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EDITORIAL

A continuing commitment to excellence

In 1900 a major milestone was achieved with the publication of the first official journal of nursing, *The American Journal of Nursing*. This journal continues to serve as a vehicle for dissemination of critical information about all aspects of the profession. Nursing has come a long way since. Currently there are many nursing journals focusing on every major area of practice. The original New York State Nurses Association journal came into being in 1938 as *The New York State Nurse*. In 1970 the name changed to *The Journal of the New York State Nurses Association* and in 1989 began to publish peer-reviewed articles. Members with a long history with the Association know that the *Journal* has kept its members well informed of the many achievements, challenges, and triumphs of nurses in the state and in the country.

The most significant feature of nursing journals is their deep commitment to serve the practitioners of the profession through publication of state-of-the art perspectives on issues affecting the profession and advances in the knowledge base that guides excellence in nursing practice areas including education, clinical, and research.

Readers of this issue will affirm the statement above as they consider the information in the featured articles. Each of the articles attests to the quest of professional nurses to elevate practice to even higher levels of excellence. The article by Carol Lynn Esposito, EdD, JD, MS, RN examines culturally-competent care and describes the current state of nursing and suggests essential work that needs to be done to better serve the diverse multicultural populations in healthcare. Melanie Kalman, RN, PhD and colleagues share the success of an interventional program to alert women of their different and specific symptoms of a myocardial infarction. This is a milestone in educating women about a health problem identified as the number one killer of women. Lastly, Dianne Cooney-Miner, PhD, RN describes clearly the case for the BSN as the educational requirement for entry into practice. This timely piece will help in getting the needed support to standardize the basic requirement for professional nursing.

Other features of the *Journal* include summaries of articles that provide quick updates on nursing and healthcare. Nurses are able to take the continuing education opportunities to earn credits to maintain certification in their specialty areas.

In all, this issue and the forthcoming ones will support practitioners' continuing quest for excellence in practice. This is an exemplary mission for the *Journal* and the New York State Nurses Association. So, read on for excellence!

Geraldine Valencia-Go, PhD, RN, CGNS, BC

Provision of Culturally Competent Health Care: An Interim Status Review and Report

Carol Lynn Esposito, JD, MS, RN

Abstract

This review reports on the current nursing literature as it relates to the progress the nursing community has made in the field of transcultural nursing. This review also reports on the current status of the nursing professions' initiative to integrate multi-cultural, diversity training into its educational programs and on the degree to which nurses' report on their preparedness to provide exemplary, culturally competent care following their educational training. The literature reveals we are still only beginning to understand how nursing's educators and employers can provide critical learning environments and workplaces for students, faculty and practitioners to grasp the concepts of transcultural nursing and to evaluate the effectiveness of our actions following training.

This status report provides the nursing profession with opportunities to be creative in designing cultural immersion experiences, faculty workshops, educational programs, certification programs, and qualitative and quantitative evaluation tools to measure the effectiveness of our cultural competence programs and experiences. Further opportunities include the dissemination of important concepts and findings through research, conferences, scholarly journals, nursing publications, staff development programs, and continuing education programs.

Introduction

The American Academy of Nursing (AAN), an organizational unit established in 1973 under the aegis of the American Nurses Association (ANA), has a public mission to:

(1) advance health policy and practice;

(2) anticipate national and international trends in health care; and

(3) address resulting issues of health care knowledge and policy

(AAN, 2012; Giger et al., 2007).

Within its infrastructure, the AAN has a number of standing committees and expert panels, including the Expert Panel on Cultural Competence, whose charge is to ensure that measurable outcomes be achieved that "reduce or eliminate health disparities commonly found among racial, ethnic, uninsured, underserved, and underrepresented populations residing throughout the United States" (Giger et al., 2007, p. 96).

The U.S. Department of Health and Human Services Office of Minority Health, established in 1986, has a public mission to improve the health of racial and ethnic minority populations through the development of health policies and programs that help to eliminate health disparities. In releasing its Culturally and Linguistically Appropriate Service (CLAS) standards, the Office of Minority Health has required health care providers to offer health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients (U.S. Department of Health & Human Services Office of Minority Health, 2005).

The 1994 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) supports the provision of care, treatment, and services in a manner that is conducive to the cultural, language, spiritual and religious needs of individuals. As the premier national accrediting body for hospitals,

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the JCAHO was seated on the committee that helped to develop the CLAS standards and has integrated cultural competency mandates within its own JCAHO standards (Underserved Quality Improvement Organization Support Center [UQIOSC], 2007).

Currently, 14 states have Medicaid and Medicare contracts with cultural competency requirements. As a major purchaser of health care services for Medicare/Medicaid, the federal government is requiring their contractors to be culturally diverse and to deliver culturally competent service and care (UC Davis Health System, Human Resources, 2012).

The 2004 U.S. Census Bureau reported that in the year 2000, White Americans accounted for 69.4% of the total population, Blacks 12.7%, Hispanics 12.6% and Asians 3.8%. The 2010 U.S. Census Bureau reported that U.S. minorities will be in the majority by 2042, increasing from 34% in 2008 to 54% in 2042. Currently, minorities outnumber non-Hispanic Whites in Hawaii, New Mexico, California, Texas, and the District of Columbia (U.S. Census Bureau, 2010). With demographic shifts in the nation, the United States health care industry has been making its way toward "cultural competency" for more than fifty years, and the talk around cultural diversity and cultural competence has seemingly become a mantra (Leininger, 2007; Liu, Mao, & Barnes-Willis, 2008; Mixer, 2008; Sanner, Baldwin, Cannella, Charles, & Parker, 2010). Nevertheless, as the United States health care system and industry moves along the continuum toward cultural competency and proficiency, we should ask: are we there yet? Are we making appropriate and exemplary progress toward the provision of culturally competent health care?

Research purposes

The purposes of this nursing literature review are to examine the *(1) concepts of culture, cultural competence, culture care, culturally competent care,* and *cultural diversity* (2) middle range nursing theories and nursing conceptual models of cultural care and diversity; and (3) currently reported levels of cultural competence of nurse educators, nursing students, and nursing practitioners.

Review of the literature

The nursing literature reveals an assortment of definitions for the concepts *culture, cultural competence, culture care, culturally competent care* and *cultural diversity*. While a full concept analysis of these terms is beyond the scope of this review, the nursing literature has been examined to offer an analysis of these concepts as they relate to nurses and nursing practice. The author notes and concurs with findings in the literature that differences in definitions and foci have led to delayed advancements toward the provision of exemplary culturally competent nursing care in the United States (Schim, Doorenbos, Benkert, & Miller, 2007).

Culture defined

Culture has been defined in anthropological terms as "that complex whole which includes knowledge, belief, arts, morals, law, custom, and many other capabilities and habits acquired by man as a member of society" (Tylor, 1958, p. 1). This definition recognizes the attributes one acquires by growing up or living in a particular society, rather than through biological inheritance (Schim, Doorenbos, Benkert, & Miller, 2007). Leininger (2001) defines culture as the "learned, shared, and transmitted values, beliefs, norms, and lifeways of a specific individual or group that guide their thinking, decisions, actions, and patterned ways of living" (as cited in Sitzman & Eichelberger, 2004, p. 95). This definition similarly recognizes the attributes one acquires and expresses by living with a particular group.

