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**THE TRANSFORMATION OF BACCALAUREATE NURSING CURRICULUM:
A MULTICULTURAL APPROACH TO OPTIMIZE CLINICAL COMPETENCE**

by

Sharon Marie Burke

A Dissertation

Submitted to the Faculty of the
Department of Educational Leadership
College of Education
In partial fulfillment of the requirements
For the degree of
Doctor of Education in Educational Leadership
at
Rowan University
April 28, 2011

Dissertation Chair: Joanne Damminger Ed.D

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Dedication

To My Family

Brendan Burke
Ashlynnne Burke
Adam Burke
Sophia Burke

This dissertation is dedicated to my family. The countless number of hours I spent during this process could only have been possible with the love, support, and understanding of my husband, daughters, and son. The hours of separation, although painful, allowed me to fulfill my life long dream of attaining the degree of Doctor of Education. I am forever indebted to you.

Abstract of The Dissertation

The Transformation of baccalaureate nursing curriculum: A multicultural approach to optimize clinical competence

By

Sharon Marie Burke

Academic Year 2011

Dissertation Chair: Joanne Damminger Ed.D

Doctor of Educational Leadership

This action research study sought to address the need for multicultural awareness in nursing education. The purpose of this action research study was to improve baccalaureate nursing students' cultural competence and multicultural awareness through infusing multicultural awareness education in the JSN curriculum. Education sessions were implemented to increase multicultural awareness to improve nursing practice. This mixed method action research project was conducted during the 2009-2010 academic year. Data collection techniques included surveying nursing faculty, administrators and baccalaureate students in the Jefferson School of Nursing as well as conducting student focus groups. Descriptive statistics and thematic coding were used to analyze data collected during this study.

This study had several major findings. Findings include that: students believe multicultural awareness education is valuable to them, the Jefferson School of Nursing (JSN) should do more to provide multicultural awareness education in the curriculum, students believe the best way to learn about culture is to listen to a member of the culture being taught, JSN students largely do not know where to find cultural resources in the practice setting, and bias exists toward breast-feeding mothers in the hospital practice setting. Identified barriers to implementing multicultural awareness were: lack of

comfort, ignorance and prejudice, lack of time in the program, lack of willingness on the part of the learner or teacher, fear, and lack of diversity in nurse educators.

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Chapter 1

Problem Statement

Introduction: Multicultural Awareness in Higher Education

Globalization continues to diversify the United States population. This trend is evidenced in higher education, and it is predicted that by the year 2020 minority students will outnumber white students (Chronicle Research Services, 2009). Despite the diversity brought to the U.S. by virtue of globalization, higher education's dominant academic culture continues to privilege white, middle-class and male values and practices (Archer, 2007). As the majority population shifts from white to multicultural, the thoughts and actions of higher education must shift to fit the needs of the consumer (Archer, 2007; Farmer, 2002; Hegarty, Walsh, Condon & Sweeney, 2009; Yarbrough & Klots, 2007). Globalization and societal change historically present challenges for most educational programs and the field of nursing education is no exception. The challenge in higher education for nurses is to ensure that professional education remains relevant and keeps abreast of societal and healthcare changes (Hegarty et al., 2009). The time for curricular reform is upon us in higher education. Higher education must commit itself to implementing dynamic educational reform if it is to be effective in educating students from culturally diverse groups (Farmer, 2002).

Globalization has also created a challenge in the delivery of health care to a variety of diverse populations. Patients need a nursing workforce that can tailor knowledge and skills to provide culturally competent care (Royal College of Nursing, 2004). Nursing curricula must change to allow the graduate the ability to provide culturally appropriate interventions and the ability to communicate an awareness of

cultural diversities in the workplace (Hegarty et al., 2009). Understanding that nurses are the largest group of healthcare workers, it is imperative to provide them with a curriculum that will allow them to be proficient and highly effective in a diverse workplace. One component of this effectiveness involves an awareness of one-self, with or of the world and others, and the ability to view various issues through different diversity lenses (Leuning, 2001).

Significance of the Study.

This action research study sought to address the need for multicultural awareness in nursing education. The Essentials of Baccalaureate Education for Professional Nursing Practice (Essentials) is an educational framework for the preparation of professional nurses, endorsed by the American Association of Colleges of Nursing (AACN). The Essentials meet the Institute of Medicines' recommendations for the core knowledge needed for all healthcare professionals. The Essentials apply to all pre-licensure and registered nurse (RN) completion programs. Program curricula are designed to prepare students to meet the end-of-program outcomes delineated under each Essential (AACN, 2008). 2008 heralded a revision of the Essentials document, based in part, on the need to recognize the impact of globalization. The AACN (2008) asserts:

The environments in which professional nurses practice have become more diverse and more global in nature. Increasing globalization of healthcare and the diversity of the nation's population mandates an attention to diversity in order to provide safe, high quality care. The professional nurse practices in a multicultural environment and must possess the skills to provide culturally appropriate care. According to the U.S. Census Bureau (2008), the nation's minority population

totaled 102 million or 34% of the U.S. population in 2007. With projections pointing to even greater levels of diversity in the coming years, professional nurses need to demonstrate a sensitivity to and understanding of a variety of cultures to provide high quality care across settings (p. 6).

In the revised Essentials document the AACN moves from five essentials, or core competencies, to nine. It is assumed, upon graduation, that the baccalaureate generalist is prepared to care for diverse populations. This need is addressed in seven out of nine of the *Essentials*. Nursing curricula must change in order to address the standards set forth by the AACN. The specific additions to the curricula are addressed per *Essential*. *Essential I* addresses the need to educate the graduate to apply knowledge of social and cultural factors to the care of diverse populations. *Essential II* addresses the need to educate the graduate to promote achievement of safe and quality outcomes of care for diverse populations. *Essential IV* addresses the need to educate the graduate to apply patient-care technologies as appropriate to the needs of a diverse patient population. *Essential V* addresses the need to educate the graduate to explore the impact of socio-cultural, economic, legal, and political factors influencing healthcare delivery and practice, discuss issues of equity, access, and social justice, and to evaluate the impact of social justice in healthcare delivery. *Essential VII* addresses the need to educate the graduate to assess health beliefs of diverse populations, provide culturally appropriate health promotion interventions, and advocate for social justice, including a commitment to the health of vulnerable populations. *Essential VIII* addresses the need to educate the graduate to recognize the impact of attitudes, values, and expectations on the care of vulnerable populations. Lastly, *Essential IX* addresses the need to educate the graduate to

use culturally appropriate approaches to care, develop an awareness of diverse beliefs and values and their impact on healthcare, and demonstrate tolerance for the ambiguity and unpredictability of the world and its effect on the healthcare system as related to nursing practice (AACN, 2008). Clearly a need exists for contemporary, relevant, multicultural awareness education and diversity training in nursing education

An Emerging Concern for the Jefferson School of Nursing.

The Jefferson School of Nursing (JSN), part of Thomas Jefferson University (TJU), is located in center city Philadelphia, Pennsylvania. The school offers three undergraduate, baccalaureate nursing programs: the traditional two year program, the Accelerated Pathway to the Master of Science in Nursing (APW), and the Facilitated Academic Course Track (FACT) toward the Master of Science in Nursing, each of these programs being accredited by the Commission on Collegiate Nursing Education (CCNE). The CCNE, stemming from the AACN ensures the quality and integrity of baccalaureate, graduate, and residency programs in nursing (AACN, 2008). The revision of the Essentials document in 2008 presented a unique challenge for nursing program curriculum. As the school approached accreditation there was reluctance to change the curricular structure since CCNE accreditation documents must show evidence that the school consistently enacts the certified curriculum. In preparation for post accreditation there was a great need to change the curriculum to meet the revised competency standards of the AACN. Each graduating class is expected to master identical core competencies, thus, an innovative strategy to deliver the content was in demand.

In 2008, as a faculty member in the school of nursing, I was briefed on the revision to the Essentials document. Subsequently, I was charged with examining the

undergraduate curriculum to identify where the curriculum specifically addressed the revised Essentials document. I identified that although many of the offered courses listed cultural diversity or cultural competency in the objectives, in actuality neither classroom teaching, nor assigned readings specifically addressed cultural diversity. This inconsistency guided my interest in finding a way to implement the necessary educational revisions without changing the overall structure of the curriculum.

Purpose of the Study

The purpose of this action research study was to improve baccalaureate nursing students' cultural competence and multicultural awareness through infusing multicultural awareness education in the JSN curriculum. The study also contributed to the JSN, by moving the curriculum, students, and the profession of nursing towards social justice. Implementing multicultural awareness education also sought to satisfy the competency standards set forth by the AACN. In addition, the AACN, as the JSN's accrediting body, sought evidence to substantiate that the JSN delivers what it promises it will in its curriculum. This change project ensured that the JSN has tangible evidence that faculty supply the multicultural education to meet the demands set forth by the AACN. The topic, addressed in several competency standards, that drove this project is cultural diversity. Despite the fact that the JSN espoused to meet the core competencies addressed in the Essentials document, it fell short on the delivery of the content.

To accomplish the goal of addressing the competency standards, this study sought to discover ways in which other schools of nursing addressed the diversity competency standards. Gathering this information allowed me to understand what tools or educational programs were currently in use, and if they were deemed effective. This

information was valuable to me as I moved forward to plan a multicultural awareness educational implementation of my own in the JSN.

This action research study intended to implement a multicultural awareness educational series for all undergraduate nursing students. At the JSN the existing nursing practicum includes an Alternative Clinical Experience (ACE) day. The ACE day is identified in the school as an educational seminar day to address clinical issues not encountered during the clinical practicum. During the new multicultural awareness education session I first presented an educational seminar specific to one culture, which was titled, "Health and Illness in the Black Population." Pre- and post-tests, small group learning sessions, and focus groups were conducted during the ACE day sessions. Data collection embedded in the ACE experiences guided future learning sessions and contributed to future cycles of the action research study.

One specific culture was selected for presentation across all student populations. I believed that consistency would be the key to collecting meaningful and consistent data from student audiences and that providing a different culture to each student group would not produce meaningful results. The rationale for selection of the Black population is discussed in Chapter 4. It is paramount to note that the purpose of this action research project was not to learn about the Black population, instead, it was to find a meaningful way to present multicultural awareness education to baccalaureate nursing students. This action research project was targeted at improving the JSN and was not intended to discuss race or racism.

This change project had potential to profoundly impact my leadership, nursing education, and the practice of nursing. As I traveled through each phase of the project I

had the ability to view my own leadership, reflect upon it, and reinforce or change current behaviors. The goal of implementing this change project was two-fold. I had the unique opportunity to contribute to my workplace by addressing the revision of the JSN's current competency standards. Furthermore, I had the unique opportunity to implement a project that is in-line with my personal values. I had the potential to provide nursing students with an understanding of perspectives different than their own. If successful, this open-mindedness could translate into their careers as professional nurses and benefit society at large.

Research Questions

This study sought to answer the following questions about the change project:

1. How does the “Implementing Multicultural Awareness Education in Undergraduate Nursing Curriculum Project,” contribute to the social and academic perspectives of nurse candidates?
2. How will nursing students perceive that multicultural education will impact their patient care?
3. What are the barriers to providing multicultural education to baccalaureate nursing students?

The study sought to answer the following questions about my leadership:

1. How were the actions put forward consistent with my espoused theory of leadership?
2. How did my leadership of the change project impact the manner in which I conduct myself in my workplace?

A mixed method of data collection was employed in this study. Mixed methods are well suited in nursing research, particularly in evaluation research. Evaluation research is the application of research methods to the study of programs, projects, or phenomena (Houser, 2008). This study collected quantitative data through the use of pre and post-test Likert scales. Qualitative data was collected through the use of two open-ended questions on post-test surveys and through focus groups.

Conclusion

This action research project could only be performed after discovery of myself through doctoral preparation. Only after reflection of ourselves can we fully understand our relationship to others in our lives and what our personal values are. This action research study was driven by an inner desire to move society toward social justice. I believe this is one important contribution I made to the world. This next chapter explains my understanding of myself as a leader in evolution.

Chapter 2

Leadership Platform

Introduction

Leaders motivate followers to perform beyond their own expectations based on the leader's idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Transformational leadership expects leaders to display conviction, to take stands on difficult issues for their followers. They excite, arouse and inspire their subordinates to accomplish with extra effort (Cheng & Baron, 2006).

Formative learning occurs in childhood through socialization and through schooling. Approved ways of seeing and understanding, shaped by our language, culture and personal experience, collaborate to set limits to our future learning (Mezirow, 1991). An effective leader seeks commitment by the follower, they are dynamic, intuitive, and possess tremendous power as change agents.

Leaders are not born they are made. To be a nursing leader one must first be a nurse. To be an educational leader one must first be an educator. My life puts me in the position to be both. The tasks of being a nurse include, but are not limited to, assessment, diagnosis, planning, implementation, and evaluation. Nursing leadership is defined by action. This action manifests in the behavior of "one who is directly involved in providing clinical care, continuously improves care and influences others" (Cook, 2001, p 33). There is transference in the practice of nursing and the practice of education. An educator, too, has tasks associated with her practice. Educational leadership can also be defined by action. This action manifests itself in the behavior of one who is directly

involved with providing education (i.e. teaching), continuously improving education, and influencing others.

The day-to-day interactions we have shape our lives and personalities. Each new day brings with it a new lesson to learn. When asked to speak about myself as a leader I reflected back on my life and thought of specific experiences that impacted me in some profound way. During my childhood I was raised in a low socioeconomic environment where I was one of few Caucasians in a predominantly African American neighborhood. Spending several years in this type of environment afforded me the ability to experience racism and reverse racism. Drawing from this experience I understand that I stand for social justice. I desire to direct my leadership to promote justice and equality for people regardless of skin color or socioeconomic status.

Directly linked with racism I experienced sexism. The healthcare system is largely patriarchal and men are typically viewed as being the decision makers and authority figures. In this type of environment nurses, who are largely women, are viewed as being subservient to men. Working day-to-day in this environment engrains this mentality into healthcare workers and perpetuates the inequitable climate. These experiences too direct my leadership to promote a level playing field for men and women alike and to move the patriarchal nature of healthcare into that of an egalitarian nature.

Throughout my professional career I found myself being thrust into leadership roles time and again. I frequently wondered to myself what others saw in me that I did not see in myself. Writing my leadership platform provided me the ability to look at myself critically, both personally and professionally. Through this process of self-discovery I found that I am a sensitive and kind person. I found that I have a voice and a

strong desire to do good things for others. I began to see what I had not seen before. Others placed me in leadership roles because my leadership is authentic. Others recognized my leadership potential before I could; thanks to them I evolved into the person I am today.

Personal Theories: Transformational and Transactional Leadership

I am a self identified transformational leader at heart but identify my leadership as transactional much of the time. As we age, we may become comfortable, complacent, or dissatisfied in our jobs. The more comfortable or dissatisfied we are, the less motivated we are to change who we are, what we are, or what we do (Baufumo, 2006; Cheng & Baron, 2006). Leaders are charged with the task of changing others. In order to do so they must be highly motivated, inspirational, intellectual, and charismatic (Bass, 1985). Transformational leaders set an example for their followers and promote dramatic changes in individuals, groups, and organizations (Burns, 1978). Bass (1985) discusses transformational leaders indicating that they motivate followers to perform beyond their own expectations based on the leader's idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Transformational leadership expects leaders to display conviction and take stands on difficult issues for their followers. They excite, arouse, and inspire their subordinates to accomplish with extra effort (Cheng & Baron, 2006). Transformational leaders define the need for change, create new visions, and muster commitment to them. They concentrate on long term goals, inspire followers to transcend their own interests for higher order goals, change organizations to accommodate their own visions rather than working with existing ones,

and mentor followers to take on greater responsibility for their development and that of others (Asrons, 2006; Hoyt & Blascovich, 2003; Pillai, Schriesheim & Williams, 1999).

Transformational leadership theory is well suited for nurse educators (Cheng & Baron, 2006; Habel & Sherman, 2010). In nursing and in nursing education individuals are trained to be highly autonomous and that autonomy can lead to complacency or dissatisfaction in the workplace (Gormley, 2003). Advances are made in health care at an incredible pace, requiring all nurses to become more knowledgeable about the measurement, improvement, and benchmarking of clinical costs, quality, and outcomes specific to nursing (Gallagher, 2005). Nurses must stay informed about the latest technologies and most up-to-date medical information. Strong leaders committed to providing the best health care service demonstrate commitment to nursing practice, inspire others to put aside their own interests for higher order goals, accommodate their own visions rather than working with existing ones, and mentor followers to do the same. They show commitment to the cause, model behavior congruent with the commitment, are educated about the cause, are interested in changing others and the organization to reach the goal, and are an inspiration to others.

I travelled through the ranks of the nursing profession beginning as a nursing assistant and evolving into the faculty role. I served as a professional staff nurse for four years with my primary responsibility being direct patient care. Taking a step forward I transitioned into a clinical charge nurse role, orchestrating the flow of patients through a high paced, urban, emergency department. Being in a leadership role provided me the unique opportunity to not only direct operations, but to role model professional behavior. My leadership journey continued as I transitioned into the role of clinical nurse specialist

(CNS). The CNS is primarily responsible for maintaining continuing education for nursing staff members. Here I was able to partner in my educational experience with my nursing practice and realized how much I enjoyed teaching. This led me to teach nursing practicum as an adjunct, which transitioned into a full time faculty position.

I am a leader in nursing looking toward being a leader in education. I obtained an undergraduate degree to be a teacher of health and exercise science prior to entering the nursing profession. Unable to obtain a full time position in health and physical education, I needed to choose a different career path. Strongly influenced by a nurse mentor, I returned to school and studied to be a professional nurse. In my role as a staff nurse I felt the principles I learned during my first undergraduate program were well suited for nursing practice. Theories learned, such as situated learning, outcome-based learning, and inquiry learning carried over professions and made me an effective patient educator.

Patient teaching is very situational. Prior to implementing patient teaching the nurse must first perform an environmental survey. Generally, patient teaching occurs at the bedside, which can be calm or chaotic. Understanding the dynamics of environment I was able to draw upon learned experiences to use creativity to create an environment conducive to patient learning. Knowledge of inquiry learning shed light upon the need to determine the educational baseline of patients, their resources and their feelings about health and/or disease states prior to teaching them. This is an essential step in providing meaningful information that is relevant and realistic for patient learners.

Obtaining a full time position as a nurse educator in my early thirties invigorated me. I remember feeling that I was going to make a difference in the world by teaching

nurses ideal practice. Ideal practice includes, but is not limited to, complying with policies and procedures, maintaining respect for others, being up to date on current practice, modeling professionalism, and being benevolent while providing patient care. I had the opportunity to watch many of my colleagues slip into a state of complacency, pick up bad habits, or fail to maintain clinical competence. After acclimating to my new role I was able to focus on my development. Developing myself professionally would include developing myself as a person as well. There are two sides of development, knowledge and being (Ouspensky, 1981). Leaders have knowledge. To be an effective leader you must have “being” or the ability to live and experience situations. You must be able to reflect on these experiences and formulate your own theory of leadership (Rodgers, 2002).

Transformational and transactional leadership are often used in combination by educators successfully (Asrons, 2006; Hoyt & Blascovich, 2003; Pillai, Schriesheim & Williams, 1999). Leadership in organizations is important in shaping workers’ perceptions, responses to organizational change, and acceptance of innovations, such as evidence based practices. Transformational leadership inspires and motivates followers, whereas transactional leadership is based more on reinforcement and exchanges (Asrons, 2006). In nursing education transformational leadership is not appropriate in many situations. I am a self-professed transformational leader who many times is very transactional in her leadership.

Transactional leaders clarify for their followers the followers’ responsibilities, the expectations the leaders have, the tasks that must be accomplished and the benefits to the self-interest of the followers for which the leader provides rewards in return for the

subordinate's effort and performance (Pillai, Schrienseim & Williams, 1999). During lectures I find it easy to be a transformational leader and serve as an inspiration to students, however as a faculty member lecture is but a small component of my job. The largest part of my job is managerial, and as such, requires transactional leadership. Transactional leaders set goals, clarify desired outcomes, provide feedback, and reward, and recognize accomplishments. They actively search for deviations from rules and intervene when standards are not met (Hoyt & Blascovich, 2003). The blending of my leadership styles contributes to my effectiveness.

Effective Leaders

In my dual practices of nursing and education, I impact nursing students, allied health students, nursing assistants, hospital administrators, university administrators, nurse educators, and nurses. A constant that exists in healthcare is the concept of a team. Drago-Severson (2006) identifies strategies used to enhance transformative learning. These strategies include supporting team work, providing leadership roles, engaging in discourse, and mentoring. Transformative practices consider how a person makes meaning of the experience in order to grow from participation and helps us to see how differences in behaviors and thinking are often related to differences in how a person constructs his or her experience (Drago-Severson, 2006). A transformational leader fosters these behaviors. My ability to make change in others stems from my knowledge of them and their knowledge of me.

Influential Qualities of Leadership

Colleagues of mine provided me with words or phrases they would use to describe me as a leader. I was told I lead by example, I care about others, and I am

highly organized. These qualities are consistent with transformational leaders (Burns, 1978; Bass 1985). I agree that I lead by example and care about others. I am committed to my colleagues and seek to gain their trust. I genuinely care about the world and the role I play in it and seek to inspire others to do the same. I am highly organized. I enjoy managing multiple tasks simultaneously and pay close attention to detail. I operate well on the scientific level and appreciate the result that will come from my organization and repetitive practice of successful planning. Through what is referred to as reflective thinking I've noticed what has worked retrospectively and have kept those practices in place (Rodgers, 2002).

The Power of Positive and Negative Influence

Language limits my ability to discuss the most positive influence I can have on someone else. There are not enough words in the human vocabulary to define life (Jaworski, 1998). At best I would say the most powerful thing I can do is to make someone think about themselves and how they can make themselves and others better, again underlying themes found in transformational leaders (Bass, 1985; Burns, 1978). In education and in nursing we serve not ourselves, but others. We do not seek wealth, power or notoriety, instead we serve as change agents. We seek to make ourselves, individuals, organizations, and the world a better place. We do this because we care and inside we know it's the right thing to do. We do it because we know, If not me, who?

Leaders are responsible for modeling professionalism and tact. Leaders are role models and for this reason must be cognizant of their behavior at all times. A role model is someone you look up to, want to be like, and connect with as a person (Wilford, 2007). Negative behavior on the part of the leader can contribute to the demise of an individual,

team, or organization. Transformational leaders appreciate the contribution their behavior has to their leadership and attempt to model appropriate behavior at all times.

Transformational leaders are committed to a cause and seek to empower groups in order to make change. Transformational leaders value and respect individuals and the work they do. They embrace change and encourage experimentation. Through empowering others they develop a citizenship. Transformational leaders seek to encourage others to develop themselves and make change for organization. They provide verbal and technical support, promote and facilitate collaboration and discussion, empower others, make themselves available when needed and lead by example (Birky & Headley, 2006).

Leading Through Reflection

While implementing my action research project I had several occasions on which to reflect on my actions. During this time I realized that my action research project stemmed from my own morals and ethics and was directed towards social justice, which is lacking in health care today (Kosa & Adany, 2007; Leuning, 2001). I believe that my transformational leadership positively contributes to my desire to attain social justice in health care. In order for nursing students to have the desire to become culturally competent they must first be inspired to do so, as a transformational leader I have the ability to inspire my students in the hopes of contributing to their practice. If their practice is deemed highly effective they have the opportunity to have a profound effect on the population they serve, ultimately, this may contribute to society as a whole, and contributes to my attempt to attain social justice in health care. I believe my true

leadership styles are largely transformational and transactional, however, I do understand there are components of social justice interwoven into my action research project.

Reflection allows individuals to look at themselves with a critical eye. Through review of what we have done we can evaluate if our actions were successful or unsuccessful. It gives us a chance to think about what we could have done better and what worked well. Reflection provides us with information to change ourselves for the better. Part of what Dewey describes as reflective thinking involves retrospective review of one's self and experience of a situation (Amobi, 2006; Rodgers, 2002). Part of reflective thinking can make you review something you fear. I fear being wrong about something and appearing uneducated or foolish. I fear this so much that at times, even when I know that I am right, I say nothing. When I reflect on those experiences I am left with feelings of frustration. Fear is a barrier to innovative teaching (Amobi, 2006). In the line of work I do, my silence could result in harm to others. I now understand my fear is a barrier to effective practice in both the hospital and in the classroom, and is an obstacle I must overcome.

The Power of a Leader

Power can be positive or negative. Most times with leadership comes power. When leaders use "power over" others they are acting in a dominating fashion. They may imposition or control others. If a leader chooses to use "power with" others they have the ability to empower others, a sense of sharing and community is fostered. Using "power with" others seeks to empower instead of dominate, imposition or control others (Kreisberg, 1992). Part of transformational leadership is the notion of empowering others. In order to empower others you must first have the opportunity to do so and the

willingness of the participant, two important powers. Power and influence are very similar. Leaders have the power to make someone's life better on one or all of the following levels: cognitive, emotional, social, spiritual and intellectual. I, as a leader, can initiate policy and curriculum change. One power that I possess is the ability to take learners along a journey with me in the classroom. I travel through my curriculum with my students. I am their first teacher and their last in the academic setting. I watch them grow, learn, and change. I see the transformation of a very analytical, rule-based, and factual learner into a critical thinker. I show them the pride I have for my profession and attempt to instill that feeling inside of them. I walk beside them on their path to become nurses, figuratively, I'm beside them every step of the way. I either empathize with or celebrate them. There is a point along this path that they leave me and walk alone. I like to think my power is the transfer of my inner love, respect, and knowledge of life and its frailty into the hearts and minds of new nurses.

Not everyone appreciates my power. Not everyone feels the way I do. No one has lived my life except for me. I have had debates with nurses and faculty members about opposing points of view. Some respect my power and encourage me. Some challenge my power and discourage me. I take solace in the notion that if everyone liked me or agreed with me, my life would be rather dull. Arguments and debates can, at times, be intellectually stimulating. I think of it as a chance to flex my "brain muscle." I find that in times of argument or debate that I learn the most. I attribute this to the fact that I tend to reflect on negative situations more commonly than positive situations and try to figure out how I could have done things better. Power is something which endures, something which can produce both physical and moral effects. Possessing power is an

important component of transformational leadership. Having power can influence others to “buy into” your goal and gain commitment of the followers. If used wisely it can change individuals, teams, and organizations (De Jouvenel, 1993).

Transformational Leadership and Caring

In *Synchronicity, The Inner Path of Leadership*, Joseph Jaworski (1998) describes denying his destiny because of his insecurity, his dread of ostracism, his anxiety, and his lack of courage to risk himself. Bass (1985) discusses transformational leaders indicating that they motivate followers to perform beyond their own expectations based on the leader’s idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Individualized consideration for me as a transformational leader translates to caring for individuals and seeking to empower them to make changes. Transformational leaders must have an ethic of care. It is what drives their leadership. Using an ethic of care a transformational leader can influence others through embracing the idea that each person deserves to be supported and nurtured. Goal setting and organizational strategies can occur under this assumption (Beck, 1994).

Beliefs and Values of Transformational Leaders

The focus of transformational leadership is change, although new directions and visions must link to the present and past of an organization, just as new knowledge must connect to what we already have internalized in order to be fully understood, embraced, and sustained (Amey, 2006). Transformational leaders seek to empower themselves and others to change to reach a goal that will make organizations, policies ,or the status quo better.

A transformational change process is inherently value based, dependent not just

on the leader's values but on those held dear by the organization and its members.

Transformational leadership values include enhancing student and faculty learning and development, increasing access, generating new knowledge, serving the community, and being agents of positive social change in an increasingly global society (Amey, 2006).

The Direction of My Leadership.

I am not certain if my leadership is in line with the administrators I serve. That is no cause for alarm. Amey (2006) states,

Today's postsecondary leaders need to guide their institutions into the future while providing the authentic insights that come from critical reflection about and deep understanding of organizational culture and values. These leaders see their own development as paramount to their ability to create environments that serve the learning needs of others, and they seek opportunities to learn and reflect on their own experiences through professional-development activities, collaborating, and reading (p. 55).

In my first leadership role I was told, not asked, to take on the responsibility of being in charge of a busy and chaotic emergency department. With this role came a great level of responsibility and accountability. In the role, I was in charge of facilitating patient flow through the department, responding to Philadelphia Fire Rescue Paramedics, and trying to keep physicians, nurses and other staff members productive. I was again told, not asked, that I was taking over the position of Clinical Nurse Specialist for the emergency department. In this role I was responsible for meeting the educational needs of 78 emergency room nurses and over 20 critical care technicians. I had to be sure they were completing annual competencies and that they were performing their job

effectively. Retrospectively, I probably could have refused both roles I was thrust into, but I didn't because I respected my manager and I wanted to please her and gain the respect of my colleagues.

Being in a leadership role was not what I expected. I quickly found out that these leadership roles were actually harder than the role of the staff nurse. I was responsible for dealing with volatile situations, following policy, disciplining, delegating, and remaining a positive role model for the staff. Constantly reaching for the proverbial brass ring, I left both power positions to undertake teaching full time.

In the school of nursing my administrators recognize me as a leader. I have been placed in leadership positions and believe I will serve as an administrator at some point in the future. My coworkers see promise in me and actively groom me to ensure the future of the school, the faculty, the students, and of course, the nursing profession remain in good hands.

Revisiting and reflecting upon my career path allow me to see myself for who I am. I am a nurse educator and a leader in the field of nursing. Acting professionally and maintaining a positive attitude and modeling professional behavior causes others to do the same. My goal in life and in leadership is to inspire others, empower others, and to continually strive to make the practice of nursing, nurse education, and the world a better place.

As a transformational leader I can define the need for change and create new visions and muster commitment to them. I can concentrate on long-term goals, inspire followers to transcend their own interests for higher order goals, change organizations to accommodate their own visions rather than working with existing ones, mentor followers

to take on greater responsibility for their development and that of others. I can do this by identifying problems within my organization, educating and empowering others to become educated about the subject to make educated decisions, model behaviors and promote the need for change. As a transactional leader, in my most managerial sense, I am able to provide reinforcement to my students and complete daily exchanges (Asrons, 2006). Being both transformational and transactional allows me to inspire and motivate students but also guide them with clear instructions and keep them on task in their studies.

Past, Present, Future

My future is in my past and my past is in my future. I am a leader in evolution. The person I once was shapes my current leadership. The leader I will become is shaped daily. My entire life I have been on this existential journey. Since birth I have been connected to the feeling associated with experiences rather than the experience itself. In essence, I am sensitive to the feelings of others, as well as my own. I reflect on specific encounters, and their outcomes, to shape all future behaviors. My future leadership is shaped by every experience I have had and by the feelings associated with it.

During adolescence, experiencing racism and sexism contributed to my sense of who I am today. During the experiences I felt confused and angry. Had I not been impacted by these experiences I would not be passionate about who I am today, in fact, I would be someone else entirely. By collecting experiences I have actually collected feelings. I have taken the memory of feelings and compartmentalized them. The memory of these feelings is available to me like documents in a file cabinet. Every

action I take to get to my future is predicated on the feelings in that storage space in my mind. Every action I take is based on feeling.

Synthetical Variables of Leadership

Intellect, emotion, behavior, and physical body integrate to make meaning of my present. I must use reasoning, planning, problem solving, abstract thinking, and creativity to teach nursing students. When I teach I must always provide the rationale for the action of the nurse. As a nursing instructor not only do I have to understand why nurses act the way they do, but I must also help others to understand that planning, problem solving, and abstract thinking are all components of what nursing care is.

