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The Impact of Cross-Cultural Experiences on the Expression of Cultural Humility

Teri L. Witter

THE IMPACT OF CROSS-CULTURAL EXPERIENCES ON THE EXPRESSION OF CULTURAL HUMILITY

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Teri L. Witter

Messiah College

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Messiah College
School of Graduate Studies
Graduate Program in Nursing

We hereby approve the Capstone Project of

Teri L. Witter

Candidate for the degree of Master of Science in Nursing

Louann B Zinsmeister, PhD, RN, CNE — August 18, 2018
Professor of Nursing
Director of Graduate Program in Nursing
Capstone Advisor

Anne B. (Nancy) Woods, PhD, MPH, RN — August 18, 2018
Professor of Nursing
Chairperson, Department of Nursing

Title of Capstone Project: The Impact of Cross-Cultural Experiences on the Expression of Cultural Humility

Capstone Advisor: Dr. Louann B. Zinsmeister

Capstone Approvers: Dr. Louann B. Zinsmeister
Dr. Anne (Nancy) B. Woods

Abstract

Cultural humility is a process in understanding and accepting differences between diverse groups of people. Nurses are challenged to develop cultural humility to care for the changing population in the United States. Nurse educators are tasked with the challenge of facilitating students' awareness and expression of cultural humility. Immersion experiences are one approach to helping students grow in their cultural humility. Along with teaching cultural humility, educators must evaluate a student's level of cultural humility. Measuring an abstract concept such as cultural humility can be a difficult. Limited instruments have been developed and used to measure the concept of cultural humility. Some instruments were reliable in measuring cultural competence. This evidence-synthesizing project reviewed pieces of evidence that examined pedagogical approaches for teaching cultural competence. One specific approach that was reviewed was immersion experiences. The evidence revealed that cultural competency education is beneficial; even so, it is a concept that is difficult to truly evaluate and measure.

Keywords: cultural humility, cultural competency, expression of cultural humility, cross-cultural experience, immersion experience, international experience, transcultural experience

DEDICATION

I am so blessed to have been so supported by family, friends, colleagues, and students along my graduate school journey. Through all the ups and downs, various people have been by my side, encouraging me through, and cheering me on!

This project is dedicated to my amazing family! I am so thankful for the way in which each one in my immediate family cheered me on. Wendell, Jeremiah, Hannah, Joel and Rebecca, you are my joy and inspiration and I am so thankful for your support. I also give thanks to my extended family. You have been my biggest encouragers along the way!

I also dedicate this project to all the students I have cared for in the past and will in the future. I am so motivated to want to learn from you. Your transparency and questions are what drives me to want to learn more. To my future students, I dedicate this project to you so that you may know my commitment to helping you grow and learn.

Most of all, I dedicate all of my life and work to my Lord Jesus Christ. I want my life to be a true reflection of Him. Colossians 3:17 says “And whatever you do, whether in word or deed, do it all in the name of the Lord Jesus, giving thanks to God the Father through him”.

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CHAPTER I

INTRODUCTION

The United States has become more diverse. The population demographics are rapidly changing. Global migration contributes to the changing cultural climate. Hughes and Hood (2007) highlighted that by the year 2050 the United States (US) population will be made up of less than half of those with European descent. By 2060, minorities are expected to make up approximately 57 percent of the US population (Loftin, Hartin, Branson, & Reyes, 2013). Furthermore, the Center for Disease Control and Prevention (CDC) (2015), the US Department of Health and Human Services (2016) and the National League for Nursing (NLN, 2015) have identified that there are many health disparities in the US. Further diversity and cultural competency education for nurses may help to provide health equity. Quality and Safety Education for Nurses (QSEN) ("Quality and Safety," 2017) included competencies about cultural issues. QSEN (2017) emphasized the need for nurses to be able to value and respect all patients no matter what background or culture. Cultural competency education is one way for improving health disparities within healthcare. The expression of cultural humility may be so important that the failure to incorporate cultural needs into patient care may lead to inappropriate care and poor patient outcomes (Aponte, 2012).

Cultural competency education may be valuable for nursing education because of the importance of cultural humility while caring for patients. The American Association of Colleges of Nursing (AACN, 2008) has identified the importance of incorporating diversity and cultural competency education into nursing curriculum. Nursing leaders acknowledge that cultural competence is important in education, which is by recommended by *The Essentials of Baccalaureate Nursing Education* including various elements of cultural competency for nursing

programs (AACN, 2008). The Center for Disease Control and Prevention (CDC) (2015) also highlighted that there are health disparities in minority populations compared to the whole US population.

There are multiple methods for attempting to teach the expression of cultural humility. One specific pedagogical method for teaching expression of cultural humility is having students participate in cross-cultural experiences. Teaching students about cultural humility is a challenging task because it is hard to measure whether a nursing student has mastered the skill of cultural competency and the best expression of cultural humility. Educators are tasked with how to best measure and evaluate the expression of cultural humility.

Health Disparities

The health needs of the general population of the United States are dramatically changing. With the influx of immigrants and the changes in socio-economic status of people, health disparities among the minorities have increased. Historically, the population of the US has been of European ancestry. However, as stated previously, it is estimated that more than half of the population will be descendants from non-European countries by the year 2050 (Hughes & Hood, 2007). This shift in patient demographics is creating challenges for health care workers to care well for their patients. Each cultural background has unique healthcare needs. In addition, the financial situation may be more challenging for those that are migrating to new locations. When there are healthcare needs for those that are financially tested, it creates health disparities (Kohlbry, 2016). Healthcare workers, such as nurses, are placed in situations in which they need to know a variety of cultural backgrounds and potential health needs for various ethnic groups. Hughes and Hood (2007) highlighted that nurses need to tailor their nursing assessments and care to be able to provide good care to all patients. Cultural competence is a skill that would

help nurses be more prepared to care for their diverse patient populations. Nurses that express cultural humility in their assessments and care help to decrease the disparities because they assist in helping patients receive the care that they need (Kohlbry, 2016).

Cultural Competency Pedagogy

Since culturally competent nurses would be beneficial to help decrease health disparities in diverse populations, nurse educators may need to create and deliver pedagogy that teaches cultural humility to nursing students. The *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) have created desired outcomes for nursing students to be able to care for a variety of health needs and populations. The outcomes desired include understanding different cultures and their health needs, as well as how to express cultural humility. Reading textbooks and research articles, lectures, and guest panels have all been used as teaching strategies. Another pedagogy is to incorporate participation in an immersion experience for the nursing students (Ferranto, 2015). An immersion experience could be an international experience or even just an inner-city experience in which the main concept is for the students to be removed from their "normal" environment and be immersed in the different culture.

Evaluation of Cultural Humility

With the variety of culture competency educational opportunities, the evaluation of a student's level of cultural competency becomes challenging. While it is a desired skill for nurses to possess, there is no specific standard for how to measure cultural competency. There are various tools that have been created to aim to measure nurses' or nursing students' level of cultural competence, but the concept of cultural humility is one that seems hard to quantify. There has been some research done on the topic of cultural competence pedagogy and the

evaluation of cultural competence. However, the research is not comprehensive, and it appears to be very sporadic. The methods available for measuring cultural competence are typically Likert-based surveys, focus groups, and interviews. The latter two methods are more time consuming and thus are deterrents for acquiring adequate feedback that measures the expression of cultural humility.

The increasing demands on healthcare workers to be culturally competent is evidenced in the changing population of the United States. Nurses are being confronted to become more competent in cultural issues. Nurse educators may attempt to include cultural humility curricular content. However, the issue remains that even though cultural humility may be taught to nursing students, nurse educators struggle to determine if such teaching of the concept is effective.

Background and Need

Historically, the population make-up of the US had been primarily those from European descent. Health care was focused on the needs of European-American people groups. Nursing care was the same for all patients. Over time, and with mass immigration of diverse people groups, the demographics of the US have changed. Because of this change, health care has needed to change. Different people groups have different genetic-linked disease processes and health needs and concerns as well as different cultural practices (Smedley, Stith, Nelson, 2003). As a result, working towards decreasing health disparities within a changing cultural climate is warranted. Nurse educators have an important role in helping educate nursing students to be culturally competent through a variety of teaching methods including cross-cultural experiences (Lindquist, 1990). As educators teach nursing students about cultural competence, determining effective evaluation methods is a priority.

Increase of health disparities in the United States.

Healthcare disparities are more prevalent with the increase in diversity. Evidence has shown that many preventable and treatable health issues are affecting more minority people groups than for Caucasian people (Betancourt, Corbett, & Bondaryk, 2014). Betancourt et al., (2014) highlighted that social determinants, including socio-economic differences and lower levels of education, poor housing situations and other all may be associated to the disparities. Even in the attempts to reform health care there continues to be an inequality in terms of patient treatment that occurs depending upon race or ethnicity (Betancourt et al., 2014). While the disparities may be related to social determinants, the ineffectiveness or lack of communication and appropriate care also contributes to the inequities (Beach et al., 2006). In the systematic review by Beach et al., (2006) studies were examined for interventions to improve the quality of care for diverse people groups.

