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A Step towards Understanding Cultural Competence in Public Health Nurses

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This is to certify that I have examined this
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and have found it is complete and satisfactory in all respects,
and that any and all revision required by
the final examining committee have been made.

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12/14/12

Date

DEPARTMENT OF NURSING

Dedication

This project is dedicated to public health nurses everywhere.

I would like to acknowledgement and thank my advisor, Dr. Rozina Bhimani for her understanding and support throughout my doctoral program. I would also like to thank my reader, Dr. Pamela Hamre, and my site mentor Julie Jagim. Special thanks to my husband for his support in the pursuit of my doctor of nursing practice.

Abstract

This paper examines issues in cultural competencies in public health nursing. Using the evidence based approach; this paper integrates literature and public health nurses' perspective in understanding cultural competence in practice. A focus group of 16 participants from a Midwestern county revealed the themes; culture is inclusive, cultural competence is a process, and moral distress in the provision of culturally competent care. Findings suggest that public health nurses take a broad perspective on cultural competency in their practice.

Introduction

Public health nurses provide care in the community, where culture and diversity abound. Recognizing the impact of the environment and social determents of health, public health nurses collaborate with community agencies and other professionals to provide holistic services that build on community strengths, focusing on health promotion and the prevention of disease. As leaders working in the community, public health nurses advocate for those who cannot advocate for themselves. Without public health nurses many voices that highlight health disparities issues would be lost.

Public health nursing is, "grounded in social justice, compassion, sensitivity to diversity and respect for the worth of all people, especially the vulnerable" (Minnesota Department of Health, revised 2007, p. 1). With a rapidly changing cultural landscape and the resultant cumulative healthcare disparities, public health nurses must reaffirm their commitment to social justice, and strengthen their understanding of cultural competence in the provision of nursing care.

Background

Conceptual Framework

Culture has been defined as a pattern of acquired behavioral responses, communicated by the family, which embrace values, customs, and beliefs that guide decision making (Giger, et al., 2007, Warren, 2008). Campinha-Bacote & Munoz (2001) consider culture to be the variable with the greatest impact on a client's health belief and practice. Culture is the lens on how you view and interpret your environment. As a process, Geiger et al. define cultural competence as:

> …having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care. Competence is an

> ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having general cultural as well as cultural-specific information so the health care provider knows what questions to ask. (p. 100).

Review of the Literature

As communities and populations change public health nurses face the increasing challenge of providing culturally competent care. The U.S. Census projects by the year 2020 more than 30% of the population will identify themselves as non-Hispanic White with continued growth in minority populations to almost 50% by 2050 (U.S. Census, 2004, 2010). Increases in minority populations in Minnesota accounted for more than fifty percent of the population growth in the 1990s, with continued growth in minority populations predicated (Ronningen, 2003). In Minnesota, the non-Hispanic White population has decreased while the minority population has increased (U.S. Census, 2010).

These demographic trends in the U. S. population indicate a change in the racial and ethnic minorities of the population being served by public health nurses. Individuals in this mosaic of culture have values, beliefs, and expectations that affect their interpretation of health, healthcare, and health behaviors (Warren, 2008). Public health nurses need to provide care that is culturally congruent in order to meet current population needs.

According to the U.S. Department of Health and Human Services, Health Resources and Services Administration (2010) the registered nurse workforce is approximately 80% non-Hispanic White registered nurses The continued growth in minority populations is a sharp contrast with the current ethnicity of registered nurses bringing into focus the need for culturally competent nursing professionals.

The nursing profession has long recognized the significance of cultural competence; on clients' perceptions of health and healthcare. In 1991 the American Nurses Association (ANA) published its position statement on cultural diversity in nursing. Nurses' awareness of cultural diversity is critical at every level of nursing practice and is essential in addressing racial and ethnic disparities (ANA, 1991). Standards of practice for the provision of culturally competent public health nursing have been addressed across professional nursing organizations, including the Quad Council of Public Health Nursing Organizations (2004).

Cultural competence is viewed as strategy to reduce health care disparities through increasing access to and quality of healthcare (Betancourt, et al, 2005; IOM, 2002; U.S. Office of Minority Health, 2001; Smedley, Stith, & Nelson, 2003). Smedley, Stith, & Nelson, defines ethnic/racial disparities in health care "as racial and ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention" (p. 3).

There is a significant body of evidence indicating that culturally competent nursing care can impact health care disparities (Betancourt, et al., 2005; Doorenbos, et al., 2005; Giger, et al., 2007 & Smedley, Stith & Nelson, 2003). Culture and language influence how healthcare is accessed and how healthcare recipients are treated, which does contribute to the disparities in healthcare. Cultural competence has been associated with a reduction in health care disparities (Beach, et al. 2006; Lie, et al., 2010; Schim, Doorenbos, and Borse, 2005).