The hardest thing to teach a nursing student is creativity. You must first be creative in order to foster creativity in others. For example, we teach nursing students that in order to rapidly deliver intravenous fluids to a patient we will use a device called a pressure bag. A pressure bag is a mesh bag that goes around the bag of intravenous fluid. There is a bladder in the bag that you can inflate. When inflated the bag produces pressure on the fluid and increases the rate of delivery of intravenous fluid. One day I had a trauma patient in need of rapid fluid administration but there was no pressure bag available. I turned my head and looked at the blood pressure cuff on the wall. I placed the blood pressure cuff around the intravenous fluids, pumped it up and voila, I had made my own pressure bag! The paramedic next to me said, "I've never even thought of that" and at that moment I knew I learned how to think outside of the box. You just can't teach that kind of thing without having discovered it yourself first. Bass (1985) indicates that in order to change the minds of others, leaders are charged with being highly motivated, inspirational, intellectual, and charismatic. I embody all of these characteristics. In the

previous scenario I was innovative and enthusiastic. That experience reinforced the need for me to be creative, yet professional and effective.

Emotion plays a big role in my present. A component of transformational leadership seeks to empower individuals. In nursing leadership, emotion is linked to empowerment. We must first have an emotional connection to someone in order to be altruistic and seek for them to change and become empowered. A touch on the hand can express warning, trust, empathy, compassion, and many other things. When teaching students to become a nurse you have many emotional variables to consider. You have to factor in your own emotions, the emotions of the students, the emotions of the hospital staff, and the emotions of the patients and their families. This ethic of care is a necessity in nursing education and is evident in my classroom and the patient's bedside.

Transformational leaders in healthcare make changes based on the ethical principles inherent in health care. We, as care providers, do what is right and above all do no harm. The expression of emotion can, at times, be a positive and influence change but it can also be negative and impede growth. I am a woman. Some men may view women as being highly emotional which can work against me. I can be viewed as frantic or fanatic instead of emotionally expressive and passionate. In this event, my points may not get across to others effectively. Therefore, the expression of emotion must be used very cautiously on a daily basis for me regardless of where I practice.

My behavior, that is how I act or react in an environment, is a huge component of my present. I have learned to portray confidence even when I may not feel confident. This is a strategy that serves me well when attempting to achieve a desired response from others. For example, if I am in a patient's room and sense something is going wrong I

remind myself to be present in the moment and to relax. Once I think this I am a more focused thinker and work effectively. I believe being present in the moment and committed to my practice reinforces my transformational leadership. As a leader, my presence and sound judgment may be inspire others to make positive changes in themselves.

My behavior is tied very deeply into my present. I have approximately 110 students per lecture. These potential nurses watch and evaluate my behavior. For many of these students I am a role model. Students will model my behavior, some will adopt it (Wilford, 2007). The slightest unprofessional behavior on my part may be viewed as appropriate and duplicated by a student. In this event I would be responsible for their display of poor behavior, which for me is unacceptable.

Witfield (2003) and Di Palma (2003) discuss the impact of a teacher's physical body. Through the use of voice and use of the eyes our bodies have their own language (Whitfield, 2003). My physical body has its advantages and disadvantages. I take pride in my appearance. I am aware that as a role model I am obligated to look and dress in a professional manner. I remind students to be aware of their own dress and appearance encouraging them to be mindful that we are judged by our appearances.

As a disadvantage I am younger than many of my peers, which is reflected in my shape and style of dress. At times I believe some faculty and staff who are chronologically older than me believe I have nothing meaningful to offer. I am youthful, yet established in my work. I have worked and studied hard. I have obtained specialty certifications in the areas I teach, and I am an expert in my content area. I once heard a student who was older than me comment that she had nothing to learn from me because I

was younger than her. Tragically she shut herself off to be receptive to my perspective thereby limiting her own knowledge. I realize my age and physical appearance may work against me; however, I now understand that they do not need to be barriers to my success. If I am viewed in a negative fashion whether it be for my body or my age I just need to be innovative. As a transformational leader I can more critically analyze the reasons behind these barriers and come up with creative solutions to overcome them. As a transformational leader I inspire and empower those within my grasp, understanding and respecting that not everyone will be receptive.

The Downside of Transformational Leadership

Transformational leadership is commonly viewed as being inspirational and contributory to society; however, we must understand the power and potential the transformational leader possesses. A review of the literature showed opposition to transformational leadership. Clabaugh (2001) drew a parallel between behaviors seen in transformational leaders and behaviors seen in the leadership style of Adolf Hitler. If we look at behaviors of Adolf Hitler we find that he convinced a critical mass of Germans that things must change. He offered a new vision for Germany and was able to muster the public support necessary to implement it. He instituted a "new order" and more than 20 million people paid with their lives. He pursued long-term goals. He altered the organization of German government to fit his own vision, rather than changing his vision to fit German government. Finally, he made certain that Germans not only took responsibility for their own development (as Nazis) but also monitored their neighbor's "development" as well. (Clabaugh, 2001). Instead of identifying the attributes of a historical monster and aligning them with transformational leadership I believe we should

appreciate the power of transformational leadership and recognize the power it has to influence individuals, groups, and organizations. While implementing this action research project I appreciated the power and influence of transformational leaders, I reflected on my actions, and attempted to use leadership approaches to maximize my desired outcomes.

Leading Change

Making change in organizations and systems is not easy work; it is complicated, it takes times, and it is seldom easy. The work of change requires great cooperation, initiative, and willingness to make sacrifices (Kotter, 1996). Strong leadership is needed to make change happen. John Kotter (1996) offers an eight-stage process of creating major change and serves as a role model for leaders to emulate. Kotter guides leaders to follow an eight-step process that organizations must go through to achieve their goals and identifies how to avoid pit falls. I believe Kotter offers the most comprehensive, and seamless change process, and for that reason I employ it in change initiatives I lead. I detail Kotter's eight-stage process of creating major change and its implications in my action research study in Chapter 4.

Conclusion

My life experiences and career accomplishments shaped me into a transformational leader. The managerial nature of my profession requires me to be a transactional leader. Health care is based on ethics; ethics are a component of transformational leadership. Transformational leadership is needed in health care and healthcare education in today's world. As a transformational leader I am currently modeling behavior to advance nursing education to inspire others to do the same. I

perform beyond expectations and I expect others to as well. I engage others in research projects to contribute to existing knowledge. I take a stand on difficult issues, but at times let my personal insecurities hold me back; certainly this is an area that I must improve upon as I move forward in leadership roles. As a transformational leader I have a vision of a brighter future for nurses, nurse educators, and health care. I understand that as I aspire to be transformational, I am much more transactional as it is required for me to perform the tasks associated with my role as a faculty member.

My transformational leadership inspires me to seek change initiatives to positively impact society at large and it inspired this study. My ability to be an effective transactional leader allows me to complete the day-to-day tasks involved in the study and supports my vision as a leader. One component of leadership is creating a vision for others to follow. In order to have a concise vision it is imperative for the leader to be well versed in the existing facts that support her vision.

In the next chapter I provide a review of the current literature as it pertains to multicultural awareness education and its potential to contribute to social justice. I discuss the current state of higher education as it relates to multicultural awareness education and build a platform for my change project.

Chapter 3

Review of Current Literature

Introduction

Scholars throughout current literature discuss diversification of the world through globalization and the implications globalization has for higher education. Educating a culturally diverse student population is a major challenge for American higher education in the new millennium (Farmer, 2002). The notion of a more diverse population lends the concept of cultural awareness as a necessity in higher education, specifically, in nursing education. Current recruitment standards seek to diversify the nursing workforce as a means to achieve cultural competence, forgetting that diversity studies are a key component of nurse education. As the nursing profession makes strides towards diversification and cultural competence, it is vital that we begin the directive by infusing diversity studies in the nursing curriculum. Important concepts or threads apparent in this literature review include social justice theory, defining cultural diversity, the current need for diversity in nursing education, and identifying obstacles to cultural diversity in higher education.

Social Justice in Higher Education

Social justice refers to an attempt to create an equitable, respectful, and just society for everyone. Equity refers to fairness, or justice, and can be understood as equity in access to healthcare and equity in health outcomes (Pauly, MacKinnon, & Varcoe, 2009). Justice is concerned with sharing resources and the way resources are shared or not shared. Justice is also about all people being able to enjoy and exercise all of the human rights. Teaching and learning toward a global perspective considers questions of

justice in relationship with health and human rights. Higher educational institutions strive for social justice in attempts to make them more socially representative, or diverse. Higher education imports equity and social justice agendas from the wider society and looks at ways of improving its performance in these respects (Brennan & Naidoo, 2008).

The goal of social justice is often assumed a given in healthcare (Kirham & Browne, 2006). As the largest group of healthcare providers, nurses are critical to health and human betterment in the global community (Leuning, 2001). A core component of nursing education is educating nurses to care for vulnerable populations. In the current healthcare setting individuals with health disparities are frequently individuals with a lack of access to care. In order for nurses to participate fully in healthcare they must develop proficiency and comfort with the changing world. They need development of a global perspective and an awareness of oneself in relationship with the world and with others. Topics of disease, knowledge, poverty, violence, the distribution of resources, or any claims that people and groups might have on a human condition must be part of teaching-learning dialogues (Kirkham & Browne, 2006; Leuning, 2001; Spector, 2009).

Social justice seeks fairness and equality for all. This is an important thread throughout nursing curriculum as an inherent component of health promotion. Health promotion embodies social justice principles and attempts to level the playing field to achieve equal access to healthcare in the United States. Health promotion involves fieldwork and education to patients in all settings, particularly to those with a lack of access to care (Potter & Perry, 2009). Research into health inequalities according to race and ethnicity has shown consistent disadvantages in health status, morbidity, and mortality for various ethnic groups. The causes of these inequalities stems from the lack

of social justice which can be directly attributed to racism and to cultural and socioeconomic differences (Kosa & Adany, 2007; Leuning, 2001).

As society becomes increasingly ethnically diverse, healthcare providers need to acknowledge the culture of their patients and be sensitive to cultural diversity (Fongwa, Sayre, & Anderson, 2008; Tashiro, 2005). As globalization diversifies our population the student population in higher education also diversifies. Despite higher education's attempts at attaining social justice, higher education's dominant academic culture continues to privilege White, middle-class and male values and practices. Working-class female, mature and/or minority ethnic students are often alienated (Archer, 2007; Gardenswartz, 1999). Clearly there is a disparity between what higher education espouses to do and what is currently practiced. According to the U. S. Census Bureau the projection for 2042 is that 54% of the population will be members of racial or ethnic minority groups. The prevailing value system for many mainstream white Americans is primarily based on the white, Anglo-Saxon, Protestant (WASP) ethic (Munoz & Luckmann, 2005). From a social justice perspective we must step away from traditional delivery of higher education, based on the perspective of a White, middle class-male prototype and move toward attaining a multi-cultural perspective (Brennan & Naidoo, 2008). Teaching and learning toward a global perspective acknowledges our discouragement with the state of the world. Listening to the experiences of those who have endured oppression is vital in understanding ourselves and our position in the world (Leuning, 2001).

Social Justice and Service Learning

Learning is tied inextricably to experience, and students will learn more when they see clear connections between academic subjects and the real world (Andrews, 2009; O'Conner, 2009). One attempt at bridging experience and didactic learning is the incorporation of service learning. Service learning allows students a chance to see perspectives other than their own; it is believed it assists prospective learners gain a more critical understanding of culturally diverse populations and strengthens self-reflective practices (Andrews, 2009). Health is a topic that cuts across boundaries of race, class, and sexual orientation (Ottenritter, 2004). Nursing education must consider cultural perspectives of patient's and their families while implementing curriculum. In order for nurses to be effective we strive for cultural competency, that is, having the ability to understand or empathize with an individual without sharing the cultural norms, beliefs, or behaviors. We attain this cultural competency through service learning (Andrews, 2009).

Service learning in nursing education is a form of experiential education that combines clinical practicum with classroom instruction and focuses on critical reflective thinking as well as on personal and civic responsibility (Ottenritter, 2004). Service learning in nursing education attempts to develop student, academic skills in addition to providing perspective for new nurses. Personal and civic responsibilities are hallmarks of service learning. Through service learning nursing students develop citizenship. Citizenship skills such as critical thinking, problem solving, collaboration, and communication are essential in nursing practice (Ottenritter, 2004). These skills are also essential in the mainstay of nursing education which is health promotion.

In order to produce highly effective nurses we should incorporate service learning with current guidelines for health promotion. Content delivered during nursing education is based, in part, on the goals of *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). *Healthy People 2010*, is a comprehensive set of disease prevention and health promotion objectives for the American population. *Healthy People 2010* is designed to meet two major goals, first to help individuals of all ages to increase life expectancy and improve their quality of life, and second, to help our nation eliminate health disparities among different segments of our population (Healthy People 2010, 2000.) Ottenritter (2004) discusses that when service learning is integrated with the science of effective health promotion and disease prevention, it provides an effective means through which institutions of higher education throughout the nation can contribute to reducing the health disparities cited in *Healthy People 2010*.

Transcultural Relationships

To provide care for individuals, nurses must attempt to understand illness states from perspectives other than their own (Fongwa et al., 2008; Leuning, 2001; Munoz & Luckmann, 2005; Spector, 2009). Nurses continually build relationships with patients of varied ethnicities; achieving an understanding of other ethnicities opens the door to sharing the human experience and should be fostered in higher education. Leuning (2001) discusses care as a universal human experience with diverse meanings and uniquely patterned expressions in different human communities. She continues to state, “culture, the gestalt of human experience and knowledge, including values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally, influences care meanings and expressions.” (p. 298)

Therefore health, from a transcultural nursing perspective, is a dynamic experience that is culturally defined (Leuning, 2001; Spector, 2009, Chapter 3).

Social Justice

In a global community, justice is concerned with resources and the way resources are shared or not shared. Questions of justice arise when more than one group is competing for the resources (Leuning, 2001). Ciulla (2003) reviews John Rawls theory of distributive justice and indicates that rational persons would choose two general principles to deal with justice issues in the real world. The first principle is the principle of equal liberty. In equal liberty each member of a community has the same right to resources as another. The second principle, the difference principle, indicates that social and economic inequalities should be arranged so that the least advantaged member of society is served and equal opportunity for services is maintained. Rawls theory is democratic in nature and speaks to social justice, that is, attempting to ensure justice and equity for all members of a society (Ciulla, 2003).

In a diversifying global community we are faced with inequities, particularly in healthcare. One of the key ethical dilemmas facing health promotion and disease prevention work is that of finding a balance between various interventions for the common good that restrict individual liberty (Labonte, 1998). Attempts to attain social justice apply directly to education and to nursing practice. Educators, working from a social justice perspective, strive for social democracy towards equity and access to resources for all members of the population (Leuning, 2001; Walker, 2003). It should be noted that striving toward social justice is something that must be affirmed and struggled for on a daily basis (Labonte, 1998).

Implementing Social Justice in Nursing Education

Social justice lends itself to nursing and nurse education in higher education settings. Nurses can and should see people and their health as embedded in social locations and the lived experience of people's lives (Leuning, 2001). Nurse educators also need an awareness of how institutional practice can maintain health inequalities. Taking up social justice leads to nursing experiences that are community based and collaborative across sectors especially early in the curriculum. Drawing on theories of justice can enhance our understanding of inequities, provide potential policy directions to reduce inequities, and make visible the influence of moral values on the choice of actions (Kosa & Adany, 2007). Most nurses work within institutional structure and under the influence of societal discourses that shape their work practices. When nurses work toward achieving social justice, inequalities amongst varied cultures emerge (Pauly, et al., 2009). Clearly, working toward social justice opens the door to health policy reform and care delivery.

Defining Cultural Diversity

There are certain psychological characteristics and experiences that all ethnically and culturally different individuals share (Diller, 2007). Prior to defining cultural diversity it is important to distinguish the difference between culture, ethnicity, and race. It is also important to determine the meaning of cultural competency.

Culture.

Culture is viewed as a lens through which life is perceived. It is the symbolic and learned non-biological aspect of human society, including language, custom, and convention, by which human behavior can be distinguished (Diller, 2007). It is a

phenomonologically different experience of reality. It is the lived experience of the person (Ayonrinde, 2003; Diller, 2007). Culture helps to determine a person's world view, or philosophy of life, and it influences how each of us views our relationship to our surrounding environment, religion, time, and each other (Munoz & Luckmann, 2005). Culture can be viewed as the blueprint for guiding human actions and decisions and includes material and nonmaterial features of any group or individual. It is more than ethnicity or social relationships. It is the learned, shared, and transmitted values, beliefs, norms, and life-ways of a particular culture that guides thinking, decisions, and actions in patterned ways (Leininger & McFarland, 2006)

A component of culture is social structure. Social structure provides broad, comprehensive, and special factors to the perception of culture. Social structure factors include religion or spirituality, kinship, politics, legal issues, education, economics, technology, philosophy of life, beliefs, and values with gender and class differences (Leininger & McFarland, 2006). Culture unavoidably impacts the ways in which people interpret and perceive health and illness and their choices in seeking and providing care (Ayonrinde, 2003). It is also important to note that because nurses and patients belong to different subcultures, their interaction is always to some extent transcultural, even when the nurse and patient come from the same general culture.

Ethnicity.

Cultural background is a fundamental component of one's ethnic background. The contemporary definition of ethnicity is that of a group of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage (Spector, 2009). To be ethnic refers to being a part of a distinguishable group whose members share a

common culture and see themselves as different from the majority or other cultures (Diller, 2007; Spector, 2009). This common culture is shaped by past facts, events, instances, and experiences of human beings, groups, cultures, and institutions that occur over time (Leininger & McFarland, 2006). The observable differences between the majority culture and the minority culture frequently serve as a basis for discrimination and unequal treatment within the larger society (Diller, 2007).

Race.

Race is widely considered to be a social construct by most scientists and biologists (Azoulay, 2006; Bhopal, 2000; Diller, 2007; Ousley, Jantz, & Freid, 2009). Defining race biologically and genetically opens the door for pseudoscientific arguments about intellectual and other types of inferiority among people of color (Diller, 2007). While biological theories based on species and subspecies have not withstood testing, social theories have not as yet made a major impact in medical sciences (Bhopal, 2000). For the purposes of this study, which examines nursing curricula, Diller's (2007) assertion on the definition of race is used. According to Diller, race is a biologically isolated population with a distinctive genetic heritage (Diller, 2007). It is defined as an actual or potential interbreeding group within a species and a category of human kind that shares certain distinctive physical traits (Merriam Webster, 2009). Among those who continue to view race as biologically based, the term often refers to divisions of human beings and is closely related to people who share common physical characteristics such as bone structure, blood group, or skin color (Lewis, Dirksen, Heitkemper, Bucher, & Camera, 2011), even though these ideas have been discredited by scientists (Azoulay, 2006; Bhopal; Ousley, Jantz, & Freid, 2009). Race can be a cause of psychological pain

and suffering and is historically linked with oppression. The term race should be used with caution for its history is one of misuse and injustice (Azolulay, 2006; Bhopal, 2000). The fear and pain associated with moving toward cultural competency is directly related to race and reducing oppression of vulnerable populations (Diller, 2007). The terms race and ethnicity are sometimes used interchangeably, but it is argued that in the United States they are distinctly different. For example, the United States government considers race and Hispanic origin to be distinct concepts. Often time federal agencies identify populations by their ethnicities (i.e. Hispanic or Latino and Not Hispanic or Latino), while the 2000 Census used five race categories to identify specific populations (Lewis et al., 2011).

Genetic Polymorphisms Related to Race and Ethnicity.

Nursing texts agree that ethnicity implies that people have biologic and genetic similarities (Adams & Koch, 2010; Adams & Holland, 2011; Jarvis, 2008; Lewis et al., Dirksen, 2011). It is now known that variations in metabolic processes among various ethnic groups can significantly impact drug therapy (Adams & Holland, 2011). This has profound implications for nursing practice. Close to 100% of human deoxyribonucleic acid (DNA) sequences are alike from individual to individual, however, a mutation as small as 0.2% in human DNA can result in major differences in a patient's ability to process different medications (Adams & Koch, 2010). Such DNA mutations are termed genetic polymorphisms.

Genetic polymorphisms are known to occur in specific ethnic groups because members have cross-bred for hundreds of years, and because members have settled in the same geographic area as one another. These practices amplify the occurrence of genetic

polymorphisms. Certain drug categories such as antidysrhythmics, antidepressants, and opioids may be metabolized differently in members of African, Native American, and Asian descent. In order to provide safe and effective medication administration to a diverse population, nurses should be familiar with polymorphisms specific to particular ethnic groups (Adams & Holland, 2011). It is impossible for nurses to have complete knowledge about all of the ethnic and cultural variations amongst patients, however, nurses must understand that differences exist, and they must make every attempt to incorporate this information into the nursing plan of care (Adams & Holland, 2011).

Cultural Diversity.

Whether called multiculturalism, cultural pluralism, diversity, cross-culturalism or interculturalism, the central idea conveyed by the term cultural diversity is difference (Farmer, 2002). Cultural diversity refers to the array of differences among groups of people with definable and unique cultural backgrounds. It speaks to the variation of values, life ways, symbols, or other features associated with a particular culture (Diller, 2007; Leininger & McFarland, 2006). Cultural diversity is strong and emotive. It is viewed as desirable within western liberal discourse. Diversity operates as a powerful justificatory discourse within policy as something that signifies the notion of, good for all, rather than just, good for some. It may be viewed as a moral discourse (Archer, 2007).

Cultural competency.

A wealth of literature exists pertaining to cultural competence. Culturally competent care is defined by the American Academy of Nursing (1992) as a complex integration of knowledge, attitudes, and skills that enhance cross cultural communication

and appropriate and effective interactions. Cultural competence is a developmental process that evolves over an extended period. Cultural competence is an ongoing commitment or institutionalization on appropriate practices and policies for diverse populations. It is the ability of systems to provide care to patients with diverse values, beliefs, and behaviors. It provides healthcare workers the ability to provide high-quality, effective health care to patient from diverse sociocultural backgrounds (Curtis, Dreachslin, & Sinioris, 2007; Green et al., 2008; Munoz & Luckmann, 2005; National Center for Cultural Competency, 2009; Slade, Thomas-Connor & Tsao, 2008).

Cultural competence is the ability to effectively provide helping services cross-culturally. It can reside in individuals, in organizations, and in systems. It includes awareness of attitudes, knowledge arenas, and skills. Moving toward cultural competence is a process that can be emotionally demanding. Developing cultural competence requires looking at the pain and suffering oppression has caused as well as looking at one's own attitudes and beliefs. Gaining cultural competence can provide personal growth in the form of self awareness, cultural sensitivity, nonjudgmental thinking, and broadened consciousness (Diller, 2007; Gardenswartz, 1999).

The Current Need for Diversity Education in Nursing Education

Colleges are only slowly waking up to the need for substantial change. Farmer (2002) asserts:

The time is ripe for higher education to assume the leadership role in meeting the challenge of America's diversity in the new millennium. The changing nature of the student population, renewed interest in interdisciplinary and collaborative research and teaching, re-examination of college curriculum,

and issues of cultural pluralism in a rapidly changing society within a global economy all provide fertile soil for the seeds of reform in American higher education. (p. 47)

The College of 2020: Students Executive Summary (Chronicle Research Services, 2009), discusses that probably, just after 2020, minority students will outnumber whites on college campuses for the first time. One might postulate that this diversification could contribute to heightened cultural awareness, however the report continues on to indicate that more students will attend classes from a distance and part time. This may disengage face-to-face discourse amongst students and limit exposure to varied cultures for college students. The report continues to discuss that the continuing diversification of the college bound population will put pressure on postsecondary education to adapt. This translates to the need for higher education to pay more attention to what factors will allow members of different ethnic groups to succeed.

There is a documented need for diversity studies in higher education, a need also exists for diversity studies specifically in nursing education (Hegarty, Condon, Walsh & Sweeney, 2009; Leuning, 2001; Kleiman, Frederickson & Lundy, 2004; Munoz & Luckmann, 2005; Pauly, MacKinnon, & Varacoe, 2009; Tashiro, 2005; Yarbrough & Klotz, 2007). As the population of most non-dominant ethnic groups in the United States grows, nursing faculty members are challenged to develop curricula that adequately prepares future nurses (Yarbrough & Klotz, 2007). There is a growing awareness in nursing of the existence of health disparities in the United States, particularly with respect to disparate treatment by race and ethnicity (Tashiro, 2005). Education about race, ethnicity, culture, and cultural competency is essential for nurses to grow as individuals

and for nurses to provide high quality, effective healthcare to patients of varied cultures. Nurses frequently face situations demanding resolution of ethical dilemmas involving cultural differences. Nursing curricula must include content on both ethics and cultural sensitivity (Yarbrough & Klotz, 2007).

Kleiman, Frederickson, and Lundy (2004) discuss that cultural awareness, cultural sensitivity, and culturally competent care are not new concerns for nursing education. They indicate this has been argued for over 45 years, and that knowledge of patient's cultural attributes affects the quality of nursing care delivered. They continue to discuss that the recognition of and responsiveness to cultural differences are considered central to providing quality care. Additionally, the failure to recognize a patient's culture and customs can have a negative impact on the patient.

Nurse educators, being nurses themselves, have a keen understanding of how healthcare systems and institutional practices can maintain health inequities. Nursing students have the opportunity to gain first-hand knowledge of the strengths and capacities of individuals, groups, and communities. Patients represent many cultural, ethnic, and disenfranchised populations, and they have different culturally influenced patterns of behavior and expectations for care (Munoz & Luckmann, 2005). The need for placing diversity in the nursing curriculum exists and is relevant to the role of the nurse (Pauly, MacKinnon & Varcoe, 2009).

It is important to note that nurses may function in many roles in their practice. The registered staff nurse, in any setting, functions predominantly as a patient advocate. The registered staff nurse is responsible for providing patient care following the nursing process, which is: assessment, diagnosis, planning, implementation, and evaluation.

This process is carried through under the guidelines and policies of individual institutions employing the registered staff nurse, as well as the guidelines set forth by state regulatory bodies. A large component of nursing practice is providing teaching, which is threaded through nursing practice in any professional role. The role of the nurse educator is much different than that of a registered staff nurse. As previously mentioned, a large component of the role of the nurse educator is teaching, however, the focus shifts away from patient teaching and focuses on pedagogy. The classroom nurse educator has to create the teachable moment rather than wait for it to happen. While in the classroom the nurse educator is responsible for creating a teaching-learning environment suitable for delivering the curriculum. In addition to teaching the art and science of nursing, the nurse educator must also teach the student nurse how to provide teaching and assess learning to the population they will potentially serve. The nurse educator is expected to serve as a classroom educator, produce scholarly work, and serve the school, college, or university employing them. Nurse educators are governed by the policies of their employers and practice under the guidelines set forth by accrediting bodies and state regulatory bodies (Bastable, 2003).

As the largest group of healthcare providers, nurses are critical to the health and human betterment in the global community. Nurses must be proficient and comfortable in dealing with individuals from multiple cultures. The challenge for nursing education is to create teaching-learning environments that nurture the development of a global perspective and an awareness of one-self in relationship with the world and others. The teaching-learning principles of health, global-local connections intentional caring, justice, challenging indifference, wholeness, transcultural relationships, and peace-making move

nurses toward viewing themselves as vital and receptive citizens of the world. The greater the nurse's understanding of globalization, the more competent she will be to address health and human betterment. (Hegarty, Walsh, Condon & Sweeny, 2009; Leuning, 2001).

Nursing, as a profession, is committed to providing an ample supply of practicing professionals and to addressing the needs of a diverse population. Many potential challenges lie ahead for the profession of nursing and consequently for nurse educators in the development of curricula in order to meet the demands associated with a changing healthcare environment (Farmer, 2002). Policy changes as well as the drive for professional advancement of nursing will continue to affect the education of nurses. It is essential that nursing curricula prepare graduates to meet the challenges associated with a changing healthcare environment (Hegarty et al., 2009). The Royal College of Nursing (2004) identifies three standards important in nursing education programs. They are quality, flexibility, and diversity. To address diversity, nurse educators must prepare nurses who can tailor knowledge and skills to cultural differences in health and healthcare. Professional flexibility and cultural competence need to be augmented by critical awareness and ability to change policy (Hegarty et al., 2009). An understanding of culturally sensitive care and ethical practice is necessary for students to integrate fully the concept of caring. Faculty and students should incorporate transcultural concepts into their classroom and clinical experiences, beginning at the undergraduate level to facilitate social justice and high quality health care. Regardless of the setting, becoming skilled in cross-cultural communication will increasingly be an asset (Diller, 2007). Higher education must commit itself to implementing dynamic educational reform if it is to be

effective in educating students from culturally diverse groups (Farmer, 2002). Nursing education must commit itself to implementing educational reform to meet competencies set forth by the AACN and in its attempts at producing highly effective care practitioners.

Obstacles to Cultural Diversity in Higher Education

Diversity education is one directive to help our society achieve social justice, however, implementation of this directive cannot flourish in the presence of oppressive structures or attitudes. Most everyone believes that working for social justice is a noble undertaking, however, prior to undertaking social justice initiatives nurse educators must educate themselves, their peers, and their students about existing barriers to achieving social equity (Stys, 2008). To oppose social justice by opposing diversity studies, in our society, would be to align oneself with elitism, and undemocraticness (Archer, 2007). Despite this sentiment it is documented that challenges associated with diversity training include heightened emotions, tension, fear, and pain (Diller, 2007; Gardenswartz, 1999), and that those who oppose such training are unintelligible or morally reprehensible (Archer, 2007).

Oppressive social conditions, such as racism, sexism, and classism, that shape access to healthcare are the same conditions that shape inequities in health with poverty being a major determinant of poor health (Pauly, MacKinnon & Varcoe, 2009). Gardenwartz (1999) discusses diversity as a high affect topic indicating that there are few right or wrong answers. He explains that in a society that tells us it is wrong to be prejudiced, just talking about these topics breaks social taboos and hence produces tension (p. 7).

Nurse educators need an awareness of how institutional practices can maintain inequities and understand their personal responsibility to influence the work of educating the next generation of nurses (Pauly et al., 2009). A component of this is maximizing the effectiveness of diversity training. It is suggested that prior to implementing diversity training, a safe environment should be created with a framework of acceptable behavior that all participants know, understand, and adhere to. Additionally, resistance should be expected. Expecting the resistance will assist the facilitator to be less defensive. Diversity training should be placed in a larger organizational context to make the information meaningful and relevant to the learner. All parties involved should discuss the complexity of diversity issues and view the learning session as an entry way to understanding. Finally, it is important to discuss that the end result of diversity is a fundamental redistribution of resources and power and a positive step toward social justice (Gardenswartz, 1999).

Identifying Cultures

Despite the fact that the word culture can be defined, the literature does not identify standardized cultures. The U. S. Census Bureau (2008) Profile of General Demographic Characteristics captures statistics based on identified race. The predominant identified races in the United States are White, Black/African American, Asian, American Indian and Alaska Native, Native American/Pacific Islander, Hispanic/Latino. The United States is a diverse nation and will continue to diversity. The current population is approximately 67% non-Hispanic white, 12% black, 14% Hispanic, 1% American Indian/Alaska Native, and 4% Asian. By the year 2050, populations that have historically been called minorities will comprise nearly 50 percent

of the total U. S. population. The biggest increase is expected to be in the Hispanic population, which is expected to double between 2000 and 2050. If racial and ethnic disparities in health and health care continue many more Americans will be at risk of poor quality health care (Mead et al. 2008). In an attempt to identify cultures essential to developing my project, I searched the U.S. Census (2008) Profile of General Demographic Characteristics specific to Philadelphia, Wilmington, and Atlantic City. The identified races, in rank order of identified members, are White, Black/African American, Hispanic/Latino, Asian, American Indian and Alaska Native, and Native Hawaiian/Pacific Islander.