The U.S. Department of Health and Human Services Office of Minority Health (2005) defines culture as the "thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups" (para. 1).

> The term culture encompasses a broad range of concepts.
>
> It is an individual concept, a group phenomenon, and an organizational reality. The construct of culture also implies a dynamic, nested, systems perspective that goes beyond discussions of race and ethnicity to include diverse subcultures. Such subcultures include communities of interest and communities with common needs. (Schim, Doorenbos, Benkert, & Miller, 2007, p. 104)

Culture pervades all aspects of life, as it pervades all aspects of health care. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given (U.S. Department of Health & Human Services Office of Minority Health, 2005). Understanding the complexities of culture becomes imperative to respond to the global health needs of people, communities, and nations (Mixer, 2008; Schim, Doorenbos, Benkert, & Miller, 2007).

Cultural competence defined

As a simplistic definition, cultural competence is "the ability to care for patients with diverse values, beliefs and behaviors, including tailoring health care to meet the patient's social, cultural, and linguistic needs" (Wood & Atkins, 2006, p. 50).

Cultural competence is also defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (U.S. Department of Health & Human Services Office of Minority Health, 2005, p. 2).

Purnell and Palunka (2003) define cultural competence as those actions that a health care professional takes to develop and raise his/her awareness of his/her existence, sensations, thoughts, and environment without letting these factors have an undue influence on those for whom care is provided, and those steps that the health care professional takes to adapt his/her care in a manner that is congruent with the patient's culture.

McFarland and Eipperle (2008) offers a definition of a culturally competent practitioner as one who is "knowledgeable and respectful of diverse cultural beliefs and practices, and partners with the client to develop a care regimen that produces the desired health outcomes within the context of the client's cultural values" (p. 51).

Cultural diversity is a concept that goes beyond the constructs of ethnicity and race.

Liu, Mao and Barnes-Willis (2008) opine that cultural competence should be considered as a process rather than an end-point. "It is more than the achievement of skills to work with people of different ethnic groups, including understanding their traditions, beliefs, customs, and values, but also including to work with the cultural context of the individual, family, or community" (p. 101; St. Clair & McKenry, 1999).

Culture care defined

Leininger asserts culture care is a synthesized, integrated and interdependent construct, not two separate concepts. She also asserts that the concept of care alone is "too fuzzy; care cannot be measured and known. Furthermore, nurses have [in the past] had no time to learn about care and culture, as they [had to] keep to medical tasks" (Fawcett, 2002, p. 133).

In developing her theory of transcultural nursing, Leininger has offered nurses' ways of thinking that are different from the medical model and traditional nursing knowledge, practice and constructs.

> From an anthropological and an historical perspective, one can see that after World War II the medical treatment emphasis came strongly into focus and took over nursing. Nurses got so caught up in following and pleasing physicians in order to get approval. They were shaped by medicine in a rapid enculturation process (Fawcett, 2002, p. 133).

In an effort to refocus nurses and the nursing profession to reflect on cultural factors that influence care, Leininger (2002a) defines culture care as "those assistive, supportive, enabling, and facilitative culturally-based ways to help people in a compassionate, respectful, and appropriate way to improve a human condition or lifeway" (p.12). Culture care has symbolic meaning and includes concepts such as *"care as protection, care as respect,* and *care as presence"* (McFarland & Eipperle, 2008, p. 49).

Culturally competent care defined

Germain (2004) defines culturally competent care as regimens of care that are rooted in a respectful and informed knowledge based on the cultural beliefs and practices of the patient and includes the patient as a partner in the development of the care plan and the desired health outcomes (p. 435).

Leininger (2006) defines culturally competent care as care that is provided when culture care values, beliefs, expressions, and patterns are explicitly known and used appropriately, sensitively, and meaningfully with people of diverse or similar cultures (p. 19).

Waite and Calmaro (2010) defines culturally competent care as those sets of "skills and behaviors that enable the nurse to work effectively within the cultural context of a client (i.e., individual, family, or community)" (p. 74).

Cultural diversity defined

Cultural diversity is a construct that is variable in quantity and quality, across place and time. In any given environment, there are varying degrees of diversity that are represented. Some communities have relatively homogeneous populations, others have a great variety of groups represented. Some healthcare organizations serve communities with little variations in socioeconomics or lifestyles, ethnicity, race or interests, while others serve communities with wide disparities and interests (Schim, Doorenbos, Benkert, & Miller, 2007). Cultural diversity is a concept that goes beyond the constructs of ethnicity and race. It includes other aspects of diversity, such as class, gender, sexual orientation, physical abilities/disabilities, and care beyond multiculturalism (Papadopoulos & Omeri, 2008). Cultural diversity is a fact of life in America.

> What was once conceptualized as the American 'melting pot' changed to being described as a 'salad' or 'stew,' in which the ingredients work together while retaining the special flavors of distinct origins and cultures. Public debate has expanded over time to include different voices that were once silent and marginalized. People of color, women, and people who are gay/lesbian/bisexual/transgendered are speaking up, achieving representation, and demanding open acknowledgement and full participation in society to a larger degree than ever before (Schim, Doorenbos, Benkert, & Miller, 2007, p. 105).

Middle range nursing theory of culture care and diversity

Madeline Leininger conceptualized her *Theory of Culture Care Diversity and Universality* in the late 1950s for use in the early 1960's. The theory is unique in that: (1) it is the *only* nursing theory focused explicitly on *culture care* as the dominant theme of nursing inquiry; (2) it is a holistic, culturally based care theory "that incorporates broad humanistic dimensions about people in their cultural life context;" and (3) it incorporates "social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, philosophy of living" and "geo-environmental factors" as potential influences of culture care phenomena (Leininger, 2007, p. 9). The purpose of her theory is to discover culturally-based care that "fits" or is congruent, meaningful, and relevant, to cultural groups and in ways in which culture influences the "lifeways" of people (Leininger, 2007, p. 9).

The *Theory of Culture Care Diversity and Universality* supports the field of transcultural nursing and requires nurses to discover "dominant care constructs" and perform in-depth studies of cultures to identify the close relationship of care to culture and ways that culture care contributes to health and well-being. The theory also replaces the once-prevailing medical and nursing ideology of focusing on diseases, symptoms, pathological conditions, and medical curing practices with "caring" as its dominant focus (Leininger, 2007, p. 9).

A unique feature of the theory is that it focuses on *emic* and *etic* care knowledge. Emic knowledge "comes directly from cultural informants as they know and practice care with their values and beliefs in their [own] unique cultural contexts" (Leininger, 2007, p. 10). These are the natural, local, indigenous root care values. Etic knowledge is derived from "outsider views of non-local or non-indigenous care values and beliefs such as those of professional nurses" (Leininger, 2007, p. 10). Both emic and etic care data are crucial factors in formulating therapeutic, culturally congruent health care plans.