One possible intervention is for healthcare workers to be educated in cultural competence (Betancourt, 2014). In the seminal work by Smedley, Stith, and Nelson (2003), cross-cultural communication for all healthcare workers was emphasized. Cross-cultural communication for nurses also will help to decrease the health disparities because the nurses will be able to have better communication with diverse populations. As nurses begin to understand a variety of cultures and how to communicate with them, then they will be able clearly communicate patient needs to the doctors as well as to the patients. As clear lines of communication are established, the hope is that there would be fewer disparities because minority people would begin to receive the information and care that is needed for their health concern. Nurses can potentially be that link to establishing improved cross-cultural communication.

Pedagogical approaches for cultural competence education.

Nurse educators have historically taught culturally sensitive topics to students using lecture format. While having a contextual background to a variety of cultures is important, it has the potential to create stereotypes of people groups at large (Betancourt et al., 2014). The teaching has been aimed at addressing attitudes, values, beliefs and behaviors within specific people groups when actually there is a lot of diversity within these people groups (Betancourt et al., 2014). However, Betancourt et al. (2014) highlighted there needs to be a fine balance between understanding and caring for a whole people group and caring for the individual.

One pedagogical approach to educating nursing students about cultural competency would be to provide a cross-cultural experience. The cross-cultural experience provides an opportunity for students to be removed from their "normal" environment and be immersed into a different culture. Students will learn new things about a culture simply because they are experiencing it firsthand (Banks, 1994). They will also begin to learn social norms of a particular people group and practice what they are learning. The opportunity of an immersion experience combines the classroom learning with experiential learning. When these two things are combined there is more potential for application of the content learned (Ferranto, 2015). The intention is then that the information learned, and the skills acquired in terms of interacting with people from a different culture would transfer to the expression of cultural humility.

Evaluation methods to determine cultural competence.

Educators are teaching cultural competency and striving to have students include cultural humility into their care of patients. The challenge that exists then is how to best evaluate the expression of cultural humility after an immersion experience. One of the most common

evaluation tools has been the use of pre-trip and post-trip surveys. These are typically based on a Likert type scale and having students complete the survey before and after the trip. The hope is that students will rate themselves differently after the trip and that the influencing factor on improved expression of cultural humility would be the immersion experience.

The evaluation process for cultural competency seems to fit more with interviews and focus groups as a means to gather data about a student's expression of cultural humility. While gathering the data before and immediately after the trip is helpful, some evidence suggests that weeks to months following an immersion experience would be even more reflective of how a student nurse expresses cultural humility (Ferranto, 2015). There are challenges to evaluating with interviews or focus groups, yet these firsthand thoughts and stories provide a clear picture of the expression of cultural humility. As educators incorporate immersion experiences into their curricula, then evaluating the pedagogy is standard. Determining the best way to evaluate a personal experience and the impact it may have on the student is the challenge.

There has been evidence that shows there are health disparities within the minority people groups (Smedley, et al, 2003). One way to create more equity is to have educated healthcare professionals be versed in cultural competency. Nurse educators may then need to educate nursing students to understand cultural humility and how to express it. Providing an immersion experience as a part of the nursing student's school experience is one pedagogical approach in teaching cultural humility. The expression of cultural humility following a cross-cultural experience should be measured to determine the benefits of the experience and the implications for the nurse's practice.

Statement of Problem

With the diverse population, nurses are being required to care for a variety of patients with different cultural needs. There has been some concern that with the diverse populations, disparities in healthcare for minorities could be related to provider and nurse behaviors (vanRyn, 2002). Nursing students are confronted with how to express cultural humility with all patients. Nurse educators are tasked to determine the best pedagogical approach for teaching students about cultural competence. Educators also are faced with how to measure nursing students' expression of cultural humility.

Purpose of the Project

The purpose of this evidence-based practice-synthesizing project was to critique or critically appraise evidence for the impact of cross-cultural experiences on undergraduate baccalaureate nursing students' expressions of cultural humility. The authors of the evidence reported that the changing climate of the population is becoming more diverse (Loftin, 2013). Nurses are now and will in the future need to care for a variety of cultural needs. Nurse educators are tasked with discovering ways to teach nursing students about cultural humility. The use of cross-cultural experiences to teach students about various cultural needs is one method for helping students to gain a deeper level of expression of cultural humility.

Evidence-Based Practice (EBP) Question

In pre-licensure, baccalaureate nursing students, does participation in a cross-cultural experience compared to no participation in a cross-cultural experience influence students' expression of cultural humility?

Significance to Nursing Education

In this evidenced based practice synthesis project, evidence was critiqued to see how participation in a cross-cultural experience affected the expression of cultural humility in nursing students. Cultural humility is becoming a "hot-topic" in today's society with the increase in immigration and diversity in the US population. Since nurses are frequently in a position to care for patients with different cultural needs, cultural humility instruction may be essential education. Additionally, Beach et al (2006) suggested that healthcare providers who are able to express cultural humility potentially decrease health disparities and inequities. The AACN (2008) has also included this significant topic in their "essentials" yet it is not an easy undertaking. Nurse educators are faced with a challenging job to provide appropriate pedagogical methods for teaching an abstract concept (Edmonds, 2012).

Definitions

The following terms are used within the context of this paper. While there may be various ways to define these terms; the definitions provided below are the working definitions for the context of this paper.

Cross-cultural experience. A cross-cultural experience is defined as a trip that requires a person to be immersed into a different cultural than his or her normal cultural for a short or long period of time.

Cultural competency. See the definition for cultural humility.

Cultural humility. A commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves. It is a process that requires humility in how one brings into check the power

imbalances that exist in the dynamics of communication (Tervalon & Murray-Garcia, 1998). Cultural humility can be interchanged with term cultural competency.

Expression of cultural humility. The expression of cultural humility is when one actively practices cultural humility.

Immersion experience. An immersion experience is when a person is fully immersed in another culture by being physically present and emotionally engaged in one's surroundings.

International experience. An international experience is a cross-cultural experience in which the immersion experience in a different culture is also in a different country.

Transcultural experience. A transcultural experience is synonymous with an international experience.

Within the context of this capstone project, the terms cultural humility and cultural competency may be interchanged.

Chapter Summary

This chapter introduced the topic of cross-cultural experiences and the impact on students' expression of cultural humility. The addressed problem was the changing and diverse US population with related health disparities, and how it affects the way nurses are providing patient care. The background and need were discussed. The purpose of the project was highlighted. The evidence-based practice (EBP) question was presented. Nurse education implications were briefly discussed. Key words used throughout the paper were defined.

CHAPTER II

METHODS

As the US population changes, so does the cultural climate and healthcare needs of patients. With the diversified culture, health disparities and inequities among minorities has become evident (Betancourt, Corbett, & Bondaryk, 2014). The inequities in healthcare have created a need for healthcare professionals to work towards decreasing the disparities. Nursing education has a role in preparing students to care for the changing cultural climate. Thus, nursing education may need to incorporate teaching students about cultural humility. Tervalon and Murray-Garcia (1998) laid a foundation of defining cultural humility as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves. It is a process that requires humility in how one brings into check the power imbalances that exist in the dynamics of communication. Therefore, the expression of cultural humility is when one actively practices cultural humility.

The nursing profession has acknowledged the importance of preparing nurses to be culturally competent when the AACN (2008) identified the importance of incorporating diversity and cultural competency education into nursing curricula. Since, cultural humility is a dynamic process, educators are challenged to determine the best pedagogical approach. One teaching method is through a cross-cultural immersion experience.

The evidenced-based practice question guiding this evidence-synthesizing project is: In pre-licensure, baccalaureate nursing students, does participation in a cross-cultural experience compared to no participation in a cross-cultural experience influence students' expression of cultural humility?

Data Collection Procedure

In this evidence-synthesizing project, the data critiqued included research and non-research articles and artifacts about cultural competency and pedagogical approaches for teaching cultural competency. Additionally, articles were included that reviewed tools and the evaluation process of cultural competence. Databases searched included CINAHL, PubMed, Medline, and ERIC. Evidence needed to be narrowed down and so criteria was developed and based on Johns Hopkins Evidence-based Practice Model (Dang & Dearholt, 2018). Evidence was classified as research or non-research and then critiqued and analyzed as to whether it supported the research question. (Figure 1).

Sample

The initial general search for articles in the aforementioned databases of cultural humility and baccalaureate nursing students resulted in 798 pieces of evidence. The search was refined to cross-cultural competency and baccalaureate nursing students plus immersion experiences and that produced 39 pieces of evidence. Other searches then included searching for cultural competency evaluation tools resulted in 19 more pieces of evidence. The databases searched included CINAHL, PubMed, and Medline. With the use of inclusion and exclusion criteria, 10 pieces of evidence were selected for evidence.