As previously discussed, race is but one component of culture (Diller, 2007). At the present time, no universally required curricula in diversity and cultural competence in health professional training exist (Welch, 1998). The predominant cultures that should be studied according to Diller (2007) and Spector (2009) include Latino, Native American, Black/African American, White, and Asian. Both Diller and Spector propose a curriculum that shadows the demographic distribution of the U. S.

A Hidden Culture

As a component of this action research project, I reviewed and discussed the literature and identify cultures that should be studied in higher education as documented by experts (Diller, 2007; Spector, 2009). I believe we fall short as research scholars and epidemiologist by failing to clearly document statistics surrounding the lesbian, gay, bisexual, and transgendered (LGBT) community.

The Mazzone Center is an agency located in center city Philadelphia that serves the LGBT community. Their mission is to provide quality comprehensive health and

wellness services in an LGBT focused environment, while preserving the dignity and improving the quality of individuals they serve (Mazzoni Center, 2007). This agency opened its doors in 1979, clearly there must have been a need for such services, however, little is documented to substantiate this need. The agency continues to this day to provide health and wellness to sexual minorities and other marginalized communities who are underserved by traditional, mainstream health care.

The Mazzoni Center (2007) asserts that access to quality professional care is one of the keystones to improving the health and well being of the LGBT community, further citing that a barrier to LGBT people is the lack of cultural competency on the part of the provider and/or homophobia and discrimination toward people of different sexual orientations or gender identities. These adverse barriers often lead to delays or avoidance of seeking out preventative or treatment services. The Mazzoni Center echoes my sentiment about the need for the LGBT community to be viewed as a culture and validates the need for inclusion in diversity studies.

The School District of Philadelphia supports multiracial, multicultural education in its kindergarten through 12th grade (K-12) schools (Mazzoni Center, GSA handbook, 2007, p. 101). According to district policy #102 (Mazzoni Center, 2007) the school district is to foster knowledge about and respect for those of all races, ethnic groups, social classes, genders, religions, disabilities, sexual orientations, and gender identities. The School District of Philadelphia envisions a society that will ensure respect for all cultures, dignity for all communities and justice for all people. To achieve this goal they assert they must recognize that multiracial, multicultural, gender education is

indispensable. This notion has the ability to be transferred to higher education, particularly in Philadelphia, and specifically in nursing education.

Conclusion

Globalization of the world has produced a need for multicultural awareness education in higher education. Scholars throughout the literature consistently detail this need specifically in nursing education where students are expected to deliver high quality care to diverse populations upon completion on their education. In order for nurses to deliver high quality care, they require cultural competence. Cultural competence refers to the ability of the nurse to appreciate the varied perspectives of patients and the ability to implement care that is professional in nature and respectful to individual cultures. Care can only be effective when the nurses and patients mutually respect one another and communicate in an open trusting manner.

Cultural competence begins in nursing education. Aligning themselves with identified core competency standards, schools of nursing must provide students the opportunity to learn about varied cultures, their norms, perceptions, and health care practices during their professional education and training. During nursing school, students should also be encouraged to perform a self-inventory where individuals can identify their own cultural perspectives, norms, and health care practices. Armed with the knowledge of whom one is as an individual, and what is culturally appropriate during nursing care delivery, graduate nurses have the ability to provide care deemed highly effective that moves health care and society towards social justice.

In the first chapter I identified the lack of multicultural awareness education that currently exists in the curriculum, in my workplace. In chapter two I described the

person I have become and my evolving understanding of my leadership. In chapter three I wrote about the current literature that exists pertaining to multicultural awareness education in higher education. In the next chapter I provide an overview of my action research study and explain the methodology I employed in the study.

Chapter 4

Methodology

Introduction

Some characteristics are universal to a research study, regardless of the philosophical assumptions. Research is systematic and rigorous; it seeks to find a disciplined truth. Systematic does not imply preplanned, rather it implies that decisions are carefully considered, options weighted, and a rational basis can be documented to support the choices that are made (Houser, 2008). Nursing research is essential for the development of a scientific knowledge that allows nurses to provide highly effective care. A solid research base will provide evidence of the nursing interventions that are effective in promoting positive patient outcomes (Burns & Grove, 2005).

This study can best be defined as applied research. In applied research a scientific investigation is conducted to generate knowledge that will influence or improve clinical practice (Burns & Grove, 2005). The purpose of applied research, in this study, is to solve a problem in a real-life practice situation. There is a current need to implement multicultural awareness education in undergraduate nursing curriculum to improve patient outcomes. In an attempt to produce baccalaureate graduates capable of providing the highly effective care required to improve patient outcomes, graduates must understand and practice cultural competence.

Applied research is similar to action research. In action research the researcher is not an outsider, she is not foreign to the organization she is attempting to improve. In action research goals are determined by those who conduct the study and the outcomes of the research are meaningful to the researcher (Hinchey, 2008). To infuse cultural

competence into the curriculum I used action research to implement multicultural awareness education seminars for nursing students. I sought to discover if the student population believed new insights could be gleaned from the sessions and what impact the training would have on their practice as professional nurses.

Collection techniques.

A mixed method of data collection was employed in this study. The philosophical assumptions that drove the study were rooted in my personal paradigms. Hower (2008) describes a paradigm as:

an overall belief system, a view of the world that strives to make sense of the nature of reality and the basis of knowledge. The disciplined study of nursing phenomenon is rooted in two broad paradigms, both of which are relevant for nursing research. These two broad paradigms are quantitative and qualitative (p. 39).

Mixed methods work well in nursing research where frequent evaluation is performed. Evaluation research is the application of research methods to the study of programs, projects, or phenomena (Hower, 2008). Mixed methods may be employed in nursing education when qualitative methods are used to represent the meaning of an experience as a model, which is subsequently tested using quantitative approaches. The use of the two approaches combined allows the researcher to appraise the role of error and generalize the results of the study to the practice of nursing education (Burns & Grove, 2005; Hower, 2008). Combining both quantitative and qualitative data allowed me to better understand the research problem by triangulating broad numeric trends from quantitative research and the detail of qualitative research. Triangulation is the combined

use of two or more theories, methods, data sources, investigators, or analysis methods in a study. It is done to increase the overall validity of the study (Burns & Grove, 2005).

Additionally, employment of a mixed method technique allowed me to explore participant views with the intent of building on the views with quantitative research so that they could be explored with a large sample of the population (Creswell, 2009).

In research, the nature of the research question directs the appropriate data collection modalities. Research questions that focus on the effectiveness of an intervention require a scientific approach, assuming effectiveness is defined as an objectively measured outcome (Hower, 2008). In this event a quantitative approach is necessary. Conversely, research questions that focus on the acceptability of an intervention require a qualitative approach. I sought to discover effectiveness of a program, which I measured numerically, but also sought to elicit affective data themes as well, which I measured qualitatively. Research can be conceptualized as a way to reach some destination, that destination being the answer to a research question (Hinchey, 2008). This action research study sought to answer the following questions about the change project:

1. How does the “Implementing Multicultural Awareness Education in Undergraduate Nursing Curriculum Project,” contribute to the social and academic perspectives of nurse candidates?
2. How will nursing students perceive that multicultural education will impact their patient care?
3. What are the barriers to providing multicultural education to baccalaureate nursing students?

The study sought to answer the following questions about my leadership:

1. How were the actions put forward consistent with my espoused theory of leadership?
2. How did my leadership of the change project impact the manner in which I conduct myself in my workplace?

My first step in this study was to determine what other schools of nursing were doing to implement diversity education in their programs. Using survey monkey, an on-line survey service I developed a three question survey asking if each program had a dedicated multicultural awareness course, if the faculty was satisfied with the materials used and what specific resources were used. Using an on-line nursing faculty directory I was able to identify deans and program coordinators for baccalaureate level schools of nursing. To attempt adequate representation I selected one faculty member from each of the fifty states in the United States. The information obtained from the survey directed my attention toward some of the resources I used to develop each education session.

I employed pre-test and post-test Likert scale surveys in this study. The pre-test captured only numerical data. The post-test captured numerical data and allowed the participants to write their personal responses to two open ended questions. I captured both quantitative and qualitative data. Employing the quantitative approach, I utilized the Likert scale, which is demonstrative of descriptive research. The Likert scale presented a set of attitude statements, and respondents were asked to express agreement or disagreement on a five-point scale. Each degree of agreement was given a numerical value, which was measured from all of the responses (Houser, 2008). I sought to capture an accurate account of the attitudes of a group of students. The descriptive data collected

provided me valuable information about the implementation of my project and opportunity to direct future education sessions (Burns & Grove, 2005).

The post-test consisted of eight Likert scale items and two open ended questions. I chose to use these open-ended questions to allow participants to respond in their own words. The participant had no predetermined answers to choose from. The advantage of eliciting this information was that it allowed me to get a wide range of responses. Disadvantages of using open-ended questions included the fact that it took the respondent longer to complete, the respondent could have misinterpreted the questions, and analysis of the data could take longer (Houser, 2008).

I also employed student focus groups after the education sessions to capture qualitative data. I used the principles of philosophical inquiry and critical social theory (Burns & Grove, 2005). Using scripted questions I examined meaning and developed theories of meaning through concept analysis. I also analyzed problems of ethics related to obligation, rights, conscience, justice, choice, intention, and responsibility (Burns & Grove, 2005). Also included in my qualitative data I employed critical social theory. Burns and Grove (2005) assert that critical social theory provides the basis for research that focuses on understanding how people communicate and how they develop symbolic meanings in a society. Here I sought to understand perceptions of students in an overall attempt to empower them to provide highly effective patient care.

When discussing racial or cultural issues, a certain level of discomfort could exist between the researcher and the participants. Focus groups were designed, as a part of this study, to obtain the participants' perceptions in a focused area in a setting that was permissive and nonthreatening (Burns & Grove, 2005). Ideally, focus groups should

consist of six to twelve members that represent the target audience (Burns & Grove, 2005; Houser, 2008). The value of the focus group is in the information collected. The interaction among focus group participants provides a powerful dynamic that is missing from quantitative collection techniques (Houser, 2008).

Role of the Researcher.

My role as a researcher, at the doctoral level, was three-fold. First, I provided leadership for the integration of scientific knowledge with other types of knowledge for the advancement of practice. I conducted an investigation to evaluate the contributions of nursing activities to the well-being of patients. I also developed methods to monitor the quality of nursing education (Houser, 2008). I used myself as an instrument of change for the JSN and for the profession of nursing. I designed, implemented, collected and analyzed data, and evaluated my findings in an attempt to improve current nursing education and to improve future nursing practice. Prior to planning and implementation of this action research project I applied for, and received Institutional Review Board (IRB) approval from both Rowan University and Thomas Jefferson University.

A large component of my role was to develop an education session that could be implemented to each student population. I believed it was of great value to conduct the same implementation for each target group and collect data to determine if there would be differences of opinion or attitude amongst different programs or program levels. I understood, of course, that in action research each cycle of research is used to inform the next, so I was prepared to make necessary changes along the way if need be.

Originally, I was most interested in presenting the topic of health and illness in the LBGT population but was disappointed to find that this population was not indicated

as being its own unique culture and that little existed in the current literature. I thought next about what would be of greatest value to the student population. The majority of the student population in the JSN is Caucasian/White. I believed these students had an adequate perception of health and illness in the white population so my attention turned toward the next largest demographic in the Philadelphia area. The U.S. Census (2000) indicated that the next largest demographic to be Black. This prompted me to develop an education session termed “Health and Illness in the Black Population.” I highlight here and throughout this document, that the intent of this project is not to discuss race and this project is not about the Black population. This action research project intends to study the perception of cultural education and cultural competency in nursing education. The Black population was selected because it was the largest demographic population in the vicinity of the JSN.

In order to create this education session, I turned toward the leaders of diversity and cultural competence in nursing, namely Munoz and Luckman (2005), Purnell and Paulanka (2003), and Spector (2009). The information found in these resources was used exclusively to develop a PowerPoint presentation which was presented for each student implementation. Each presentation was preceded by a pre-test and concluded with a post-test and focus groups.

The Multicultural Awareness Education Session Overview

Having reviewed the relevant literature about cultural competence and identifying a target population to discuss, I designed an education session suited to meet the identified need for diversity education in the JSN. An introduction of the education session started with a discussion of the need for culturally competent health care. The

importance of organizations' and individuals' understanding of patients' cultural values, beliefs, and practices were discussed, specifically, their link to providing effective patient care (Purnell & Paulanka, 2003). Next, a brief discussion of self-awareness ensued.

During this discussion the audience was asked to take a personal inventory to determine their own cultural beliefs. During this time the audience was invited to provide commentary if so desired.

The next component of the education session was an introduction to the 12 domains essential for assessing the ethnocultural attributes of an individual, family, or group which were: inhabited localities, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health-care practices, and health-care practitioners (Purnell & Paulanka 2003). Figure 1, Purnell's Model for Cultural Competence, provides an overview of topics addressed during the education session.

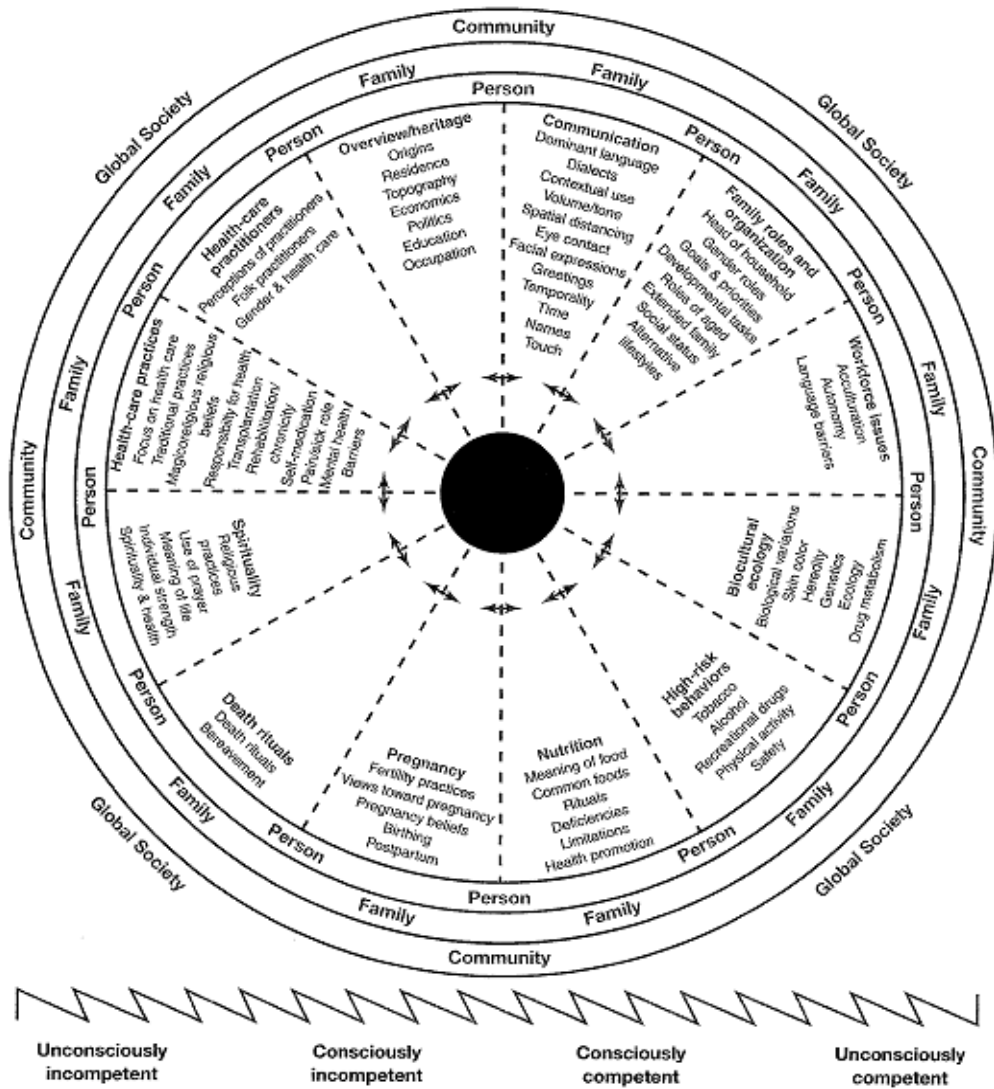


Figure 1. Adapted from “Purnell’s Model for Cultural Competence,” by L. Purnell and B. Paulanka, 2003, *Transcultural Health Care: A Culturally Competent Approach*, 2nd ed., p. 10. Copyright 2008 by F. A. Davis.

The focus of the education session then turned to health and illness in the Black population. All of the previously discussed ethnocultural attributes, found in the works of Munoz and Luckman (2005), Purnell and Paulanka (2003), and Spector (2009) were

presented as they applied uniquely to the Black Population. Guest speakers identified as belonging to the Black population were invited to discuss their own perspectives as being providers and receivers of care. Audience members were also encouraged to discuss their conceptions or misconceptions of the material presented as well as personal experiences as they applied to the discussion.

Context

Context is described as the body, the world, and the concerns unique to each person within which that person can be understood (Burns & Grove, 2005). I practice, full time, as a nurse educator at Thomas Jefferson University (TJU), in the Jefferson School of Nursing (JSN). The JSN is located in urban, center-city Philadelphia. Our mission is as follows:

As an integral component of Thomas Jefferson University (TJU), the Jefferson School of Nursing (JSN) shares the institutional mission and vision of the University. The faculty of the Jefferson School of Nursing is committed to the vision to be among the premier educators of nurses in the nation, to be a leading innovator in the provision of quality health care and to be a contributor to healthcare and educational research.

The Mission of the Jefferson School of Nursing is to educate qualified, diverse individuals at the associate, baccalaureate, master and doctoral levels for nursing practice. The faculty is dedicated to educating professional nurses who will form and lead the integrated healthcare delivery and research teams of tomorrow; to discovering new knowledge that will define the future of clinical care through investigation from the

laboratory to the bedside and into the community; and to setting the standard for quality, compassionate and efficient education, and patient care for our community and for the nation.

The Mission is carried out in an atmosphere of teaching excellence, scholarship and community service. The School's Mission is supported through collaboration with the Jefferson School of Health Professions, the Jefferson School of Pharmacy, the Jefferson School of Population Health, Jefferson College of Graduate Studies, Jefferson Medical College, Thomas Jefferson University Hospital, the Jefferson Health System partners and other regional and state affiliates ("Jefferson School of Nursing Editor," 2009).

My primary responsibility in the JSN is facilitating the flow of the FACT program. Again, the FACT program consists of a cohort of nursing students who complete the entire baccalaureate degree in one calendar year. Facilitating the flow of the program includes providing lectures to the undergraduate baccalaureate students, as part of curriculum implementation. My fields of specialty are medical-surgical nursing and critical care nursing. The lecture component of my position is, in fact, the smallest component of my position in the JSN. Faculty are expected to plan and coordinate clinical practicum activities; recruit; interview; and hire adjunct faculty; oversee daily operations of courses we coordinate and maintain active memberships in JSN committees; and continue to practice as registered nurses, part time, in our specialty areas.

Sampling Frame.

The available population to study is termed the sampling frame (Houser, 2008). The JSN undergraduate baccalaureate students were the available population and were volunteer participants of the study. This population included junior and senior nursing students, as well as the FACT students. There were approximately 140 juniors, 120 seniors, and 100 FACT students. These numbers were subject to change, depending on quarterly attrition.

There are minor scheduling details and differences in clinical practicum hours between the traditional BSN students and the FACT students. These details made scheduling a bit daunting, however, manageable. For cycle two of the study I identified clinical practicum dates available to employ the study. As faculty we have the ability to schedule what is termed alternative clinical experience (ACE) days. For both the juniors and the seniors I selected a date. Students had the opportunity to attend their regularly scheduled practicum or the ACE experience, thus having a choice to self select themselves as study participants.

To capture the quantitative data, gathered from the pre-test and post-test Likert scale statements I used probability sampling. To choose probability sampling, every member of the available population has an equal probability of being selected for the sample because they self-select (Houser, 2008; Burns & Grove, 2005). Selection bias should not have occurred because I did not affect the selection of the subjects for the experiment (Houser, 2008). Inclusion or exclusion criteria for the study participants did not apply in this study.

The FACT students have a scheduled ACE day during each clinical practicum, the traditional BSN students do not. For this reason, when sampling the FACT students I also allowed them to self select. The students had the choice to either attend the educational forum or complete a written assignment about the particular culture I was presenting in the forum. Again, inclusion and exclusion criteria did not exist.

To capture a sample for all of the focus groups I again used probability sampling. I arbitrarily wrote the word “focus group” on the back of the informed consent forms. When students entered the room I distributed the consent forms in a “face up” fashion so that neither I, nor the participant were aware if their form stated “focus group” on the back. This allowed my sample to be completely random, reducing the chance of bias. Those students who were not selected for the focus group were asked to write a one-page reflection on the information presented during the ACE experience. These reflection papers were stored in a secure, locked office and are intended for use for future research.

Change Framework

Leadership in organizations often begins with one or two people (Kotter, 1996). As a developing leader, it is important to implement change projects in my organization that are both in line with my personal values and good for my organization and society at large. John Kotter devised an eight-step change process that used during the implementation of my change project. Kotter developed his eight step process after gaining experience as an organizational leader, studying organizational change, and studying leadership. Each stage of Kotter’s eight step change process specifically targets one of the eight fundamental errors that he deems undermine transformation efforts. Careful planning, sequential implementation, and evaluation are cornerstones of Kotter’s

process. Kotter stresses the importance of following each step of his change process in a sequential manner to develop second order change in organizations (Kotter, 1996).

During the first step of my change implementation, I diagnosed the needs of my organization. Kotter (1996) refers to this as establishing a sense of urgency for the change. Once the need was identified, I demonstrated the importance of the proposed change to the stakeholders in my organization. This occurred when I asked for permission to conduct the education sessions during ACE experiences. Kotter then indicates I needed to create a powerful guiding coalition. I identified and recruited a cadre of respected organizational members to lead the change. In essence this translated into explaining my proposed change project to other faculty, particularly my administrators. My implementation directly involved the student body, and I needed assistance from my peers in accessing different student populations at different times. Step two of Kotter's eight-step change model is creating a shared vision. Following Kotter's model I was vigilant, clear, and convincing in my communication with stakeholders and peers. I understood I needed to negotiate with others to allow me to go forward with my implementation. I did not underestimate the need for frequent communication of my vision and plan was not underestimated. I modeled professional behaviors required of the vision and plan and built trusting relationships with my peers. I needed to encourage members of my organization to set aside personal interests in favor of the vision and plan.

As my change implementation progressed, I moved into step five of Kotter's (1996) change model, which is empowering others to act on my vision. I encouraged members of the organization to make efforts to remove obstacles and barriers to the

vision and implementation. Luckily, the only identified barriers were feelings of being uncomfortable while speaking to the student groups. Next, in step six I planned for and created short-term wins. I reinforced that change is a process, not an event. Each planned implementation was viewed as a success and a learning opportunity to assist in planning the next implementation. Being a reflective practitioner I consolidated improvements and produced more change, step seven of Kotter's model. I continued to demonstrate the need and importance of my change project. I was prepared to show skeptics the value of my work if necessary. I planned to do this by capitalizing on successes I had encountered to bring credibility to my work. I understood that once my change project was complete I would need to take the evidence of its worth and institutionalize it. This is what Kotter refers to as anchoring changes in the organization's culture. I planned to articulate and communicate my findings and demonstrate the importance of my project to the re-culturalization of the organization.

Change is not a linear process and one change theory alone cannot be used for each organizational issue. Kotter's (1996) change theory was easy for me to use as a transactional leader, but as I reflected upon the impetus for my action research project I understood that it was driven by what Fullan (2001) describes as moral purpose. Moral purpose means acting with the intention of making a positive difference in the lives of others. Moral purpose drives me as a transformational leader. Fullan attests that hopeful leaders cause greater moral purpose in themselves, bury themselves in change, and naturally build relationships and knowledge. These qualities were essential to the success of my action research project and toward my goal of attaining social justice in the health

care forum. Blending the leadership styles of Kotter and Fullan were a perfect compliment to my leadership style and the success of my project.

Data Collection

The conclusions from a research study are only as good as the data that are used to draw them (Houser, 2008). The data collection techniques I used included surveys and focus groups. The initial pre-test I used was a Likert scale. As previously discussed, a Likert scale is a scale that measures attitude statements, or the opinion of a subject, ranked on five or seven point scales. The degree of agreement or disagreement is given a numerical value, and a total can be calculated. The Likert scale is the most commonly used of the scaling techniques. (Burns & Grove, 2005; Houser, 2008). The pre-test is purely quantitative and consisted of ten items.

The post-test I used included a Likert scale, in addition to two open-ended questions, as mentioned previously. I chose to include open-ended questions to elicit the participants' responses in their own words. It was also intended to allow me, as a researcher, to understand the varied perspectives of nursing students as individuals.

For the traditional BSN students and the FACT students, I also used focus groups to capture qualitative data. When implementing the education series for the traditional BSN students, both junior and senior, I had no more than 60 students per class. The smaller group size allowed more interaction to occur during the education sessions which were followed by a focus group session. The FACT classes consisted of approximately 100 students each, and the larger group sizes can be detrimental to individual interactions. Burns and Grove (2005) and Houser (2008) agree that a focus group should

consist of six to twelve members. I chose ten participants for each focus group to be a representative sample.

A focus group is an in-depth, qualitative interview with a small group of people, considered to represent the target audience. Focus groups seek to obtain the participants' perceptions in a focused area that is permissive and nonthreatening (Burns and Grove, 2005; Houser, 2008). The interaction of participants in focus groups provides a chance for dialogue. Participants not only discuss their own opinions, but, have the opportunity to react to the ideas of others (Bogdan & Biklen, 2007; Houser, 2008).

Houser (2008) lists advantages of focus groups. First, discussions can be recorded with audio and video for later review and transcription, both of which were utilized during this study. Next, observations of nonverbal behavior, reactions, and misunderstandings can be documented. This is yet another valuable source of information that can be used for future research. Finally, unanticipated but related topics can be explored, and results of the interview are immediate.

Data analysis.

In this mixed method data collection, data analysis is both quantitative and qualitative. Quantitative analysis refers to the analysis of numbers. This analysis takes raw data and turns it into something understandable (Houser, 2008). Descriptive statistics involves taking large amounts of numerical data and reducing these data to some meaningful value in order to describe the characteristics of a group (Corty, 2007). The entry and analysis of numerical data in this action research project was completed with the assistance of the Predictive Analytics Software (PASW), formerly know as the Statistical Package for the Social Sciences (SPSS). Not only was information captured

on participants, it was used to draw inferences. In this event the statistics are termed inferential statistics (Corty, 2007). The mean, or average score, is a measure of central tendency. Central tendency is the value around which scores tend to cluster. To draw inferences based on groups the mean can be used to make generalizations about groups (Corty, 2007; Houser, 2007). Grouped frequency distributions were also obtained using PASW. Grouped frequencies list the values of the dependent variable, grouped into ranges, to demonstrate the frequency with which each range of values occurs (Corty, 2007). Because Likert items were used on the pre- and post-tests frequency distribution charts allowed for easy analysis and assisted in making inferences amongst groups. Frequency statistics were used during cycles I through III and inferences drawn from that data for individual student cohorts. An overall analysis viewed the means of data collected during all cycles to draw inferences from the entire student body.

Collecting open-ended questions and filming focus groups allowed me to review the data collected for initial impressions. Burns and Grove (2005) discuss immersion into the data. This involves reflecting on the film and audio collected during the focus groups and reading and rereading the data gathered from the open-ended questions. Next, the data is reduced. At this point in time meaning is attached to elements in the data, known as coding. Classes, persons, properties, and events will emerge as codes (Burn & Grove, 2005; Houser, 2007). For this study these codes were recorded in a codebook. Appropriate codes were documented that related to the setting and context, viewpoints of participants, activities of participants, relationship between participants, and interaction of the group as a whole (Houser, 2007).

Once developed, I used the codebook to observe units of analysis. The unit of analysis is something that can be interpreted in a meaningful way. Examples of units of analyses include phrases, artifacts, or descriptive paragraphs. Units of analysis are grouped together into similar codes (Houser, 2007). After coding of the units of analysis were completed I evaluated the codes to identify overall themes. Identifying themes required in-depth review of the codes and data. As a result, themes emerged that encompassed several codes. Themes are implicit, recurring, and unifying ideas derived from the qualitative research data (Houser, 2007).

To grow and learn as a researcher and an educational leader as a result of this project, I chose to study my leadership, just as I studied my subjects. In order to learn about my leadership I reflected upon the actions taken and feelings experienced during this action research study. Reviewing what one did and what one felt is termed reflective practice (Greenwood, 1998). Schon (1983) discusses that reflective practice involves action and reflection on action. As I proceeded with my study I attempted to be present in the moment and think about what I was doing while I was doing it. I used a journal to document my actions and experiences, cumulatively, and at the end of the study I reviewed my actions to explore the understandings I brought to them and themes that emerged.

Confidentiality.

The research participant has the right to anonymity and the right to assume that data collected will be kept confidential (Burns and Grove, 2005). Complete anonymity exists in this study for each participant who completed the pre-test and post-test. I had a responsibility to protect the anonymity of subjects and to maintain the confidentiality of

data collected during the study (Burns & Grove, 2005). To maintain confidentiality of participants of the study I kept a master list of the subjects' names and code numbers locked in my desk drawer at work. Any written correspondence with information about a participant contained only the code I had assigned to them.

As Bogdan and Biklen (2007) suggest, I had focus group participants sign a promise of confidentiality (see Appendix A). The form stated that I intended to protect the confidentiality of what members of the discussion group said during the course of the study. I also asked that the participants promise not to communicate or talk about information discussed during the course of the focus group with anyone outside the focus group or myself.

Limitations and Validity.

Limitations are restrictions in a study that may decrease the generalizability of the findings; they may be theoretical or methodological. It was a limitation that ACE dates were preset and are subject to cancelation. Theoretical limitations are weaknesses in a study framework. Failure to make the educational experience or research questions clear could have led to theoretical limitations (Burns & Grove, 2005). Methodological limitations are weaknesses in the study design that can limit the credibility of the findings and restrict the ability of the findings to be generalized (Burns & Grove, 2005). By using a strong study design, multiple settings, control over implementation, control over data collection, and a statistician I reduced the limitations of both my qualitative and quantitative data collection and analysis.

In order to ensure validity of qualitative research, Houser (2007) suggests using four criteria to establish trustworthiness of qualitative conclusions. They are credibility,

dependability, confirmability, and transfirmability. To enhance credibility, I used method triangulation. Method triangulation is the use of multiple data collection methods used within a study to explain a phenomenon, or a difference between groups. Using pre- and post-tests and focus groups allowed me to capture a more complete and insightful view of the phenomena being studied (Burns & Grove; Houser, 2007). After identifying possible limitations of the study and making attempts at insuring validity, the next step in the project was to consider the logistics of the project, namely negotiating with administrators and considering the resources required for the action research study to occur.

Negotiations and resource requirements.

This study required some negotiation. A proposal of the study was provided to the Associate Dean of the JSN. After describing the study, its purpose, and the plan for implementation, both on paper and in person, and attaining the appropriate IRB approval its implementation was approved. Resource requirements for the study included room reservations, audio-visual technical assistance, paper, and access to a photocopier.

Length of study and timeline overview.

Cycle I of the study started in February of 2010. Based on information obtained from other schools of nursing, in addition to resources found independently, I began planning the structure of the educational project. Planning of the educational project included reviewing existing materials related to the culture, developing teaching materials, and verifying the accuracy of the teaching materials. Cycle I also included implementation of an education session April 1, 2010. I compiled and presented culturally significant information, gathered from the experts in transcultural nursing. I

also arranged to have two members of the Black culture, who were also healthcare workers, speak to the students about their experience in health care.