Method

The purpose of this study was to explore how public health nurses practice culturally competent care when providing nursing care to diverse populations in a Midwestern county and

to understand the current educational needs in relation to cultural competence of public health nurses in a Midwestern County.

Design

The primary research design was qualitative methodology using a focus group for data collection. Data gathered from the focus group was transcribed, coded, and analyzed by the researcher using thematic analysis to identify common themes related to cultural competence.

Sample and Setting

A convenience sample of sixteen public health nurses between ages 21 and 66 from one Midwestern county was used. The county population is 200,226 with total land area of 6,859.91 square miles. The county's population is condensed in urban areas.

Ethical Consideration

The PI obtained approval from the Institutional Review Board at St. Catherine University. Informed consent was obtained from participants prior to the study. The public health nurses were aware that participation was voluntary and they could leave the focus group at any time.

Protocol

Public health nurses from a Midwestern county were invited to participate in the study. An email was sent inviting participants to take part in the focus group at the end of a regularly scheduled public health unit meeting. Nurses were asked to participate in a focus group lasting approximately 60-75 minutes with other public health nurse where the topic was to understand issues related to cultural competency in public health nursing. Focus group questions were developed using the Krueger methodology (Krueger & Casey, 2009). After the conclusion of the unit meeting public health nurses who volunteered to participate in the focus group returned to

the meeting room. Participants consented to the study before the focus group was initiated. The Primary Investigator (PI) led the focus group, which was audio-taped. The PI also took field notes immediately following the focus group regarding observations made during the focus group.

Data Collection and Analysis

Data was collected using open ended questions and transcribed verbatim from the audiotape. After transcription the researcher read through the data several times to understand the content of the transcript. Then the transcript was analyzed for codes based on the similarity of contents. Once codes were identified, common codes were collapsed into categories. Categories were further analyzed; discrepancies were resolved and final themes emerged.

Rigor

Lincoln and Guba's (1994) qualitative standards of credibility, dependability, confirmability, and transferability were utilized. Credibility was maintained by transcribing the data verbatim and PI using bracketing to set aside preconceived, ideas, expectations or assumptions. The confirmability was maintained by data being analyzed by another researcher with qualitative expertise. Dependability and Transferability was achieved when data findings were situated with other literature. Data saturation was achieved with thick descriptions that repeated similar thoughts.

Results

Three themes emerged from the focus group data; culture is inclusive, cultural competence is a process, and moral distress in the provision of culturally competent care.

Culture is inclusive.

Participants identified culture as being very diverse and inclusive at the same time. Multifaceted aspects of human character were identified as being the part of different cultural groups. For example, race and ethnicity of Hmong, Hispanic, Native American, Somali, Black, Croatians, Serbians, Finnish, were prominent examples but they also included religion such as Catholic, Jewish, Jehovah's Witness as part of cultural diversity. Other life identity such as gay, straight, transgender, or socio-economic stratification of homeless, unemployed, uninsured, underinsured, were considered having different culture. Most considered blind, deaf, foster families, grandparent families, adoptive families, and immigrants as a mosaic of cultural fabric. Participants stated:

> "Culture is not restricted to race but encompasses nationality, religion, family composition, financial status, generation, sexual orientation, and location… It's not just the color of our skin…There is a culture I mean there is a culture in every group of people that we work with. I think as White Anglo Saxon Americans we have our own culture, Native Americans have their own culture, we have to develop some kind of understanding within each culture to be able to really understand them"
>
> "Not only that you also have your poor population and their needs, and your middle class population and affluent population you can subset that into your drug population, and single parent population…Right it's kind of the frame work in which you're living.".

Cultural competence is a process.

Culturally competent care was seen as a part of daily life and interactions. Public health nurses identified respect, interest, and listening to be the core processes of cultural competency. Public health nurses stated, "It is respecting the different cultures and beliefs" and "I think it is

more important that you show you are interested in the person and willing to listen rather than knowing everything about them."

Defining culturally competent care for populations also included being open-minded and incorporating the client's culture in the plan of care. One public health nurse stated, "I think being culturally competent is going in with an open mind for everybody we see and being non-judgmental about the things we see that are different from our culture and different from our way of life different from our beliefs." Another participant added, "Being aware of a persons' culture their beliefs not imposing your own and delivering services that appropriately fit it."