Inclusion criteria. Data were eligible for inclusion if the sample pertained to answering the research question. Inclusion criteria also included current evidence, with-in the past five to

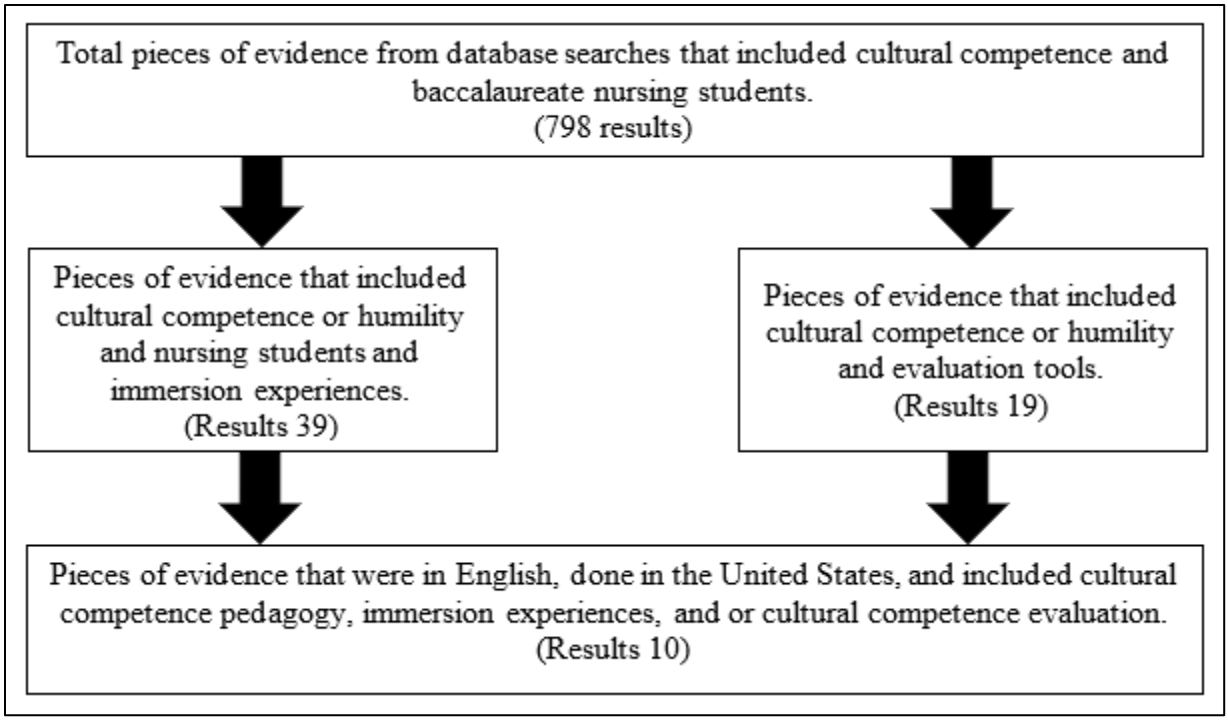

Figure 1. Data collection procedure.

ten years, as well as seminal works or textbooks related to the topic. Other criteria included internet sites from professional organizations with reliable credibility. Quantitative and qualitative research studies were included. Selection of criteria included purposive sampling because it was helpful to have purposeful evidence. Non-experimental research was included because the area of study is so small that randomized controlled studies are not available. Finally, the evidence was included if the research was based in the United States.

Exclusion criteria. Articles or studies were excluded as data if they did not support the evidenced-based practice question. Non-English evidence pieces and those published prior to 2007, unless it was a seminal work, were also excluded.

Evidence-based Practice Model

The Johns Hopkins Evidence-Based Practice (JHEBP) Model (Dang and Dearholt, 2018) was used to critically appraise the evidence. In this model, Dang and Dearholt (2018) developed a five-level rating system for data appraisal for research. The appraisal tools are first divided into research and non-research evidence. The evidence appraisal tool then provides a level rating for the pieces of evidence. Levels I, II, and III are considered research and levels IV and V are considered non-research.

Level I rating is the first category of evidence because it is usually an experimental study done with randomized control testing or a systematic review of a randomized control test. Level II rating is a quasi-experimental study in which the study may have some manipulation of an independent variable but may lack random assignment. Level III rating would be a non-experimental study or a qualitative study. Once the level of research study has been categorized, it is then given a quality rating; A, B, or C. A quality rating of A is high quality because the results are consistent and generalizable, the sample size is sufficient and has adequate control, and definitive conclusions could be drawn from the study. The quality rating of B is good quality because it has reasonable consistent results, sample size and some control. Reasonable recommendations could be drawn from this quality of evidence. Finally, a rating of C or low quality or major flaws would be given to evidence that has inconsistent results or an insufficient sample size, which leads to the inability to draw conclusions (Dang & Dearholt, 2018).

The non-research appraisal includes the level IV and V ratings. Level IV rating could be clinical practice guidelines or a consensus or position statement. The quality rating for level IV includes an A rating or high quality because it is supported by a professional organization, a systematic review of literature or has consistent results. Dang and Dearholt (2018) suggest that

this quality rating shows strength and definitive conclusions and clear evidence. Good quality rating or a B also is supported by a professional organization and has reasonable results. This evidence evaluates the strengths and limitations of the research as well. A low quality or rating of C is not sponsored by an official organization and is poorly designed and inconsistent or insufficient results. Level V rating could be a literature review, or an organizational experience such as a quality improvement or financial evaluation. Level V rating could also be a community standard, a clinician experience, or a consumer preference. This level is also rated A for high quality because the expertise is evident and definitive conclusions could be drawn. The rating of B is good quality because the evidence is credible, and some conclusions could be drawn. A rating of C is of low quality or has major flaws because conclusions cannot be drawn, and the expertise is questionable (Dearholt & Dang, 2018)

Summary

In the methods section, the methods of research were introduced. The data collection procedure for sample collection was described with defined inclusion and exclusion criteria. The Johns Hopkins Evidence Based Practice model (Dearholt & Dang, 2018) was identified as the tool used for critically appraising the data. Finally, the JHEBP model was described in depth for the use of critically appraising the data.

CHAPTER III

LITERATURE REVIEW AND ANALYSIS

With the climate of the population changing in the United States, the healthcare needs of diverse people groups are dynamically changing. Therefore, healthcare workers need to be aware of the cultural needs of a variety of people groups. This need has implications for nurses and nurse educators; since nurses may need to learn about different cultures. They may also need to learn how to provide culturally humble care. Educators might need to explore a variety of pedagogical approaches for teaching nursing students about cultural competence, as well as how to measure changes in cultural competence.

Pedagogical approaches for cultural competence

Kardong-Edgren and Campinha-Bacote (2008) identified that there was a lack of evidence-based research on how and what to teach in relationship to cultural competency. In this non-experimental, descriptive study, the purpose was to evaluate the graduating nurses' cultural competency from four programs that used different curricular approaches. The various approaches included incorporating cultural topics into courses, specific classes, and immersion experiences. The authors of this study used only a posttest design to measure students' cultural competency. A Likert scale instrument was used for a posttest survey called the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R©).

Four schools were chosen to administer the IAPCC-R© tool to graduating BSN students. A snowball sampling technique was used to choose the sample for the study. There were 293 potential participants, however only 218 students actually participated (N = 218). Each participant completed the IAPCC-R© survey and each survey was coded with a number for

tracking purposes. Those that chose to participate could enter their names in a raffle to win $50. Once the surveys were completed, the data was analyzed using the statistical test of analysis of variance (ANOVA).

The IAPCC-R© instrument was designed to measure five cultural constructs related to cultural competence: desire, awareness, knowledge, skill, and encounters (Campinha-Bacote, 2007). Kardong-Edgren and Campinha-Bacote (2008) identified that the IAPCC- R© tool has been well used and is reliable because it has a Cronbach's alpha of 0.83. A panel of transcultural healthcare professionals verified content validity and face validity was established by a review of experts (Riley, 2010).

The results showed that all scores were within the culturally aware range and that no strategy appeared to be better than another (Kardong-Edgren & Campinha-Bacote, 2008). They found no significant difference between the various programs *(F, 3214= 1.24, p > .05).* Data showed that a majority of all participants had traveled outside the US on vacation, some had taken an anthropology course, and others had been on a mission trip. The various immersion experiences demonstrated opportunities for cultural encounters, which is key in developing cultural competency (Kardong-Edgren & Campinha-Bacote, 2008).

The study performed by Kardong-Edgren and Campinha-Bacote (2008) is classified as level III and quality C because the study is a quantitative non-experimental descriptive study and the results are of low quality because the statistical data, along with the literature review raised more questions than conclusive evidence for one specific pedagogical approach. There were also several threats to internal validity identified. Selection bias was a threat because of the snowball sampling method. In addition, instrumentation was a threat to internal validity because of the use of a Likert scale instrument and the self-reporting. External validity threats included

selection effects because of the selection bias, and measurement effects because of the instrumentation.

Aponte (2012) performed a program evaluation on teaching cultural competence as a pedagogical approach. This program evaluation was done in one undergraduate nursing program that incorporated the AACN cultural competency toolkit (AACN, 2011) into their nursing curriculum. This evaluation examined the 15-week curriculum and explored how cultural competency was taught and incorporated into the assignments. The AACN had established five competencies from Campinha-Bacote's Model of Cultural Competence (CBMCC) (Campinha-Bacote, 2011), which were suggested for BSN graduates. The CBMCC five constructs include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Aponte, 2012). This nursing program incorporated these components into the curriculum (Aponte, 2012).

The CBMCC helped to shape the 15-week course for this small, urban, BSN School. The purpose of this hybrid course was to serve as an elective in the nursing program for those in the BSN degree program. It was required for those moving from an associate degree to a BSN to provide nursing students an opportunity to grow in culturally humble care. The course was taught two times before this evaluation. There were about 30 to 40 students in each class, so about 60 to 80 students in total ($N = 60 – 80$). The students completed online assignments, group projects, and experiential opportunities.