As cycle I unfolded, I reflected on the four components of action research, plan, act, observe, and reflect, and how each cycle informs subsequent cycles. Cycle II of the study began in May of 2010. During this time I conducted two multicultural education sessions for traditional BSN, senior students as well as FACT senior students. Utilizing the learning from cycles I and II, I planned improvements to the education session and implemented a third education session to the FACT junior students during August of 2010. Embedded in each cycle was my analysis of the collected materials and analysis of myself as a leader and change agent.

Conclusion

This mixed method action research study sought to discover what existing multicultural awareness education materials were available, what barriers to implementing such teaching existed, and how students believed sessions such as this would impact their future patient care. The study set out to satisfy the core competencies set forth by the AACN and move the JSN towards the principles of social justice. Data collection techniques included surveying and conducting focus groups to gather quantitative and qualitative data. Data were analyzed using PASW and thematic coding, and the length of the study spanned seven months. In the next chapter I outline the planning, implementation, and evaluation of cycle 1 of this action research study.

Chapter 5

Cycle I: Planning and Implementing Action Research

Introduction

Cycle I marked the initial research, planning, development, implementation, and assessment of my change project. This cycle, conducted during April of 2010, was multifaceted and involved and served as the platform for cycles II and III. Cycle I was designed to collect data regarding what educational information was in use in schools outside of the JSN. In cycle I also designed a meaningful education session, implemented and evaluated two sessions, and derived meaning from what had occurred during each session to shape the structure and delivery of the following cycles of action research. During this cycle I developed and employed a survey to nursing faculty; researched the topic of health and illness in the Black population; developed teaching materials; verified accuracy of developed teaching materials; applied for seed money; and administratively planned, scheduled, and implemented an education session. I was the change agent in cycle I, which is consistent with action research (Hinchey, 2008). Also consistent with action research, this action research project, sought improvement of a curricular deficiency; included systematic inquiry, which included information gathering, analysis, and reflection; and led to an action plan which generated a new cycle of the action plan (Hinchey, 2008).

Survey Development

Surveys represent one modality to gather large amounts of data on what participants think (Hinchey, 2008). Surveys provide an efficient way to collect data. Surveys yield responses that are usually easy to tabulate, and the resulting data are easy

to analyze (Patten, 2001). As part of cycle I, I developed three surveys. The first survey (see Appendix B) was intended to poll other schools of nursing regarding their current use, if any, of cultural diversity teaching materials. The second survey (see Appendix C) intended to collect information prior to implementing a cultural education session, and the third survey (see Appendix D) intended to collect information after implementing a cultural education session.

Patten (2001) asserts that the first step in conducting questionnaire research is to determine the objectives for the research and be specific. For each survey developed, I visited my research questions and gave thought to what I was attempting to discover. Based on these objectives I wrote specific survey questions using a 5 point Likert scale as answer options. Using a survey was feasible because I had access to my target population of interest, as well as informed consents (Patten, 2001).

The intent of the first survey (see Appendix B) was to collect information, from other schools of nursing, to assist me in development of my first education session. Using an online resource, I identified 50 nursing administrators, at the baccalaureate level, throughout the United States. I deliberately selected one individual from each state to attempt representation of nursing curriculum throughout the country. I was aware that participants were likely to have ready access to the worldwide web so I explored the use of Survey Monkey.com (<http://www.surveymonkey.com/>). Survey Monkey allows anyone to log on and design a survey, hosts the survey, and generates reports based on responses (Hinchey, 2001). Using Survey Monkey, I developed a three-question survey (see Appendix B) to elicit some specific information. I decided to keep the survey brief, understanding as a full time faculty member that time to answer surveys is limited.

The first survey question was intended to collect factual information. I asked if the respondent's school of nursing had a dedicated multicultural awareness course in their undergraduate curriculum. The answer choices for this question were yes or no. Seeking to implement a multicultural awareness education program at the JSN, I wished to elicit the value other nursing faculty have in their own multicultural education materials. For this reason I chose to use a Likert-type item. Likert items are used when you are attempting to elicit a respondents' attitude or level of agreement with a statement (Patten, 2001). In the survey, the second question was only to be answered if the respondent's school had a multicultural awareness course in their curriculum. The question asked if the respondent was satisfied with the multicultural awareness education materials in their program. The answer options were strongly agree, agree, neutral, disagree, or strongly disagree.

After development and launch of my initial survey, my attention shifted to development of the pre- and post-test surveys for the traditional junior BSN students. The pre-test (see Appendix C) was intended to collect demographic information as well as opinions of traditional junior BSN students. The survey asked the participants to identify their respective backgrounds and their age, an intentional area denoted as "other" was placed as an option for background with a space for participants to fill in their racial background. The possible answers for racial background were taken from Patten's (2001) text on survey development and intended to be representative of the most common races as identifiers for participants. The following seven questions were five point Likert opinion scales. These questions sought to determine opinions about students' ability to learn about diverse populations in nursing school, comfort dealing with diverse

populations, and belief that cultural competency is a component of highly effective nursing care.

Finally I developed the post-test questionnaire (see Appendix D). The survey had a series of five point Likert opinion items as well as two open ended questions. The post-test sought to determine the methods by which students learn best about diversity, their comfort level with diverse populations, and the importance of diversity education. I then used two open ended questions. The first question sought to determine how the education sessions changed, or did not change participants' views of multicultural awareness education. The second question sought to elicit the perceived barriers to multicultural education at the JSN. I valued the use of open ended questions on the post-test and believed rich data would be provided by participants. The value in the open-ended questions was that it allowed respondents to respond in their own words, in narrative fashion in an attempt to elicit emotion or meaning. (Polit & Beck, 2008).

Focus Group Development

A focus group, which is becoming increasingly popular in the study of health problems, is a type of group interview in which researchers bring a representative group of people together to focus on the perceptions of a particular issue (Hinchey, 2001; Polit & Beck, 2008). While planning the focus groups I was aware that I would serve as the moderator who would guide the discussion. For this reason I chose to use semi-structured interview questions (see Appendix E). In a semi-structured interview the moderator asks some predetermined questions but also allows participants time and opportunity to explore other areas they think are relevant (Hinchey, 2001; Polit & Beck, 2008). During the focus group sessions I intended to elicit participants' feelings about

diversity and diversity issues and asked specific questions about their personal experiences with such issues in the patient care area. In addition, I sought to determine if participants believed that healthcare providers are guilty of stereotyping patients and how faculty could better prepare student nurses for dealing with diverse patient populations.

When developing the focus group I intended to collect a random sample of the target audience. To do so, I wrote the words “focus group” on the reverse side of ten of the informed consent documents that were to be handed out to each member of the audience. After the audience had been seated and come to order I asked participants to review the reverse side of their informed consents. I then informed those selected for the focus group where to proceed after the education session for the focus group session.

Material Development

Part of material development for the education sessions included a survey of nursing educators and administrators throughout the 50 states, as previously described. Of the 50 administrators polled throughout the United States, 12 responded which translated a 24% response rate. These results are discussed and analyzed in further detail under results. The survey did not provide me with specific information that would be of particular value to the action research project. Without having overwhelming information about what is currently used for diversity education in baccalaureate schools of nursing I did a review of current texts on the topic, specific to nursing education. I searched the TJU library for available reference materials. Three sources were identified as pertaining to multicultural education for nursing. During the months of January and February of 2010 I reviewed the three selected references and critically thought about my student population and the patient population they served.

As previously discussed, the decision was made to educate my student population regarding health and illness in the Black population, as I believed it would contribute to the homogenous population of students in the JSN. I developed a PowerPoint presentation and sent the completed document to five members belonging to the African American culture to elicit their feedback and attempt to verify the information presented, specifically avoiding any member of non-African descent, as the reference materials pertained mainly to African Americans. Three of the five individuals who were sent the materials were not health care workers. This was done intentionally to determine if there was any difference in opinion between the black health care worker's opinions of the material, versus the non-health care workers' opinions of the material. Of the five individuals asked to review the materials, four responded they believed the materials were relevant and accurate. One African American health care worker disagreed with the views presented in the materials and argued that the published references were inaccurate but offered no other information. Shortly after eliciting this individual's feedback it came to my attention that he, in fact, descended from Africa as an adult, therefore I decided his input might not contribute to my presentation in a meaningful way and proceeded with the materials I gathered and synthesized.

Application for Seed Money

During Cycle I an interesting opportunity in the JSN presented itself. A yearly offer of seed money for scholarly work was offered in the JSN by the Faculty Research Committee. Monetary awards ranged in amount based on requests presented in proposal format by interested researchers. Knowing that I planned to offer guest speakers for my implementation parking and refreshments, I decided to write a proposal for the seed

money. I met with the Associate Dean for Faculty Development in the JSN to assist me in writing my proposal. After careful consideration I determined that \$300.00 would cover the cost of what I had planned for each cycle. I hoped to receive an award to reduce my out of pocket expenses related to my project. I was awarded the sum of \$300.00 by the Dean of the JSN and the Faculty Affairs Committee.

Planning, Scheduling, and Implementation

My role in this action research project was one of researcher, planner, educator, administrator, and facilitator. From the administrative perspective much needed to be accomplished prior to classroom implementation of the first education session. I requested audio-visual equipment for the four planned education sessions, as well as auditorium space for the large group implementation and a small conference room for the focus groups sessions. I also secured an individual to video record the focus group sessions. Other administrative tasks I performed included manually photocopying the pre- and post-tests, statements of confidentiality, and handouts for the education sessions; ordering refreshments for my guest speakers, securing my guest speakers, and finally implementing the sessions. The ACE day sessions were scheduled on the school calendar. On April 28, 2010 I conducted the first education session to the traditional junior class as the last action in cycle I. This group was comprised of 114 participants.

A pre-test was administered to the first target audience, and then I provided an education session. I discussed the topic of health and illness in the Black population. This education session was based on a synthesis of three resources. The topics discussed included a discussion of: the background of members of the Black population; demographic and new immigrant profiles of members of the Black population; traditional

definitions of health and illness of members of the Black population; traditional methods of health maintenance and protection of selected communities of the Black population; traditional methods of healing of selected communities of the Black population; current health care problems of members of the Black population; and demographic disparity as it is seen health manpower distribution. A more rich description of the education session can be found in chapter 4.

The words “focus group,” were written on the back of the informed consent forms. The informed consent documents were administered by my administrative assistant and myself, prior to the education session. Prior to starting the session students were asked to look at the back of their forms and hold them up if they stated “focus group.” It was then discussed that those students were asked to participate in the focus group session, but again, participation was voluntary. Students were asked to complete the pre-test and once finished to place the form in a box. Next, I introduced the education session and my guest speaker who then presented the material and took time to answer questions or clarify information. Immediately following the session students were asked to complete the post-tests and, once completed, place them in a box. The administrative assistant brought the boxes to my office and locked them inside.

Data Collection, Entry, and Analysis

The data collected during Cycle I included quantitative data from the pre- and post-test Likert scales and qualitative data from the open-ended questions and focus group sessions. The pre-test surveys were administered prior to the first education session in the assigned auditorium, 90 seconds per question was allotted to complete the survey, the same amount of time allotted to students during didactic testing. Students

were asked to place completed surveys in a box. Post-test surveys were administered immediately following the education session, 90 seconds per question were allotted, and once complete, surveys were placed in a box and brought to the JSN by an administrative assistant. Immediately following the post-test surveys, those students randomly selected to participate in the focus group were instructed to meet in a designated conference room. After completing the confidentiality statements, the semi-structured focus group was conducted and filmed. The quantitative data was manually entered into PASW and descriptive statistics were obtained. A total of 114 participants completed pre-tests and 116 completed post-tests. The mean for each test question was obtained in order to determine participants' agreement or disagreement with each statement on the test. Thematic coding was performed on the open-ended questions and focus group transcriptions in order to uncover emerging themes.

One hundred and fourteen students responded to the pre-test survey. See demographic distribution information in Table 1 and Table 2. You will notice the predominate race/ethnicity to be Caucasian/White and age range to be 18-25 years of age.

Table 1

Participant Self Identification of Race/Ethnicity

Race/Ethnicity	n	%
Arab	3	3
Asian/Pacific Islander	16	14
Black	10	9
Caucasian/White	76	66
Hispanic	4	3
Latino	1	1
Multiracial	3	3
Other	1	1
Total	114	100

Table 2

Participant Self Identification of Age

Age	n	%
18-25	71	62
26-35	33	29
36-45	9	8
46-55	1	1
Total	114	100

When asked if students believed nursing education regarding multiple cultures was valuable in undergraduate nursing education 97% of the students agreed. Ninety seven percent of students also believed awareness of other cultures would allow them to provide better patient care than they were able to give at that point in time. When asked if students felt they had multiple learning opportunities related to multicultural awareness education, only 59% were in agreement. 74% of students reported witnessing effective patient care delivery to cultures outside their own and 75% of students disagreed that they felt uncomfortable providing care to cultures they were unfamiliar with. No clear consensus was found on two pre-test survey questions. First, when asked if students had witnessed ineffective or inappropriate patient care delivery to cultures other than their own 42% agreed, 13% were neutral, and 37% disagreed. Second, when asked if students knew where to find information regarding cultures in the hospital setting 36% agreed they knew where to look while 39% of students disagreed they knew where to find the material.

The post-test survey had both a quantitative Likert scale and two qualitative, open ended questions. Eighty-eight percent of the 116 respondents agreed that having an

understanding of only their own culture could have a negative impact on the patient care they render while 99% agreed that appreciating a patient's cultural perspectives was a necessary component of highly effective nursing care. When asked the best way to learn about multiple cultures, 62% of respondents disagreed book learning was best, 54% disagreed looking at electronic resources was best, but overwhelmingly, 94% agreed listening to individuals from multiple cultures was the best way to learn about varied cultures. Approximately seventy-one percent of respondents reported they felt comfortable discussing multiple cultures within the context of their nursing classes, 90% disagreed that culture has little to do with nursing care, and 92% believed the JSN should do more multicultural awareness education sessions to potentially improve patient care.

Thematic coding was performed on the open-ended questions. When asked to indicate how the education session did or did not change the way students thought about multicultural awareness education, 116 students responded. There were two main themes. Fifteen percent reported no change occurred. Fifty-three percent of students reported that multicultural awareness education was important to providing patient care. When asked to indicate what students believed were barriers to multicultural awareness education, 116 students responded. Of those respondents, 7% reported lack of diversity in nursing education to be a barrier, 10% reported lack of willingness amongst individuals and prejudice/racism as barriers, 14% reported fear as being a barrier, 25% reported ignorance, and 30% reported the lack of comfort in discussing the topic to be a barrier. It is interesting that although 75% of students agreed they were comfortable discussing multicultural topics during class on the Likert scale, 30% reported the topic as being uncomfortable on the open-ended question.

An audio/visual recording of the focus group session was transcribed. The focus group consisted of 10 students who participated in the education session. When asked if students could recall the first time they learned about culture at the JSN, students were unsure. One student reported “that day,” while two others reported learning about the topic in two different classes. Overall students agreed that what had been provided was too superficial. They continued on to say that the JSN presents stereotypes of the same cultures over and over again, and that the stereotypes were not always found to be true in clinical practice.

When asked what was most memorable about the education session, one student reported the emotional response of another student. A small discussion ensued regarding the emotionally charged nature of the student in question. One student expressed empathy, verbally recognizing he never considered her point of view. When asked if students had a chance to provide care for a patient from a different culture during clinical practicum and what they learned, students agreed they had the chance but did not comment specifically about new information learned. When asked what was learned from this, the focus shifted away from culture and moved toward language. During this conversation two students reported witnessing nurses provide care to non-English speaking patients without attempting to use an interpreter service. This clearly disturbed the students who reported the behavior as being “unprofessional.” Another student reported witnessing a nurse ask an Asian patient, and her family, about the need to possibly incorporate the yin and yang into her care. The student reported, “In the maternity ward a nurse came in and said, ‘I see that you are Asian; I am wondering if you

have any preferences with the yin and the yang.’ It surprised me because I did not even know about it because I do not practice it. The nurse was really good about it.”

When asked how the term “multicultural awareness” made students feel, one student responded by saying we can never understand each culture in detail but that we could develop some understanding, while another student began speaking about her personal account of viewing health care workers stereotyping patients in an emergency department. She stated, “I think everyone stereotypes, and as a young person it is hard to come to terms with that. I spent a lot of time thinking I was not prejudiced at all, and I did not stereotype but when I realized I did, I found it very hard to deal with.”

During the focus group, similar to the Likert scale and open-ended questions, students agreed learning about multiple cultures would prove beneficial to patient care and positively impact their practice as a registered nurse. Students disagreed that they had been given enough information about multiple cultures during their education in the JSN. When asked how faculty could better prepare students to meet the needs of patients of varied cultures, students expressed having a specific diversity class. Students reported that ACE days were not the ideal time to present diversity education and that credits should be reallocated to create an entire diversity course. When asked if students believed healthcare workers stereotyped cultures during practice, the majority of students agreed, some citing specific instances. One student commented that she noticed poor care in the post-partum nursing clinical practicum. When asked to elaborate she indicated that she asked the nurse she was working with if they would be getting a lactation specialist to assist her patient with breastfeeding. The student continued on to say that the nurse handed her a bottle of infant formula explaining that, “those patients

get WIC,” and “would not breast feel anyway.” The student identified that the patient she was caring for was an adolescent, Black mother, and that no breastfeeding education had been offered or provided.

Emerging Themes

This student population, as speculated, reported to be largely homogenous, specifically representing the Caucasian demographic. Participants overwhelmingly believe that nursing education regarding multiple cultures is valuable in undergraduate nursing education and believe awareness of others cultures will allow nursing students to provide better patient care, and that the JSN should do more multicultural awareness education sessions. Participants reported that a lack of knowledge about other cultures could have a negative impact on patient care and that appreciation of other cultures is a component of highly effective care. Participants also agreed that they witnessed effective patient care delivery to cultures other than their own during practicum in the hospital. Participants disagreed they had ample learning opportunities to learn about other cultures during their education in the JSN. Participants reported feeling neutral when asked if they have witnessed ineffective care to cultures other than their own in the hospital or when asked if they knew where to go to find information about other cultures in the hospital setting. Participants disagreed that they feel uncomfortable providing care to cultures with which they are unfamiliar. Participants disagreed that reading a book or using electronic resources is the best way for them to learn about multiples cultures, instead, they report listening to individuals from multiple cultures is the best way for them to learn about various cultures.

While reviewing the data stemming from the focus group and the open-ended questions, I found that the majority of students felt impacted, in some way, by this education session. As previously stated, students reported the importance of multicultural awareness and sensitivity and could freely identify barriers to providing this type of education. Lack of willingness to learn, prejudice/racism, fear, ignorance, and feelings of being uncomfortable are the barriers reported most frequently by this group. Perhaps some of these variables may be modified while others cannot.

Students clearly believed that the best way for them to learn about a culture other than their own would be to hear it from a member of that particular culture, specifically noting that a Caucasian presenting this topic was not helpful. I had not anticipated this occurring, particularly because I had included two guest speakers belonging to the identified population. In action research, the learning acquired from one cycle serves to improve the next (Hinchey, 2008). During the next cycle I planned to use the invited minority health care workers to play a more integral part in the presentation and offer more of their opinions or life stories to make the session meaningful to the audience.

A component of this analysis includes reflection back to the initial research questions. The first questions sought to determine how this action research project contributed to the social and academic perspectives of nurse candidates. To answer this question I turned back to the statistics. Students believed strongly that multicultural education was valuable in undergraduate nursing education. The expression of this sentiment echoes the need for further diversity studies listed in the *Essentials* revision (AACN, 2008). Only about half of the students questioned during Cycle I believed they

had ample opportunities to learn about multiple cultures in their undergraduate education. This implies the JSN needs to improve upon its current curriculum.

From the academic perspective, it should be noted that approximately forty percent of students do not know where to find information regarding multiple cultures in the hospital setting. This could indicate a gap in nursing curriculum to a non-healthcare worker, however, it is a reality in current healthcare practice. Inpatient staff nurses tend to receive diversity training during their orientation to the institution. Each institution has its own method for storing and sharing information related to culture. For this reason it is not possible for nurse educators to indicate where graduate nurses are to look for such materials, as it varies from hospital to hospital. This information does indicate that adjunct nurse educators may not be discussing culture or culturally competent care during hospital based clinical practicum. From a social perspective, the majority of students reported feeling comfortable discussing culture during their nursing classes on the Likert items, however, about one third of students remarked on the open ended question that this subject was uncomfortable for them to discuss publicly.

To revisit the second research question, I sought to answer how nursing students would perceive multicultural education to impact their patient care. Close to 100% of students reported such education would allow them to provide better care. Clearly the voice of the student indicates they want this education, and they believe this education will have a profound impact on the care they will render throughout their careers.

The third research question asked what the perceived barriers to multicultural education were. This information was obtained on the post-test. In rank order from greatest reported to least reported, the perceived barriers were: the topic is

uncomfortable, ignorance, fear, prejudice, lack of willingness of the learner or educator, and the lack of diversity of nurse educators. It is not currently clear how these barriers can be overcome, but for the purpose of encouraging student discussion during education sessions, I must foster the notion of a safe environment.

Reflections of My Leadership

Cycle I marked a period in my life where I had the ability to take didactic learning of research designing and planning, as well as theory of organizations and organizational culture and apply it to my practice. Data analysis allowed me to learn about my action research project, but reflective practice allowed me to learn about myself as a leader. During cycle I, I planned my first education session to be conducted during the month of March. Sometimes the best-laid plans are rendered useless as evidenced by my first education session being cancelled due to blizzard conditions. The cancellation of the planned education session challenged me to be creative and flexible. I was disappointed that I was unable to move forward as I had planned, yet realized that the best plans may not be actualized due to forces beyond my control. Reflecting back on what had occurred, I realized that I had changed as a person. Instead of being angry or upset I was relaxed and changed my plan in an attempt to salvage my project. At this point I started comparing bedside nursing to being a nurse educator. I realized that there are some things that absolutely must be addressed, situations that are life or death. These are the situations I should act fast and decisively on. When it comes to nurse education, in the classroom it would be rare to encounter such a delicate situation. When it comes to implementing projects, there is time to complete tasks without great involvement of risk.

In the teaching arena it is okay to make a mistake, as long as I learn from it and improve on my practice. Truly this is at the heart of action research.

I also learned that I am a brave person. During my first education session I presented the topic of health and illness in the Black population as a Caucasian female. I discussed a topic foreign and uncomfortable to me, to the participants, realizing that the topic was also uncomfortable for them. During the first session I realized that I truly was applying a transformational approach to my leadership. I acknowledge that I was uncomfortable, the topic was uncomfortable, but that in order to achieve greater understanding of the world that we needed to start talking to one another. I believe I inspired many participants that day, but I also inspired myself. Traditionally, transformational leaders are known to be charismatic, inspirational, intellectually stimulating, and have influence over their followers (Hoyt & Blascovich, 2003). Through personal reflection, I understand that I embodied all four of the aforementioned behavioral characteristics during my education sessions.

Action researchers plan, act, observe, and reflect (Hinchey, 2008). When I reflect upon my session, I believe my plan was effective, the education session successful, and data collected. Now I reflect upon what went well and what could have been better. During my education session, I felt as though something was missing as I began to present health and illness in the Black population. After thinking about what could have been improved, I realized that I wanted to tell the participants why I selected the Black population as my first identified culture, and realized myself that not only is this population a culture, but this population has been subject to racism, and the persistence of racism throughout U.S. history. Based upon my thoughts, reflection, and research, I

decided to include Critical Race Theory (CRT) for my next education sessions to explain why the Black culture may face disparities in health care settings.

Racism produces rates of morbidity, mortality, and overall well being that vary depending on socially assigned race. Eliminating racism, therefore, should lead toward health equity (Ford & Airhihenbuwa, 2010). CRT originated in legal studies and is grounded in social justice. It can be defined as a critique of racial reform efforts targeted toward the inherent discrimination against minorities in the American legal, educational, and healthcare systems. CRT asserts that racial inequities exist, to this day, and seeks to move society toward social justice by illuminating the disparities that exist in the U.S. today (Closson, 2010; Ford & Airhihnebuwa, 2010; Price, 2010). CRT is a reality in the U.S., and I believe the addition of the topic to the education session is necessary for those not affected by CRT to understand its impact on health and illness in the Black population.

Based on feedback from cycle I, I also believed I should expand the role of the minority health care workers. Students overwhelmingly agreed that the best way for them to learn about cultures other than their own is to hear it from a member of the culture that they are learning about. For this reason, I plan to incorporate more conversation, and plan to have the minority health care workers provide commentary during my presentation in the classroom setting.

Change Philosophy

Kotter's (1996) eight step change theory was followed during cycle I. While planning, I diagnosed the needs of the JSN and developed a plan for improving upon an identified problem. I next sought out respected and informed individuals necessary to

help me lead my change project. I shared my vision through communication with key stakeholders, provided my education session to participants, and empowered them to make conscious efforts to achieve my vision. I realized that change is a process, not an event, and planned for future sessions and their success. Moving forward into the next cycle I realized I needed to continue to demonstrate the need and importance of my change project in hopes of re-culturing the JSN organizational values, beliefs, and norms.

Reflecting back on my leadership, during cycle I, I realized that although many of my actions and interactions were transactional, the intent of the actions was transformational. I realized I intended a change for the JSN, a meaningful change that had the potential not only to make a positive difference in the lives of the students in the JSN but also the lives of society as a whole. This is what Fullan (2001) refers to as moral purpose. I understand now that my change initiatives were enacted by blending the change theories of both Kotter (1996) and Fullan.

Fullan (2001) indicates that leaders, as change agents, are driven by moral purpose but that leadership is situational. Fullan asserts that effective leaders know that change is a process, not an event, and that it takes time and relationship building in order to create long lasting change. According to Fullan, knowledge building is a key essential to change. Knowledge building takes personal commitment and cooperation from those involved in the change process. Effective leaders guide people through differences and enable differences to surface. Kotter (1996) and Fullan also acknowledge that change involves risk. If a change is meaningful to a leader, that leader may need to “stick their neck out” to get somewhere. Truly, if a leader is driven by moral purpose, as am I, they are willing to take a risk to maximize their potential.

Conclusion

Cycle I of this action research project included surveying schools of nursing; researching, planning, and implementing an education session; applying for, and being awarded seed money; securing guest speakers; administrative tasks; and collecting and analyzing qualitative and quantitative data. I believed cycle I to be both a success and a learning experience. It was identified that many students do not know where to find materials related to culture during their hospital based clinical practicum experiences. A discussion of where to find such information, or who to ask for help, will be included in the education sessions for subsequent action research cycles. All data collected informed my next cycle of research and sought to answer my research questions. In the next chapter, I discuss the implementation of cycle II and discuss the analysis of the collected data.

Chapter 6

Cycle II: Implementing and Improving Upon Action Research

Introduction

Cycle II of this action research project included the modification of the education session delivered in cycle I, implementation of two additional education sessions, data collection, and analysis. After reflecting upon the learning that occurred during cycle I, I intended to include a small discussion of CRT during my PowerPoint presentation and expand the role of the minority speaker in the next education session. This notion is consistent with practical action research, in which a practitioner identifies a classroom or curricular problem and methodically works toward identifying and implementing a specific change strategy (Hinchey, 2008). Understanding that action research is cyclical, involves information gathering, analysis, and reflection, I intended to improve on cycle II by incorporating CRT (Hinchey, 2008). To do this, I adapted the works of Closson (2010), Ford and Airhihnebuwa (2010), and Price (2010) to assist student nurses in understanding the components of CRT related to the culture of the African American population and the impact of CRT to health care equity. I also met with the minority guest speakers and discussed expanding their role and allowing more time for them to detail their own life experiences as members of the African American community in the health care arena. As indicated at the conclusion of cycle I, I also added a discussion of where students should look to find information about culture in the hospital setting and indicated who to ask for assistance with finding such information, should the need arise during clinical practicum.

The first education session implementation was conducted on May 6th, 2010, the second on May 21st, 2010. The decision was made to combine the two education sessions, into one cycle, due to their proximity on the academic calendar.

Planning, Scheduling, and Implementation

The planning and scheduling associated with cycle II was similar to that which was done during cycle I. Acquiring rooms, scheduling and requesting speakers, and securing audio/visual equipment was conducted in the usual fashion. The dates available for the education session again fell on scheduled ACE days. These days were fixed and could not be changed or modified, unless there was a weather or campus emergency as seen during cycle I, in which there were blizzard conditions warranting a university closure. The scheduled date of the ACE day for the senior BSN population was May 6th, 2010, and the next scheduled ACE date for the senior FACT population was May 21st, 2010. For this reason, and as previously discussed, education sessions two and three were combined into one cycle of action research. The analysis of data will be presented separately.

The second and third implementations of the education sessions included the addition of CRT and had 30 minutes allotted to allow speakers to detail their experiences in the health care field. Prior to the education session I asked the guest speakers to reflect on experiences they had, related to their culture, that in some way were significant to them. This included their experiences as both health care workers and health care recipients. The speakers were relatively consistent with the content they delivered in education sessions two and three, and were the exact speakers used during cycle I.

Participation in education sessions two and three was voluntary and focus group selection mimicked what was carried out during cycle I.

Data Collection, Entry, and Analysis

Reflecting upon the data collection, entry, and analysis performed in cycle I, and its success, I decided to replicate the work pattern seen in cycle I. As a review, pre-tests were distributed prior to the education sessions, allowing students 90 seconds per question to answer. Once surveys were completed they were placed in a box. At the conclusion of each education session, post-tests were distributed allowing 90 seconds per question, and once completed, they were placed into a box and brought to the JSN by an administrative assistant. The numerical data collected from the pre- and post-tests were entered into PASW, where again, descriptive statistics were performed. The open-ended questions found on the post tests were also handled in the same fashion as cycle I and thematic coding was performed on the data.

At the conclusion of each education session, again, focus groups were conducted in a separate conference room. Each focus group session contained 10 student members chosen by random selection. As was seen in cycle I, video recording of each session was performed, the audio portion of the focus group transcribed, and the findings reviewed and coded to identify themes.

The analysis of implementation two, whose intended target audience was the senior BSN students, indicated there were 105 respondents. Demographic information regarding race/ethnicity and age, specific to this cohort can be found in Table 3 and Table 4. You will again notice the predominate race/ethnicity distribution to be predominantly Caucasian/White and age range to be 18-25 years of age.

Table 3

Participant Self Identification of Race/Ethnicity

Race/Ethnicity	n	%
Arab	0	0
Asian/Pacific Islander	21	20
Black	1	1
Caucasian/White	78	74
Hispanic	3	3
Latino	0	0
Multiracial	1	1
Other	1	1
Total	105	100

Table 4

Participant Self Identification of Age

Age	n	%
18-25	67	64
26-35	32	30
36-45	5	5
46-55	1	1
Total	105	100

When asked if respondents believed nursing education regarding multiple cultures was valuable in undergraduate nursing education 94% of the students agreed. Ninety-six percent of respondents also believed awareness of other cultures would allow them to provide better patient care than they were able to give at that point in time. When asked if respondents felt they had multiple learning opportunities related to multicultural awareness education, only 54% were in agreement. Seventy percent of respondents reported witnessing effective patient care delivery to cultures outside their own while in a different question 47% of respondents reported witnessing ineffective/inappropriate care delivery to cultures other than their own. Sixty-two percent of respondents disagreed

they felt uncomfortable providing care to cultures with which they were unfamiliar while 23% reported they felt uncomfortable providing nursing care to cultures other than their own. Finally, 21% of respondents identified they knew where to find cultural education materials in the hospital while 67% of respondents disagreed.