Participants indicated that cultural competency was a part of daily process which included initial client assessment, ongoing assessment and meeting their clients' needs. If during their practice something confronted them or they had little knowledge from a cultural perspective, they searched for knowledge via the internet and diversity trainings. "I agree, getting a good history but if there is some things I don't understand I will try to learn it myself." Public health nurses indicated processing the information is required so they can attend to their clients need keeping in mind their cultural context. Participant said, "I think a lot of how I provide care that is more culturally appropriate is this dance I do with clients. It's kind of … not really being the authoritarian but working with them recognizing where they are at yet with them and yet always having a goal of better health in the end."

Moral distress in the provision of culturally competent nursing care

Public health nurse voiced some frustration and reflected on many challenges that are encountered in the provision of culturally competent care. It was apparent that nurses struggled with personal values and ethics. Values tensions between public health nurse and the clients they care for were evident as one public health nurses voiced,

> "One of my challenges is you will do an assessment because somebody wants the service and you're looking at the assessment thinking that's the granddaughter or that's the daughter and she wants to get paid to take care of grandma or grandpa and that's a challenge for me but that's probably their culture because they have no money and this is one way of helping them survive in their community but I would say to my parents I will come and help you but you pay me but I'm in a different culture than that person so I internalize that I wouldn't say that to them but that's one of my difficulties."

While several agreed to this concern another public health nurse stated,

> "I think something I have to remember for me is a challenge is I can present services to an individual just like you've been talking, I can't make them accept, I can only offer what I can offer. I can't make everything all better. You know I can't be all things to all people and sometimes that is a little hard, especially when that is an elderly person issues."

Public health nurses also voiced frustration about not being able to connect with other public health colleagues to navigate and learn from each other's experiences in the delivery of culturally competent care. One public health nurse expressed,

> "We all have issues where we hit the wall with a client and my issues might be different than (other public health nurses). I feel you don't get the chance to really talk about that how it really feels to hit the wall because it's bound to affect how you work with the next client when they hit that certain wall as well. Let me just say an example is clients that live on a very small budget and they don't have food in the refrigerator but yet they have three cats and two dogs so they have to spend money on litter and food and vet and whatever or clients who have children in some cases small children babies who go back

> to using and they abandon those kids and that's a wall for me because even though I understand addiction in my mind that's not Ok and that's why I was there to try to help and I think that sometimes if you don't recognize that and talk about it with whoever and sort it out it will affect how you approach the next person. So that's kind of a frustration I recognize it as a challenge for me."

Discussion

Most public health nurses acknowledged that culture is broad and includes many variations, not being confined to race or ethnicity. Public health nurses also recognized the overlapping and melding of cultural components which is consistent with definitions of culture in Giger (2013) and Leininger& McFarland (2002).

Participants described cultural competence as a process. In their article, Racher and Annis (2007) discuss the challenges of working with diverse clients in the community recognizing cultural competence as a process requiring a life-long commitment. Jirwe, Gerrish, and Emani (2006) examined the essential components of cultural competence described in nine theoretical frameworks. Their analysis revealed, "Cultural competence can be seen as a step-by-step process where the nurse becomes culturally aware and then makes an effort to continuously develop this knowledge" (p14). Schim, Doorenbos, and Borse (2005) reflect that cultural competence is a behavioral construct, and healthcare providers should coordinate their competencies with current client populations. Our results support the literature findings that culture is inclusive and it is a part of the process of public health practice.

Public health nurses voiced moral distress when sharing challenges in the provision of culturally competent care. Moral distress has been defined as occurring when "You know the ethically appropriate action to take, but are unable to act upon it" (AACN, 2009, p.1) and/or

"You act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity" (AACN, 2009, p. 1). Public health nurses voiced distress when their own value system was in conflict with their client's value system. However, if nurses use the lens of social justice where preserving human dignity is paramount; these value tensions are likely to ease.

Limitation of Study

The sample size is restricted to one large county in Minnesota. In addition, it is possible that in the focus group, some people may not have contributed all of their thoughts. These study participants are from a Midwestern county and therefore, results must be interpreted with caution.

Conclusion and Recommendations

In this study public health nurses recognized that culture is a complex phenomenon and that culturally competent care is a process. Culture has powerful influence on health, healthcare and health behaviors. The nursing profession has the ability to impact policies and outcomes related to culturally competent care and health care disparities. Important aspects of culturally competent care include being aware of one's own culture while not letting it influence others, respecting differences while demonstrating an understanding of the client's culture, and the ability to modify care to be consistent with the client's cultural needs. It is recommended that moral distress as it relates to the provision of culturally competent care should be addressed so both nurses and their clients engage in a nurturing, trusting relationship that fosters human dignity and growth.