The feedback from the students showed that it helped them learn to be more understanding and sensitive to those from other cultures. This sentiment came from the cultural awareness activities. The students identified that their cultural knowledge increased throughout the course work and that it would be transferable in nursing skills. Students identified self-

reflection as the most valuable lesson learned from the class because it allowed them to reflect on their own culture, beliefs and biases that impacted their expression of cultural humility (Aponte, 2012). The faculty identified that as the course progressed, visible positive changes were noticed in students' discussion posts and interactions about cultural topics. The faculty also appreciated the ease of teaching this class.

Aponte's (2012) non-research evidence would be rated as a level V for Program Evaluation and would be graded a B quality. The B quality rating was because the information appears to be accurate and grounded on standards by the AACN. Aponte (2012) explained the curriculum, but only provided some evaluative feedback from students following the course.

Another pedagogical approach was to use specific cultural nursing modules. Govere, Fioravanti, and Tuite (2016) completed a quasi-experimental design study that evaluated the effectiveness of the use of the Culturally Competent Nursing Modules (CCNMs). The U.S. Office of Minority Health (2014) developed three modules that consisted of three hours each with a pretest and posttest, information tools, and case studies. The authors used a pretest and posttest design to evaluate the level of cultural competence using the five cultural constructs from the IAPCC-R© (Campinha-Bacote, 2007): awareness, desire, encounters, knowledge, and skills.

The convenience sample was juniors and seniors in mid-Atlantic nursing school. Sample size was eighteen participants (N = 18). The participants were enrolled in a summer medical-surgical course and were invited to voluntarily join in the study. Institutional Review Board (IRB) approval was obtained. The instruments used to evaluate the data were a demographic assessment designed by the researcher and the IAPCC-R© (Campinha-Bacote, 2007). The

IAPCC-R© has been found to have construct validity with a Cronbach's alpha .85 and a Guttman split-half of .83 and a reliability of .78 to .96 (Govere et al., 2016).

Govere et al. (2016) administered the demographic instrument and the IAPCC-R© tool prior to completing the education modules for cultural competency. The participants had two weeks to complete the modules and then the IAPCC-R© was administered. Descriptive statistics were used to evaluate the demographic information, cultural competence constructs, and feedback from the CCNM modules. Paired *t* test analysis was done to compare the pretest and posttest scores from the IAPCC-R©. Statistical significance was considered $p < .05$. If any pretest or posttest scores were missing, the researchers substituted the mean score.

The demographic results of the study showed homogeneity and because the sample was small, that cultural competence could not be attributed to the demographics (Govere et al., 2016). The paired *t* test showed that IAPCC- R posttest scores had significantly increased ($p = <$ .001) compared to the pretest scores in the areas of participants' cultural awareness, cultural encounters, cultural knowledge, and cultural skills, but did not affect the cultural desire construct (Govere et al., 2016). For the level of cultural competence, the scores prior to the education resulted in 89% of participants being culturally aware and 11% being culturally competent. After the education, 11% were culturally proficient, 67% were culturally competent, and 22% stayed at the culturally aware level (Govere et al., 2016).

Govere et al. (2016) concluded that the CCNMs are an effective tool for training in cultural competence. The results showed that the cultural desire of the students remained consistently high between the pretest and posttest and thus the desire for cultural awareness may have affected the learning with the modules. The modules were multisession experiences and so the researchers concluded that assisted in the learning process. Finally, the modules were

specific to the field of nursing and cultural competence for nursing which also seems to have a positive effect on the learners because it is specific to the role of the nurse.

This evidence is level II with a B quality rating. There are several threats to internal validity. First, there is selection bias because of the small sample size. Instrumentation is a threat because of the use of a self-reporting Likert scale survey in the IAPCC-R©. Mortality was a threat because one participant did not complete the posttest. External validity was threatened with selection effects due to selection bias, measurement effects due to instrumentation, and reactive effects due to the pretest and posttest. No power analysis was done. There also was a lack of diversity in the demographics of the participants. However, Govere et al., (2016) demonstrated that the sample differences were normally distributed and thus showed the sample size to be effective. Govere et al. (2016) suggested more studies need to be done and to test behavioral outcomes that resulted from the module training.

Gallagher and Polanin (2014) performed a meta-analysis on the impact of cultural sensitivity training and the positive impact on patient outcomes. In the study, data were compiled and reviewed about various programs that incorporated cultural competence training, and evaluated cultural competency for nursing students and nurses. Twenty-five studies that implemented an intervention to help develop cultural competence in nursing students and nurses were reviewed ($N = 25$) (Gallagher & Polanin, 2014). Various measurement tools were used to measure cultural competence such as the IAPCC-SV©, the Transcultural Self-Efficacy Tool (TSET) (Jeffreys & Smodlaka, 1999), the Cultural Self-Efficacy Tool (CSES), and the Caffrey Cultural Competence Healthcare Scale (CCCHS) (Caffrey, Neander, Markle, & Stewart, 2005).

Gallagher and Polanin (2014) used an extensive process for reviewing and determining the inclusion or exclusion of reviewed studies. The inclusion criteria were that a study must

have incorporated a cultural competence education program and a tool to measure cultural competence (Gallagher & Polanin, 2014). Other inclusion criteria were the use of a pretest and posttest evaluation of cultural competence or studies that used a treatment-control design. Both authors of this study independently performed the search and screening process and then they agreed on what studies would be used. There was no exclusion language or date restrictions. The coding consisted of organizing demographic information, outcome measures, length of study time, and how each program was implemented. Again, both authors independently coded the studies and had a high rate of agreement (90%) and they worked to improve upon those they disagreed.

The effect size for all 25 studies was the standardized-mean difference. However, Gallagher & Polanin (2014) used two different types of effect size. The first one was for treatment-control designs; represented by the difference in posttest means divided by the pooled standard deviation. The authors determined the inverse variance to determine the effect size for each variable. The second effect size was for pretest and posttest designs. This type of effect size looks at the magnitude of the correlation between the scores and accounts for potential bias in the difference. The authors used sensitivity analyses to test for differences in the effect sizes. When studies did not report means and standard deviations, the authors used *p* value and or *t* statistic to calculate the effect size.

Based on their review and analysis of 25 studies, Gallagher and Polanin (2014) reported a positive impact on nurses' and nursing students' cultural competence related to sensitivity training. Only four studies revealed a slight decrease in cultural competence, which could be explained by the age discrepancies and varying developmental stages of an experienced

nurse. In addition, experienced nurses might be more receptive to specific education where students may find such education too abstract.

Gallagher and Polanin (2014) found that it was difficult to synthesize the teaching methods because there was a lack of curriculum description for the cultural training. Many of the studies reported using simple lecture and discussion format as the professor taught about cultural information, while some studies also added reflective journaling or multimedia components. Other programs focused on immersion experiences or simulation techniques to develop cultural competence. In the critique of the studies, Gallagher and Polanin (2014) highlighted that only a few studies were of high standards in terms of research parameters and even those had flaws. They concluded that more research that is thorough would be beneficial to help explain the value of education in relation to cultural competence.

This meta-analysis by Gallagher and Polanin (2014) was rated as a level III with a quality rating of B for the thoroughness of the study and analysis. However, Gallagher and Polanin (2014) recommended that the authors of the reviewed studies replicate these studies with increased focus on rigor and more complete descriptions of curricula.

Immersion Experiences as Pedagogical Approach

One specific pedagogical approach is for students to have a cross-cultural experience through immersion. Allen, Smart, Odom-Maryon, and Swain (2013) performed a quasi-experimental quantitative study that examined students' cultural competence after a short-term international healthcare experience. The researchers identified that in order to decrease the health disparities among the minority groups within the United States, nurses and nursing students must learn more cultural humility. Allen et al. (2013) highlighted that cultural humility is a process and an immersion experience is part of the process for nursing students.

The research method was a pretest-posttest design that explored students' self-reported perceived cultural competence during a three-credit, three-week immersion experience course to Peru between 2006 and 2009. In this four year study, 77 students participated in the research process ($N = 77$). Of the 77 participants, only 65 were nursing students while the other 12 were from pharmacy and nutrition. No power analysis was done. IRB approval was obtained.

The Caffrey Cultural Competence in Healthcare Scale (CCCHS) (Caffrey, Neander, Markle, & Stewart, 2005) was used to examine self-perceived knowledge, self-awareness, and comfort with skills in relation to cultural competence and self-efficacy. This scale was chosen to expand on the original Caffrey work with a larger sample size and to evaluate a participant's cultural competence (Allen et al., 2013). Cronbach's alpha was calculated to measure the pretest and posttest reliability of the CCCHS (Allen et al., 2013). The validity of the instrument was not described in the research report. The CCCHS was chosen based on its cost effectiveness compared to other self-reporting instruments that aim to measure cultural competence.

The participants completed pre-trip coursework and were given the pre-trip self-assessment instrument, which was the CCCHS. The CCCHS was a Likert type self-reported scale. A brief sociodemographic questionnaire was also distributed (Allen et al., 2013). The post-trip self-assessment instrument was mailed to participants one month after the trip to Peru. The participants of the course were instructed that consent would be assumed when choosing to participate in research, but the completion of the instruments was optional and confidential. Each instrument was given a personal ID number in order for the pre and post trip instruments to be linked at the end of the study for data collection purposes. The instruments were not reviewed until after final grades were posted.

Descriptive statistics were used to analyze the data collected about demographics. Descriptive statistics performed included the means and standard deviations of profession, age, gender, language skills, and exposure to other countries.