There were 92 respondents for the post-test, and of these respondents 89% agreed having an understanding of only their own culture could negatively impact the patient care they deliver. One hundred percent of respondents agreed that appreciating a patient's cultural perspective was a necessary component of highly effective nursing care. When asked how respondents best learn about multiple cultures, only 2% identified by reading books, 8% identified by looking at an electronic resource, and 94% identified by listening to individuals from multiple cultures. This suggested that my role in presenting "Health and Illness in the Black Population" required some further thought prior to the implementation of the next cycle. Specifically, I needed to expand the role of the minority health care worker and remove myself from the presentation. Ninety-seven percent of those surveyed felt comfortable discussing multiple cultures within the context of their nursing classes, and 72% disagreed that a patient's culture has little to do with the care the respondent provided to them. Ninety percent of the respondents believed the JSN should do more multicultural awareness education sessions to potentially improve patient care. This is discussed in further detail below.

Thematic coding performed on the first open-ended question of the post-test drew three main themes. When asked how the education session had or had not changed the way the respondent thought about multicultural awareness education, 90 of 92 students responded. Of those responses, 26% indicated no change, 67% believed multicultural

awareness was important to providing effective patient care, and 14% believed it should be a mandatory part of the curriculum. When asked to indicate the perceived barriers to multicultural awareness education six themes emerged. Of the 90 respondents, 11% perceived a lack of diversity in nurse educators to be a barrier, 31% reported a lack of willingness on the part of the learner or educator, 28% reported prejudice/racism, 8% reported fear of the subject, 22% reported ignorance of the subject, and 31% reported discomfort publicly discussing the topic as being a barrier.

The focus group for education session two, as seen with education session one, contained 10 members, was randomly selected, and was audio/video taped and transcribed. When asked to identify when students in this target audience recalled learning about cultural diversity at the JSN, the results were mixed. While some students did not respond at all, others mentioned different classes. The consensus amongst the group was that although the topic was introduced, the material covered was insufficient to meet their future needs as registered nurses. When asked what was most memorable about the education session performed that day, several students commented that they appreciated the discussion of applying the information learned during the session to the clinical practice setting. One student in particular commented, "I thought it was good to reinforce the process on how to begin talking to someone about their culture, or religion, because it was always presented to me as the facts, but never discussed how to begin asking patient's about their culture." Another student commented, "...I think today we really talked about the application. We talked about overcoming barriers."

All students in the focus group agreed that they had the opportunity to care for a patient from a different cultural background than their own during clinical practicum.

When asked if participants knew where to find information about various cultures in the clinical setting, few answered. Of those who answered, they referred to their own workplace, not their clinical practicum sites, and indicated the information available only pertained to Hasidic Jews, and was available through a national organization not associated with the hospital workplace itself. Clearly there is room for improvement in clinical practice. Since there is no current standard for locating or housing diversity materials that are accessible to healthcare staff, this likely deters highly effective nursing care delivery. The term “multicultural awareness” did not have any particular meaning to participants when asked.

Participants were asked to describe instances where patient care was affected either positively or negatively, secondary to a nurses knowledge of the patient’s culture. One participant discussed a community health nurse who delivered care to a highly Latino population. The participant described the actions taken by the nurse to immerse herself into the Latino culture by taking Spanish classes and learning about dietary norms associated with the population which she incorporated into the care she rendered.

Participants seemed to have an easier time recalling negative patient care related to a lack of knowledge of a patient’s culture, particularly in the focused setting of maternal/newborn health. Three participants reported that young, minority mothers were not offered breast feeding consultations citing that nurses, in three different healthcare settings, indicated that this population was “not likely” to continue breastfeeding after discharge. One student commented, “...it was presumed that if the mother was African American that she was going to bottle feed. It goes against everything we learned in class.” A fourth participant reported nurses used the term “Asian baby syndrome” to

refer to the practice of Asian babies being cared for primarily by the babies family members, and not the new mother. The participant reported that these babies tended to cry often, and that staff nurses harbored resentment against this cultural practice as opposed to understanding it.

Participants gave mixed results when asked the best way for faculty to provide multicultural education. One participant felt an individual diversity course would not be helpful while another indicated it would. Most students agreed that multicultural education should occur throughout their nursing education and that the focus should be on implementation and application as opposed to memorization of facts. Finally, when asked if participants believed health care workers stereotype patients, the majority agreed. One student stated, “Yes, a prime example is in what we talked about in maternity. You cannot assume mothers don’t want to breastfeed.”

The analysis of education session three, whose intended target audience was the senior FACT students, found there were 96 respondents. Demographic information regarding race/ethnicity and age, specific to this cohort can be found in Table 5 and Table 6. The predominant race/ethnicity distribution was again Caucasian/White and the majority age was 26-35 year olds.

Table 5

Participant Self Identification of Race/Ethnicity

Race/Ethnicity	n	%
Arab	0	0
Asian/Pacific Islander	6	6
Black	6	6
Caucasian/White	79	85
Hispanic	0	0
Latino	0	0
Multiracial	1	1
Other	2	2
Total	96	100

Table 6

Participant Self Identification of Age

Age	n	%
18-25	38	40
26-35	40	42
36-45	12	13
46-55	5	5
Total	96	100

One hundred percent of respondents both agreed that nursing education regarding multiple cultures is valuable in undergraduate nursing education and that awareness of other cultures would allow them to provide better patient care than they currently provide. Eight-one percent of respondents agreed they had multiple learning opportunities related to multicultural awareness during their undergraduate nursing education. While 74% agreed they had witnessed effective patient care delivery to cultures other than their own, 58% reported they had also witnessed ineffective/inappropriate patient care delivery to cultures other than their own. Sixty-one percent of respondents did not report feeling uncomfortable providing care to cultures

they were unfamiliar with. When asked if respondents knew where to find information about cultures other than their own in the hospital setting this target audience was split, 41% agreed, 21% remained neutral, and 32 disagreed. A comparison of the pre-test findings from cycle I and cycle II can be found in Table 7 listed below.

Table 7

Comparison of Cycle I and Cycle II Pre-test Results (n= 315)

Variable	Scale	Cycle I %	Cycle II %
Education regarding multiple cultures is valuable in nursing education	Strongly agree	63	57
	Agree	33	40
	Neutral	2	2
	Disagree	1	1
	Strongly disagree	1	0
Awareness of other cultures will allow me to provide better patient care than I provide now	Strongly agree	62	65
	Agree	34	32
	Neutral	2	3
	Disagree	0	0
	Strongly disagree	2	0
Multiple opportunities to learn about culture were available to me in the JSN	Strongly agree	14	10
	Agree	45	52
	Neutral	26	17
	Disagree	14	21
	Strongly disagree	1	
Culturally competent care was witnessed during clinical practicum	Strongly agree	28	13
	Agree	46	60
	Neutral	12	19
	Disagree	12	8
	Strongly disagree	2	0
I am comfortable caring for other cultures	Strongly agree	3	3
	Agree	8	20
	Neutral	13	16
	Disagree	54	43
	Strongly disagree	22	18
I know where to find cultural information in the hospital setting if needed	Strongly agree	7	6
	Agree	29	26
	Neutral	25	16
	Disagree	32	47
	Strongly disagree	7	5

An analysis of the post-test results for the third education session indicated a total of 82 students responded. Eighty-seven percent of respondents agreed that having an understanding of only their own culture could have a negative impact on the patient care they delivered. Ninety-five percent appreciated that a patient's cultural perspective was a necessary component of highly effective nursing care. When asked about the best way for respondents to learn about multiple cultures, 5% indicated by reading a book, 10% by looking at an electronic resource, and 87% by listening to individuals from multiple cultures. This, as seen in cycle I, gives rise to further expanding the role of the minority guest speaker and has implications for future course development. Eighty-three percent of respondents agreed they felt comfortable discussing multiple cultures within the context of their nursing classes and 89% disagreed that a patient's culture had little to do with the care they could provide them. Finally, 88% of students agreed the JSN should do more multicultural awareness education sessions to potentially improve patient care. A comparison of the post-test data results between cycle I and cycle II can be found in Table 8.

Table 8

Comparison of Cycle I and Cycle II Post-test Results (n= 290)

Variable	Scale	Cycle I %	Cycle II %
Understanding only my own culture negatively impacts care I deliver	Strongly agree	48	42
	Agree	40	46
	Neutral	4	5
	Disagree	2	5
	Strongly disagree	6	2
A patient's cultural perspective is a necessary component of highly effective nursing care	Strongly agree	71	60
	Agree	28	36
	Neutral	1	2
	Disagree	0	1
	Strongly disagree	0	1
I am comfortable discussing culture in my nursing classes	Strongly agree	21	24
	Agree	50	55
	Neutral	18	15
	Disagree	10	5
	Strongly disagree	1	1
Culture has little to do with nursing care	Strongly agree	2	2
	Agree	3	2
	Neutral	5	4
	Disagree	47	55
	Strongly disagree	43	37
The JSN should do more cultural awareness education	Strongly agree	50	50
	Agree	42	39
	Neutral	6	8
	Disagree	2	2
	Strongly disagree	0	1

Thematic coding was again performed on the open-ended questions found on the post-test. When asked to indicate how the education session had or had not changed the way the respondent thought about multicultural awareness education, two main themes emerged. Of the 82 respondents, 21% reported the session did not change the way they thought. Fifty-two percent of respondents believed it was important to providing effective patient care.

When asked to indicate what respondents perceived as barriers to multicultural awareness education, 10% reported a lack of diversity of nursing educators, 27% a lack of willingness on the part of the learner or educator, 26% prejudice/racism, 10% reported fear, 13% reported ignorance, 16% reported a lack of time in the program, and 31% reported the uncomfortable nature of discussing the topic publicly.

A focus group of 10 participants was again audio/video recorded as seen in previous data collection methodology. When asked when participants recalled learning about cultural diversity for the first time, participants recalled it being discussed in three courses, which fell during the first term of their academic education in the JSN. One participant reported how meaningful it was to him when an instructor brought members of the community who had been diagnosed with human immunodeficiency syndrome (HIV) to speak to the class. All students in this target audience agreed that they had all cared for cultures other than their own during clinical. When asked what the term “multicultural awareness” meant to them, one respondent stated it meant that, “. . .all patients are not the same, they are not all English speaking and White.” Another participant responded that it was “something that was always evolving because things are always changing.” Another participant responded, “I don’t like the term multicultural diversity. It is important to remember that culture is not only about race.”

Participants in this focus group were also asked to describe instances where patient care was affected either positively or negatively, secondary to a nurse’s knowledge of the patient’s culture. One respondent spoke of a Latino nurse who served a predominantly Latino population. This respondent indicated that the nurse provided highly effective care to the population, because as a member of the culture, she

understood the cultural norms, beliefs, and basic dietary patterns. Another participant reported effective patient care when the nursing staff in an intensive care unit wrote simple directions in a patient's native language on the patient's wall, and incorporated a Haitian health care worker in the patient's daily plan of care.

Participants in this focus group also reported a lack of cultural sensitivity specific to the maternal/newborn population. One participant noted, "...the population was mainly Latino women. These nurses refused to print anything out in Spanish for them, or get a translator phone. One woman was in labor, and they asked her if she wanted an epidural but she didn't speak English." Participants in this audience also reported a lack of cultural sensitivity in the maternal/newborn setting citing that nurses "jump to conclusions about teen mothers and breastfeeding" and that nurses, "have their stereotypes." When discussing a clinical practicum rotation, one participant mentioned she witnessed a nurse state, "This patient is Indian, or Asian, or something." The participant went on to say she felt this comment was inappropriate, and she was insulted the nurse did not take the time to know the correct ethnicity.

The majority of this focus group did not believe they received enough diversity education at the JSN but disagreed on the best way for faculty to teach this content. Again there was debate about having a single course, ACE day sessions, or threading the content through the curriculum. This group was unique in that two participants spoke of service learning they had participated in at other schools and commented that they would like to see students interacting more with the community, if at all possible.

At the conclusion of cycle II, as seen at the conclusion of cycle I, as part of my analysis I revisited my research questions. In the first question I ask how this study

contributed to the social and academic perspectives of nurse candidates. As seen during cycle I, both sets of participants in cycle II strongly agree that nursing education regarding multiple cultures is valuable in nursing education and that the JSN should do more cultural education settings.

The second research question sought to determine how nursing students perceived multicultural education would impact their nursing care. Just under 100% of students believed recognizing and including culture into nursing care was a component of highly effective nursing practice, and that further understanding of culture would allow them to provide better patient care. The data collected during these three cycles substantiates the need and perceived worth of this action research project and the initiation of future diversity projects. Students again widely reported they do not know where to find information regarding culture in the hospital, despite the fact it was discussed during the education session. I believe this is largely due to the lack of uniformity found in the current practice setting and is a potential project for future study. From the social perspective, it is again interesting to find that although approximately 90% of participants report they are comfortable discussing culture, publically, in their nursing classes, it is the most frequently reported barrier to education on the open-ended questions. This is identical to what was found during cycle I. It is not clear why this discrepancy exists.

Finally, students were again asked to identify the barriers they perceived to receiving multicultural education in their nursing education. In rank order from most reported to least reported, the perceived barriers were: the uncomfortable nature of the topic, lack of willingness on the part of the learner or teacher, prejudice, ignorance, lack of time in the program, lack of diversity of nurse educators, and fear.

Emerging Themes

Cycle II ushered in emerging themes, some consistent with those found during cycle I, and some new. Again I found the populations surveyed to be predominantly Caucasian. Overwhelmingly, students believed in the value of multicultural education and believed it will allow them to better provide nursing care. Students indicated that culture has a definite impact on the care they rendered and expressed comfort while providing care to patients with unfamiliar cultures. Students overwhelmingly agreed that the best way to learn about other cultures was by listening to a member of the particular culture, there was still a small amount of feedback indicating that a Caucasian should not be presenting this topic at all. This led me to rethink my presentation strategy.

Expanding the role of the minority guest speakers may not have been effective at increasing the meaningfulness of the discussion. I believed now that planning for the next session should include a presentation of “Health and Illness in the Black Population,” to be presented only by a Black healthcare worker in an attempt to maximize the impact on the audience. Interestingly, participants in implementations two and three reported feeling comfortable discussing various cultures within the context of their nursing classes, however they reported the opposite on the open-ended question found on the post-test.

An unexpected finding found in cycle II as well as cycle I, was the contrast between what students were taught during lecture versus what is being practiced in the post-partum nursing setting. Participants in both cycles, a total of three student cohorts, have identified inferior care to the post-partum patient regarding breast-feeding. This finding likely requires further investigation in the future.

Reflections of My Leadership

Bolman and Deal (2001) describe leadership as a gift of oneself to a common cause and a higher calling. Reflecting back on myself as a self identified transactional and transformational leader I began to realize there was something more to my leadership. In the previous chapter I described how I combined the change philosophies of both Fullan (2001) and Kotter (1996), I now realized that I also must add servant leadership as a leadership style that drives my action research project. This project stemmed from my belief that the JSN should do more to meet the needs of our student population, in hope to one day improve the curriculum at the JSN but also to improve society at large. This project was envisioned through my own sense of moral purpose, which I believe ties closely with transformational leadership. As a faculty member in the JSN, I serve both the organization, the student population, and society. Servant leadership may be viewed as an extension of transformational leadership. Servant leaders are characterized as committing themselves to the success of their subordinates and to the organization. (Taylor, Martin, Hutchinson & Jinks, 2007).

Reflecting upon myself during Cycle II, I realized I displayed conceptualization, foresight, and a commitment to the growth of others. This was done both in the planning and implementation of the action research project and are qualities consistent with my newest addition to my espoused leadership styles, servant leadership (Crippen, 2005). I believe that I have grown as a leader by understanding my personal beliefs. It is important to me to be authentic, empathetic, and present in the moment to make the best decisions for myself, for those I serve, as well as to the organization to which I am a part.

In a study of three hundred educators (Crippen, 2005) the most common perceptions of servant leaders is that they: are true humanitarians; put others before self; are caring and compassionate; are balanced; empower others; are servant first, then leader; and are transformational. When reviewing the preceding list, I understand all of the qualities to be true of myself. I have a strong desire to improve the JSN, student nurses, and nursing practice. My action research project sought to move healthcare toward social justice and was driven by transformational leadership. Transformational leadership is mutually beneficial to leader and follower and the leader serves to empower others to become leaders themselves (Komives, Dugan, Owen, Slack, & Wagner, 2011). My day-to-day interactions, planning, and scheduling are largely transactional, and my implementation and personal ethic for the project are consistent with servant leadership.

Change Philosophy

During cycle II the change philosophies of Kotter (1995) and Fullan (2001) were still in place. I believe Fullan's assertion that change, particularly this action research project, should be driven from a sense of moral purpose, which is consistent with transformational and servant leadership. I also realized that Kotter's systematic and methodical change theory allowed me to implement two additional education sessions in a fashion similar to the first implementation, which I believed was consistent with transactional leadership. Using transactional leadership I completed the tasks necessary to meet my goals and conduct my project. I refer to this as transactional leadership because it involved the performance of tasks to facilitate the action research project that were not driven by inspiration (Komives et al., 2011). At the conclusion of cycle II, I found myself to be largely a transformational and servant leader. I believed myself to be

driven by an inner desire to improve education and practice, and to give back to the organization that believed I do a good job and encouraged me to fulfill myself professionally. Reflection upon my leadership and actions during cycle II led me to believe that a blend of transformational, transactional, and servant leadership coupled with the change theories of Fullan and Kotter were a successful combination leading the remaining cycles of this action research project.

Conclusion

Students recognize the importance of incorporating culture into health care, are interested in learning more while in the JSN, and can cite positive and negative outcomes relative to the cultural sensitivity of nurses in the practice realm. Students also reported that the best way for them to learn about other cultures was by a member of the culture itself, a point that cannot be overlooked in this action research project.

Using the information collected in cycle II, I understood that I needed to change my final cycle to further expand the role of the minority health care workers in my education sessions. It was expected that by implementing this change, the classroom sessions would be more meaningful to the audience. In the next chapter I detail the changes made for cycle III, the data collected, and the findings.

Chapter 7

Cycle III: Concluding Action Research

Introduction

Cycle III marked the final implementation of this action research project. In this cycle the junior FACT students voluntarily completed pre- and post-tests, received an education information session, and participated in a focus group. As previously mentioned, the learning in cycle II convinced me to expand the role of the minority health care worker during the implementation of cycle III. This is what Hinchey (2008) refers to as an action plan. Due to the data collected in cycles I and II, I was aware that to authenticate the learning experience for the student participants, I needed to enlarge the role of the representative from the identified minority culture.

Planning, Scheduling, and Implementation

Student participants in cycles I and II reported that the best way for them to learn about various cultures was by listening to individuals from that culture, a sentiment expressed quantitatively on post-test scores, qualitatively on post-test open-ended questions, and during focus groups. I realized at the summation of cycle II, that although I did expand the role of the minority health care worker during my cycle II presentation, that the role could be further developed to be more meaningful to student learning.

The scheduled ACE day fell on Friday August 13, 2010. This date was non-negotiable making scheduling straightforward. I had already received a commitment from my guest speaker, however there was a need to meet with her to discuss her expanded role. My guest speaker agreed to meet with me, in person, on Monday August 2, 2010. During this meeting she agreed to present the topic of health and illness in the

Black population. I furnished her with a copy of the PowerPoint slides, references, and notes from previous sessions. I discussed that I would introduce the topic, administer the pre- and post-tests, and conduct the focus groups. As part of my introduction I explained that I would discuss where student nurses could find information about culture in the hospital setting. I would also discuss whom students should ask in the event needed materials could not be found. This was done to keep in line with the identified gap in current practice (see cycle I), and to maintain consistency with information delivery amongst the groups. My guest speaker would then present “Health and Illness in the Black Population.” In the usual fashion, a large auditorium, conference room, and audio/visual were requested through university services prior to the event on August 13th.

Data Collection, Entry, and Analysis

Students again had the opportunity to select in or select out of the education sessions. As seen during cycles I and II, students were randomly assigned to focus group sessions. As seen in previous cycles, focus groups were audio/video recorded for later transcription.

All quantitative data collected on the pre- and post-test were entered into PASW and descriptive analyses performed. The qualitative data from the open-ended questions were reviewed and coded. The audio/visual recordings from the final focus groups were transcribed and thematically coded.

A total of 107 participants responded to the pre-test survey. The demographic frequency distribution for race/ethnicity and age are listed in Table 9 and Table 10. The demographics for race/ethnicity are similar to previous cohorts, however 52% of respondents were 26-35 years old compared to 42% in the previous cohorts.

Table 9

Participant Self Identification of Race/Ethnicity

Race/Ethnicity	n	%
Arab	1	1
Asian/Pacific Islander	19	18
Black	3	3
Caucasian/White	74	71
Hispanic	5	5
Latino	0	0
Multiracial	2	2
Other	0	0
Total	107	100

Table 10

Participant Self Identification of Age

Age	n	%
18-25	44	41
26-35	56	52
36-45	4	4
46-55	1	1
56+	2	2
Total	107	100

When asked if participants agreed they had multiple learning opportunities related to multicultural awareness there was no clear consensus. Of the responses, 39% agreed they had multiple opportunities, 39% remained neutral, and 21% disagreed. When asked if participants witnessed effective patient care delivery to cultures other than their own 51% agreed, 32% remained neutral, and 16% disagreed. Participants, again, gave no clear consensus when asked if they had witnessed ineffective/inappropriate patient care delivery to cultures other than their own by reporting 38% agree, 29% neutral, and 33% disagreed. The fact that 29% of participants remained neutral was a bit unsettling. In the nursing profession the expectation is that nurses deliver high quality care to all patients

regardless of race, creed, or gender. The data suggests this may not have been evidenced by nurses in practice who were being observed by nursing students.

Sixty-four percent of participants felt comfortable providing care to cultures they were unfamiliar with while 18% remained neutral and another 18% disagreed. When asked if participants knew where to go to find information about various cultures in the hospital setting 44% disagreed, 19% remained neutral, and 24% agreed. Finally, when asked if participants knew where to find information about cultures other than their own in the hospital setting 44% agreed, 24% disagreed, and 19% remained neutral. A comparison of the pre-test results among all cycles can be found in Table 11 below.

Table 11

Comparison of Cycle I, Cycle II and Cycle III Pre-test Results (n= 422)

Variable	Scale	Cycle	Cycle	Cycle
		I %	II %	III %
Education regarding multiple cultures is valuable in nursing education	Strongly agree	63	57	59
	Agree	33	40	35
	Neutral	2	2	6
	Disagree	1	1	0
	Strongly disagree	1	0	0
Awareness of other cultures will allow me to provide better patient care than I provide now	Strongly agree	62	65	66
	Agree	34	32	31
	Neutral	2	3	3
	Disagree	0	0	0
	Strongly disagree	2	0	0
Multiple opportunities to learn about culture were available to me in the JSN	Strongly agree	14	10	7
	Agree	45	52	32
	Neutral	26	17	39
	Disagree	14	21	20
	Strongly disagree	1	0	2
Culturally competent care was witnessed during clinical practicum	Strongly agree	28	13	14
	Agree	46	60	38
	Neutral	12	19	32
	Disagree	12	8	16
	Strongly disagree	2	0	0
I am comfortable caring for other cultures	Strongly agree	3	3	2
	Agree	8	20	16
	Neutral	13	16	18
	Disagree	54	43	41
	Strongly disagree	22	18	23
I know where to find cultural information in the hospital setting if needed	Strongly agree	7	6	5
	Agree	29	26	23
	Neutral	25	16	22
	Disagree	32	47	43
	Strongly disagree	7	5	7

Ninety-nine students completed the post-test, and of these students 89% believed a lack of understanding of other cultures could negatively impact patient care rendered, 8% disagreed. When asked if appreciation of a patient's cultural perspective was a necessary component of highly effective care students overwhelmingly agreed with a

response rate of 98% agreement. Respondents were then asked how they best learned about multiple cultures, of these respondents 88% agreed listening to individuals from multiples cultures was the best way for them to learn about cultures outside their own. Participants were asked about their comfort level while discussing multiple cultures in their nursing classes, of the respondents, 83% felt comfortable. Eighty-eight percent of respondents believed a patient's culture impacted the care provided to them and 90% agreed the JSN should do more multicultural awareness education sessions to potentially improve patient care. A comparison of post-test results from cycles I, II, and III can be found in Table 12.

Table 12

Comparison of Cycle I, Cycle II, and Cycle III Post-test Results (n= 389)

Variable	Scale	Cycle	Cycle	Cycle
		I	II	III
		%	%	%
Understanding only my own culture negatively impacts care I deliver	Strongly agree	48	42	49
	Agree	40	46	40
	Neutral	4	5	3
	Disagree	2	5	5
	Strongly disagree	6	2	3
A patient's cultural perspective is a necessary component of highly effective nursing care	Strongly agree	71	60	68
	Agree	28	36	30
	Neutral	1	2	1
	Disagree	0	1	1
	Strongly disagree	0	1	0
I am comfortable discussing culture in my nursing classes	Strongly agree	21	24	32
	Agree	50	55	52
	Neutral	18	15	12
	Disagree	10	5	3
	Strongly disagree	1	1	1
Culture has little to do with nursing care	Strongly agree	2	2	0
	Agree	3	2	5
	Neutral	5	4	7
	Disagree	47	55	50
	Strongly disagree	43	37	38
The JSN should do more cultural awareness education	Strongly agree	50	50	38
	Agree	42	39	52
	Neutral	6	8	9
	Disagree	2	2	1
	Strongly disagree	0	1	0

The open-ended questions found on the post-test were reviewed and thematically coded. When asked to indicate how the education session had or had not changed the way participants' thought about multicultural awareness education 21% reported no change, however, 37% indicated it was an important component of effective patient care delivery. No other themes were predominant related to this question.

Participants were asked to indicate what they believed were barriers to multicultural awareness education. Twenty-one percent of respondents indicated that the topic was uncomfortable to talk about, thus being a barrier. Seventeen percent of participants reported a lack of willingness amongst the learner and another 17% reported ignorance as a barrier. The next theme noted was that 14% of participants reported a lack of time in their already busy schedules to learn a new topic. Ten percent of respondents indicated that fear of the subject is a barrier and finally, 3% of participants reported a lack of diversity in nurse educators as a barrier to multicultural awareness education.

The final focus group was transcribed and analyzed. I found this group to agree that although multicultural education was addressed early in the curriculum, what was presented was inadequate to prepare the group for professional practice. Participants had no clear consensus on the best way for faculty to deliver multicultural education in the curriculum, one student believed a course was needed, while several other students believed simulation or role playing were better education modalities. Participants in this group expressed they felt uncomfortable during the education session. This contradicts the majority opinion that students felt comfortable discussing multicultural topics in the context in their nursing classes, yet validates the presence of the recurring theme found on the open-ended, post-test question.

This focus group, again, identified serious practice flaws in the post-partum nursing arena. One student noted, “In the teen mom population the nurses here jump to conclusions about breast feeding. The nurse said the mom would most likely not continue breast feeding and refused to have the lactation consultant come in.”

As in the analysis of the first two cycles, again I returned to my research questions. I first sought to answer how this action research project contributed to the social and academic perspectives of nurse candidates. As seen during cycles I and II, students overwhelmingly agree that education regarding multiple cultures was valuable in undergraduate nursing education (100% agreed). Again, as seen in the previous two cycles, close to 90% of participants believed the JSN should do more to provide diversity studies to the undergraduate students throughout their education. These statistical findings substantiate the need for further diversity studies in the JSN, and proves they are of value not only to the AACN but to the students at large. Cycle III proved to be identical to cycles I and II in that students largely reported feeling comfortable discussing culture in their nursing classes (83%) on a Likert item, yet most commonly reported feeling uncomfortable discussing the topic on the open-ended post-test questionnaire. I cannot draw any conclusions regarding the discrepancy during this cycle.

When asked how students perceived multicultural education would impact their care, the results mimicked those seen during cycles I and II. All participants in this group agreed that awareness of other cultures would allow them to provide better care than they could currently provide. In addition, the majority of students (98%) believed appreciating a patient's culture was a necessary component of highly effective nursing practice.

Finally, this study sought to determine the perceived barriers to providing multicultural education to baccalaureate nursing students. The students identified their perceived barriers on an open-ended post-test question. The results in order from most reported to least reported are as follows: the topic is uncomfortable, ignorance and

prejudice, lack of time in the program, lack of willingness on the part of the learner or teacher, fear, and lack of diversity in nurse educators.

Participants during this cycle were largely homogenous so I expected to find their responses to be relatively similar, however, participants tended not to be in agreement on the pre-test when responding to questions, while on the post-test, they answered relatively consistently. This is difficult to analyze but one must wonder if the education session increased awareness, thought, or consensus among the group. On one hand I might believe the group was impacted by my intervention in such a way that it changed their thought process in a short period of time. Conversely, this might be an example of “group think,” where the students form consensus in order to please the presenter or researcher.

Another interesting observation is that during this cycle, the presenter was a member of the Black population. In reviewing all feedback, there was no commentary noted about the ethnicity of the guest speaker, whether good or bad. It is unclear if making this change contributed to the action research project. The absence of negative commentary may suggest the change was an improvement over previous education sessions and proved to be of benefit to the audience.

Perhaps most enlightening about cycle III is that this focus group elucidated a problem that is occurring in current nursing practice aside from the intent or purpose of this action research project. Students during this cycle of action research identified inferior care to vulnerable populations in the post-partum setting. A similar finding was found in each focus group. This theme has shown itself four times throughout this project and implies the need for investigation of the topic.

Reflections of My Leadership

During this cycle my leadership qualities and traits remained the same. I continued to be driven by transformational and servant leadership while conducting this action research in a very transactional fashion, in order to complete the project according to schedule. To say that my leadership style had not changed does not indicate that I, as a leader, did not change. At the conclusion of cycle III I realized that I had grown profoundly. As I reflected back on my decision to increase the role and presentation of the minority health care worker, I believed the intervention to be a success. I learned that I cannot be a control freak and that it is okay to relinquish my hold over the presentation. I learned to listen to student feedback. The students were telling me since cycle I to expand the role of the minority guest speaker, and I did gradually. I should have made a greater change earlier in the project and learned to trust in others. This action research project was very meaningful to me and I had trouble letting go of complete control. When I carefully let go, the project improved. Anecdotally, students during the cycle III education session appeared to be more engaged and willing to participate in classroom discussion than previous cycles. This observation, coupled with the overwhelming opinion that learning from a member of a particular culture was beneficial, led me to believe the change in the presentation was beneficial and likely meaningful to the target audience. By far, this was the biggest learning experience from this cycle.

Conclusion

The information learned during cycles I and II led me to believe that the education sessions should be improved upon, specifically by expanding the role of the Black health care worker while speaking about health and illness in the Black population. After meeting with the volunteer speaker, explaining my findings, and asking permission, the revised education session was implemented. Pre- and post-tests and focus groups sessions were completed and results analyzed. The homogeneity of the group proved not to be a factor in the Likert scale results from the pre-test, however it may have contributed to the similarity found on the post-test results. In the next chapter a comprehensive analysis of descriptive statistics from all student groups combined is presented and discussed.

Chapter 8

Analysis and Implications

Introduction

This action research project, conducted in the JSN, addressed problems related to the JSN and the practice of nursing. To be more specific, the JSN was failing to adequately meet the essentials set forth by the AACN revisions. Failure to meet these essentials had the potential to impact the ability of entry-level nurses to provide highly effective care. The project involved systematic inquiry including information gathering, analysis, and reflection, all of which led to an action plan. The action research conducted was cyclical and included the steps of: planning, acting, observing, and reflecting. This chapter will review the action research cycles, provide answers to the study research questions, and propose implications for future research. Self study leadership research questions will be answered in Chapter 9.