Another unique feature of the theory is that it is conceptualized upon three modes of nursing actions: (1) culture care preservation/maintenance ("those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures retain, preserve or maintain beneficial care beliefs and values"); (2) culture care accommodation ("those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe and effective care"); and (3) culture care re-patterning/restructuring ("those assistive, supportive, facilitative, or enabling professional acts or decisions that help people reorder, change, modify, or restructure their lifeways and institutions for better healthcare patterns, practices or outcomes") (McFarland & Eipperle, 2008, p. 49, Leininger, 2006, p. 15). These three modes guide nursing practitioners, students, and educators to use culturally-based specific-care values, beliefs, and practices to assure and maximize wellness, prevent illness, alleviate cultural stresses, and help to sustain the quality of cultural life. "Most importantly, the three modalities would guide practitioners away from using largely inappropriate, routine, unsafe, traditional, or destructive actions that failed to fit or to be acceptable to cultures" (Leininger, 2007, p. 11). Inappropriate cultural care often leads to cultural conflicts, clashes, and imposition of non-therapeutic practices that would be rejected by the patient (Fawcet, 2002, p. 135).

Fawcett, Newman and McAllister (2004) have added dimensions to Leininger's *Theory of Culture Care Diversity and Universality* by establishing six criteria for theory application in advance practice nursing. The six criteria are that the application of the theory should: (1) be inclusive, rather than exclusive; (2) foster a focus on the whole person rather than the disease or illness; (3) consider the patient's/family's/significant other's perception of the situation; (4) be holistic in nature; (5) facilitate autonomous nursing practice; and (6) encourage diverse ways of knowing, including empirics, ethics, aesthetics, personal knowing, and sociopolitical knowing (p. 136).

Conceptual model of cultural competency

Campinha-Bacote (1998) developed a model of cultural competency by establishing essential components of cultural competence in the domains of cultural (1) awareness; (2) knowledge; (3) skill; (4) encounters; and (5) desire.

Cultural awareness involves a self-examination and self-assessment of one's own culture and its potential influence on his/her ways of thinking and behaving. This process is essential if the provider wishes to avoid imposing their own values upon their patient's (Campinha-Bacote, 1998; Sealey, Burnett, & Johnson, 2006).

Cultural knowledge involves obtaining information about the worldviews of different cultural groups, including knowledge about how its members (1) interpret illnesses; and (2) what causes the group attributes to illness. Cultural knowledge also involves obtaining information about the degree of acculturation of the individual in order to assess whether the patient is fully immersed in his/her own cultural values as opposed to having been acculturated and consciously rejecting his/her group's cultural practices (Campinha-Bacote, 1998; Sealey, Burnett, & Johnson, 2006).

Cultural skill involves the ability to collect relevant data that reflects the patient's health history and presenting problem, as well as accurately and appropriately perform a physical examination that is congruent with and respects the beliefs, practices, and values of the cultural group (Campinha-Bacote, 1998; Sealey, Burnett, & Johnson, 2006).

Cultural encounters involve the process of engaging in direct encounters with patients from diverse cultural backgrounds in order to increase the practitioners repertoire of responses and communications, both verbal and non-verbal. These encounters also serve to validate, clarify, modify, and sometimes negate pre-conceived notions about other cultures (Campinha-Bacote, 1998; Sealey, Burnett, & Johnson, 2006).

Cultural desire involves the motivation of the practitioner to want to engage in cultural encounters and advance along the continuum of cultural competency in the provision of culturally competent health care (Campinha-Bacote, 1998; Sealey, Burnett, & Johnson, 2006).

Levels of cultural competence within the nursing community

The importance of considering patients' culture as an integral part of assessing health needs, planning, and implementing culturally appropriate nursing care has been endorsed by many nursing and government organizations, including the Transcultural Nursing Society, the American Nurses Association Council on Diversity in Nursing Practice, the American Academy of Nursing Expert Panel on Cultural Diversity, the American Academy of Nursing, the U. S. Department of Health and Human Services Office of Minority Health, the Centers for Medicare Services, and the Joint Commission on Accreditation of Healthcare Organizations (Sealey, Burnett, & Johnson, 2006).

Acquiring cultural competence requires health care practitioners to see themselves as becoming culturally competent as opposed to merely mirroring or mimicking behavior in a culturally characteristic manner. Cultural competence, therefore, requires more than just an understanding of race and ethnicity; it requires a higher level of knowledge and understanding gained from conceptual and theoretical perspectives. Skills, attitudes, and personal beliefs must be linked to care designed to meet the needs of marginalized groups, individuals, or communities of people who have similar or distinct characteristics that might also differentiate those people from the mainstream (Giger et al., 2007).

Although we have made great advances in the development of ethnonursing research methods and transcultural nursing theories and concepts, Barbee and Gibson (2001) have articulated that:

> We need to recognize that despite the number of 'dog and pony shows' and books that purport to deal with 'cultural diversity', talking and writing about cultural diversity without consciously and forthrightly dealing with [it] in nursing education [and practice] are essentially empty exercises that will continue to perpetuate the status quo (as cited in Waite & Calamaro, 2010, p. 74).

The question, therefore, has become: have we, albeit unintentionally, essentially perpetuated the status quo?

Review of the nursing literature has revealed that the majority of nurses continue to believe they are less confident and inadequately prepared to provide sustained, culturally competent care to patients from diverse cultures, often regardless of their educational experiences or personal experiences (Fawcett, 2002; Giger, et al., 2007; Leininger, 2007; Leininger, 2002b; Levine & Perpetua, 2006; Luna & Miller, 2008; McFarland & Eipperle, 2008; Mixer, 2008; Papadopoulos & Omeri, 2008; Waite & Calmaro, 2010).

Tools that assess and measure cultural competence

Testing the effectiveness of transcultural theories and models requires the application of both qualitative and quantitative methods. Several quantitative scales have been developed to assess and measure cultural competence in nursing. One such scale is the *Cultural Diversity Questionnaire for Nurse Educators*, which is based on Campinha-Bacote's (1998) model of cultural competence. The instrument includes items which measure cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire and contains 55 statements that the respondents are asked to express their level of agreement with on a five-point Likert-type scale. Content validity of the scale was reported in the research of Sealey, Burnett, and Johnson (2006). This study, domiciled in Louisiana, revealed that very few of the responding nurse educators had formal preparation to teach transcultural nursing and generally felt uncomfortable doing so (Sealey, Burnett, & Johnson, 2006, p. 138). The researchers suggested that "perhaps the existing low levels of cultural competence among generic students, masters students, and practicing nurses is the result of erroneous approaches to teaching cultural competence" (Sealey, Burnett, & Johnson, 2006, p. 139; Bond, Kardong-Edgren & Jones, 2001).

Another quantitative scale measuring cultural self-efficacy is the *Cultural Self Efficacy Scale (CSES)*, a 26 item, 5-point Likert scale, which is designed to measure the perceived sense of self-efficacy of nurses in caring for culturally diverse patients. The CSES is the "most frequently used tool for measuring cultural competency" (Kardong-Edgren & Campinha-Bacote, 2008, p. 39). This scale was used by Liu, Mao, and Barnes-Willis (2008) in their study of community health nurses who were in their last semester of a California state-funded university nursing program. This instrument contains items that are grouped into three subscales and measure knowledge of: (1) cultural concepts; (2) cultural patterns of specific ethnic group; and (3) skills in performing cultural care. Participants in this study were asked to rate their perceptions of confidence about their cultural knowledge, patterns, and skills in caring for three ethnic groups of patients: Blacks, Latino-Hispanics, and Southeast Asians. Content validity of the scale was reported and Cronbach's alpha coefficients of the instrument ranged from 0.86 - 0.98. Results of the study revealed the students' self-efficacy ratings for all items fell between the "neutral" or "non-committal" rating of confidence (Liu, Mao, & Barnes-Willis, 2008, p. 103). Kardong-Edgren and Campinha-Bacote (2008) have advised against using the *Cultural Self Efficacy Scale* with student nurses because "most cultural competency tools have been normed on practicing nurses" and student nurses are often not aware of what it is that they do not know (p. 39, as cited in Coffman, Shellman & Bernal, 2004).