References

American Association of Critical Care Nurses (AACN). (2009). *Position statement: Moral distress* Retrieved from http://www.aacn.org/WD/practice/Docs/Moral_Distress.pdf

American Nurses Association. (1991). *Position statement: Cultural diversity in nursing practice.* Retrieved from http://www.nursingworld.org/Mobile/Code-of-Ethics

Beach, M. C., Gary, T. L., Eboni G Price, E. G., Robinson, K., Gozu, A., Palacio, A., Smarth, C., Jenckes, M., Feuerstein, C., Bass, E. B., Powe1, N. R. & Cooper, L .A. (2006). Improving health care quality for racial/ethnic minorities: a systematic review of the best evidence regarding provider and organization interventions. *BMC Public Health*, *6*(104) DOI: 10.1186/1471-2458-6-104

Betancourt, J. R., Green, A. R., Carrillo, J. E. & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2). 499-505. DOI: 10.1377/hlthaff.24.2.499

Campinha-Bacote, J. & Munoz, C. (2001). A guiding framework for delivering culturally competent services in case management. *Case Manger 12*(2). 48-52.

Doorenbos, A. Z., Schim, S. M., Benkert, R. & Borse, N. N. (2005) Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research, 54*(5), 324-331.

Giger, J. N. (2012). *Transcultural nursing: Assessment & intervention (6th ed.).* St. Louis, MO: Elsevier Mosby.

Giger, J., Davidhizar, R. E., Purnell, L., Harden, J. T., Phillips, J. & Strickland, O. (2007). American academy of nursing expert panel report: Developing cultural competence to

eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing, 18*(2). 95-102. DOI: 10.1177/1043659606298618

Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, D.C. National Academies Press

Jirwe, M., Gerrish, K. & Emani, A. (2006). The theoretical framework of cultural competence. *The Journal of Multicultural Nursing & Health, 12*(3). 6-16.

Krueger, R. A. & Casey, M. A. (2009). *Focus groups: A practical guide for applied research (4th ed.).* Thousand Oaks, CA: Sage Publications, Inc.

Lie, D. A., Lee-Rey, E., Gomez, A. Bereknyei, S. & Clarence H. Braddock III, C. H. (2010). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine, 26*(3). 317–25. DOI: 10.1007/s11606-010-1529-0

Leininger, M. & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research, and practice (3rd ed.).* New Your, NY: McGraw-Hill.

Lincoln, Y. S., & Guba, E. G. (1994). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Minnesota Department of Health. (Revised 2007). *Cornerstones of public health nursing*. Retrieved from http://www.health.state.mn.us/divs/cfh/ophp/resources/docs/cornerstones_definition_revised2007.pdf

Oberle, K. & Tenove, S. (2000). Ethical issues in public health nursing. *Nursing Ethics, 7* (5): 425-38.

Quad Council of Public Health Nursing Organizations. (2004). Public health nursing competencies. *Public Health Nursing 21*(5), 443-452.

DOI: 10.1111/j.0737-1209.2004.021508. x

Racher, F. E. & Annis, R. C. (2007). Respecting culture and honoring diversity in community practice. *Research and Theory for Nursing Practice: An International Journal, (21)4,* 255-270.

Ronningen, B. J. (2003). *Immigration tends in Minnesota.* [PowerPoint slides]. Retrieved from www.demography.state.mn.us/DownloadFiles/immig72103.ppt

Schim, S. M., Doorenbos, A. Z., & Borse, N.N. (2005). Cultural competence among Ontario and Michigan healthcare providers. *Journal of Nursing Scholarship, 37(*4), 354–360.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, D.C. National Academies Press. Retrieved from http://www.nap.edu/catalog/12875.html

U. S. Census Bureau (2004). *U.S Interim projections by age, sex, race and Hispanic origin.* Retrieved from http://www.census.gov/population/www/projections/usinterimproj/natprojtab1a.pdf

U. S. Census Bureau (2010). *State and county quick facts.* Retrieved from http://quickfacts.census.gov/qfd/states/27/27137.html

U. S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) (2010). *2010 National healthcare disparities report.* Rockville, MD. Retrieved from http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf

U.S. Department of Health and Human Services, Health Resources and Services Administration (2010). *The registered nurse population: Findings from the 2008 national sample survey of registered nurses*. Washington, D. C. Retrieved from

http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf

Warren, B. J. (2008). Ethnopharmacology: The effect on patients, health care professionals, and systems. *Urologic Nursing*, 28(4), 292-295.