Research questions

Using a mixed methods approach, this action research project sought to answer the following research questions:

1. How does the “Implementing Multicultural Awareness Education in Undergraduate Nursing Curriculum Project,” contribute to the social and academic perspectives of nurse candidates?
2. How will nursing students perceive that multicultural education will impact their patient care?
3. What are the barriers to providing multicultural education to baccalaureate nursing students?

A self-study of my leadership was also performed during this action research project.

The study sought to answer the following questions about my leadership:

1. How were the actions put forward consistent with my espoused theory of leadership?
2. How did my leadership of the change project impact the manner in which I conduct myself in my workplace?

Overview of Action Research Cycles

Cycle I.

Three cycles of action research were performed for this project. Each cycle intended to discover new information and to inform and improve subsequent cycles and included the steps of: planning, acting, observing, and reflecting. Cycle I occurred during April of 2010. The planning for cycle I first involved identifying an organizational problem and then substantiating a change initiative following a review of relevant literature. The next step included the development of an education session that would serve to both inform nursing students and provide the ability to collect quantitative and qualitative data. Administrative planning during cycle I included convincing administrators of the need to implement the project, recruiting and securing minority guest speakers, reserving on-campus auditoriums and audio/visual equipment, and copying necessary forms for the education session.

The step of acting, during cycle I, involved the presentation of the constructed education session to the traditional junior BSN students. I provided an interactive lecture on the topic of health and illness in the Black population that incorporated minority guest speakers. I also administered and collected pre-and post-tests and conducted a focus

group. Following the data collection, I used PASW to provide descriptive statistics for Likert items and performed thematic coding on open-ended post-test questions and focus group transcriptions. The steps of observation and assessment occurred as I watched students during the lecture and focus group and as I reviewed and analyzed the results generated from both the descriptive statistics and thematic coding documents.

The step of reflection during cycle I included a reflection on the first cycle of action research as well as a reflection on myself as a leader. I believed the administrative planning to be largely successful, however, the student feedback indicated that I should expand the role of the minority guest speakers. Reflection of my espoused leadership at the conclusion of cycle I affirmed my belief that I was a transactional and transformational leader.

Cycle II.

Cycle II occurred during May of 2010. Cycle II again followed the steps of: plan, act, observe, and reflect. Cycle II was unique in that I was able to perform the education session and data collection for two student populations, first the traditional, senior, BSN students, and also the FACT senior students. Planning for cycle II included expanding the role of the minority guest speaker and performing administrative tasks similar to that seen during cycle I. During the step of “acting” during cycle II, I facilitated the education session, collected pre- and post-tests, and performed focus group sessions. All quantitative data collected during cycle II were entered into PASW for analysis and all qualitative data were transcribed and thematically coded.

Observations during cycle II included my personal observation of the student population during the education session and focus groups. As I reflected upon the data

collected during cycle II, I was again prompted to look at the role of the minority guest speaker. Based on student feedback I was again prompted to give thought to a further expansion of the role of the guest speaker. I believed that doing so would make the education session more meaningful to the target audience.

Cycle III.

Cycle III, during August 2010, marked the last cycle of this action research project. The planning of cycle III mimicked that of cycle II, however, during the planning phase I also had a face-to-face meeting with one of the minority guest speakers. This speaker had participated in all of the education sessions and agreed that her role should be expanded to make the session more meaningful to the target audience. We discussed the proposed changes and proceeded with the revision accordingly.

My actions during cycle III revolved around facilitating the revised education implementation, collecting quantitative and qualitative data entering quantitative data into PASW for analysis, and transcribing and analyzing qualitative data in a fashion identical to that found during cycles I and II. During the observation phase of cycle III, I again made personal observations during the education sessions and focus groups and then reviewed an analysis of the data. Despite the changes made to expand the role of the minority guest speaker, students' opinions did not indicate this change had any impact on the meaning they derived from the education session.

Self-reflection of my espoused leadership was revealing during cycle III. At the summation of cycle III, I still believed myself to be both a transactional and transformational leader, but I realized that there were forces driving my leadership that could be found outside the tenets of these two leadership theories, and I believed that my

actions and beliefs were in line with those found in servant leaders. This subject is discussed in further detail in the next chapter.

Research Question Conclusions

Cycles I through III provided both qualitative and quantitative data collected from four unique student populations. The data from each group were reviewed individually, but the conclusion of cycle III provided me the ability to perform a comprehensive data analysis. Descriptive statistic reports for each cohort can be found in Appendix F, Tables F1-F9 and Appendix G, Tables G1-G8.

Research Question 1

The first question asked how the education session contributed to the social and academic perspectives of nurse candidates. Six themes emerged from pre- and post-test data regarding students' academic perspectives. The identified themes are as follows: multicultural education is valuable in undergraduate nursing curriculum, the JSN should do more to incorporate multicultural education in the curriculum, students did not have enough exposure to multicultural awareness education, many students did not know where to locate educational resources regarding culture in the practice setting, and the best way for students to learn about culture is by listening to a member of the culture they are learning about. One theme emerged from pre-test data regarding students' social perspectives of multicultural education, that theme being that comfort is not a feeling universally felt by all students during in-class conversations on the topic. A discussion of each identified theme follows.

Multicultural education is valuable in undergraduate nursing education.

Comprehensive thematic coding was performed on post-test data from all cycles of data collection. A list of inductively developed thematic categories can be found in Table 13. Fifty-two percent of the JSN student participants surveyed responded that multicultural awareness is important to providing patient care. Students are clearly articulating the value they place on learning about multiple cultures. Their opinion, coupled with the documented need for this information in the *Essentials*, echoes the need to address this content in the undergraduate curriculum.

The JSN should do more to incorporate multicultural education in the curriculum.

This action research study sought to address the need for multicultural awareness in nursing education. Chapter 1 addressed the guidelines regarding multicultural awareness in nursing curriculum, as detailed by the AACN, and discussed how a lack of such awareness was an emerging concern for the JSN. In order to address the need for multicultural education it was first necessary to substantiate the need existed. Students identified that they value multicultural education and expressed that the JSN should do more to incorporate multicultural education in the curriculum. This information is powerful and will be used as a platform to discuss ways to implement multicultural awareness education in the existing nursing curriculum in the future. This information will also be used as a means to address the global issue of diversity ignorance on a larger scale detailed later in this analysis.

Table 13

Post-test Inductively Developed Thematic Categories

Category	Thematic Category	Key terms	Characteristic responses
Thought change	T1	No change, has not changed	Q1. I do not think it changed too much but it did get me thinking about it in terms of the healthcare system
	T2	Importance, important to care, necessary, needed care	It emphasized the importance of its impact on patient care
Barriers	B1	Lack of faculty diversity,	Q2. All white teachers, the culture of nursing is mostly that of white women
	B2	Lack, willingness, desire, want	No one wants to talk about it
	B3	Stereotype, bias, prejudice, racism	Racism, fear, and unawareness of issues
	B4	Fear, afraid, apprehensive, reluctant	I feel that there are barriers to multicultural awareness because people are afraid of explaining how they feel
	B5	Lack of knowledge, ignorance	Ignorance, not willing to be open to different views
	B6	Comfort, uncomfortable, uneasy	Comfort is a large issue, I know that I wanted to say things but I would not speak up
	B7	Lack of, need more	Too fast paced to include

Students did not have enough exposure to multicultural awareness education.

Exposure to diverse patient populations would be expected in an urban setting, however, 20% of student participants denied having multiple learning opportunities related to multicultural awareness during their undergraduate nursing curriculum. This statement may indicate that although students are exposed to diverse patient populations, necessary information regarding these patient populations has not been provided to student nurses assigned to care for them. This statement also validates the earlier claim that a lack of multicultural awareness education is an emerging concern for the JSN.

Many students do not know where to locate educational resources regarding culture in the practice setting.

Nurses rely on up-to-date educational resources to provide safe and effective patient care on a daily basis in the practice setting. One example might be the use of a computer based drug guide that offered the most up-to-date information on pharmacotherapy. Inability to access these resources can profoundly impact patient care. Nursing faculty in didactic and clinical settings have a responsibility to educate students about the resources available to them, where to locate them, and how to use them. The fact that students do not know where to locate educational resources regarding culture in the practice setting is alarming and needs to be addressed. To speculate about the issue at hand I first wonder if faculty currently provide the necessary education regarding these materials to students. Next, I wonder if the issue is simply that these materials are housed at very different locations, or are not available to students in the practice setting. A combination of my previous speculations is likely; regardless, this issue needs to be

addressed. I believe the best way to begin to tackle this issue is by presenting these findings in a BSN faculty meeting where the issue can be discussed.

One plausible solution to remedy the situation is to disseminate this information during a BSN meeting and to seek help developing a consistent means of providing this education to the nursing faculty responsible for student practicum. I recommend task force development to determine what materials exist in the practice area. Once again, it may be possible that not all settings are equipped with cultural teaching materials. This could easily become a project for students to work on as part of alternate clinical experiences or as part of their research or informatics courses. I also believe this issue may be an implication for future research.

Comfort is not a feeling universally felt by all students during in-class conversations.

While eliciting data on how this action research project impacted the social perspectives of nurse candidates it was identified on a Likert scale that 7% of BSN students felt uncomfortable discussing multiple cultures within the context of their nursing class, however, 28% reported discomfort as an issue on an open-ended question (see table 13). These findings beg the question, What is it about multicultural awareness education that makes students uncomfortable? Not only do I believe that discomfort is a component of the social perspectives of nurse candidates, but it is also identified and discussed in research question three as a barrier to providing multicultural awareness education in the JSN.

The best way for students to learn about culture is by listening to a member of the culture they are learning about.

Students overwhelmingly believed that listening to individuals from multiple cultures was the best way for them to learn about cultures outside their own. During the cycles of this action research project I continuously expanded the role of people of the Black culture during the presentation of health and illness in the Black population based on feedback from the student participants. As a faculty member I believe it is important to listen and respond to the student population you serve in an attempt to provide meaningful education. Faculty serve as action researchers whose goal is to generate some improvement they believe is important to improve an educational experience (Hinchey, 2008). Students are clearly identifying, in solidarity, their preferred method for learning about multiple cultures. Substantiating the need for more multicultural education awareness in the undergraduate curriculum is a first step toward a much larger goal of either infusing multicultural education throughout the curriculum or developing a course exclusively dedicated to diversity study.

I believe this study has provided enough information for me to act locally, in the JSN, with a much loftier goal of acting globally. Not only do I hope to develop a course of study in the JSN, I hope to develop a multicultural video series. I realize the importance of Fullan's (2001) relationship building and Kotter's (1996) creating and sharing a vision as I plan to move forward with this project. In order to do this, I hope to contact one or more of the references I used to develop my education sessions. I hope to have a collaborative venture among experts in the field and with a publishing company to create an interactive video series to present cultural education to nursing students as

presented by people of the culture. Such a product could be marketed to nursing programs throughout the U.S. to meet the needs of schools of nursing. Based on participant reports that the best way for them to learn about culture is by a member of the culture itself, it only makes sense to review the literature and secure members of specific populations for each cultural education lesson in the video series. I have already established a professional working relationship with two major publishing companies and have had several opportunities to network with nursing experts throughout the U.S. I am hoping that maintaining positive relationships with both entities will allow me the opportunity to share my vision and move toward my larger goal of developing the video series.

Research Question 2

The second research question sought to answer how nursing students perceived multicultural education would impact their patient care. It was identified on Likert items that students believed a patient's culture had much to do with their nursing care, and that further awareness of cultures would allow them to provide better patient care than they were currently able to provide. Fifty-three percent of the student body substantiated these claims by indicating that multicultural awareness education is important to providing effective patient care. The fact that this percentage is not higher is cause for concern and is an area for future study.

Lack of multicultural education may contribute to stereotyping and ineffective patient care.

Surveyed students believed that healthcare workers stereotyped the populations they served, and that stereotyping, in addition to a lack of cultural sensitivity, had a

negative impact on nursing care rendered. Mostly anecdotal information was elicited when students answered this question during the focus group sessions. The students who provided feedback discussed their own experiences with direct observation of nursing care. Students reported positive nurse-patient relationships and patient care outcomes when nurses made attempts to incorporate culture into care delivery. Conversely, students readily reported observing marginalization of vulnerable populations in healthcare when nurses stereotyped or did not incorporate cultural sensitivity into the care they rendered. I believe a lack of multicultural education in nursing curriculum may be a contributing factor to the stereotyping witnessed by BSN students during their practicum experiences. The *Essentials* denote that professional nurses should demonstrate ethical behavior in patient care. Certainly nurses who stereotype violate the values of altruism, human dignity, integrity, and social justice. I believe a more concerted effort needs to be put forward in nursing curriculum, specific to multicultural awareness education. I believe doing so may reduce negative health care outcomes.

This study revealed that students are passionate about and believe cultural awareness should be incorporated into nursing care, unfortunately this is not necessarily behavior that is modeled exclusively by professional nurses in the workplace. When students observe nurses stereotyping the patients they serve it triggers powerful emotions in the students, and they are quick to point out the irony between what is taught in school and what is carried out in clinical practice (Crenshaw et al., 2011). In future studies I suggest that nurse role models be chosen more selectively for participation with nursing students, the caveat being this will not paint a realistic picture of clinical practice.

Clearly there is room for improving cultural awareness initiatives not only in pedagogy but in clinical practice as well.

Research Question 3

Research question three sought to identify the barriers to providing multicultural awareness education in the JSN. When asked to indicate the barriers to multicultural awareness education participants identified the following in order from most reported to least reported: the topic is uncomfortable, ignorance, lack of willingness, prejudice, lack of time, fear, and lack of diversity in nurse educators. A discussion of each barrier is further explored in the following paragraphs.

Discomfort as a barrier.

Students report multicultural awareness education is an uncomfortable topic for them to talk about in the classroom setting, thus serving as a barrier to multicultural education. Discomfort was discussed briefly as a contributor to students' social perspectives (see research question 1) and was also the most commonly reported barrier to multicultural education. A contradiction was noted while comparing the open-ended post-test questions results to the post-test Likert Items. Over one-quarter of respondents to the open-ended post-test question identified that the topic of culture was uncomfortable to discuss in person (see Table 13). This contradicted the Likert item found on the post-test where it was found that 78% of respondents felt comfortable discussing multiple cultures within the context of their nursing classes. This begs the question, "What can be done about this?" Future studies could attempt to discover the factors that make nursing students feel uncomfortable while discussing multicultural awareness in their classes. Perhaps generating small groups, as opposed to large groups, would be a more

comfortable modality when attempting to have students discuss topics of multiculturalism.

Future study on this topic would likely produce more concrete reasons for student discomfort, however, in the interim, the documented need to address this content area cannot be ignored. It is clear from this action research project that students will talk if given the opportunity. As previously discussed it would likely be helpful to place students in small groups when attempting to have students discuss topics of multiculturalism. It is also important to have the discussion facilitator provide a comfortable environment in which to communicate and model open and understanding discussion.

I believe change starts with a conversation. I also believe students need nursing role models who demonstrate professionalism and nonbiased care to inspire them to transcend and improve themselves. Service learning is also a suggestion for getting students involved with and learning about diverse communities. Providing service learning for a large number of nursing students would be a complex task to orchestrate and implement but may be a feasible modality to enhance comfort for students learning about various cultures.

Ignorance, lack of willingness, prejudice, and fear as barriers.

Little to no information was collected to expound upon the incidence of ignorance, lack of willingness, prejudice, and fear as barriers to multicultural education. These may be barriers that cannot be easily overcome. The only information I could discuss, other than to report the incidence of each reported barrier, would be purely speculative so I offer these barriers as potential topics for future research.

Lack of diversity of nurse educators as a barrier.

The *Essentials* assume that a baccalaureate generalist should be able to practice in a variety of practice settings and provide care to diverse populations. Lack of diversity among nurse educators was reported as a barrier to providing multicultural awareness education in nursing. I tend to agree with this notion and realize there are no easy answers to this dilemma. There is also a lack of diversity seen in the health care profession in general which I believe translates into the lack of diversity seen in nursing education (Allen, 2008). I offer no solutions to this problem but hope that as our society grows and diversifies so shall health care provider diversity.

Lack of time as a barrier.

Finally time, or lack thereof, was identified as a barrier to multicultural awareness education. It is true that schools of nursing, particularly the JSN, have much to cover in a relatively short period of time (Kumagai & Lypson, 2009). Be that as it may, I believe if the importance of incorporating multicultural awareness education in the curriculum is communicated to the faculty and its value is shared by faculty members, then creative solutions can be found to overcome this barrier. As previously stated, change starts with a conversation. Conversation plants a seed for change that if nurtured may bloom into success.

In an overall review of the focus group transcriptions the rhetoric reinforced the belief of students that multicultural awareness education was a component of highly effective nursing care, and that the JSN should do more to prepare nurses dealing with diverse populations. The results of this study clearly identify this as a need in providing effective nursing care so it behooves the nurse education profession to etch the time

needed to sufficiently address this in the curriculum. Students could not agree consistently about the best way for JSN faculty to provide multicultural education. Some students reported the content should be infused throughout each course, some indicated it should be a free standing course, and others believed it should be presented in a unique way prior to each clinical practicum experience to better serve each patient population. These suggestions may be helpful to nursing administrators in making curricular changes.

Limitations of the Study

This action research study was conducted in a center city, baccalaureate level, school of nursing, which is part of an academic university. One limitation of the study is that it expresses only the thoughts and opinions of baccalaureate level candidates. As the researcher, I was aware going into the study that action research is seldom generalizable but it was my intention to contribute to nursing education curriculum in general. Additionally, descriptive statistical analysis of participants revealed that the majority of respondents identified as being Caucasian (73%) between the ages of 18-35 (91%), which limits the results to reflect the opinion of a Caucasian in early adulthood.

Implications for Future Research

This action research project not only answered research questions, but also provided implications for future research. In the next few paragraphs I offer suggestions for future research based on the outcomes of this study. This study identified the barriers to multicultural education as perceived through the eyes of the students. The first, and most commonly reported barrier was discomfort with dealing with multicultural issues. A further investigation could be performed to elucidate the reasons students feel discomfort and methods to overcome this barrier.

Many students do not know where to locate multicultural education materials in the practice settings. This has implications for nursing education and nursing practice. Further investigation should be conducted to identify if such materials exists, and if so why they are not being talked about or used.

Lack of willingness was reported as a barrier to multicultural education. As previously stated, no information specific to this barrier was collected. Lack of willingness could be on the part of the learner, the educator, the organization, or any combination of the preceding. It would be valuable to survey nurse educators to ascertain their perception of the barriers to providing multicultural education. It would also be of value to interview educators who teach diversity studies to glean new insights into the characteristics required to be an effective teacher of the subject. Perhaps an evaluation of perceived barriers on the part of the student and teacher could identify common barriers that could be further investigated and eventually overcome.

In the focus group sessions, while discussing culture, one topic identified in each group was the care delivery rendered during the post-partum period. Post-partum nursing is not a focus of this action research study and is a specialized care delivery setting foreign to me as a registered nurse or nurse educator. It cannot be overlooked that students, in each separate cohort, observed bias toward minorities in the post-partum setting. It was reported that young Black mothers were not offered adequate breast-feeding education or resources because they reportedly would “bottle feed anyway.” Breast-feeding is known to be an important component of neonatal immunity as well as an opportunity for mother-child bonding (Ebenezer, 2010; Grassley, 2010; Laantera, Pietila, & Polki, 2010; Whalen & Crampton, 2010). While this topic was unexpected, the

fact that it appeared in focus groups among all cohorts, each cohort having variable clinical practicum sites, suggests there is a clinical issue in post-partum nursing that needs to be further investigated. This finding will be brought forward to the JSN administration and recommended as an area for future research. My expectation would be that a maternal-newborn content specialist would be the best primary investigator on such research, but I would desire to be a co-investigator.

Next Steps

Hinchey (2008) asserts that action research allows the practitioner to do something about an issue at hand. A prerequisite to my next set of actions is the development of an action plan. With a written record of this action research project, the findings may be shared with fellow faculty of the JSN as well as the administration of the organization. Sharing the findings of the study is valuable in substantiating the need for programmatic change. It will be important to disseminate my findings among the faculty of the JSN in hopes of finding supporters for my proposal to develop a multicultural awareness course.

Sharing of the information discovered in this project is not limited to the JSN. The intention is also to share this information at various nursing and/or educational conferences by way of a poster presentation. A poster presentation would allow me an opportunity to present the work I have performed and to establish a network of educators interested in similar work. Another way to disseminate the information gathered in this project will be to seek publication in professional journals.

Conclusion

This chapter answered three of this study's research questions, provided an overall analysis and discussion of collected data, listed potential limitations of the study, provided implications for future research, and suggested future actions to be taken. The outcomes of this action research project serves as the springboard for my attempt to improve nursing practice.

Significant learning occurred as a result of this study. Students believe the JSN should offer more multicultural awareness education. Their belief echoes the sentiment of the *Essentials* and provides me with a platform to introduce a curricular change to administrators in the JSN. In order to be influential and lead change it is imperative to remember the tenets of change theory. This study had several major findings. Findings include that: students believe multicultural awareness education is valuable to them, the Jefferson School of Nursing (JSN) should do more to provide multicultural awareness education in the curriculum, students believe the best way to learn about culture is to listen to a member of the culture being taught, JSN students largely do not know where to find cultural resources in the practice setting, and bias exists toward breast-feeding mothers in the hospital practice setting. Identified barriers to implementing multicultural awareness were: lack of comfort, ignorance and prejudice, lack of time in the program, lack of willingness on the part of the learner or teacher, fear, and lack of diversity in nurse educators. This action research project discovered a very real need to improve upon an already incredible curriculum. These findings will be brought forward, in the near future, with creative and innovative ideas about how to increase cultural awareness in education without decreasing core content delivery.

For nurses to provide highly effective care, nurse educators must create teaching-learning environments that nurture awareness of one-self in relationship with others and the world (Leuning, 2001), and that is the intent of this project. Future steps of this project seek innovative and meaningful ways to create teaching-learning environments to produce highly effective nurses. The next chapter details my leadership journey as the researcher and leader of this project, provides a reflective look at my applied leadership throughout the cycles of action research, and answers the last two questions of this research project.

Chapter 9

Leadership Evolution

Introduction

During the course of my doctoral studies I was given an opportunity to learn about leadership paradigms and determine who I believed myself to be as a leader. At the beginning of the program I was a faculty member for only a few short years, but had maintained leadership positions in the hospital setting to draw upon when determining what kind of leader I believed myself to be. Initially I knew I wanted to make significant changes in nursing education and nursing practice but did not know how, why, or what motivated me. During my four and a half years in the doctoral program at Rowan University I built a solid knowledge base regarding educational, organizational, and change theory. I also continued working as a full-time faculty member in the JSN and practiced part-time as an emergency room nurse. As my practice and education grew, so did my experience and self awareness. I realized that a fledgling transformational and transactional leader grew into transformational, transactional, and servant leader. As my experience grew, so did my understanding of my internal motivators and my leadership identity.

Summary of Espoused Leadership

Leadership in organizations is important to motivate followers, create change, and accept innovations. In order to change practice, leaders must persevere during times of change and understand that change is a process (Asrons, 2006). I espoused early on to be a transformational and transactional leader as described in Chapter 2. Transformational leaders are known to be innate motivators who foster a climate of trust to induce

followers to transcend personal wishes for the sake of a larger vision (Komives, et al., 2011; Pillai, Sriesheim, & Williams, 1999). It was easy for me to reflect back on myself as a charge nurse running a busy urban trauma center. I needed nurses to do their best work, to try to work quickly and effectively to get acutely ill patients to their next destination, whether that destination be discharge or admission to the hospital. The ever-present goal in my mind was what was best for the patients being cared for in the department, and what was best for patients waiting to be seen in the waiting room. Motivating a team of ten to twenty nurses to move patients as quickly and safely as possible was no easy task. It, like the tenets of transformational leadership, involved persuasion, charisma, and trust (Leithwood, 2007). I was then, and continue to be a transformational leader.

When I contemplate who I am today as a leader, I see that I am still very much a transformational leader with a deep sense of care for my students. I create a teaching-learning and advising climate based on trust and mutual respect. I seek to, and do, inspire student nurses to be their personal best but to understand when they care for others that personal feelings come second to the care being provided. I give examples of professionalism during nursing lectures and discuss the benefits of achieving organizational versus personal goals. I also practice what I preach, in that, when I practice part-time as a staff nurse I continue to embody the tenets of transformational leadership in an effort to elevate the status of the professional nurse and contribute to the organization where I work. In reviewing the leadership journal that I kept throughout my project, I reflected on the following entry, in reviewing what I had written, I noticed the following entry, "The first education session was very hard for me to do. I was so

nervous and I was very uneasy being a white woman while talking to the class about black people.” After reading that comment I thought about how courageous I was to attempt my project. I probably could have taken an easier route. This made me wonder, “Why did I choose to do this?” The answer is clear, it is because I care and I believe in what I do. At this point in time my transformational leadership is very clearly a part of me. Transformational leadership creates a vision and inspires others to go beyond the mere requirements of their job, as do I (Aarons, 2006).

I also continue to be a transactional leader. Transactional leaders are clear in their communication, identify tasks and expected outcomes to be achieved, and articulate the benefit of accomplishing tasks (Pillai, Schrisheim, & Williams, 1999). Transactional leadership is based on exchanges between the leader and the follower. It is more practical than transformational leadership and has a greater emphasis on meeting specified goals (Aarons, 2006; Komives et al., 2011; Leithwood, 2007). While reviewing my leadership journal I paged through numerous copies of emails and notations about planning and meeting goals. None of these entries specified how I was feeling during the dissertation process, however, they did showcase my organizational abilities and ability to facilitate the completion of tasks. I think of transactional leadership as being my default leadership when I am setting goals and determining how they will be achieved in a transparent fashion, but am not driven by a specific purpose to do so. Leadership is situational, and at times I am charged with just getting a job done. In these situations, and in situations that tend to not inspire me, I fall back on the give and take seen in transactional leadership (Komives et al., 2011). As a leader, I find transformational

leadership to be more rewarding and to create more long-lasting relationships between myself and students I serve, than transactional leadership.

Leadership Questions

The study sought to answer the following questions about my leadership:

1. How were the actions put forward consistent with my espoused theory of leadership?
2. How did my leadership of the change project impact the manner in which I conduct myself in my workplace?

Leadership question #1: Actions and espoused theories.

The first question asks if my actions were consistent with my espoused theory of leadership, in other words, do I practice what I preach. The action research project conducted in this study was complex and involved negotiations and planning. This project was not simply a means to an end, rather it served to satisfy an internal motivator of mine which is to move nursing, and society, toward social justice. Beginning this action research project I believed my leadership to be purely transactional and transformational. As I grew as a student, a faculty member, and a person I realized that I follow the tenets of servant leadership. The largest bit of learning that came from examining the first leadership question was that I realize that not only am I a change agent, but I too am susceptible to change. While leading this action research project I was driven by my personal interest in the subject of diversity and conducted myself in a fashion to complete the change project. I firmly believe that leadership is situational and when found facing new projects and opportunities, my leadership may change to suit my personal or professional needs. I will continue to explain an answer leadership question #

1 through the categories of transactional, transformational, and servant leadership related practices.

Transactional leadership.

Transactional leadership is an exchange based process (Komives et al., 2011).

Transactional leaders are more managerial in nature than inspirational. They are rational and transparent in their decision-making and linear in their actions. Transactional leaders set goals and determine how those goals will be met, many times motivating followers to accomplish tasks based on extrinsic motivators (Leithwood, 2007).

During this action research project I acted, at times, in a very transactional fashion. Much of the work I performed to complete this action research project was planning. During the planning phase of this project my actions were linear, straightforward, and clear-cut. The notion of transactional leadership being an exchange based process (Komives et al., 2011) translated to me as a “give and take.” I enacted this “give and take” mentality when negotiating access to the junior BSN student population. Essentially I bartered with a faculty member and asked her if I could use her assigned ACE experience to use for my study. Having built a positive working relationship with the afore mentioned faculty member, she was willing to allow me access to her ACE day. She, in turn, was extrinsically motivated to surrender her ACE day by no longer having to plan, implement, and evaluate her own ACE experience.

Environment and context shape the success of leadership initiatives (Komives et al., 2011). Leadership theory, in action, is situational and experience and practice guide the leader in decision-making. There were several times during this action research project that my leadership was demonstrated in a transactional manner, and I discovered

that transactional leadership is but one of the theories I successfully enacted to complete my work during this project.

Transformational leadership.

Literature indicates transformational leaders focus on followers' needs, pursue shared goals, and empower others to become leaders themselves (Komives et al., 2011). Transformational leaders are known to be charismatic, inspirational, and intellectually stimulating to their followers. Komives et al. (2011) identified five exemplary practices specific to transformational leadership. Transformational leaders: model appropriate behavior and set expectations, inspire a shared vision, challenge the status quo, enable others to act, and encourage the heart. The next few paragraphs explain the manner in which I enacted these leadership practices during this action research project.

I believe that in order to be credible you must practice what you preach, therefore, in order for me to be credible to my study participants it was necessary that I model the behavior I expected of them. During my education sessions I substantiated the need for multicultural awareness in nursing practice and frequently discussed existing disparities in health care. I was sure to engage students in conversations, frequently discussing personal experiences I had had regarding culture and health care, and encouraged them to share their own stories. I discussed social justice and my dream of attaining such a lofty goal, and suggested ways to attain this goal.

During my education sessions I substantiated the need for multicultural awareness education and encouraged participants to envision working in a health care system where disparities did not exist. Inspiring a shared vision was not an easy task. During educational sessions I drew on personal charisma to engage students and passionately

communicated the need to become more educated about our society as it relates to health care. I discussed that although the education session was occurring only once for them during their education in the JSN, my dream was to have similar sessions interwoven for future classes. I encouraged students to commit to becoming life-long learners and pointed out that educating themselves about the populations they would be serving was a contributing factor to the efficacy of their future practice. During this project I also enlisted the help of several faculty members. It was necessary for me to share my vision with them and enlist them for their help and support of future initiatives.

During this action research project I challenged the status quo. Each educational session implemented included a discussion of health disparities as well as disparities specific to the Black culture. I was quick to inform students that material being presented was compiled from works of cultural experts in the field. Participants were intellectually stimulated during these conversations, frequently disagreeing with information being presented. I found here that not only was I challenging the status quo of health care inequity, but participants were also challenging the status quo by disagreeing about what is currently cited as being relevant and factual about culture. These conversations allowed for deep discussion, shows of emotion, and perhaps development of better understanding about the status quo. Challenging the process involved a willingness to examine and change the status quo on my part, and on the part of the participant (Amey, 2006).

Empowerment in my practice played a key role in enabling others to act during this action research project. I believe my passion and my ability to articulate and share my vision inspired not only the gatekeepers in the JSN but students as well. Relationship

building, negotiating, and securing guest speakers were necessary components of this action research project. I believe those faculty and guest speakers who assisted me in facilitating this project would be interested in assisting me in future endeavors regarding this topic.

On a larger scale I served to enable student participants to act. A component of transformational leadership that is near and dear to my heart is the notion of forming mutually beneficial relationships between the leader and the follower (Drago-Severson, 2006). Transformational leaders transform others by developing capacity in followers and empowering them to become leaders themselves (Asrons, 2006; Birky & Headley, 2006; Komives et al., 2011). As a teacher I place high value on the success and happiness of my students. As a nurse I place high value on justice in health care. The practice of enabling students to become future leaders in nursing and hopefully health care justice proponents moves me toward my goal of contributing to attaining social justice.