The participants age ranged from 19 to 52-year-old with a mean age of 24.4 (SD = .07). Ten participants described themselves as something other than Caucasian-Americans. Eighteen percent of the 77 students described themselves as fluent in another language besides English and participants exposure to another country varied from none to being born in another country. The participants experience also varied in their exposure to caring for patients of different cultural backgrounds.

Allen et al., (2013) described that initially, repeated measures analysis of variance were used to examine the changes in cultural competency between the four different cohorts. However, because there was no statistically significant difference in scores, they pooled the data across the cohort groups. The researchers used parametric paired t-tests as they compared the pre-trip and post-trip instrument answers on cultural competency (Allen et al., 2013). The researchers also ran Wilcoxon signed-rank test, but the results were similar and so the researchers opted to not report on the non-parametric results. The significance testing was .001 with a Bonferroni type adjustment due to the comparisons of the 28 tested items. All data was calculated using the SPSS software (Allen et al., 2013).

Allen et al., (2013) found high internal consistency among the 28 test items and the overall results. Cronbach's alpha was .92 for the pretest and .95 for the posttest. The internal consistency for knowledge (pre - .89; post - .92) and comfort were high (pre - .85; post - .92). For the awareness dimension, it was .71 for pre-trip and .81 for post-trip. Statistical significance was found in 23 out of the 28 items and the mean increase range was from

.4 to 1.1. The authors of this study were primarily interested in the changes in the dimensions of knowledge, comfort, and awareness as well as overall cultural competency. The knowledge dimension had a mean increase that was 6.0 (5.7), $p < .001$. For the comfort dimension the mean increase was 5.7 (6.5), $p < .001$. The awareness dimension held a mean increase of 3.7 (3.5), $p < .001$. The overall cultural competency mean increase was 17.5(15.4), $p < .001$. Results showed that 62 participants had higher overall cultural competency scores post-immersion compared to pre-trip, five had no changes, while 10 students had lower perceived cultural competence. Knowledge, comfort, and awareness scores increased after immersion experience, but self-perceptions of skill competencies were not reflected in the survey (Allen et al., 2013).

The study by Allen et al. (2013) was a quasi-experimental one-group pretest- posttest design level II, with a quality rating of B. It was considered a single study and had an intervention of an immersion experience. However, it did not have a control group and the participants were not randomly assigned. There were some threats to internal validity. Selection bias was a threat due to the self-selection of participants. In addition, instrumentation was a threat because of the lack of reliability and validity identified for the instrument. Maturation was a threat due to the period of the study and the potential change in participants over time. External validity threats were selection effects because of the selection bias and measurement effects because of lack of reliability and validity evidence of the measurement tool. These threats hinder the generalizability of the study.

Isaacson (2014) also conducted a mixed method study that was a non-experimental research. This purpose of this study was to evaluate nursing students' understanding of cultural competency prior to an immersion experience and following the immersion experience. Because the study was a mixed methods design, the study used descriptive and inferential statistics to

analyze questionnaires pre and post trip as well as hermeneutic phenomenology to evaluate the students' reflective journals. A convenience sampling method was used to select the participants. Participants were senior nursing students during the academic year of 2009 to 2010 and they were invited to participate in the study that included either a four-day immersion experience (group 1) or a two-week immersion experience (group 2) on the Northern Plains reservation. There were eleven baccalaureate students that were selected for participation in this study from a small Christian liberal arts nursing program ($N = 11$).

Isaacson (2014) used a quantitative method to collect results from the Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals-Student Version (IAPCC-SV©) (Campinha-Bacote, 2007). This questionnaire was used pre and post immersion experience. As the qualitative portion of this study, the students used reflective journals to process experiences and feelings. The study had IRB approval. Participants also selected pseudonyms to protect confidentiality as they answered the IAPCC-SV© and completed the reflective journal. The data were not reviewed until after grades were posted for the semester, so students were assured that participation would not influence the study.

The IAPCC-SV© is similar to the IAPCC-R© in that it measures four categories of cultural competence (proficient, competent, aware, and incompetent) and five constructs (desire, awareness, knowledge, skill, and encounters) (Campinha-Bacote, 2007). This instrument has demonstrated face validity by review from transcultural experts and a Cronbach's alpha of .78 (Isaacson, 2014). This instrument was completed by participants before and after the immersion experience and both times sealed in an envelope for confidentiality. Students also answered questions in their reflective journal before and after the immersion experience.

The quantitative descriptive data was then analyzed by the SPSS Version 19. The comparison between the two groups was done with independent samples *t* test and paired *t* tests for the pre and post immersion test (Isaacson, 2014). The qualitative data was evaluated using the hermeneutic phenomenology, which took extensive time to evaluate and look at the literature to determine what the participant was attempting to say. Isaacson (2014) noted that data saturation was achieved by the fifth journal but all eleven were included in the hermeneutical analysis. Rigor and trustworthiness was addressed throughout the research process. Isaacson (2014) created an environment for participants to share preconceived ideas and thus credibility was maintained as well as transferability evidenced by thorough descriptions from participants. Dependability was evidenced by the participant's examples. Isaacson (2014) established confirmability by having colleagues and experts review the data.

The quantitative study findings showed cultural competence scores in Group 1 ranged from 57-71 (M = 64.87, SD = 5.38) and Group 2 ranged from 57-61 (M = 59.33, SD = 2.08). Post trip cultural competence scores for Group 1 ranged from 53-65 (M= 57.63, SD = 3.74) and Group 2 ranged from 69-74 (M = 71.33, SD = 2.52). Campinha-Bacote (2007) defined cultural awareness with scores from 41to 59, cultural competence from 60 to 74, and cultural proficiency from 75-80.

To compare the differences between the pre and posttest results, independent sample *t* tests were done to examine cultural competence. Group 1 consisted of eight students (n = 8) and group 2 consisted of three students (n = 3). The results showed a significant difference between group 1 and group 2. Participants in group 1 identified more perceptions of cultural competence (p = .037). The posttest reflected participants shift in cultural competence again with significant differences between group 1 and group 2 (p = .000). Paired samples *t* tests were done to examine

the reported levels of cultural competency and there was a significant decrease in total levels in group 1 from pre-trip (M = 64.88, SD = 2.08) to post trip (M = 57.63, SD = 3.74, p = .008) (Isaacson, 2014). In group 2 there was a significant increase in cultural competency from pre-trip (M = 59.33, SD = 2.08) to post-trip (M = 71.33, SD = 2.52, p = .045).

The qualitative data revealed that students had negative preconceived thoughts about their understanding of American Indian populations, but the participants categorized themselves as culturally competent. However, after the immersion experience the participants identified a broadened understanding of this people group and the IAPCC-SV© scores reflected this shift as well (Isaacson, 2014). According to the IAPCC-SV© scores, the participants were culturally aware in group 1 post immersion. In group 2 post immersion, the participants were rated as being culturally competent. Three themes were identified through the analysis and they were seeing with closed eyes, seeing through a fused horizon, and disruption to reshaping. These themes depicted the reality that students were not as culturally competent as they thought they were prior to the immersion experience. Students' perspective allowed them to become more aware of the diversity within cultures and the need to be more culturally aware to care better for patients.

This mixed methods study by Isaacson (2014) had some strengths because it was a mixed study and compared the qualitative and the quantitative data. This study was rated as a level III with a quality of B for the reasonably consistent results and the use of the mixed method approach to draw conclusions. However, there was selection bias in the convenience sample, which was a threat to internal validity. Instrumentation was a threat to internal validity because of the self-reported nature of the IAPCC-SV©. These threats eliminate the study from being generalizable. Isaacson (2014) suggested that the results of the narratives would make this data

transferable. The qualitative research has some credibility evidenced by the reflective journal learning experiences. There is also auditability and fittingness that was evidenced by the clear research process description and appropriateness of others in finding meaning to the research.

Ferranto (2015) reviewed one school's cross-cultural experience for nursing students that traveled to Tanzania for eight days. The purpose of this interpretive qualitative study was to highlight that participation in an international cross-cultural experience would be beneficial to nursing students as they prepare to care for a variety of patients (Ferranto, 2015). The cross-cultural experience included clinical experiences in clinics, children's homes, and a variety of social settings within the Tanzanian culture (Ferranto, 2015). The course was led by faculty to ensure structure and time for reflection. Pre-trip coursework included classes on global health, and country related information about the Tanzanian culture. Data collection included reflective journaling, focus group discussions, and personal interviews. This took place during the experience, one-month post trip, and six months post experience.

There were various themes related to cultural humility that were identified and coded (Ferranto, 2015). First, the data were collected, sorted, and ranked. Then the data were coded and reviewed multiple times by the students and two faculty members. The focus groups were also recorded and were reviewed for data collection of themes. More data were compiled and compared during the six-month follow-up interviews.

Ferranto (2015) highlighted that short-term immersion experiences warrant further investigation as an appropriate teaching strategy for cultural competence. Short-term experiences appeared to be more conducive for nursing students because of the rigor of most nursing curriculum and semester abroad experiences are costlier and often prohibitive to students simply because of logistics. While Ferranto (2015) identified that students experienced culture

shock, they also gained self-awareness, cultural empathy, and leadership skills that ultimately led to a deeper expression of cultural humility.

