Signature

8 August 2013

Date

LuAnn B. Gaines

Name

Chairperson/Director of Nursing

Title

Address of Facility

1301 Avenida Cesar Chavez, Los Angeles, CA 91754

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Appendix E: Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

A Quantitative Correlational About the Cultural Awareness Among Nursing Students
Renee Martin-Thornton

DATE: December 16, 2013

TO: Ryan Cornner, Dean of Institutional Effectiveness

FROM: Renee Martin-Thornton

SUBJECT: Memorandum of Understanding with East Los Angeles College

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Purpose:

Gain knowledge regarding the impact of the integrated cultural curriculum on cultural awareness in nursing students.

Collaborative Effort:

The final results of the study will be given to East Los Angeles College in order to be kept on file at the Office of Institutional Effectiveness and college library. East Los Angeles College will be provided summary results of the data collected at ELAC. In addition, a brief presentation may be offered to the campus to summarize implications of the study results.

Mrs. Martin-Thornton, understands that participation is purely at the discretion of those individuals that recruits and that the college will not be actively involved in helping to secure participants. Students interested in the project and who volunteer to participate will go through the informed consent procedures as defined in the host institution IRB documentation. The primary recruitment process will be to provide in-class time to review recruitment documentation and complete the approved survey and these activities will be coordinated with the Nursing Department Chair, Ms. Lurelean Gaines. All survey data will be anonymous and no additional student level data will be provided by the college.

Ryan Cornner, Dean of Institutional Effectiveness — Date: 12-16-13

Renee Martin-Thornton — Date: 12-16-13

Appendix F: Informed Consent Form

INFORMED CONSENT: PARTICIPANTS 18 YEARS OF AGE AND OLDER

Dear Study Participant,
My name is Renee Martin-Thornton and I am a student at the University of Phoenix working on a Ph. D. Higher Education Administration degree. I am doing a research study entitled A Quantitative Correlational Study About the Cultural Awareness Among Nursing Students. The purpose of the research study is to assess the level of cultural awareness among nursing students currently enrolled and attending a program using an integrated cultural curriculum to teach cultural concepts.

Your participation will involve the completion the 36-item Cultural Assessment Survey (CAS). This will take approximately 40-55 minutes. For the purposes of this study, the sample size will include 60 graduating nursing students who are currently enrolled in the participating associate-degree nursing program, in a large metropolitan area such as in Los Angeles.

You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any penalty or loss of benefits. The results of the research study may be published but your identity will remain confidential and your name will not be made known to any outside party.

In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, a possible benefit from your being part of this study is by having the satisfaction of contributing to educational research. The possible benefits of this study especially to academic nursing program administrators are the need to emphasize the development of cultural competence as a significant nursing student-learning outcome. Results from this research may guide future programming regarding types of teaching strategies preferred and subsequent research to determine effectiveness of certain
teaching methods in the promotion of cultural competence.

If you have any questions about the research study, please call me at_____

For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. Renee Martin-Thornton, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. If interviews are done, they may be recorded. If they are recorded, you must give permission for the researcher, Renee Martin-Thornton, to record the interviews. You understand that the information from the recorded interviews may be transcribed. The researcher will develop a way to code the data to assure that your name is protected.
5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study may be published.

"By signing this form, you agree that you understand the nature of the study, the possible risks to you

as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here."

(☐) I accept the above terms. (☐) I do not accept the above terms. (CHECK ONE)

Signature of the interviewee _____ Date _____

Signature of the researcher _____ Date _____

Current version 032012

Appendix G: CAS Individual and Subscale Scores

Cultural Awareness Subscales and Individual Questions Mean Scores

Variable Domain	*n*	Minimum	Maximum	*M*	SD
General Education	46	66.00	97.00	83.4783	8.32063
Question 1	51	4.00	7.00	6.2549	.86817
Question 2	51	2.00	7.00	5.8235	1.29160
Question 3	50	4.00	7.00	6.3600	.82709
Question 4	51	4.00	7.00	6.5294	.75771
Question 14	51	1.00	7.00	6.0392	1.41366
Question 16	49	1.00	7.00	6.0816	1.41181
Question 18	51	2.00	7.00	6.4706	1.02670
Question 19	49	1.00	7.00	4.4082	1.68224
Question 21	51	2.00	7.00	6.0784	1.05533
Question 22	51	1.00	7.00	5.4706	1.89053
Question 24	51	3.00	7.00	6.0980	1.04412
Question 25	51	3.00	7.00	6.3137	.96933
Question 26	51	4.00	7.00	5.8431	1.18950
Question 27	51	3.00	7.00	5.9804	1.08610
Cognitive Awareness	48	15	49.00	33.8958	7.58846
Question 5	51	1.00	7.00	5.2353	1.79542
Question 6	51	1.00	7.00	4.9608	1.66085
Question 7	50	1.00	7.00	5.4400	1.40204
Question 11	51	1.00	7.00	4.3333	2.03634
Question 15	51	1.00	7.00	4.7255	1.76724
Question 17	49	1.00	7.00	4.9184	1.73009
Question 20	49	1.00	7.00	4.4082	1.88103

Cultural Awareness Subscales and Individual Questions Mean Scores

Variable Domain	*n*	Minimum	Maximum	*M*	SD
Research Issues	43	11.00	28.00	19.7907	4.02112
Question 28	49	2.00	7.00	5.1837	1.43865
Question 29	44	1.00	7.00	4.7500	1.55705
Question 30	45	4.00	7.00	4.9778	1.17722
Question 31	45	1.00	7.00	5.0444	1.29607
Behavior Comfort	46	18.00	42.00	36.1087	5.86223
Question 8	47	1.00	7.00	6.3404	1.55027
Question 9	49	1.00	7.00	6.3878	1.33567
Question 10	51	2.00	7.00	6.4314	1.10009
Question 12	50	1.00	7.00	5.8400	1.75383
Question 13	47	1.00	7.00	4.6809	2.09665
Question 36	49	1.00	7.00	6.2449	1.53474
Patient Care	51	22.00	35.00	31.5294	3.45458
Question 23	51	4.00	7.00	6.1961	.98020
Question 32	51	4.00	7.00	6.6863	.61612
Question 33	51	1.00	7.00	6.3922	1.07849
Question 34	51	1.00	7.00	6.2549	1.18056
Question 35	51	1.00	7.00	6.0000	1.35647

Total Score	51	171.00	237.00	200.6667	16.00208

Note. The total CAS mean score was 200.6667, the minimum CAS mean score was 171.00, and the maximum CAS mean score was 237.00.