The final transformational leadership practice I included in this action research project was encouraging the heart. This refers to the ability to recognize individual and group accomplishments (Kouzes & Posner, 2003). Frequently during education sessions I discussed how each student was capable of being a change agent. I identified that as I spoke to them I was acting as a change agent (Kouzes & Posner, 2003). I believe that sharing my hopes and dreams for a fair and equitable health care system as well as discussing the role culture plays in effective nursing practice inspired and empowered students to think about their daily lives and daily practices. I do believe reinforcement and further conversation on multicultural topics and current health care issues would have

a much larger impact on the empowerment and inspiration of students as they progressed through the nursing program and into the practice arena.

Servant leadership.

After reading cycle I, I realized there was a purpose to my work other than contributing to society at large, and that was I was contributing to my organization! My developing leadership really came together for me after cycle I. I attended the JSN as an undergraduate and graduate student, practiced as a registered nurse at TJUH, and eventually was hired as a faculty member in the JSN. I understood that a large component of my action research project served the organization I had been tied to for many years. I cared about the organization, and its reputation, and sought to improve it.

Servant leadership is an extension of transformational leadership. Followers' emotional attachment to the leaders and their attachment to their leaders' beliefs is a result of transformational leadership (Taylor, et al., 2007). Servant leaders commit themselves to the success of their subordinates and to the organization they serve (Crippen, 2005; Komives et al., 2011; 3Taylor, et al., 2007). Kiefner Greenleaf first wrote about servant leadership. Greenleaf first served as a lineman for AT&T and then moved into a management position. Greenleaf believed that through one's service, a person would be recognized as a leader (Crippen, 2005). I can draw a parallel between Greenleaf's service with AT&T and my service with Jefferson. Through service I would be recognized as a leader.

There are ten characteristics of servant leadership. They are: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of others, and building communities (Crippen, 2005). Listening is an

important component of understanding. This is a concept I strive to work on, particularly before making decisions that affect others. It is important to appreciate other's realities before making decisions that impact their lives. To be empathetic is at the heart of the nurse. We intuitively do it while providing care. Understanding the implications of the feelings of others drives what we do and drives how I lead.

Healing and awareness are other characteristics of servant leaders (Crippen, 2005). The desire to heal, while being present in the moment, drives nurses and drives my leadership. I enact the art of persuasion frequently as a leader. I believe the follower must understand why they are following a certain course of action and must believe the outcome is desirable to themselves as well as the leader. Conceptualization is another large component of my leadership. I believe "showing the way" is a form of persuasion that helps to gain buy-in of the follower (Kouzes & Posner, 2003). Foresight, another component of servant leadership is enacted in my leadership as I discuss the final objectives I seek, or are sought by others in healthcare. I believe strongly that as a leader we must discuss relevant healthcare issues. Concentrating on deficiencies in current healthcare practices allows individuals to form a frame of reference for the need for change. Blending the concepts of "where we are now," and "where we need to be," allows individuals to brainstorm and discuss innovative and creative ways to improve clinical practice.

Stewardship is a necessary component of the faculty role (Sergiovanni, 1992). As a faculty member and developing leader, I care for the institution that employs me and willingly serve the needs of the organization. As a servant leader, I am deeply committed to the growth of people, specifically, the growth of the students I serve. I believe the trust

gained through my transformational leadership blends well with establishing a plan for growth of the student population. After a trusting and caring relationship between faculty and student is formed, communities are built. I believe my communities to be ones of mentoring. I believe that if you listen to students and remain empathetic, they will trust you, trust that you have their best interests in mind, believe in your vision and will model the behavior you demonstrate for them. This action research project sought to discover new information but was tied deeply into my persona as a faculty member and my desire to improve upon what currently exists in the JSN.

One way a servant leader serves others is by advocating on their behalf. Sergiovanni (1992) discusses the practice of servant leadership by detailing: purposing, empowerment, and leadership by outrage. The following few paragraphs describe how these concepts were enacted in this action research project.

Purposing

Purposing refers to actions taken by a leader that assist others to understand and become committed to the organization's basic purposes. Purposing was at the heart of my planning for this action research project. I shared the values of the JSN and AACN and aimed to create a way to seek buy in from students to assist me in improving nursing care. According to its mission statement the JSN is dedicated to educating professional nurses who will form and lead the integrated healthcare delivery teams of tomorrow (JSN editor, 2009). The JSN strives to deliver its curriculum according to the standards set forth by the AACN. I believe a component of that leadership will strive toward attaining social justice as it pertains to healthcare delivery. Purposing was implemented in this action research project during my education sessions as I shared my personal values and

the values of the JSN with the student population. By enacting purposing during education sessions I wished to create a community of individuals that shared the values important to both the JSN, myself, and nursing care.

Empowerment.

After discussing the values shared by myself and the JSN, and encouraging students to be committed to the need for multicultural awareness education, it was time to discuss how to act on the shared vision of the student body and the school of nursing. The notion of empowerment was on my mind as I planned this action research project and shared publicly during education sessions. Empowering individuals in education includes teaching others how to make changes; in essence enabling individuals to make change (Sergiovanni, 1992). An important component of my leadership in this action research project was to plant a seed in students, nurture the seed, and then hope it grows to its fullest potential. The metaphor of the seed is the value of multicultural awareness as it is shared by the JSN and the AACN. If a common seed is planted amongst students (purposing), then nurtured (empowerment), hopefully the importance of multicultural awareness education will be fostered throughout the career trajectory of new nurses.

Leadership by outrage.

I believe the entire action research project presented in this dissertation was based on the notion of leadership by outrage. Sergiovanni (1992) describes leadership by outrage to be leadership that arises when school standards fall. I believe healthcare standards pertaining to social justice and multicultural awareness to be low. I also believe, as previously stated, that the JSN can do a better job at meeting the diversity standards detailed in the *Essentials* document.

Leadership by outrage, and the practice of invoking outrage in others, challenges the status quo and further empowers others to act (Sergiovanni, 1992). It was rather easy to invoke outrage in others when presenting health and illness in the Black population. During these education sessions emotions ran high, including my own, and I believe a better awareness of the need to discuss multiple cultures became evident to most in attendance. I believe it takes courage to enact leadership by outrage and am proud of the risks I took in this action research project toward improving nursing education and practice.

I blend my leadership styles in a manner that best serves my organization and my personal and professional goals. Figure 2 represents a visual depiction of my leadership. I continue to believe myself to be largely transformational but to embody and be motivated by my servant leadership. I believe it is impossible, and exhausting at times, to embody all of the characteristics required of servant and transformational leaders and many times just need to get tasks performed. For this reason I depict lightening strikes stemming from my transactional leadership. They represent the quick and often meaningless actions that occur to get this type of work completed. You will note an arrow from transactional leadership to servant leadership. This is to demonstrate that servant leadership is tied to transformational leadership and that all three leadership styles in my approach are interconnected. It is also important to show that although I accomplish necessary goals and tasks through my transactional leadership, the lightening strikes are not in a constant connection with a larger goal. My servant leadership seeks to first serve the JSN and then follow a hierarchy of importance to me. Finally, my

transformational leadership seeks to serve my ultimate goal of obtaining social justice in healthcare, thereby positively contributing to society at large.

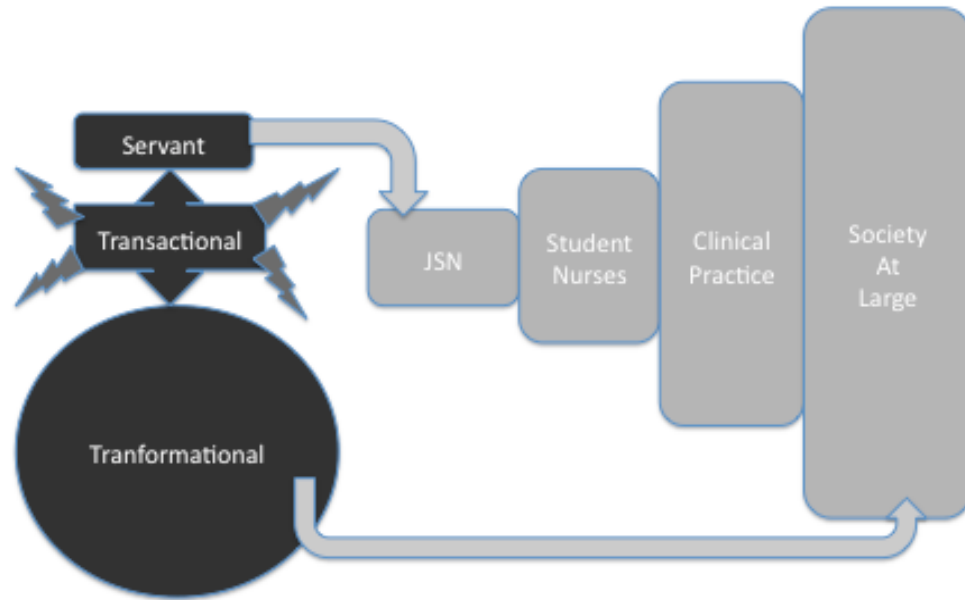


Figure 2. Visual Depiction of My Leadership.

Research question #2: Leadership in the workplace.

The second research question asked how my leadership of the change project impacted the manner in which I conduct myself in the workplace. At the end of this action research project I see how I changed as a leader, a faculty member, and a person. I truly believe, as does Fullan (2001), that relationship building is paramount in businesses and organizations. I found that having positive professional relationships with my peers facilitated getting some of my tasks performed with ease. I see more clearly that articulating personal goals for the project could not be underestimated. I believe that

when others learned about my change project, and discovered the reason prompting the change, they were committed to helping me, which served to benefit the student population, JSN, and potentially nursing practice.

I understand now that I am a role model to students and to my peers in the workplace. I also understand that I am a potential future leader in the JSN and must continue to model myself to fit the needs and standards set forth by the institution. In the next section I elaborate more on the combination of things that define my leadership.

There is much discussion about the relationship between transformational and transactional leadership, particularly stating that transactional leadership serves little more than to achieve goals and reward subordinates and that transformational leadership inspires subordinates to transcend themselves and work toward a higher goal at the request of their leader (Asrons, 2006; Hoyt & Blascovich, 2003; Pillai et al., 1999).

Throughout cycle I, I still believed myself to only be a transformational and transactional leader. At the summation of cycle I, I had an opportunity to review my work as well as my leadership journal. At that point in time I realized the forces driving me to undertake my action research project were not what I had initially thought them to be. I believed I was motivated to improve society at large, a notion I agree is transformational, however, that notion could only be obtained in this project by making an improvement in my organization, something I had overlooked for quite sometime. I understood that akin to personality, leadership must be developed, and that effective leaders develop in order to meet the individual needs of the organizations they serve (Taylor, Martin, Hutchinson, & Jinks, 2007).

Leadership identity development.

At the conclusion of this action research project it is important to reflect upon myself as a leader in evolution and to consider how my leadership has evolved over time. Developing a leadership identify is related to how one sees oneself as a leader, the ways in which that perception changes over time, and how one's identity as a leader fits her personality (Komives et al., 2011). I have selected to use the leadership identity model (LID) as a tool to retrospectively evaluate my development as a leader.

The LID (see Figure 3) is comprised of six developmental stages that detail the complex ways in which individuals define leadership and identify themselves as leaders. Each stage builds from the previous stage and allows leaders to realize their personal growth in their own leadership and relationships (Komives et al., 2011). Five categories influence the development of leadership identity. They are: the broadening view of leadership, a developing self, group influences, developmental influences, and a changing view of self with others. Six stages develop sequentially as a leader develops: awareness, exploration/engagement, leader identified, leadership differentiated, generativity, and integration/synthesis.

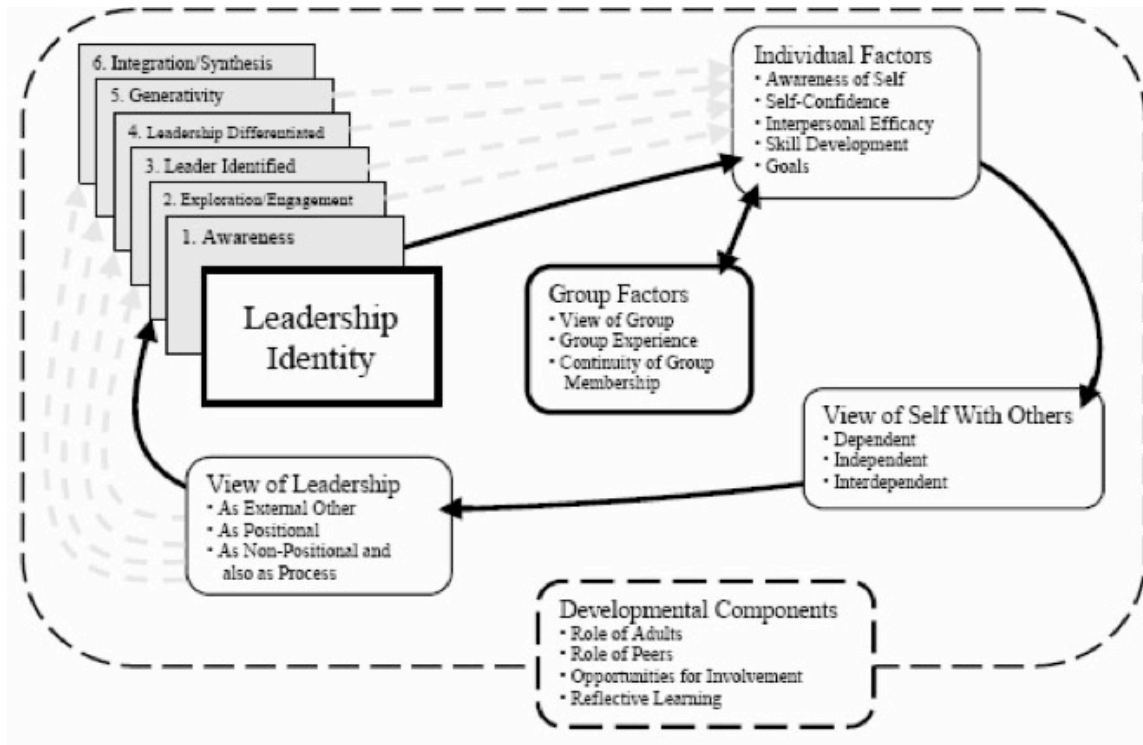


Figure 3. Leadership identity model. Adapted from “The Handbook for Student Leadership Development (2nd ed.),” by S. R. Komives, J. P. Dugan, J. E. Owen, C. Slack, and W. Wagner, 2011. Copyright 2011 by Jossey-Bass.

Of this six-stage LID model most college-aged individuals have at least achieved LID stage 3 (Komives et al., 2011). I believe at the inception of this action research project, by virtue of my personal and professional experiences, I was in LID stage 4, the leadership differentiated stage. During this leadership development stage identity as a leader is a result of hierarchal position. During this earlier developmental stage I was aware that I had the ability to make an impact on others by virtue of holding a leadership title. During stage 4, I had many opportunities to work with diverse groups, which challenged me to become more self-aware and confident in my interactions. Groups influenced me in LID stage 4, particularly when dealing with people whose views were different than my own. Working with diverse groups allowed me a chance to learn to

network and collaborate with others. During stage 4 of my leadership identity development I worked with peers in the workplace who served as mentors and assisted me in making sense of new experiences I was having as a leader. Most importantly, during LID stage 4, I began to value interpersonal relationships and started thinking about the need for interdependence in the workplace. Much of this I learned from JSN administrators as I realized the level of their reliance on the faculty to be the backbone of the school.

As a leader in evolution I believe myself now to be in LID stage 5, which is generativity. The five categories that allowed development in this model again were: view of leadership, developing self, group influences, developmental influences, and view of self with others. In the generativity LID stage, being a leader is a stable aspect of personal identity rather than depending upon a position of leadership in an organization. I felt this most at the end of cycle III during faculty meetings in the JSN. As I sat in meetings or reflected on my workday I realized that strong leaders in organizations are the backbone of those who hold the position of authority, in essence they are supporters of the organization and its mission. It became clear and salient to me that perhaps my leadership was best served not by being the boss, but by being a good role model and the best employee I could be. I also understood that leaders without a title have a powerful influence over other organizational members and have the ability to influence others toward commitment to shared organizational goals. In chapter 2, I wrote about who I believed myself to be as a leader in development. One thing I mentioned in chapter 2 was that I could not understand why I felt as though I was always thrust into leadership positions. I believe now that those in charge, with wisdom and authority, were able to

see and feel the support I gave them even though I was unable to see the qualities in myself.

The next category of the LID that influences the generativity stage is developing self. During the generativity stage the leader is aware of personal strengths and mindful of the beliefs and values embedded in their actions. They can articulate their passion for causes and feel a sense of responsibility to mentor younger members. In the previous paragraph I eluded to the fact that I believe myself to be a leader, even when not in charge, and that I possess leadership qualities that those in positions of power easily identify. I have become aware of my personal talents and strengths, and I believe I am better able to direct my energy in the workplace toward achieving goals. One of the talents I possess is the voice I tried so hard to find during LID stage 4. I now find myself more comfortable expressing thoughts and ideas without the fear of appearing foolish in front of others. I now truly believe I put important goals ahead of personal insecurities. My leadership has grown exponentially in that regard.

The last component of developing self in LID 5 refers to the accountability for mentoring younger members of the organization. I believe that as each year passes that I am a member of the JSN that my dedication to the organization grows. I am personally committed to the continued excellence of the JSN and believe strongly that new faculty must be mentored and nurtured in order to keep the JSN stable and secure. I now feel accountable to instilling my passion and support for the JSN in others.

My group influences have changed in LID stage 5. Instead of being a committed member and hard worker for the JSN, my role shifts to role model and mentor. This role has always been a strong suit for me in my clinical practice. Having the knowledge,

wisdom, and expertise required to be a mentor in the JSN serves as an internal motivator for me and creates a familial relationship with other organizational members. I appreciate having the ability to influence others in a positive way.

My developmental influences have also changed. During the generativity stage, leaders value their peers and can reflect and receive honest feedback. I believe strongly that honesty is the best policy, however, honesty sometimes leads to hurt feelings. I understand now that a certain level of finesse is required to both give and receive honest criticism. More importantly, I believe I have grown when it comes to receiving honest feedback with which I disagree. In previous LID stages I would immediately react to honest criticism, and develop hurt feelings, as opposed to taking time and reflecting on the exchange that occurred. Enough time and growth has occurred in me to understand that I should take time to think about my actions, maintain accountability for them, and consider others' opinions about them. I believe future growth and self-improvement stem from conscientious reflection.

Finally, in the generativity stage leaders deepen their commitment to fostering a sense of interdependence in their organization. I would have never believed this to be true in previous LID stages but understand now this is so very true. As a young faculty member I often enjoyed working alone and at times believed I did a better job than anyone else. This type of isolation limited my personal and professional growth and limited my access to others as well as their access to me. As I became more comfortable and acclimated in the JSN I slowly let my guard down. During my doctoral studies and this action research project I really developed an understanding of the need for others in my life and their need for me. In order for a chain to be strong and complete each

individual link must wrap itself around the two other links that lie adjacent to it. I really never understood that, nor did I take time to think about it. Clearly this analogy makes sense to me now and serves as a metaphor for my new sense of self interrelations with others. My awareness has developed my leadership and contributed to my abilities as a change agent.

Change Philosophy

At the inception of this action research project I strongly identified with transformational and transactional leadership and began my work following Kotter's (1999) eight step change process. The eight steps in Kotter's process were: establish a sense of urgency for the need to change, create a powerful guiding coalition, create a shared vision, communicate the vision and plan, empower others to act on the vision, plan for and create short-term wins, consolidate improvements and produce more change, and anchor changes in the organization's culture. The process was systematic and repetitive. While following this change theory I had frequent discussions with peers and administrators, shared my vision, and articulated my vision frequently.

Application of Kotter's change model.

During cycle I, I went through the steps of action research (plan, act, observe, reflect). During the step of reflection I realized that as I concluded the cycle I had inadvertently forgotten about the driving force behind the project, which was moral purpose. Taking a retrospective view of cycle I, I realized my leadership was rather transactional, as I now believe Kotter's change theory to be. During cycle I, my actions may not have necessarily been driven by my desire for meaningful change, instead laced with nervousness and self-doubt about completing such an ambitious task. I understand

that while being faced with a huge task at a time where my self-confidence was wavering, that I became very transactional in my approach to accomplishing the task. For this reason I believe Kotter's theory initially worked well for me, but that there was something missing. In the following paragraphs I detail the steps of Kotter's (1999) theory, its relationship to this action research project, and the interrelatedness of other change theories to this project.

Establishing a sense of urgency.

During this step, leaders are to identify the needs of the organization and to articulate the need for change. In the early phases of this action research project I identified the need to address multicultural awareness in the curriculum, as outlined in the *Essentials*, and articulated this need to administrators in the JSN as well as asking for permission to study this by the Institutional Review Board at TJU. Stating the obvious need for change was easy to do, and I faced no resistance in my endeavors. What was lacking in my communication, and not required in Kotter's theory was a declaration of my passion for the topic to be studied and the forces driving my project. This ties in with transactional leadership, which is transparent (Komives et al., 2011). In this project I align myself most closely with transformational and servant leadership and am driven by a sense of purpose and inspiration, both of which I feel are missing in Kotter's theory.

Creating a powerful guiding coalition.

Identifying and recruiting respected organizational members to lead change are requirement of Kotter's (1999) second step. This step was essentially not enacted in this project. Although I did share my vision with those close to the project, I was alone in leading this change initiative, thereby being a coalition of one. I believe this step to be

important to change initiatives, however, it was not a necessary step for me in this action research project as it is defined in Kotter's work.

Creating a shared vision.

Creating a shared vision is one component of Kotter's (1999) change model that was applied and was aligned with my identified leadership. During this step leaders describe their vision amongst stakeholders, demonstrate its need and importance, and address the scope of the vision. The description of my vision was most commonly communicated with the students of the JSN. As the most important population in the study I felt it necessary to articulate the status quo in nursing education and practice, discuss guidelines set forth by the AACN, and detail actions to be taken to produce change.

Communicate the vision and plan.

My vision and plan for this action research project were communicated widely, frequently, and consistently to my study population and to minority guest speakers. It was not necessary to participate in frequent communication with JSN administrators during this action research project, as this was a pilot project. I anticipate that as I move forward in an attempt to change our curriculum the need for the change will be communicated frequently to members of the JSN.

Empowering others to act on the vision.

Empowerment is tied in closely with both transactional and servant leadership (Komives et al., 2011; Leithwood, 2007; Sergiovanni, 1992). In this action research project I strongly encouraged participants to become active change agents. I shared my passion and enthusiasm with participants as it pertained to improving multicultural

awareness in practice and education, and discussed the mutual benefits to improving said awareness to nurses, educators, and patients alike. Moving into the future I anticipate the need to empower JSN staff to be part of my change initiative, to encourage JSN staff to try new approaches to include multicultural awareness in their courses, and to make a public effort to remove barriers to implementing multicultural awareness education.

Plan for and create short-term wins.

This is another component of Kotter's (1999) theory that seems rather transactional to me. Kotter indicates that during this step the leader should reinforce that change takes time, and that benchmarks toward successful change be identified. He also states that focus should be paid on skeptics and resisters. To me, this step seems linear and uninspiring. I do not believe much thought is required and that this serves a transactional and linear (Leithwood, 2007) function. I can appreciate how reinforcement will allow others to understand change takes time but do not find this step to be necessary to all change initiatives. I had no need to enact this step in this action research project and would not believe it to be a component of curricular change.

Consolidate improvement and produce more change.

This next step of Kotter's (1999) theory is an extension of its predecessor. During this step Kotter reminds us to continue demonstrating the need for change, continue attempts at turning resisters into supporters, and trumpet success made. Again, I find this step linear and uninspiring and not a necessary component of curricular change at the JSN. I do appreciate the need to possibly employ such a strategy if attempting loftier goals, such as changing curriculum from a medically based model to a conceptual model in which every member of an organization would need to be an active change agent.

Anchor changes in the organization's culture.

The final step of Kotter's (1999) change model suggests that leaders focus on institutionalizing changes and assist in re-culturing organizational values, beliefs, and norms. I believe this is an important step to take as a leader, although not a step that was necessary or applicable for me to apply in this project. As a leader I appreciate the need to engrain changes into the fabric of organizations. I anticipate that as I move forward with my attempts to change the JSN curriculum that changes related to multicultural awareness become a more recognizable component embedded not only in the mission of the JSN but in its curriculum as well. As my leadership of the action research project grew and I reflected upon my actions I found that I did not identify as strongly with Kotter's change model as I did with Fullan's (2001) change theory.

Application of Fullan's change model.

Leadership is required for problems that do not have easy answers (Fullan, 2001). At the inception of this action research project I was moved to create change in the JSN because I wanted to contribute to my organization, profession, and society at large. This component of my action research project cannot be overlooked and explains my application of Fullan's (2001) change theory. In his change theory, Fullan asserts that five components of leadership represent independent but reinforcing forces for positive change. The components of leadership identified by Fullan are: moral purpose, understanding change, relationship building, knowledge creating and sharing, and coherence making. Comparing Fullan's work to the work of Kotter (1999), it appears to me that Fullan uses the talents of the leader to make change as opposed to Kotter who uses a linear, systematic, and repetitive approach to making change. Although I agree

with some of what Kotter suggests in his eight-step change model, I find Fullan's theory to be more applicable in my current leadership. This action research project was driven by moral purpose, a notion explained by Fullan to mean acting with the intention of making a positive difference in the lives of others.

Moral purpose.

Moral purpose, or acting with the intent to improve others, was the driving force for my action research project and it is the basis of my leadership. To lead with moral purpose I identified a real problem that faced the curriculum of the JSN, healthcare, and society as a whole. Understanding that I am a single person with a limited capacity, I understood that I needed to begin my own change initiative by creating a meaningful, yet accomplishable, project that could serve to substantiate future work, hence this action research project. Moral purpose allowed me to articulate my vision and plan, remain passionate in my pursuits, model exemplary behavior, and be authentic and inspirational to those who participated in my study.

Understanding change.

Fullan (2001) asserts that leaders must use a variety of leadership styles and understand the process of change. Certainly leadership is situational and there is not a one size fits all style of leadership. I understood this notion throughout my change initiative and will be better able to apply this to my learning as an outcome of action research. I identify with Fullan and his assertion that change consists of nonlinearity and that transformation cannot be possible without accompanying messiness. Understanding that change is a process, can be messy, can arouse emotions, and usually takes time can help relieve some of the stressors associated with it. Although this action research

project did not make direct change in the overall curriculum, it may impact the manner in which participants' practice nursing. I believe this action research project generated enough data to substantiate future curricular changes that can have a wide impact on nursing practice and healthcare administration.

Relationship building.

Leaders create relationships (Fullan, 2001). In an answer to my second leadership question I established myself to be in LID stage 5. A component of this stage of generativity is the recognition by the leader that interdependence is a necessary component of successful leadership. Interdependence refers to relationships. During this action research project I focused heavily on the importance of relationships and relationship building. Having developed professional relationships rich with mutual respect I found initiating conversations and convincing others to share my vision much easier than if I had not developed these relationships. I believe strongly that relationship development assists in overcoming obstacles and facilitates goal achievement.

Knowledge creating and sharing.

Development of professional working relationships can assist in the sharing of knowledge within organizations. Effective leaders understand the value of establishing and reinforcing knowledge exchange among organizational members (Fullan, 2001). This action research project, in part, sought to create new knowledge. The value of this new knowledge will be shared with organizational members in attempts to improve the curriculum. It cannot be underscored that the knowledge generated by the action research project is intended to serve a much larger goal than informing the curriculum of the JSN.

Future attempts will be made to share information generated by this action research project to improve nursing education, the practice of nursing, and society at large.

Coherence making.

Fullan (2001) describes change as a process that can be chaotic, but that out of this chaos comes creative ideas and strategy development. Fullan further discusses that sometimes systems need to be disturbed, even provoked, to achieve desired outcomes. This notion is at the heart of my action research project. Although not discussed by Fullan, I believe that in order for a leader to disturb a system that the leader must be brave enough to do so. I also believe the intestinal fortitude required to disturb systems to create meaningful change requires passion and authenticity, components found in transformational and servant leaders. Effective leadership means guiding people through differences and enabling differences to surface (Fullan, 2001). This is a concept that is very important to understanding the need for multicultural awareness in nursing education and practice. Changing systems to both identify the need for multicultural awareness education and provide solutions to meet the established needs requires creative leadership. A leader, like myself, driven by moral purpose must be willing to be provocative to achieve desired outcome.

Final thoughts on change theory application.

As my leadership grew and the action research project progressed, I realized that I had grown and changed. Initial intimidation when faced with a large project caused me to act in a transparent and linear fashion, for this reason Kotter's (1999) change theory seemed like a logical change theory to align my change initiative with. Looking closely at my action research project I realized that it was not the project that was important to

me, but my reason for selecting the project. The moral purpose of my project became clear. As I facilitated cycles II and III, I made several changes to the project to improve outcomes. This led me to look more closely at Fullan's (2001) change theory which indicates that change stems from meaning within the change agent. This also ties in closely with my association with stewardship and servant leadership. Fullan also discusses the importance of relationship building, which I found to drive the success of my project. Fullan asserts that leadership style varies according to the situation with which the change agent is dealing. I realized as a change agent, I too was susceptible to change.

At the conclusion of the last cycle of this action research project I realized I finally found the voice that I had been too insecure to use at the inception of the project. Relating change and leadership theory to my action research project allowed me to apply my own leadership and develop as a leader. I was truly passionate about this project and my passion drove me to take a stand on some difficult issues during the process. The passion I felt for the project translated into my practice both as an educator and as a staff nurse. No longer did I have a fear of appearing foolish, as I spoke about during my leadership platform, now I had the courage to speak up. Not only do I write in this dissertation that change begins with a conversation, I mean it, and this message is evident in the person I am today.

Conclusion

As children's personalities grow and develop based on personal experiences, so must leadership. Continual examination of self is an ongoing journey. Leadership should be tailored to fit each individual's personality, experience, and background

(Taylor, et al., 2007). I currently understand myself to be a leader relying on and driven by the tenets of transactional, transformational, and servant leadership. I also understand that just as my life and career are evolving, so too is my leadership. It will undoubtedly be shaped and tailored to suit my needs and the needs of the organizations I serve throughout my career. At the conclusion of this action research project I realize it is better to speak up and risk appearing foolish than to say nothing and risk losing meaningful conversation. After all, change begins with a conversation. As I move into the future, as an integral member of the JSN and a contributor to the nursing profession, it is important to realize that there is much to be done to enhance curriculum and that I have the ability to make a difference. Current trends, beliefs, ideologies, even curriculum are fluid and ever changing. Our approach to tackling important issues, taking a stand against injustice, and improving society should be as dynamic as the challenges we face as leaders. This action research project is one contribution to nursing education and the nursing profession. As a leader my self-development and contribution to education, research, and practice will continue to grow and become even more substantial over time.