In this qualitative study, the sample was a convenience sample and the participants self-selected class participation. There were eight participants in this study ($N = 8$). The data collection methods were reflective journaling, focus group discussions and interviews. The students completed eight journal entries while in Tanzania. There were two different focus group discussions, one four weeks after return home and one four and half weeks after return home. Finally, there were personal interviews that were conducted about six months after the trip (Ferranto, 2015). In this qualitative study, the redundant themes were identified through the data collection methods (Ferranto, 2015). The themes were:

1. Feelings of disequilibrium and culture shock.
2. Greater self-awareness and a new understanding of prejudice and bias.
3. A deeper understanding of similarities and differences.
4. An enhanced awareness of "others"" and the development of cultural empathy.
5. A sense of loss ensued after returning home.
6. Descriptions of the international cultural experience as life-changing; the development of cultural humility.

There was credibility in this study by triangulation in data collection. The auditability and fittingness were confirmed through the conclusions of what the students learned from the experience. Ferranto's (2015) study would be classified as a level III qualitative study and graded as a B quality. The B rating was for reaching data saturation with theme redundancy from participants, and reasonable recommendations consistent with literature review and the study results.

Kohlbry (2016) also examined the impact of an immersion experience on cultural competency for baccalaureate nursing students. Specifically, a need was identified for better cultural competency for nurses so that patients receive safe and effective care (Kohlbry, 2016). Campinha-Bacote's model of cultural competence (Kardong-Edgren & Campinha-Bacote, 2007), along with the recommendations from the AACN (2008) and QSEN (2017) were used as the framework for this study. Cultural competency was described as a process that is impacted by cultural encounters and face-to-face experiences.

The methodology for this study was a mixed methods design. Kohlbry (2016) used a descriptive survey design along with a qualitative questionnaire post experience. The convenience sample population was 121 nursing students from three universities over a five-year period (N = 121). The students participated in a service-learning experience that focused on healthcare delivery (Kohlbry, 2013). The instruments that were used were the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals - Student Version (IAPCC-SV©) (Campinha-Bacote, 2007) and the Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1993).

The instruments were tested for reliability and validity. In other studies, the IAPCC-SV© had a Cronbach's alpha of about 0.87 (Kohlbry, 2016). The CSES had a Cronbach's alpha range of 0.86-0.98 also from an integrative review. An expert panel (Kohlbry, 2016) determined content validity for both instruments. Data from pre and post trip surveys were analyzed with SPSS version 19.0. The qualitative data were gathered with a questionnaire with six open-ended questions for participants to answer. The responses were entered into Atlas.ti version 7, coded, analyzed, and reviewed for patterns and or themes. The demographic data was also reviewed and mean, frequencies and correlation were calculated (Kohlbry, 2016).

In this study, three different universities with nursing programs participated. After IRB approval from each university, the researcher met with each faculty that would be leading the trips. Informed consent was obtained from participants and participation was not required or dependent on their grades. The participants completed demographic information and a pre-trip survey and then a post-trip survey two weeks after the trip. In a post-trip meeting, qualitative questionnaires were completed. However, not all participants completed the post-trip information because they did not attend the meeting (Kohlbry, 2016).

Kohlbry (2016) found that the age of participants was correlated to the cultural encounters. The older the participant, the stronger the correlation, possibly explained by the fact that older respondents had more time for encounters. Both pre- and post-trip surveys showed an increase in means of all constructs of cultural competence and self-efficacy. However, there was no significance found between pre- and post-trip levels of cultural competence (Kohlbry, 2016). An unexpected finding was that some participants rated themselves higher on the pre-trip survey compared to the post-trip survey. This finding was possibly due to the participant's preconceived ideas about their own understanding of cultural competence and because of the experience, his or her perspective changed. Overall, there was a heightened awareness of cultural competence because of the immersion service-learning experience.

The qualitative data showed that the post-trip interviews had themes related to Campinha-Bacote's model that were cultural knowledge, cultural skill, and cultural awareness (Kohlbry, 2016). Other themes that emerged were cultural sensitivity, cultural self-efficacy, and identifying cultural barriers that supported the constructs of cultural encounters and desire. In addition, faculty participation in the service-learning component as well as students' direct

contribution to healthcare enhanced the learning outcomes for students learning more about cultural awareness, sensitivity, and competence.

The research by Kohlbry (2016) was a level III and quality B. The study was a mixed non-experimental study. The B quality is good because there are reasonably consistent results and recommendations that could be concluded.

In the quantitative part of this study, there were threats to internal and external validity. Selection bias was a threat because of the convenience sampling. Instrumentation was a threat because of self-reporting methods of the instruments. Threats to external validity included selection effects because of selection bias and measurement effects because of instrumentation.

The qualitative questionnaires and coding the answers appeared fitting and credible as evidenced by the themes that were developed and the thorough process of obtaining the results and reaching data saturation. This credibility is notable because of the prolonged engagement with participants and the use of triangulation in the research design. The data collection process was dependable in that the analytical techniques were all completed in the same way, were appropriate, and documented well in the study.

Kohlbry (2016) identified that this study had some limitations. The limitations included lack of studying gender differences and a lack of comparison between pre-trip experiences and cultural competency. These limitations limit the ability to generalize results (Kohlbry, 2016). Some participants did not return the post-immersion experience questionnaire that also created a gap in the research. However, the use of international experiences in nursing education will "contribute to the students' cultural encounters, knowledge, skills, awareness, sensitivity, self-efficacy, and understanding of cultural barriers" (Kohlbry, 2016, p. 308-309).

Instruments for measuring cultural competence

Hughes and Hood (2007) did a quantitative, non-experimental, descriptive review that examined Saint Luke's College of Nursing's curriculum for teaching transcultural nursing. The purpose was to evaluate the Cross-Cultural Evaluation Tool that measured attitudinal and behavioral changes of baccalaureate nursing students before and after the implementation of the transcultural curriculum (Hughes & Hood, 2007). They defined cultural sensitivity as foundational to obtaining cultural competence, which is a skill to be acquired like other clinical skills. The Giger-Davidhizar Transcultural Assessment Model and the Cross-Cultural Evaluation Tool (Giger & Davidhizar, 2004) were used to evaluate the nursing students' cultural sensitivity.

Hughes and Hood (2007) stated that nursing curricula traditionally struggled to emphasize diversity and highlighted stereotypes and differences rather than the need for understanding of various cultures. However, as the population has changed over the past several decades, schools were forced to broaden their curriculum and include cultural information in the content as a part of holistic nursing (Hughes & Hood, 2007). At Saint Luke's, not many students had experience with cross-cultural classes. Faculty also had little knowledge or teaching experience related to transcultural nursing. This college incorporated transcultural nursing into their curriculum as they were moving from a diploma school to a baccalaureate program. There were two levels of nursing classes and both incorporated transcultural learning in the curriculum. In the second level, a cultural evaluation tool was given to the students at the beginning and end of the cultural content, so a comparison could be made about students' culturally sensitive choices.

The study used the Cross-Cultural Evaluation Tool (Freeman, 1993) which provided a cross-cultural interaction score (CIS) and evaluated the participants' results. The sample size was 218 from five different classes ($N = 218$). This was a convenience sample. The study compared the pretest and the posttest results using the paired *t* test. The results showed consistent increase in cultural sensitivity after participants had cultural sensitivity training (Hughes & Hood, 2007). The Cronbach's alphas for the CIS results ranged from .73 to .84. The increases were again, after the cultural sensitivity training. The paired *t* test had a statistically significant increase ($p < .01$) after the cultural and Hood (2007) used factor education. Hughes analysis on the CIS tool based on the Principal Components Analysis (Tabachnick & Fidell, 1989). The tool showed four themes. The first factor theme was sharing across cultures with value for individual perceptions. This theme showed a 24.4% variance. The second theme was students acting with cultural awareness and sensitivity. This factor showed a 13.1% variance. The third theme was how students collaborated with people from diverse cultures with fairness and openness. This factor showed an 8.1% variance. Finally, the fourth theme was students embracing cultural diversity while maintaining their own culture. This factor showed a 6.0% variance. In total, these four factors showed a 51.9% variance for cross-cultural interaction (Hughes & Hood, 2007).

Hughes and Hood (2007) did not present the reliability and the validity of the CIS tool. However, because of Hughes and Hood's (2007) analysis on the CIS tool, the CIS tool may be considered valid and reliable for cultural sensitivity and may potentially be used in other programs. Hughes and Hood (2007) identified that the CIS tool was one instrument that can be used for assessing cultural sensitivity. The curriculum at St. Luke's was fashioned to help student nurses begin to develop a cultural sensitivity for all patients. With the use of the CIS

tool, the educators were able to evaluate the effectiveness of the transcultural curriculum. The faculty identified that as students develop the sensitivity to various cultures, they begin to adjust their nursing assessments and care to help with the variety of cultural needs (Hughes & Hood, 2007).

This study by Hughes and Hood is a level III with a quality level of B. It was a non-experimental descriptive study with reasonably consistent results and sufficient sample size. There were several threats to internal validity. There was a threat to internal validity because of selection bias due to the convenience sample selection. History was a threat to internal validity because the study examined participant's experiences over two years. Instrumentation was a threat to internal validity because of the self-reported survey used. It may be difficult to have transferability because of the basic level of interpretation of the data.