A third quantitative scale measuring the process of cultural competence over time is the *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals*. The instrument was developed by Campinha-Bacote (1998) and is a 20 item, 4-point Likert scale tool that measures the constructs of cultural (1) awareness; (2) knowledge; (3) skill; and (4) encounters. Internal consistency of the instrument was determined to be high (alpha =0.81 - 0.86). This instrument was used as a pre-test and post-test by Wilson, Sanner and McAllister (2010) in their study of 28 Health Science faculty teaching nursing and other allied health students (p. 71). The instrument was used before a continuing education cultural awareness program, was provided to the faculty, was also used immediately after the workshop, and was repeated at three months, six months, and again twelve months following the program. Results of the study revealed that the faculty scores improved in cultural (1) awareness; (2) knowledge; (3) skill; and (4) encounters immediately following the program; however, there was a decrease in the mean score of four items over time "indicating that some faculty were still uneasy about personal cultural competence concepts, such as still having frustration when their values and beliefs clash with others, their knowledge about world views, personal stereotyping and the inability to recognize personal limitations when working with persons of other cultures" (Wilson, Sanner, & McAlister, 2010, p. 71).

The *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised*© was used as a post-test in Kardong-Edgren and Campinha-Bacote's (2008) study on graduating students from four schools of nursing. The study evaluated the effectiveness of four different nursing program curricula in producing culturally competent nursing graduates. One program integrated Madeline Leininger's theory of transcultural nursing into its program, one program integrated Campinha-Bacote's model of transcultural nursing into its program, one program used a mixed integrated approach, and one program utilized a free-standing two credit culture course within its curriculum. The instrument used was a 25-item scale that measured the five cultural constructs of cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire, with five items addressing each construct. The instrument reportedly had a reliability coefficient Cronbach's alpha of 0.83 (Kardong-Edgren & Campinha-Bacote, 2008, p. 39). Results of the study revealed, even without the benefit of a pre-test, that regardless of the approach used, the students scored *only* in the culturally aware range. "Programs with the most diverse student bodies, most international students, oldest and youngest student bodies, also did not faire better than any other program" (Kardong-Edgren & Campinha-Bacote, 2008, p. 40).

The *Openness to Diversity and Challenge Scale (ODCS)* was used in Sanner, Cannella, Charles, and Parker's (2010) study to determine the effectiveness of a cultural diversity forum on nursing students' cultural sensitivity as measured by their openness to diversity. The instrument used was an eight-item Likert scale that measured the students' openness to diversity and challenge. The scale reportedly had a reliability score of Cronbach's alpha of 0.83 (Sanner, Cannella, Charles, & Parker, 2010, p. 59). Forty-seven out of 125 students who registered and attended a Diversity Forum agreed to participate and complete both the ODCS pre-test and post-test. The results of the study suggested that diversity forums were more effective with older, minority women (Sanner, Cannella, Charles, & Parker, 2010, p. 60).

Recent qualitative studies addressing nursing students perceptions of their level of cultural awareness following culturally specific curricula enhancements include Wood and Atkins (2006) (studies of communities in Choluteca, Honduras); Levine and Perpetua (2006) (studies of communities in Honduras, Mexico, Nepal, the Phillipines, Russia, and Slovenia); and Ndiwane, et al., (2004) (studies of underserved immigrant communities in Worchester, Massachusetts). In all three studies, the overarching goal was to increase the student's capacity to value diversity, acquire cultural knowledge, and provide appropriate, culturally-sensitive care. Although all students self-reported an increase in cultural knowledge and awareness following their experiences, there were reported limitations related to the practitioners abilities to maintain sustainable changes in practices (Levine & Perpetua, 2006).

Table 1. Scales Measuring Cultural Competence

Scale	Measures	Reliable Uses
Cultural Diversity Questionnaire for Nurse Educators	* Cultural Awareness * Cultural Knowledge * Cultural Skills * Cultural Encounters * Cultural Desire	55 item, five-point Likert scale for use with nursing educators
Cultural Self Efficacy Scale	* Cultural Concepts * Cultural Patterns of Ethnic Groups * Skills in Performing Cultural Care	26 item, five-point Likert scale for use with practicing nurses
Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals	* Cultural Awareness * Cultural Knowledge * Cultural Skills * Cultural Encounters	20 item, four-point Likert scale for use with nursing faculty, practicing nurses, and nursing students
Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised	* Cultural Awareness * Cultural Knowledge * Cultural Skills * Cultural Encounters * Cultural Desire	25 item, five-point Likert scale for use with practicing nurses and nursing students
Openness to Diversity and Challenge Scale	* Openness to Diversity * Openness to Challenge	8 item, five-point Likert scale for use with older, minority nurses

Implications for organizations

As much as we would like to think that the current status of transcultural nursing and education translates into effective education programs and exemplary provisions of culturally competent care, the literature may be indicating otherwise. We are still only beginning to understand how the nursing profession can provide critical learning environments and workplaces for students, faculty and practitioners to grasp the concepts of transcultural nursing that go beyond the constructs of race and ethnicity and include such subcultures as gay/lesbian/bisexual/transgendered, blind, deaf, and the mentally challenged communities and then evaluate the effectiveness of our actions and implementations. "With more than 4,000 distinct cultures in the world, there are more culture care constructs to be discovered in the future" (Leininger, 2007, p. 11).

Nevertheless, this interim status report provides us with opportunities to be creative in designing cultural immersion experiences, faculty workshops, educational programs, certification programs, and quantitative and qualitative evaluation tools to measure the effectiveness of our cultural competence programs and experiences (Luna & Miller, 2008, p. 2). We are also provided with further opportunities to disseminate important concepts, information and findings through research, conferences, scholarly journals, nursing publications, staff development and continuing education programs.

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Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms

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Abstract

Objective: To test the use of acronyms to increase women's knowledge of female prodromal and myocardial infarction (MI) symptoms using acronyms, and the appropriate response to these symptoms.
Design: A quasi-experimental design.
Method: An educational program, emphasizing two acronyms, was presented and knowledge of female heart attack, prodromal symptoms, and appropriate response was tested before and after the presentation.
Participants: The sample consisted of 51 women.
Results: Knowledge scores increased from 81% pre-test to 91% post-test. This difference was statistically significant on a paired sample t-test, with each subject serving as her own control. Scores measuring knowledge of content specific to the acronyms also improved and were statistically significant.
Conclusion: Lack of knowledge of female heart attack symptoms may contribute to the delay of women seeking care and appropriate treatment, thus increasing morbidity and mortality. The findings from this study demonstrated that an educational program that focused on the use of acronyms was effective in increasing women's knowledge of female prodromal and MI symptoms.

Introduction

Epidemiology

Cardiovascular disease (CVD), which includes diseases of the heart, brain blood supply, and vascular system, has been the number one cause of death since 1900 (Rosamond et al., 2008). The prevalence of CVD in the United States (US) is estimated to be 36.3% of the total population or about 80 million people in 2006 (Rosamond et al., 2008). About every 26 seconds, an American will have a coronary event and once every minute a coronary death occurs (Rosamond et al., 2008). Increasing the awareness of symptoms of an MI and the need to immediately call 9-1-1 is a component of the cardiovascular health goal of the Centers for Disease Control (CDC) (CDC, 2012).