References

- Adams, M. P., & Holland, L. N. (2011) *Pharmacology for nurses: A pathophysiologic approach* (3rd ed.). Boston: Pearson Publishing.
- Adams, M. P. & Koch, R. W. (2010). *Pharmacology: Connections to nursing practice*. Upper Saddle River, NJ: Pearson Publishing.
- Allen, L. (2008). The nursing shortage continues as faculty shortage grows. *Nursing Economic\$, 1*(26), 35-40.
- Andrews, D. J. (2009). The hardest thing to turn from: The effects of service-learning on preparing urban educators. *Equity & Excellence in Education, 42*(3), 272-293.
- American Academy of Nursing. <http://www.aannet.org/i4a/pages/index.cfm?pageid=1>
- American Association of Colleges of Nursing, Task Force on the Revision of The Essentials of Baccalaureate Education for Professional Nursing (2008). *Report of the AACN Task Force on the essentials of baccalaureate education for professional nursing practice*.
- Archer, L. (2007). Diversity, equality and higher education: A critical reflection on the ab/uses of equity discourse within widening participation. *Teaching in Higher Education, 12*, 635-653.
- Amey, M.J. (2006). Leadership in Higher Education. *Change 38*(6), 55-58.
- Amobi, F. (2006). Beyond the Call: Preserving Reflection in the Preparation of “Highly Qualified” Teachers. *Teacher Education Quarterly 33*(2), 23-35.
- Asrons, G. A. (2006). Transformational and transactional leadership: Association with attitudes toward evidence-based practice. *Psychiatric Services, 57*(8), 1162-1169.
- Ayornrinde, O. (2003). Importance of cultural sensitivity in therapeutic transactions: Considerations for healthcare providers. *Disease Management Health Outcomes, 11*(4), 233-248.
- Azoulay, K. G. (2006). Reflections on race and the biologization of difference. *Patterns of Prejudice, 40*(4), 68-76.
- Bass, B. M. (1985). *Leadership and Performance Beyond Expectations*. New York: Free Press.

- Bastable, S. B. (2003). *Nurse as educator: Principles of teaching and learning for nursing practice* (2nd ed.). Sudbury, Massachusetts: Jones and Bartlett Publishers.
- Baufumo, M. E. (2006). Changing Teaching Practices. *Teaching PreK* 8(37,) 10-12.
- Beck, L. (1994). *Reclaiming Educational Administration*. New York: Teachers College Press.
- Bhopal, R. S. (2000). *Ethnicity, race, and health in multicultural societies: Foundations for better epidemiology, public health and health care*. Oxford, New York: Oxford University Press.
- Birky, V. D, Headley, S. & Shelton M. (2006). An Administrator's Challenge: Encouraging Teachers to Be Leaders. *NASSP Bulletin* 90(2), 87-101.
- Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theory and methods*. Boston, MA: Pearson.
- Bolman, L. G. & Deal, T. E. (2001). *Reframing organizations: Artistry, choice, and leadership* (3rd ed.). San Francisco, CA: Jossey-Bass.
- Brennan, J., & Naidoo. (2008). Higher education and the achievement (and/or prevention) of equity and social justice. *Higher Education*, 56, 287-302.
- Burns, J. M. (1978). *Leadership*. New York: Harper and Row.
- Burns, N., & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique, and utilization*. St. Louis: Elsevier.
- Ciulla, J. B. (2003). *The ethics of leadership*. Belmont, CA: Thompson Wadsworth.
- Cheng, H. & Baron M. (2006). Nursing Director's Leadership Styles and Faculty Members Job Satisfaction in Taiwan. *Journal of Nursing Education* 45(10), 404-411.
- Chronicle Research Services (2009). *The College of 2020: Students Executive Summary. Report of the Chronicle Research Services*.
- Clabaugh, G. (2001). Looking for leadership: Longing for a Führer. *Educational Horizons* 79(3), 106-107.
- Closson, R. B. (2010). Critical race theory and adult education. *Adult Education Quarterly* 60(3), 261-283.
- Cook, M. (2001). The attributes of effective clinical nurse leaders. *Nursing Standard* 15(35), 33-36.

- Corty, E. W. (2006). *Using and interpreting statistics; A practical text for the health, behavioral, and social sciences*. St. Louis: Mosby.
- Crenshaw, K., Shewchuk, R. M., Haiyan, Q., Staton, L. J., Bigby, J. A., Houston, T. K., Allison, J., & Estrada, C. A. (2011). What should we include in a cultural competence curriculum? An emerging formative evaluation process to foster curriculum development. *Academic Medicine* 86, 333-341.
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd Ed.). London, England: Sage.
- Crippen, C. (2005). Servant leadership as an effective model for educational leadership and management: First to serve, then to lead. *Management in Education* 18(5), 11-16.
- Curtis, E. F., Dreachslin, J. L., & Sinioris, M. (2007). Diversity and cultural competence training in health care organizations: Hallmarks of success. *The Health Care Manager*, 26(3), 255-262.
- Diller, J. V. (2007). *Cultural diversity: A primer for the human services*. Belmont, CA: Thomson Higher Education.
- DiPalma, C. (2003). Teaching women's studies, E-mailing cancer. In D. P. Freedman and M. S. Holmes (Eds), *The teacher's body: Embodiment, authority, and identity in the academy*, pp. 41-57. Albany, NY: State University of New York.
- De Jouvenel, B. (1993). *On power: The natural history of its growth*. Indianapolis: Liberty Fund.
- Drago-Severson, E. (2006). Learning-Oriented Leadership. *Independent school* 65(4), 58-64.
- Ebenezer, J. (2010). Supporting breastfeeding. *Innovait*, 3(12), 714-718.
- Farmer, V. L. (2002). Meeting the challenge of cultural diversity in higher education in the new millennium. Lima, OH: Wyndham Hall Press.
- Fongwa, M. N., Sayre, M. M., Anderson, N. L. R. (2008). Quality indicator themes among African Americans, Latinos, and Whites. *Journal of Nursing Care Quality*, 23(1), 50-57.
- Ford, C. L., & Airhihenbuwa, C.O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis [Supplemental material]. *American Journal of Public Health*, 100, 30-34.
- Fullan, M. (2001). *Leading in a culture of change*. San Francisco: Jossey-Bass.

- Gallagher, R. M. (2005). National Quality Efforts: What Continuing and Staff Development Educators Need to Know. *The Journal of Continuing Education in Nursing* 36(1), 29-45.
- Gardenswartz, L. & Rowe, A. (1999). *Managing diversity in health care manual*. San Francisco: Jossey-Bass.
- Grassley, J. (2010). Adolescent mothers breastfeeding social support needs. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 39(6), 713-722.
- Green, A. R., Betancourt, J. R., Park, E. R., Greer, J. A., Donahue, E. J., & Weissman, J. S. (2008). Providing culturally competent care: Residents in HRSA Title VII funded residency programs feel better prepared. *Academic Medicine*, 83(11), 1071-1079.
- Greenwood, J. (1998). The role of reflection in single and double loop learning. *Journal of Advanced Nursing*, 27(5), 1048-1053.
- Gormley, D. (2003). Factors Affecting Job Satisfaction in Nurse Faculty: A Meta-Analysis. *Journal of Nursing Education* 42(4), 174-178.
- Habel, M., & Sherman, R. O. (2010, October). Transformational leadership: A growing promise for nursing. *Nursing Spectrum*, 10, 34-39.
- Hegarty, J., Walsh, E., Condon, C. & Sweeney, J. (2009). The undergraduate education of nurses: Looking to the future. *International Journal of Nursing Education Scholarship*, 6(1), 1-11.
- Hinchey, P. H. (2008). *Action research primer*. New York: Peter Lang.
- Houser, J. (2008). *Nursing research: Reading, using, and creating evidence*. Sudbury, MA: Jones and Bartlett Publishers.
- Hoyt, C. L., & Blascovich, J. (2003). Transformational and transactional leadership in virtual and physical environments. *Small Group Research* 34(6), 678-715.
- Jarvis, C. (2008). *Physical examination & health assessment*. (5th ed.). St. Louis, MO: Elsevier.
- Jaworski, J. (1998). *Synchronicity: The inner path of leadership*. San Francisco, CA: Berrett-Koehler Inc.
- Jefferson School of Nursing Editor. (2009). Mission of the Jefferson School of Nursing. Retrieved from <http://www.jefferson.edu/jchp/nursing/mission.cfm>.

- Kirkham, S. R., & Browne, A. J. (2006). Toward a critical theoretic interpretation of social justice discourses in nursing. *Advances in Nursing Science, 29*(4), 324-339.
- Kleiman, S., Frederickson, K., & Lundy, T. (2004). Using an eclectic model to educate students about cultural influences on the nurse-patient relationship. *Cultural Diversity, 25*(5), 249-253.
- Komives, S. R., Dugan, J. P., Owen, J. E., Slack, C., Wagner, W. (2011). The handbook for student leadership development (2nd ed.). San Francisco, CA: Jossey-Bass.
- Kosa, K., & Adany, R. (2007). Studying vulnerable populations: Lessons learned from the Roma Minority. *Epidemiology & Society, 18*(3), 290-299.
- Kotter, J. (1996). *Leading change*. Boston, MA: Harvard Business Press.
- Kreisberg, S. (1992). *Transforming power: Domination, empowerment and education*. Albany, NY: State University of New York Press.
- Kouzes, J., & Posner, B. (2003). *The leadership challenge*. San Francisco, CA: Josey-Bass.
- Kumagai, A. K., & Lybson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782-787.
- Laantera, S, Pietila, A, & Polki, T. (2010). Knowledge of breastfeeding among pregnant mothers and fathers. *Journal of Perinatal & Neonatal Nursing, 24*(4), 320-329.
- Labonte, R. (1998). Health promotion and the common good: towards a politics of practice. *Critical Public Health, 8*(2), 107. <http://search.ebscohost.com>
- Leininger, M. M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory*. Sudbury, MA: Jones and Bartlett
- Leithwood, K. A. (2007). Transformation school leadership in a transactional policy world. In *The Jossey-Bass reader on educational leadership* (pp. 183-196). San Francisco, CA: Jossey-Bass.
- Leuning, C. J. (2001). Advancing a global perspective: The world as a classroom. *Nursing Science Quarterly, 14*(4), 298-303.
- Lewis, S. L., Dirksen, S. R., Heitkemper, M. M., Bucher, L., & Camera, I. M. (2011). *Medical-surgical nursing: Assessment and management of clinical problems*. (8th ed.). St. Louis, MO: Elsevier.
- Mazzoni Center (2007). *Raising the bar*. Annual Report. Philadelphia: PA.

- Mead, H., Cartwright, S., Jones, K., Ramos, C., Woods, K., & Siegel, B. (2008). Racial and ethnic disparities in U. S. Health Care: A chartbook. The Commonwealth Fund.
<http://www.commonwealthfund.org/Content/Publications/Chartbooks/2008/Mar/Racial-and-Ethnic-Disparities-in-U-S--Health-Care--A-Chartbook.aspx>
- Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco, CA: Jossey-Bass.
- Moriarty, J. (2009). Rawls, Self-Respect, and the Opportunity for Meaningful Work. *Social Theory & Practice*, 35(3), 441-459. <http://search.ebscohost.com>
- Munoz, C., & Luckmann, J. (2005). *Transcultural communication in nursing education* (2nd ed). Clifton Park, NY: Thomson Delmar Learning.
- National Center for Cultural Competence (2009). *Report of the Georgetown University Center for Child and Human Development on Cultural Competence*. Retrieved from:
<http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#ccdefinition>
- O'Connor, M. P. (2009). Service works: Promoting transition success for students with disabilities through participation in service learning. *Teaching Exceptional Children*, 41(6), 13-17.
- Ottenritter, N. W. (2004). Service learning, social justice, and campus health. *Journal of American College Health*, 52(4), 189-191.
- Ousley, S., Jantz, R., & Freid, D. (2009). Understanding race and human variation: Why forensic anthropologists are good at identifying race. *American Journal of Anthropology*, 139, 68-78.
- Ouspensky, P. D. (1981). *The psychology of man's possible evolution*. New York, NY: Vintage Books.
- Patten M. L. (2001). *Questionnaire research: A practical guide*. Los Angeles, CA: Pyrczak Publishing.
- Pauly, B. M., MacKinnon, K., & Varcoe, C. (2009). Revisiting "who gets care?" Health equity as an arena for nursing action. *Advances in Nursing Science*, 32(2), 118-127.
- Philadelphia GSA Handbook* (2009). Mazzoni Center. Philadelphia, PA.

- Pillai, R., Schriesheim, C. A., & Williams, E. S. (1999). Fairness perceptions and trust as mediators for transformational and transactional leadership: A two sample study. *Journal of Management* 25(6), 897-933.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott, Williams & Wilkins.
- Potter, P. A., & Perry, A. G. (Ed.). (2009). *Fundamentals of Nursing*. St. Louis: Mosby.
- Price, P. L. (2010). At the crossroads: Critical race theory and critical geographies of race. *Progress in Human Geography*, 34(2), 147-174.
- Purnell, L. D., & Paulanka, B. J. (2003). *Transcultural healthcare: A culturally competent approach*. Philadelphia: F.A. Davis.
- Race. (n.d.). In *Merriam-Webster Online Dictionary*. Retrieved October 10, 2009, from <http://www.merriam-webster.com/dictionary/race>
- Rodgers, C. (2002). Defining Reflection: Another Look at John Dewey and Reflective Thinking. *Teachers College Record* 104(4), 842-866.
- Royal College of Nursing. (2004). The future nurse: The future for nurse education: A discussion paper. Retrieved October 10, 2009, from http://www.rcn.org.uk/downloads/aboutus/policy_and_consultations/policy_unit/imported/nurse-education.doc
- Schon, D. A. (1983). *The Reflective Practitioner*. New York: Basic Books.
- Sergiovanni, T. J. (1992). Leadership as stewardship. In *The Jossey-Bass reader on educational leadership* (pp. 183-196). San Francisco, CA: Jossey-Bass.
- Spector, R. (2009). *Cultural diversity in health and illness* (7th ed.). Upper Saddle River, NY; Pearson . Retrieved October 10, 2009 from http://www.R2Library.com/marc_frame.aspx?ResourceID=1114
- Slade, D., Thomas-Connor, I., & Man Tsao, T. (2008). When nursing meets English: Using a pathography to develop nursing students culturally competent selves. *Cultural Competence*, 29(3), 151-155.
- Stys, J. C. (2008). Social analysis formation for nurse educators. *Nursing Education Perspectives*, 29(6), 366-369.
- Tashiro, C. J. (2005). Health disparities in the context of mixed race: Challenging the ideology of race. *Advances in Nursing Science*, 28(3), 203-211.

- Taylor, T., Martin, B. N., Hutchinson, S., & Jinks, M. (2007). Examination of leadership practices of principals identified as servant leaders. *International Journal of Leadership in Education*, 10(4), 401-419.
- U.S. Census Bureau, U.S. Census Bureau News. (2008). Retrieved from <http://www.census.gov/Press-Release/www/releases/archives/population/012496.html>
- U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000. Retrieved from http://www.healthypeople.gov/Document/html/uih/uih_bw/uih_1.htm
- Walker, M. (2003). Framing social justice in education: What does the capabilities approach offer? *British Journal of Educational Studies*, 51(2), 168-187.
- Welch, M. (1998). Required curricula in diversity and cross-cultural medicine: The time is now. *Journal of the American Medical Women's Association*, 53, (Suppl), 121-123.
- Whalen, B. & Crampton, R. (2010). Overcoming barriers to breastfeeding continuation and exclusivity. *Current Opinion in Pediatrics*, 22(5), 655-663.
- Whitfield, P. (2003). The day the foreign devil came to class: My teaching body in China. In D.P. Freedman and M.S. Holmes (Eds.), *The teacher's body: Embodiment, authority, and identity in the academy* pp. 99-104. Albany, NY: State University of New York.
- Wilford, S. (2007). Modeling Appropriate Behaviors. *Scholastic early childhood today*, 21(5) 8-9.
- Yarbrough, S., & Klotz, L. (2007). Incorporating cultural issues in education for ethical nursing practice. *Nursing Ethics*, 14(4), 492-502.

Appendix A: Promise of Confidentiality

Promise of Confidentiality

This form is intended to protect the confidentiality of what members of this discussion group say during the course of this study, *Implementing Multicultural Awareness in Undergraduate Nursing Curriculum*. Please read the following statement and sign your name, indicating that you agree to comply.

I promise that I will not communicate or talk about information discussed during the course of these focus groups with anyone outside of my fellow focus group members and to facilitators. I also understand that the researcher will not identify me personally in any way.

Name: _____

Signature: _____

Facilitator Signature: _____

Appendix B: Survey Monkey Results

4/10/2010 SurveyMonkey - Survey Results

SurveyMonkey Logged in as "SharonBurke" [Log Off](#)

[Create Survey](#) [My Surveys](#) [Address Book](#) [My Account](#) [Need Help?](#)

You have a **basic account**. To remove the limits of a basic account and get unlimited questions, [upgrade now!](#)

survey title: **Implementing Multicultural Awareness** [Edit Title](#)

[design survey](#) | [collect responses](#) | [analyze results](#)

current report: [Default Report](#) [Add Report](#)

[View Summary](#) [Browse Responses](#) [Filter Responses](#) [Crosstab Responses](#) [Download Responses](#) [Share Responses](#)

Response Summary

Total Started Survey: 12
Total Completed Survey: 12 (100%)

Page: Default Section

1. My program has a dedicated multicultural awareness course in the undergraduate nursing curriculum. [Create Chart](#) [Download](#)

	Response Percent	Response Count
Yes <input type="checkbox"/>	33.3%	4
No <input type="checkbox"/>	66.7%	8
answered question		12
skipped question		0

2. I am satisfied with the multicultural awareness education materials in my program (if applicable): [Create Chart](#) [Download](#)

	Response Percent	Response Count
Very Unsatisfied <input type="checkbox"/>	9.1%	1
Unsatisfied <input type="checkbox"/>	0.0%	0
Neutral <input type="checkbox"/>	36.4%	4
Satisfied <input type="checkbox"/>	45.5%	5
Very Satisfied <input type="checkbox"/>	9.1%	1
answered question		11
skipped question		1

3. Please indicate the title of the multicultural awareness education resource used in your program: [Download](#)

	Response Count
1. No separate course; rather embedded	11

1. No separate course; rather embedded Fri, Jan 29, 2010 1:52 PM [Find...](#)

surveymonkey.com/MySurvey_Respons...

1/4

4/10/2010

SurveyMonkey - Survey Results

in all our nursing courses

2.	No specific reference....	Tue, Jan 26, 2010 3:10 PM	Find...
3.	we have a substantial initiative that includes programming for faculty and students. It seems to work well.	Wed, Jan 20, 2010 6:35 PM	Find...
4.	We wrote our own.	Thu, Jan 14, 2010 9:14 PM	Find...
5.	n/a	Thu, Jan 14, 2010 1:24 PM	Find...
6.	It is integrated into several of our courses including fundamentals, essentials, health promotion, med/surg, women/children/families, and gerontology.	Thu, Jan 14, 2010 9:18 AM	Find...
7.	We do not have a specific education resource. We incorporate ethnic diversity and cultural competency throughout our course work	Wed, Jan 13, 2010 5:39 PM	Find...
8.	textbooks, readings, and media vary by course and faculty member; examples include training materials from Federation of Associations of Schools of Health Professions (FASHP) and the Society of Human Resource Management; Books, Journals, Magazines, Newsletters, such as <ul style="list-style-type: none"> • Guide to Culturally Competent Health Care • Public Health Observatory Handbook of Health Inequalities Measurement • Healthier Minorities, Healthier America o Department of Health and Human Services, Office of Minority Health Available from 2009- A newsletter from the Office of Minority Health. • Ethnicity and Disease <ul style="list-style-type: none"> o The International Society on Hypertension in Blacks, Inc. An international journal on ethnic minority population differences in disease patterns. Addresses the causal relationships in the etiology of common illnesses through the study of ethnic patterns of disease. Draws from research in epidemiology, genetics, health services, social biology, and anthropology. • Ethnicity & Health <ul style="list-style-type: none"> o Carfax Publishing Limited Available: in 1996 to 6 months ago Academic Search Premier. Ethnicity & Health is an international academic journal designed to meet the world-wide interest in the health of ethnic groups. • The IHS Primary Care Provider <ul style="list-style-type: none"> o The IHS Primary Care Provider is a monthly publication of the Indian Health Service (IHS) Clinical Support Center. The goal of The Provider (as it is commonly referred to) is communication. It targets health care professionals including, among others, physicians, nurses, pharmacists, dentists, and dietitians. • Journal for Minority Medical Students <ul style="list-style-type: none"> o Spectrum Unlimited, Inc. 	Wed, Jan 13, 2010 5:21 PM	Find...

surveymonkey.com/MySurvey_Respons...

2/4

4/10/2010

SurveyMonkey - Survey Results

A non-technical publication designed to inform its readers of the most pressing issues in medical education. Its aim is to promote medical careers among all minority students in order to increase the numbers of physicians providing health care to the under served populations of African American, American Indian, and Hispanic.
<http://www.minoritymedicalstudents.com>

- Journal of the National Medical Association
 - o The Journal of the National Medical Association is the primary source for specialized clinical research activities related to the health problems of African Americans and other minority groups in the inner cities. Special emphasis is placed on the application of medical science to improve the health care of underserved populations both in the United States and abroad. The journal has the following objectives: to expand the base of original peer-reviewed literature, recognizing the need for greater dissemination of information; to offer appropriate and timely recognition of the significant contributions that physicians who serve the underserved populations are making in the quest by medical science to improve the health of all people; and to sustain interest by member and nonmember physicians in the overall goals and objectives of the National Medical Association.
- Journal of Cross-Cultural Gerontology
 - o Kluwer Academic Publishers
The Journal of Cross-Cultural Gerontology is an international and interdisciplinary journal providing a forum for scholarly discussion of the aging process and the problems of the aged throughout the world
- Journal of Transcultural Nursing
 - o SAGE Publications
Explores the influence of culture on nursing practice and the delivery of Health Care.
- Journey to Wellness
 - o An online health magazine for African Americans. JourneyToWellness.com allows visitors to actually listen to archived audio of the Journey to Wellness nationally syndicated radio programs, as well as read program-related articles and link to credible related resources.
- Social Work in Health Care
 - o Haworth Press
Publishes articles in research, clinical practice, education in health care, collaborative relationships, and social health policy.
- Transcultural Psychiatry
 - o Published by the Division of Social & Transcultural Psychiatry, McGill University in conjunction with SAGE Publications.
Provides a forum of communication for psychiatrists and other mental health practitioners as well as social scientists

surveymonkey.com/MySurvey_Respons...

3/4

4/10/2010

SurveyMonkey - Survey Results

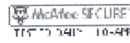
around the world concerned with the relationship between culture and mental health.

9. Multicultural and Community Perspectives	Wed, Jan 13, 2010 3:27 PM	Find...
10. Transcultural Nursing	Wed, Jan 13, 2010 3:26 PM	Find...

10 responses per page

< 1 >

answered question	11
skipped question	1



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Contact Us	FAQs	Anti-Spam Policy	Employee Satisfaction	
We're Hiring	Contact Support	Email Opt Out / Opt In	Market Research	

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Appendix C: Implementing Multicultural Awareness Education in Undergraduate Nursing Curriculum

Pretest

Directions: Clearly circle your answer of choice. Do not write your name on this form. There are 2 pages, please complete both.

1. I identify myself as (select one only):
Arab
Asian/Pacific Islander
Black
Caucasian/White
Hispanic
Indigenous or Aboriginal
Latino
Multiracial
Other: _____ (please print your response)

2. My age is between:
18-25
25-35
36-45
46-55
55+

3. I believe education regarding multiple cultures is valuable in undergraduate nursing education

Strongly Agree Agree Neutral Disagree Strongly disagree

4. I believe awareness of other cultures will allow me to provide better patient care than I provide now.

Strongly Agree Agree Neutral Disagree Strongly disagree

5. I have had multiple learning opportunities related to multicultural awareness during my undergraduate nursing education.

Strongly Agree Agree Neutral Disagree Strongly disagree

6. I have witnessed effective patient care delivery to cultures other than my own.

Strongly Agree Agree Neutral Disagree Strongly disagree

7. I have witnessed ineffective/inappropriate patient care delivery to cultures other than my own.

Strongly Agree Agree Neutral Disagree Strongly disagree

8. I feel uncomfortable providing care to cultures I am unfamiliar with.

Strongly Agree Agree Neutral Disagree Strongly disagree

9. I know where to go to find information about cultures other than my own in the hospital setting.

Strongly Agree Agree Neutral Disagree Strongly disagree

Appendix D: Implementing Multicultural Awareness Education in Undergraduate Nursing Curriculum

Post Test

Directions: Clearly circle your answer of choice. Do not write your name on this form. There are 2 pages, please complete both. Please print your answers to the open ended-questions.

1. Having an understanding of only my culture can negatively impact the patient care I deliver.
Strongly Agree Agree Neutral Disagree Strongly disagree
2. Appreciating a patient's cultural perspectives is a necessary component of highly effective nursing care.
Strongly Agree Agree Neutral Disagree Strongly disagree
3. Reading a book is the best way for me to learn about multiple cultures.
Strongly Agree Agree Neutral Disagree Strongly disagree
4. Looking at an electronic resource (i.e. the internet) is the best way for me to learn about multiple cultures.
Strongly Agree Agree Neutral Disagree Strongly disagree
5. Listening to individuals from multiple cultures is the best way for me to learn about cultures outside of my own.
Strongly Agree Agree Neutral Disagree Strongly disagree
6. I feel comfortable discussing multiple cultures within the context of my nursing class.
Strongly Agree Agree Neutral Disagree Strongly disagree
7. I feel that a patient's culture has little to do with the care I provide them.
Strongly Agree Agree Neutral Disagree Strongly disagree
8. The Jefferson School of Nursing should do more multicultural awareness education sessions to potentially improve patient care.
Strongly Agree Agree Neutral Disagree Strongly disagree

9. Please indicate how this educational session has or has not changed the way you think about multicultural awareness education:

10. Please indicate what you believe are barriers to multicultural awareness education:

Appendix E: Implementing Multicultural Awareness Education in Undergraduate

Nursing Curriculum

Focus Group Script

1. When is the first time you recall learning about culture at the Jefferson School of Nursing. What was most memorable about this lecture?
2. Have you had a chance to provide care to a culture other than your own during your clinical practicum? How did it make you feel? Did you learn anything new?
3. When you hear the term “multicultural awareness,” how does it make you feel?
4. Can you describe patient care that was positively impacted by a nurse’s knowledge of their culture?
5. Can you describe patient care that was negatively impacted by a nurse’s knowledge of their culture?
6. How do you believe learning about multiple cultures could impact your practice as a registered nurse?

7. Do you believe you have been given enough information about multiple cultures throughout your education at the Jefferson School of Nursing?
8. How could faculty better prepare students to meet the needs of patients of varied cultures?
9. Do you believe health care workers stereotype cultures, if so, does this impact the care they receive?

Appendix F: Comprehensive Pre-Test Descriptive Statistics

Table 1

Participants Delineation of Race (n= 422)

Race	Frequency	Percent
Arab	4	1.0
Asian/Pacific Islander	62	14.9
Black	20	4.8
Caucasian/White	307	73.6
Hispanic	12	2.9
Latino	1	.2
Multiracial	7	1.7
Other	4	1.0
Total	422	100

Table 2

Participants Delineation of Age (n= 422)

Age Range	Frequency	Percent
18-25	220	52.3
26-35	162	38.5
36-45	30	7.1
46-55	7	1.7
56+	2	.4
Total	422	100

Table 3

Participants Belief that Nursing Education Regarding Multiple Cultures is Valuable in Undergraduate Nursing Education (n= 422)

Parameter	Frequency	Percent
Strongly Agree	248	58.8
Agree	156	37.0
Neutral	13	3.1
Disagree	4	.9
Strongly Disagree	1	.2
Total	422	100

Table 4

Participants Belief Awareness of Other Cultures Will Allow Them to Provide Better Patient Care than They Provide Currently(n= 422)

Parameter	Frequency	Percent
Strongly Agree	272	64.5
Agree	137	32.5
Neutral	11	2.6
Disagree	0	0
Strongly Disagree	2	.5
Total	422	100

Table 5

Participant Belief that Multiple Learning Opportunities Related to Multicultural Awareness Were Available In the JSN (n= 422)

Parameter	Frequency	Percent
Strongly Agree	44	10.4
Agree	190	45.0
Neutral	106	25.1
Disagree	79	18.7
Strongly Disagree	3	0.7
Total	422	100

Table 6

Participants Witnessed Effective Patient Care Delivery to a Culture Other Than Their Own (n= 422)

Parameter	Frequency	Percent
Strongly Agree	73	17.3
Agree	211	50.1
Neutral	86	20.4
Disagree	47	11.2
Strongly Disagree	4	1.0
Total	422	100

Table 7

Participants Witnessed Ineffective/Inappropriate Patient Care Delivery to Cultures Other Than Their Own (n= 422)

Parameter	Frequency	Percent
Strongly Agree	33	7.8
Agree	161	38.2
Neutral	90	21.3
Disagree	124	29.4
Strongly Disagree	14	3.3
Total	422	100

Table 8

Participants Felt Uncomfortable Providing Care to Unfamiliar Cultures (n= 393)

Parameter	Frequency	Percent
Strongly Agree	15	3.8
Agree	58	14.8
Neutral	61	15.5
Disagree	184	46.8
Strongly Disagree	75	19.1
Total	393	100

Table 9

Participants Knew Where to Find Information Regarding Culture in the Hospital Setting(n= 393)

Parameter	Frequency	Percent
Strongly Agree	23	5.9
Agree	101	25.7
Neutral	76	19.3
Disagree	167	42.5
Strongly Disagree	25	6.4
Total	393	100

Appendix G: Comprehensive Post-Test Descriptive Statistics

Table 1

Participants Belief that an Understanding Only their Culture Could Negatively Impact Patient Care Delivery(n= 388)

Parameter	Frequency	Percent
Strongly Agree	175	45.1
Agree	167	43.0
Neutral	16	4.1
Disagree	15	3.9
Strongly Disagree	15	3.9
Total	388	100

Table 2

Participants Belief that Cultural Perspectives Are a Necessary Component of Highly Effective Nursing Care (n= 388)

Parameter	Frequency	Percent
Strongly Agree	254	65.3
Agree	128	32.9
Neutral	4	1.0
Disagree	1	0.3
Strongly Disagree	2	0.5
Total	389	100

Table 3

Participants Belief that Reading a Book was the Best Way To Learn About Multiple Cultures (n= 388)

Parameter	Frequency	Percent
Strongly Agree	1	0.3
Agree	23	5.9
Neutral	93	24.0
Disagree	224	57.7
Strongly Disagree	47	12.1
Total	388	100

Table 4

Participants Belief that Electronic Resources are the Best Way to Learn About Multiple Cultures (n= 389)

Parameter	Frequency	Percent
Strongly Agree	4	1.0
Agree	41	10.5
Neutral	112	28.9
Disagree	204	52.4
Strongly Disagree	28	7.2
Total	389	100

Table 5

Participants Belief that Listening to Individuals from Multiple Cultures is the Best Way to Learn About Culture (n= 388)

Parameter	Frequency	Percent
Strongly Agree	159	41.0
Agree	195	50.3
Neutral	22	5.7
Disagree	11	2.8
Strongly Disagree	1	0.3
Total	388	100

Table 6

Participants Felt Comfortable Discussing Culture During Nursing Class (n= 388)

Parameter	Frequency	Percent
Strongly Agree	97	25.0
Agree	204	52.6
Neutral	59	15.2
Disagree	24	6.2
Disagree Strongly	4	1.0
Total	388	100

Table 7

Participants Felt Patient Culture Has Little to Do With Care Provided to Them (n= 388)

Parameter	Frequency	Percent
Strongly Agree	6	1.5
Agree	11	2.8
Neutral	20	5.2
Disagree	200	51.5
Strongly Disagree	151	38.9
Total	388	100

Table 8

Participants Believed JSN Should Do More Multicultural Awareness Education Sessions To Improve Patient Care (n= 389)

Parameter	Frequency	Percent
Strongly Agree	184	47.3
Agree	167	42.9
Neutral	30	7.7
Disagree	6	1.5
Strongly Disagree	2	.5
Total	389	100