Loftin et al. (2013) identified that cultural humility is vital for nurse educators to teach, but it is a challenge to measure. This integrative review explored various tools that measured cultural competence in nurses and nursing students (Loftin et al., 2013). The review examined 11 instruments in terms of purpose, framework, psychometric properties, methodology and intention ($N = 11$). The instruments were self-administered, and most were based on a Likert scale. Conceptual models were often the foundation for these assessment tools such as Campinha-Bacote's model of competent care, which focuses on the provider attributes of cultural awareness, cultural desire, cultural knowledge, cultural skill, and cultural encounters model (Loftin et al., 2013). This model highlights the need for ongoing training and development with multiple assessments over time for cultural humility.

Loftin et al. (2013) acknowledged that there are limitations with some of these assessment tools. For example, the sample population used for the IAPCC-R© is typically a

convenience sample and thus hard to draw generalized and transferable conclusions to other groups of nurses or nursing students. Another limitation is the threat to internal validity by testing because these tools are self-administered so respondents may answer according to what may be the most socially appropriate answer and not a true answer (Loftin et.al, 2013). The AACN has defined culturally competent baccalaureate nursing students to possess the following characteristics: "awareness of personal cultural, values, beliefs, attitudes, and behaviors; skill in assessing and communication with individuals from other cultures; and assessment of cross-cultural variations" (Loftin et.al., 2013, p. 8). Of the tools reviewed, only two instruments measured all three characteristics.

This integrative review highlighted the importance of assessing nursing students' cultural humility and using one of the instruments identified will guide future research (Loftin et. al., 2013). Loftin et al. (2013) suggested that establishing a tool of measurement is necessary for assessing cultural competency. This review is classified as a Level V and given an A quality for its scientific rationale and thorough review of the various instruments.

Summary

In this evidence-synthesizing project, this literature review and analysis included reviewing the data from the literature about cultural competence pedagogy, immersion experiences and cultural competency, and evaluation methods for cultural competence. The literature was critiqued and appraised according to the JHEBP model.

CHAPTER IV

RESULTS AND SYNTHESIS

The current population of the United States is becoming more diverse. With the increase in diversity, healthcare is seeing more health inequities in various ethnic groups. In many cases, the inequities may be the result of a lack of understanding about a particular people group. This presents a problem for nurses and more specifically for nurse educators. Nurse educators may need to incorporate more cultural humility education into an already full curriculum.

The purpose of this evidence-based practice-synthesizing project was to examine the expression of cultural humility in pre-licensed nursing students. Not only was the purpose to examine the expression of cultural humility, but also to examine the pedagogical approaches for cultural humility and the best measurement instruments for cultural competency. Healthcare workers, such as nurses, encounter various people groups and needs of people from different cultures. The AACN (2008) has highlighted that cultural competence is an important component in nursing education.

Since cultural competence also has importance in nursing education, nurse educators may need to focus some of the curriculum around understanding various cultures. Curricula for nursing schools may include specific courses about cultural competence, online learning modules, or even cross-cultural experiences that are pedagogical approaches to teaching this topic. In all nursing curricula, educators need to determine if the learners are processing the content through an evaluation of cultural competence.

The evidence-based practice problem research question was: In pre-licensure, baccalaureate nursing students, does participation in a cross-cultural experience compared to no participation in a cross-cultural experience influence students' expression of cultural humility?

Throughout this evidence-synthesizing project, the evidence was reviewed and critiqued according to the JHEBP model. The evidence included quantitative, qualitative, mixed methods research, and non-research pieces. All pieces of evidence were given a level of research evidence-and rated in terms of the quality of each piece of evidence. Identified in the review of evidence were three main themes.

The first theme was examining the various pedagogical approaches for teaching about cultural competence. Within this theme, four pieces of evidence were identified (Aponte, 2012; Gallagher & Polanin, 2014; Govere et al., 2015; Kardong-Edgren & Campinha-Bacote 2008). Educators used traditional classroom lectures, hybrid classes, cultural competency modules, and immersion experiences to teach concepts related to cultural competence. There was no significant difference between approaches highlighted. No matter what the pedagogical approach was used, students' cultural competency awareness increased. These pieces of evidenced ranged from II to V using the JHEBP model. There was one level II, two level III, and one level V. An overall quality rating for this theme was B.

The second theme that was identified was the use of an immersion experience as a specific pedagogical approach for teaching cultural competence. Within this theme, there were four pieces of evidence identified (Allen et al., 2013; Ferranto,2015; Isaacson, 2014; Kohlbry, 2016). Various pieces of evidence were reviewed that incorporated four-day immersion experiences to three-week immersion experiences. Before and after these experiences, the students' level of cultural competence was measured and compared. The results showed an increase in cultural knowledge, comfort, and awareness. However, since there was a selection bias with the sample groups, the participants may have preconceived ideas about cultural competence that would have influenced the level of cultural competence. These pieces of

evidence ranged from level II to III using the JHEBP model. There was one level II and three level III pieces. The overall quality rating for this theme was B.

The third theme identified was effective evaluative tools for measuring cultural competence. Two pieces of evidence were identified for this theme (Hughes & Hood, 2007; Loftin et al., 2013). The evidence showed that the topic of cultural competence is hard to quantifiably measure because it is hard to measure an abstract concept. There are various tools available for measuring cultural competence. The IAPCC-R© and the IAPCC-SV© were the instruments that were used the most often when measuring cultural competence. There was one level III quantitative study and one level V integrative review. The overall quality rating for this theme was an A -.

Summary

In this evidence-synthesizing project, three main themes were identified within the evidence that was reviewed: pedagogical approaches for teaching cultural competence, immersion experiences for teaching cultural competence, and effective evaluative tools for measuring cultural competence. Each piece of evidence was reviewed and given a level and a quality rating. These pieces of evidence were further divided into themes that helped to answer the evidence-based practice question. Within these themes, the level of evidence ranged from II to V and had overall quality ratings from A- to B. (See Appendix B).

CHAPTER V

DISCUSSION AND CONCLUSION

Discussion of Findings

Cultural competency is a pressing topic in today's culture. With the increase in diversity within the population, healthcare workers are faced with the need to interact with populations from different cultural backgrounds. Healthcare inequities have become apparent as a result of lack of knowledge and understanding of cultural needs of diverse people groups (Beach et al., 2006).

The purpose of this evidence-synthesizing project was to critique the evidence for the impact of cross-cultural experiences on undergraduate baccalaureate nursing students' expressions of cultural humility. The evidence-based practice question was: In pre-licensure, baccalaureate nursing students, does participation in a cross-cultural experience compared to no participation in a cross-cultural experience influence students' expression of cultural humility?

Implications of Findings

The evidence reviewed all acknowledged the importance of cultural competence for nursing students. The evidence highlighted there are many approaches for teaching cultural competence including cross-cultural immersion experiences. Participants in an immersion experience had significant increases in cultural awareness scores on the IAPCC-R© (Campinha-Bacote, 2007) following the experiences (Allen et al., 2013; Isaacson, 2014; Ferranto, 2015; Kohlbry, 2016). The focus of this evidence-synthesizing project was to explore the impact of an immersion experience on students' expression of cultural humility. Despite that the studies struggled to quantify the abstract concept of the expression of cultural humility, the evidence displayed that there was some impact on nursing students because of the immersion experiences.

The studies acknowledged that no matter the pedagogical approach used, cultural humility education was an important concept to include in nursing education curriculum.

Limitations of Findings

The topic of expression of cultural humility is a challenging topic to quantify. Cultural humility is an abstract concept that is difficult to evaluate with a quick Likert-type scale. Within this evidence-synthesizing project, ten pieces of evidence were reviewed in attempts to try to discover what impacts a nursing student's expression of cultural humility. Because the concept of cultural humility is one that is dynamic and ongoing, it is difficult to capture an accurate picture of how one expresses cultural humility. Thus, in this project, a limitation was that it was difficult to find evidence that quantified the impact of various pedagogical approaches on one's expression of cultural humility. Furthermore, in most of the studies, the convenience samples were used and thus there was selection bias which means it was difficult to generalize the findings.

Gaps in the Findings

There were limited research studies on the impact of immersion experiences on a nursing students' expression of cultural humility. Also, the studies were unclear about specific definitions of cultural competence and cultural humility. Since this is a topic that is becoming more prevalent now, there is a lack of long-term research investigations on the expression of cultural humility years following an immersion experience.

Recommendations for Future Research

While there have been some studies done on the impact of cross-cultural experiences on nursing students' expression of cultural competence, in the future there could be more robust studies performed. Furthermore, these studies should include larger sample sizes and be more

diverse in gender, age, and ethnicity. Another suggestion for future studies would be to evaluate the level of cultural competence five years after the immersion experience. Future research could also include examining the impact of classroom cultural competence education in conjunction with a cross-cultural immersion experience. Another consideration for future research would be to examine the expertise level of the nursing faculty for teaching cultural competence. Finally, studies could be done on the psychometrics of the cultural competence measuring instruments.

Impact on Nursing Education

As evidenced throughout this project, cultural competence is an increasing area of concern for nursing students with the dynamic changes occurring in the population of the United States. Cultural competence is a difficult concept to measure. Further dialogue may need to include refining and defining specific terminology related to cultural competence and the expression of cultural humility.

The author of this project would propose that expressing cultural humility is a process and becoming more culturally aware takes time. Within nursing education, educators should approach cultural humility as a journey. Students need to learn the art of hearing the narrative of a person's life experience. Learning this art would best take place in the context of being immersed in another culture as a supplement to classroom learning. As a student learns the textbook knowledge, the immersion experience would allow for the application of knowledge.