Women and CVD – causes and risk

Coronary heart disease (CHD) is subsumed under the term CVD, and is recognized as the leading cause of death in women in the US and the world (Evangelista & McLaughlin, 2009; Mosca, Mochari-Greenberger, Dolor, Newby, & Robb, 2010; J.L. Thanavaro, Thanavaro, & Delicath, 2010). CVD is estimated to affect nearly one in two women, and in 2007 alone, almost half a million women in the US died from CVD (Mosca, Barrett-Connor, & Wenger, 2011). Deaths for CVD among women occur at about 1 per minute in the US (Mosca, Benjamin, et al., 2011). The rate of CVD mortality is falling in both men and women; however, the mortality rate is decreasing less vigorously in women (Mosca, Barrett-Connor, & Wenger, 2011). Women typically

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have their first CVD event 10 years later than men (Lloyd, 2009; Rosamond et al., 2008). The risk of CVD increases after menopause (Sherwood et al., 2010). One reason women experience CVD later is because estrogen decreases after menopause. Estrogen is cardioprotective and affects the sympathetic nervous system (Sherwood et al., 2010). A decrease in estrogen results in a "sustained increase in hemodynamic load that may contribute to pathological, structural and functional changes in the heart and blood vessels" (Sherwood et al., 2010, p. 403). Mercuro and colleagues (2010) found that estrogen causes arterial vasodilatation and improves endothelial function. In addition, a woman's heart and blood vessels, including the coronary arteries, are smaller than those of men. Women's unique physiology coupled with decreased estrogen adds to the risk of older women having an MI.

CVD research until the late 1980s sampled predominately men, so the picture of "normal" cardiac symptoms is skewed toward a male diagnostic picture. Women, with a different set of symptoms, are assessed with male symptoms in mind and not for the symptoms more typical of their gender. This leads to under diagnosis and less treatment for women (Berger, Jordan, Lloyd-Jones, & Blumenthal, 2010). MI symptoms that are different from men's symptoms may be one reason women have more unrecognized MIs than men (McSweeney et al., 2003). MIs in women are unrecognized 26% to 54% of the time (Leening et al., 2010). Also, women are more likely to die from their first MI; 38% of women die within one year after the first MI compared to 25% of men (Bello & Mosca, 2004).

Experts assert that compared to men, women have more unrecognized MIs and are more frequently misdiagnosed and discharged from emergency departments (ED) without appropriate treatment. They are less likely to have an electrocardiogram within 10 minutes of hospitalization and less likely to receive a cardiologist's care. This may explain the 20% higher in-hospital complication rate for women after an MI (Banks, 2008; Evangelista & McLaughlin, 2009). Research within the last decade indicated that fewer than one in five physicians knew that women have a greater CVD mortality rate when compared to men and may not assess women for cardiac disease (Mosca et al., 2005). What is clear is that effective treatment exists for female MI patients. However, these treatments are time dependent, and all women, as well as care providers, need to be able to identify MI symptoms and respond appropriately (DeVon, 2011).

Prodromal and MI symptoms

Symptoms typically seen in males experiencing an MI may not be the same symptoms seen in females (McSweeney & Coon, 2004). Unlike men, six months to one year prior to having an MI, women may experience prodromal symptoms (McSweeney, O'Sullivan, Cody, & Crane, 2004). Typical prodromal symptoms include fatigue, anxiety, chest discomfort, indigestion, shortness of breath, and sleeping difficulties (McSweeney, O'Sullivan et al., 2004). Other less common prodromal symptoms are shoulder discomfort, dizziness, headaches that are more severe or more frequent, or vision problems (Evangelista & McLaughlin, 2009; McSweeney et al., 2003; O'Keefe-McCarthy, 2008).

Experts assert that compared to men, women have more unrecognized MIs and are more frequently misdiagnosed and discharged from emergency departments (ED) without appropriate treatment.

Chest pain is the most frequent symptom women experience during an MI. However, chest symptoms in women are more likely to be described as an aching or pressure and less often as crushing substernal pain. In McSweeney and Coon's study (2004), up to 40% of the women stated they had no initial chest pain during an MI and 25% reported no pain or mild pain during the MI event. Women are less likely to have classic angina, and more likely to have angina that continues with rest, pain that awakens them from sleep, and non-specific changes on electrocardiograms (DeCara, 2003; Miller et al., 2001). Besides chest pain, other common MI symptoms include unusual fatigue; pain radiating to the back, jaw, shoulder, or arm; and shortness of breath. Less common symptoms women experience are cold sweats, flushing, nausea, and dizziness (McSweeney et al., 2003).

Women's knowledge

Women's lack of awareness of heart disease risk and knowledge of typical female MI symptoms has been an issue permeating the literature for the past two decades (Fahs & Kalman, 2008). While more women are becoming aware of their risk for heart disease, many continue to harbor misconceptions about their personal cardiac risk and symptoms. Consequently, further research focusing on educational interventions is needed. Women's lack of awareness about gender differences in MI symptoms means they are less likely to recognize their symptoms and less likely to seek treatment if they experience symptoms (Mosca et al., 2010). Timely treatment is important since prompt reperfusion can reduce MI mortality and morbidity rates (Nguyen, Saczynski, Gore, & Goldberg, 2010). From 1997 to 2006, there was an increase in women's knowledge about heart disease but there has not been an increase in knowledge from 2006 until now (Mosca et al., 2010). In fact, almost half of American women do not know that CVD is the leading cause of death for women and that they should contact emergency medical assistance if they have cardiac symptoms (Mosca et al., 2010).

Interventions are needed to teach women about CVD and, specifically, symptoms that are more typical in a female having an MI. All women need to be educated about CVD risks, prodromal symptoms, and female MI symptoms in order to increase early recognition and treatment (Mosca, Benjamin, et al., 2011; Shah, 2010). While knowledge alone is not enough to change behavior (Dracup, et al., 2009), effective education is

the first step to behavior modification and a healthier lifestyle (Mosca et al., 2010; Thanavaro et al., 2010). The latest American Heart Association (AHA) guidelines emphasize the need to educate women about CVD (Mosca, Benjamin, et al., 2011).

The purpose of this study was to increase women's knowledge of female prodromal and MI symptoms using acronyms, and the appropriate response to these symptoms.

Methods

This pilot study used a quasi-experimental, pre-test, post-test design. Institutional Review Board (IRB) approval was obtained from Upstate Medical University (UMU) and Binghamton University (BU). Subjects were recruited through community locations, such as senior centers in upstate New York. Inclusion criteria for this study were women self-identified as postmenopausal who were able to speak and read English. All participants were given a $20 gift card for participating.

Sample

The sample of 51 women was recruited from two community venues in upstate New York (NY), one rural and one urban. Subjects were eligible if their last menstrual period was one or more years ago, they spoke English, and they stated that they were able to read English at a 6th grade level. The mean age was 68 years, range 49 to 89 years old. The majority of the sample was Caucasian (92%). The sample was overwhelmingly suburban/urban (n=44) and well-educated (see Table 1).

Table 1. Demographics

Education	Frequency (%)
High School or General Equivalency Diploma (GED)	8 (15.7%)
Some College or Associate Degree	19 (19.6%)
Baccalaureate Degree	11 (21.6%)
Post Graduate	22 (43.1%)
Primary Residency	**Frequency (%)**
Rural	7 (13.7%)
Suburban	32 (62.7%)
Urban	12 (23.5%)
Race	**Frequency (%)**
African American	2 (3.9%)
Caucasian	46 (92.2%)
Other	1 (2%)
No Answer	1 (2%)

Procedure

Fifty-one postmenopausal women consented to take the pre-test, view the educational program, and take the post-test. The format for the program was modeled after a successful program to increase awareness of strokes among rural populations (Pierce et al., 2011). This format was an hour and a half PowerPoint® presentation developed by the researchers called *Matters of Your Heart*. The program was delivered in the community to groups of women. A script for the researchers to follow provided consistent information to each group. Immediately after the presentation the subjects took the post-test, which was the same as the pre-test. The test took about 30 minutes to complete.

Two acronyms were developed by the authors to help women remember prodromal and MI symptoms. For the prodromal symptoms, the acronym FACTSS was used. The deliberate misspelling of FACTSS was highlighted for the women to help them remember the longer list of warning signs. FACTSS stood for **f**atigue, **a**nxiety, **c**hest discomfort, **t**ummy (indigestion), **s**hortness of breath, and **s**leeping difficulties. For MI symptoms, the acronym CURB was used. CURB represented **c**hest sensation or pain, **u**nusual fatigue, **r**adiating pain to back jaw or arm, and **b**reathing difficulties.

Instrument

Validity

The *Matters of Your Heart* instrument was developed by the authors based on the literature, specifically to measure women's knowledge of CVD risk factors, female prodromal and MI symptoms as well as the appropriate responses should those symptoms occur. A factor analysis was conducted. Eigenvalues of 3 or higher were retained as this was an obvious drop point in the scree plot. Only items with correlations of .60 or greater were retained in the factors. This exploratory factor analysis resulted in a three-factor solution containing 26 items. Factors were labeled a) causes, b) at risk and c) female symptoms and response. Factor one included typical causes of heart disease, such as high blood pressure and/or high cholesterol. Factor two included items regarding risk of heart disease in relation to women such as loss of estrogen and Factor three included women's symptoms of heart disease such as unusual fatigue and the appropriate response to heart attack symptoms, such as calling 9-1-1.

Reliability

A reliability analysis using Cronbach's alpha was conducted to describe how internally consistent the items in the instrument performed. Items from each factor were entered into a model which generated a total Cronbach's alpha coefficient of .877.

Statistical analysis

Quantitative data analysis was completed using PASW 18®. Instrument validity and reliability were calculated. Pre-test, post-test scores with 26 items were compared using a paired sample t-test. A Cohen's d was calculated to identify effect size post hoc. A Cohen's d is a measure of the standardized mean differences and is the preferred

For this study, the authors chose to sample only postmenopausal women, since women generally experience MIs ten years after men.

calculation for measuring effect size with t-tests (Cronk, 2012). Nominal and ordinal level data were used to compare outcomes on demographic variables with independent t-tests and one-way Analysis of Variance (ANOVA).

Results

Forty-one of the 51 women had complete pre- and post-test questionnaires on all items thus their data were used in the factor and statistical analyses. Overall, 36 of the 41 women had a positive change in pre- to post-test scores. Each question was scored as correctly answered equaling 1 point or incorrect with 0 points. Correct scores were summed and based on 100%. The mean pre-test score was 81% and the mean post-test score increased to 91% (n=41), the post-test mean increased to 94% for the 43 women competing all items on the test (see Table 2).

Table 2. Descriptive statistics pre-test and post-test grades *Matters of Your Heart* instrument

	Pre-test	Post-test
N completed	41	43
Mean (SD)	80.98 (6.61)	94.35 (5.23)
Variance	43.73	27.43
Minimum	66.67	66.67
Maximum	92.59	100

A paired sample t-test was used to calculate the difference in mean scores, with each subject serving as her own control. This difference was significant (see Table 3). A post hoc Cohen's d was calculated to indicate the effect size brought about by this educational program. The paired sample t-test mean was -9.93 with a standard deviation of 7.04 producing a Cohen's d value of 1.41; a value of .80 or higher is a large effect size. According to Cohen (1988) with an alpha of .05, d of 1.40, you would need a sample size of as few as 20 subjects to have a power of .99 (p.55). Thus, even though this is a small sample, the difference in knowledge should be easily detectable for this sample of 41 women. To analyze the three factors identified in the instrument, raw subscores were computed. Possible scores for Factor 1, Causes ranged from 15 to 60 points; Factor 2, Risks 4 to 16 points; and Factor 3, Symptoms and Response ranged from 17 to 43 points. Raw scores on all factors increased pre- to post-intervention (see Table 3).

Table 3. Paired t-test results

Questions	T value	DF	P value	Significance
All	-8.44	40	.000	**
MI Symptom Related	-8.438	40	.000	**
(CURB)				
Prodromal Symptom Related	-7.200	40	.000	**
(FACTSS)				
Factor 1 Causes	-2.759	40	.009	**
Factor 2 Risks	-5.791	40	.000	**
Factor 3 Symptoms & Response	-3.353	40	.002	**

*p < .05; **p < .01; DF = Degrees of Freedom

The change in scores related to the two acronyms emphasized in this program was also calculated. On the pre-test, only 34% of the sample correctly identified the symptoms reflected in the CURB acronym, while on the post-test 100% of the sample correctly identified these symptoms. On the pre-test, only 24% could identify the prodromal symptoms in the FACTSS acronym correctly, while 97% correctly identified them on the post-test. Improvements on both acronyms were statistically significant. This analysis indicates that, not only did women's overall knowledge of female heart attacks improve, but their knowledge specific to female symptoms of heart attacks and warning signs were significantly improved using an acronym approach.

Of the 41 women completing the post-test, 10 were 75 years of age or older and 28 were 65 or older (24%). However, there was no significant difference in knowledge scores by age group, primary residence or race (see Table 4).

Discussion

The educational program increased women's knowledge of female prodromal and MI symptoms and the need to call emergency services if cardiac symptoms occur. More specifically, the use of the acronyms was a particularly useful tool for increasing the women's knowledge of female prodromal and acute MI symptoms. These findings support the *Healthy People 2020* goal to increase awareness of adults regarding MI symptoms and the need to call 9-1-1 if these symptoms occur (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2013).

Table 4. Demographics and post-test knowledge of female heart attack

Test	Independent Variable (group size)	Mean Score	Test Value	P value
Independent t-test	Age Group		T = .60	.56
	64 or younger (13)	91.88		
	65 or older (28)	90.58		
ANOVA	Primary Residence		F = 1.56	.22
	Rural (6)	92.96		
	Suburban (25)	89.59		
	Urban (10)	93.31		
Independent t-test	Race		t =.787	.436
	Caucasian (37)	91.25		
	Other (4)	88.57		

Findings from this study are limited by the small sample size, which predominantly included Caucasian, postmenopausal, and well-educated women. In addition, this was a regional program, including women from three counties in a wide geographical area of approximately 300 miles in upstate New York. The homogeneity and limits of location reduces generalization of the findings. Although the authors attempted to reach ethnically diverse and rural populations, these populations were not adequately represented in the sample. In addition, the one group only, pre-test, post-test design is a weakness of this study.