Educators should work to incorporate cultural education throughout the curriculum and supplement the education with experiences that would complement the classroom learning. Many nursing programs are acknowledging the need for cultural competency education and attempting to incorporate various pedagogical approaches for teaching cultural humility. As a

result of this evidence-synthesizing project, nurse educators should attempt to include cultural competence education in their curriculum in the classroom and supplement the learning with an immersion experience. Educators should also work towards measuring the impact of the education on the expression of cultural humility.

Chapter Summary

In this chapter, the problem, the purpose, and the evidence-based practice question was reviewed. Also, limitations and suggestions for future research were highlighted. Finally, the impact of cross-cultural experiences and pedagogical approaches on nursing education was discussed.

Summary of Project

In this evidence-synthesizing project, the topic of the pedagogical approaches for teaching cultural humility was examined. Specifically, this project compared immersion experiences with traditional classroom learning. The evidence also reviewed various approaches for measuring cultural competency. The purpose of the project was to determine if cultural competence or the expression of cultural humility improves after an immersion experience.

In chapter one, the project was introduced and included the problem statement, the background and need, the purpose statement, the evidence-based practice question, the significance to nursing education, and definitions for terms used throughout the project. In chapter two, the methods for data collection and critique were discussed. In chapter three, the literature was reviewed and analyzed. In chapter four, the results of the collection of evidence were reported and synthesized. Finally, in chapter five, implications, limitations, future recommendations, and the impact of the topic on nursing education was discussed.

Cultural humility is the process of learning to understand people from a variety of backgrounds. Nurse educators must teach students how to begin this process of expressing cultural humility towards patients. The evidence has shown that cultural awareness can decrease health disparities and inequities. Nurses that practice culturally humble care can help to improve healthcare for the increasing diverse population.

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Appendix A

Data Summary Table

Authors & Date	Evidence Type	Setting, Sample, & Sample Size	Content	Study Findings that Help Answer the EBP Question	Limitations/Critique
Allen, C., Smart, D., Odom-Maryon, T., & Swain, D. (2013)	Quasi-Experimental Quantitative	Over four-year period, students in a health professions course traveled to Peru to learn about healthcare. *N* = 77	This study compared 4 cohorts' experiences while traveling to Peru. The participants were given a pre and posttest to evaluate cultural competence-specifically knowledge, comfort, & awareness. Used the CCCHS instrument.	Post immersion scores - 62% of participants had higher cultural competence scores. These findings were similar to previous studies.	Threat to internal validity because of selection bias due to participants self-selecting. Threat to instrumentation because of the pretest/posttest design. Threat to maturation because the study spanned a four-year period and participants may change.
Aponte, J. (2012)	Program Evaluation	One urban nursing school taught two hybrid cultural competency nursing classes for 15 weeks. *N* = 60 - 80	The hybrid class used the AACN toolkit for teaching cultural competency. Campinha-Bacote's model was used as basis for this course.	At the completion of the class, students identified the importance of being more culturally aware can influence patient care.	This was given a quality rating of B for a thorough evaluation of the hybrid cultural competency course. Results were presented clearly and concise. Being a level V non-research piece of evidence, it

Authors & Date	Evidence Type	Setting, Sample, & Sample Size	Content	Study Findings that Help Answer the EBP Question	Limitations/Critique
					would be challenging to draw generalizable conclusions from these results.
Ferranto, M. (2015)	Qualitative (Interpretative)	Clinical settings in Tanzania. Participants were Caucasian first-generation college students. *N* = 8	Short-term cross-cultural immersion experience in Tanzania. Purpose of this study was to evaluate efficacy of short-term experience. Journaling, focus groups and interviews were done to collect data.	Sound theoretical background provided as rationale for trip. Effective pedagogical approaches were incorporated into pre-trip and during trip.	Participants may have preconceived bias to developing countries. Sample is convenience, homogenous group. Only immediate thoughts and feelings were evaluated, and so data collected does not and may not have long-term implications.
Gallagher, R., & Polanin, J. (2014)	Systematic review and meta-analysis	*N* = 25. Studies were selected by strict inclusion criteria that implemented one or more interventions as pedagogical approach to cultural competence.	The systematic review examined studies that incorporated a intervention to improve cultural competence.	The review showed that there are many methods to teach cultural competence. It was concluded that education in this topic is helpful either way.	

Authors & Date	Evidence Type	Setting, Sample, & Sample Size	Content	Study Findings that Help Answer the EBP Question	Limitations/Critique
Govere, L. Fioravanti, M., & Tuite, P. (2015)	Quasi-experimental Quantitative	Nursing school in mid-Atlantic region of US. Convenience sample of junior and senior nursing students. Voluntary participation. *N* = 18.	Pretest, posttest design assessing cultural construct scores and cultural competence scores before and after Completing Cultural Competence Nursing Modules (CCNMs).	Confirmed that cultural competence education is helpful for nursing students. The use of the CCNMs is a free-online resource that can be incorporated into a nursing curriculum.	Selection bias due to convenience sample, and lack of diversity in the sample group. Threat to internal validity in instrumentation due to pretest/posttest design. Mortality was a threat because one person did not complete the posttest.
Hughes, K. & Hood, L. (2007)	Descriptive Non-Experimental Quantitative	Diploma program transitioning to baccalaureate program. *N* = 218.	This study used the Cross-Cultural Interaction Score (CIS) to evaluate the effectiveness of the curriculum design to incorporate cross-cultural education. Pre/posttest instrumentation was distributed before and after education.	The CIS may serve as an effective tool for measuring cultural competence.	Threat to internal validity of selection bias because of convenience sample. Also, maturation threat because of the time period that the transcultural education began and when the evaluation tool was administered.
Isaacson, M. (2014)	Mixed study – Non-experimental and Qualitative Research	Immersion experience for senior nursing students on Native	This study examined students' level of cultural competence before	This mixed method design helped to show the importance and the	Threats to internal validity include selection bias due to convenience sample

Authors & Date	Evidence Type	Setting, Sample, & Sample Size	Content	Study Findings that Help Answer the EBP Question	Limitations/Critique
		American Reservation. Convenience sample of two groups of students. *N* = 11.	and immediately following a 4-day trip and a 2 week trip. The IAPCC-SV© was done to assess cultural competence and then hermeneutical analysis was done with the reflective journals.	impact of cross-cultural experiences on the expression of cultural competence.	and instrumentation due to pretest/posttest design. Study not generalizable due to the sample, but it could be transferable because of the detailed descriptions in the data. Attempts were made for triangulation between the quantitative and qualitative data.
Kardong-Edgren, S. & Campinha-Bacote, J. (2008)	Quantitative, Non-Experimental Descriptive study	Four groups of graduating nursing students from snowball sample of different nursing schools. *N* = 218	All students were given the IAPCC-R© that measured the level of cultural competence of healthcare workers.	No difference in outcomes related to pedagogical methods as evidenced by the IAPCC-R©. Immersion experiences provided opportunities for cultural encounters and that affected the IAPCC-R© score for encounters and cultural competence.	Internal threats included selection bias and instrumentation. No significant difference was noted in the cultural competence outcomes from the four pedagogical approaches.

Authors & Date	Evidence Type	Setting, Sample, & Sample Size	Content	Study Findings that Help Answer the EBP Question	Limitations/Critique
Kohlbry, P. (2016)	Mixed Study Non-Experimental Quantitative Qualitative	Three California Nursing schools who had participants that went on service learning trips around the globe from 1-3 weeks. *N* = 161 pre-trip and *N* = 121 post-trip.	Participant's level of competency was measured with the IAPCC- SV and the Cultural Self-Efficacy Scale pre-trip and post-trip and then six questions were asked, and themes identified post-trip.	Findings helped to identify that the use of immersion experiences can assist in educating about cultural humility.	Inability to determine appropriate length of immersion trip. Limited diversity in the population of the sample. Unable to regulate or account for the various previous international experiences. Difficulty in generalizing results.
Loftin, C. Hartin, V. Branson, M., &Reyes, H. (2013)	Literature Review	Integrative Review: Examining instruments used to evaluate cultural competency. *N* = 11.	Critique of 11 instruments that measure cultural competence.	Helpful in determining which instrument may be the most helpful for measuring cultural competence.	Some instruments may have been missed. Further testing of the studies may need to be done.

Appendix B

Data Synthesis

Level	Number of Pieces of Evidence	Author and Quality Rating of Study	Overall Quality Rating
Level II: Quantitative, Quasi-Experimental Study	2	Allen, C., Smart, D., Odom-Maryon, T., & Swain, D. (2013), C Govere, L. Fioravanti, M., & Tuite, P. (2015), B	B-
Level III: Quantitative, Non-Experimental Study Descriptive, Qualitative Mixed study	6	Kardong-Edgren, S. & Campinha-Bacote, J. (2008), C Ferranto, M. (2015), B Gallagher, R., & Polanin, J. (2014), B Hughes, K. & Hood., L. (2007), B Isaacson, M. (2014), B Kohlbry, P. (2016), B	B
Level V: Literature Review, Expert Opinion, Organization Experience (Quality Improvement, Financial	2	Aponte, J. (2012), B	A-

Level	Number of Pieces of Evidence	Author and Quality Rating of Study	Overall Quality Rating
Evaluation, Program Evaluation, Case Report, Community Standard, Clinician Experience, Consumer Preference		Loftin, C. Hartin, V. Branson, M., &Reyes, H. (2013), A	