Future research should include an experimental design using an intervention group and a control group, a larger sample size, targeting ethnically diverse and rural women, which will improve the external validity of this program. The authors have increased contacts in both rural and ethnically diverse populations and plan to conduct the next study with a sample that adequately represents these two populations. For this study, the authors chose to sample only postmenopausal women, since women generally experience MIs ten years after men. However, since all women need to know symptoms of MIs and the need to call 9-1-1, if they are experiencing symptoms, future research should include women of all ages. This study measured knowledge immediately after the program. Research, using a longitudinal design, is needed to determine if increased knowledge is sustained over time and, more importantly, if women respond appropriately by contacting emergency medical services if MI symptoms are experienced. Further, research using an experimental design is warranted to answer the question as to whether an acronym approach is more successful than a general educational program.

In conclusion, this study found that using acronyms in an educational program to increase women's knowledge about cardiovascular disease was effective. This is important because almost half of American women are not aware that they are at risk for CVD (Mosca, Benjamin et al., 2011). In addition, they lack knowledge about the symptoms most typical to women who are having an MI. Lack of knowledge of female MI symptoms reduces the likelihood that a woman will seek immediate emergency care in the event of an MI (DeVon, 2011). The overall goal is to reduce morbidity and mortality from CVD in women and this may be achieved by providing education and facilitating behavior change. Education is the first step toward preparing women to seek earlier treatment for prodromal or MI symptoms. Women educated by nurses are of major importance as stated in the new AHA guidelines (Mosca, Benjamin et al., 2011). A research study using an experimental design is being planned to further determine the effectiveness of the use of acronyms to teach women symptoms. If the use of acronyms is found to be effective in a subsequent study, the findings can then be shared with hospitals, community health agencies, and other healthcare organizations. Using the Internet or a mobile device application may be useful in disseminating this information to women. The more aware women are of female prodromal and MI symptoms, the better prepared they will be to be proactive in seeking appropriate care. Although there are several limitations, this is the only study to date that has focused on increasing knowledge of female heart attack symptoms among women who have not experienced a heart attack. Since heart disease is the number one killer of women, this study adds to the body of knowledge for both researchers and clinicians.

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Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing

Dianne Cooney Miner, PhD, RN

As part of the important national dialogue on the nurse of the future, in October 2010 the Institute of Medicine (IOM) released *The Future of Nursing: Leading Change, Advancing Health.* This report joins the ongoing dialogue among key stakeholders in and outside the nursing profession focused on transforming the education of nurses in response to an increasingly complex health care environment. The goals of this transformation are to prepare graduates with the knowledge, skills and attitudes necessary to: a) function as members of interdisciplinary teams, b) provide high quality care across the continuum and c) assume expanded roles as providers of care, designers/managers/coordinators of care and as members of the nursing profession (American Association of Colleges of Nursing [AACN], 2008). Baccalaureate nursing education (BSN) is the recognized vehicle for this transformation and the required foundation for all other graduate nursing education in high needs areas such as advanced practice and nursing education. In recognition of the critical importance of a baccalaureate nursing preparation, the IOM recommends that the nursing workforce should be at least 80% baccalaureate prepared by 2020 (Institute of Medicine of the National Academies [IOM], 2010).

The IOM's efforts to transform nursing education are neither new nor single-handed. This current IOM report follows a 2001 report to Congress from the *National Advisory Council on Nurse Education and Practice* (U.S. Department of Health and Human Services, Health Resources and Services Administration [USDHHS, HRSA], 2001) that recommended innovation in nursing education with a goal of increasing the percentage of the basic nursing workforce with BSN preparation to 66% by 2010; a goal that has not been achieved (USDHHS, HRSA, 2010). In 2003, another IOM landmark report (*Health Professions Education: A Bridge to Quality*) outlined a competency framework for the education of all health professionals focused on interdisciplinary teamwork, patient-centered care, integration of research into practice, development of skills to support quality improvement and utilization of information technology. Using these IOM competencies, the American Association of Colleges of Nursing (AACN) released a report entitled the *Hallmarks of Quality and Patient Safety* (2006) and the Quality and Safety Education for Nurses (QSEN) website (http://www.qsen.org/competencies.php) was created that provides blueprints for innovative curricular content for use in nursing education. These publications

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A BSN graduate possesses the leadership skills and educational background that fosters the creativity and innovation necessary to the reformation and transformation of today's healthcare system.

provide guidelines that prepare a new workforce to assume critical roles in patient safety and to reshape work environments that support quality outcomes. Most recently, in a 2010 study commissioned by *The Carnegie Foundation for the Advancement of Teaching*, Benner and colleagues point out the shortcomings of current nursing education models and suggest innovative teaching and learning strategies to produce competent and safe practitioners. The report challenges the profession to move away from its multiple pathways in nursing education and unify behind adopting the BSN as the entry level or generalist credential required for practice. In the same year that the Carnegie report was released, the Tri-Council for Nursing (AACN, American Nurses Association [ANA], American Organization of Nurse Executives [AONE] and the National League for Nursing [NLN]) called for all registered nurses to advance their education in recognition of the key contributions that a more highly educated nursing workforce can make in promoting high quality patient care (AACN, ANA, AONE, & NLN, 2010).

This call for reform from national leadership in nursing, higher education and health policy is strengthened by numerous studies that demonstrated the relationship between higher levels of nursing education and improved patient outcomes. In a touchstone article by Aiken, Clarke, and Cheung (2003) the researchers report that every 10% increase in the proportion of nurses holding baccalaureate degrees in acute care settings is associated with a 4% decrease in the risk of patient death and failure to rescue. Other studies also linked greater proportions of baccalaureate prepared nurses as part of the hospital workforce to less patient mortality (Estabrooks, Midodzi, & Cummings, 2005; Friese, Lake, & Aiken, 2008; Tourangeau, Doran, & Hall 2007). More recently in a prospective longitudinal study in 21 hospitals over 84 calendar quarters Goode and Blegen (2009) found that patients cared for by BS-prepared nurses experienced significant reduction in length of in-patient stay, a decrease in hospital acquired pressure ulcers and reductions in cardiac mortality. The value of a higher educated nursing workforce also has been shown to impact the ratings of quality demonstrated in the work environment. Weinberg, Cooney–Miner and Perloff (2011, 2012) reported that the percent of BS- prepared nurses on a unit is positively and significantly associated with the quality of the work environment reported by all members of the interdisciplinary team. In addition, the researchers found that measures of quality patient care were significantly and positively associated with the higher quality work environments on units where a higher percentage of baccalaureate-prepared nurses were employed. While research continues to identify the differences in outcomes that a baccalaureate-prepared nursing workforce can achieve, the educational framework for baccalaureate nursing education outlines the practice-focused outcomes and the delineated knowledge and skills that are responsible for these achievements.

The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) provides an educational framework for baccalaureate pre-licensure and RN completion programs to produce educational outcomes that support quality patient care and the advancement of the profession. Nine *Essentials* or curricular elements compose the framework. *Essential I* acknowledges the fundamental importance of building baccalaureate nursing education upon a solid foundation in the liberal arts and sciences. Liberal education provides students with the basis for the development of intellectual and practical abilities instrumental to nursing practice and fosters the development of a personal value system based on ethical and professional standards. Students learn to value diversity and apply principles of social justice, and cultural factors into the care of diverse populations. Graduates with a strong basis in the liberal arts and sciences communicate effectively, and integrate multidisciplinary knowledge and methods of inquiry into their practices. *Essential II* recognizes the need to prepare graduates with leadership knowledge and skills to provide quality patient care, coordinate the work of health care teams and implement systems measures that insure continuous quality improvement. Students learn to apply leadership concepts and skills in their clinical practicum. Based on the analytic abilities and theoretical perspectives that they develop through their liberal education, they integrate ethical and critical decision-making into their experiences in patient care to promote cultures of safety and caring. A BSN graduate possesses the leadership skills and educational background that fosters the creativity and innovation necessary to the reformation and transformation of today's heathcare system.

Essential III identifies that the practices of BSNs must be grounded in the translation of evidence into practice. Nurses today and in the future must continually ask good questions about patient care, work environments and patterns of practice. Practice can no longer be based on tradition or on heuristic processes; it must be based on evidence. Baccalaureate-prepared nurses can form these good questions because of their study of the research process. They can hypothesize quality outcomes and are taught to evaluate and apply credible evidence to answer questions that they raise or the problems that they uncover. With backgrounds in information management and applications in patient care technology (*Essentials IV*), baccalaureate graduates work to support safe nursing practice across the continuum of health care. Computer and information literacy are crucial program outcomes. In laboratory, simulation and clinical practicum experiences baccalaureate students become facile with technologies such as clinical information systems that enhance practice and learn how to participate in the evaluation of new technologies in the future settings where they will practice.

Since nursing practice and health care are continually shaped and governed by health care policy, health care financing and regulation, *Essential V* mandates the inclusion of content on health care policy, finance and regulatory environments in the baccalaureate nursing curriculum. Students examine policy and explore the impact of socio-cultural, economic, legal and political factors on nursing practice and health care delivery. Programs provide students with opportunities to engage in the political process and to lobby for issues of importance to the profession. With this background, the BSN can be expected to not only articulate issues of concern to elected officials but also to work to create and shape policy through grassroots initiatives or as a member of local, state and/or national organizations committed to patient advocacy, professional advancement and health care reform.

High performance patient-centered interdisciplinary work teams depend on high quality interprofessional communication and collaboration. Following the recommendation of *Essential VI*, BSN programs emphasize the importance of high quality and timely communication, inter-professional respect, informatics, evidence and collaborative skills as necessary attributes for high performance work teams. Many baccalaureate nursing programs offer opportunities for interprofessional education where students from different health care disciplines (most requiring doctoral level preparation for entry) participate in learning activities that nurture the development of collegial relationships and work models. Students learn to develop these relationships when their curricula emphasize the shared goals of the interdisciplinary team, the valuing of the unique contribution of each discipline, and the development of communication skills. Interprofessional education models assist students with learning and practicing skills to share information, understand different perspectives and manage conflict. Students learn that all members of the team share accountability for patient care outcomes and quality work environments.

Baccalaureate nursing programs base their curricula on health promotion and disease prevention throughout the lifespan and introduce students to nursing interventions and practices that meet the needs of individuals, families, groups, communities and populations. Programs integrate *Essential VII* into course work where students are taught to assess protective and predictive factors that influence the health of these multiple levels of patients. Public health principles are stressed and ecological models introduced as the basis for determining health. Health and illness are explored as global concerns. Clinical experiences and learning outcomes stress the use of evidence-based practices in health teaching, counseling, outreach, health screenings and disease intervention. Many programs provide students with opportunities to participate in global-health care experiences. Clinical judgment and decision-making skills focus on primary prevention, case finding, resource allocation and disaster preparedness and disaster management. Content on genetics and genomics are now expected content in BSN curricula. For these reasons BSN preparation is recommended by the American Public Health Association (1996), and the Quad Council of Public Health Nursing Organizations (2004) as the minimal education credential for population-focused nursing practice.

Clinical experiences and learning outcomes stress the use of evidence-based practices in health teaching, counseling, outreach, health screenings and disease intervention.

Essential VIII acknowledges that as a profession, nursing exists because of its social mandate to promote the well-being of the society that it serves and that the profession's continued development occurs within a historical, legal and contemporary context that is guided by its enduring core values. These core values of altruism, autonomy, human dignity, integrity and social justice are integrated into all course work, clinical, laboratory and co-curricular experiences. Caring is a central concept and ethics the guiding principle. The importance of professional accountability and responsibility are clear expectations for student conduct. Faculty work to guide, mentor and support students in the development of these professional values and values-based behaviors as they form their professional identities, acknowledge their professional responsibilities, and commit to a professional life that requires life-long learning.

The final curricular element, *Essential IX*, describes the expectations for baccalaureate generalist nursing practice. It outlines the practice-focused outcomes that the BSN achieves through the integration of the knowledge, competencies, skills, attitudes, values and accountabilities outlined in *Essentials I* through *VIII*. This synthesis results from didactic preparation, laboratory and simulation experiences and rich and varied clinical practicum that prepare BSN graduates to assume the professional roles of provider of care, designer/manager/coordinator of care and member of a profession. Patients, families, communities and employers of BSNs can expect that these nurses have acquired core knowledge of the health and illness needs of diverse patients across the lifespan and that they demonstrate clinical judgment and accountability for safe and effective patient care. They have skills that promote a highly effective nurse-patient relationship and have beginning mastery of psychomotor, technical and communication skills necessary for practice. This practice originates from a sound base of core scientific principles that can be implemented across a variety of health care environments.

BSNs conduct comprehensive assessments and implement holistic, patient-centered evidence-based care. They manage acute and chronic physical and psychosocial conditions and integrate knowledge of pathophysiology, pharmacology and pharmacogenetics into their patient care management. They can design, coordinate and manage the care of individuals or the care of large populations. They facilitate

transitions in care through safe discharge planning and patient teaching. With course work in emergency preparedness and disaster management they work to protect the communities they serve. With a beginning understanding of complementary and alternative therapies and end-of-life care they enhance the quality of life for patients and families.

BSNs have the knowledge and competencies necessary to respond to a changing health care environment whether it is changes in the demographics and health needs of the populations or changes within the organization and systems where they practice. They act as advocates, leaders, resource managers and adopters of technology in their work settings. As members of the interdisciplinary team they collaborate with others and coordinate care to produce high quality outcomes and safe work environments. Ethics and caring are central to their professional identities which arise from the core values of altruism, autonomy, human dignity, integrity and social justice. As members of a profession they are accountable for the continual evaluation and development of their practices and assume a personal role in the guidance and development of the profession.

In conclusion, the educational framework for baccalaureate nursing education outlines the practice-focused outcomes and the delineated knowledge and skills that are responsible for quality patient outcomes, safe and selective work environments, and the continued evolution of the profession that have been identified by research and are called for by national leadership. As New York moves closer to transforming its professional nursing workforce by requiring a BS within 10 years from graduation in the interest of promoting quality care and the advancement of the profession it should be clear why the BSN is the required credential for this transformation.

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WHAT'S NEW IN THE HEALTHCARE LITERATURE

Is longer better?

Witoski Stimpfel, A., Sloane, D.M., & Aiken, L.H. (2012). The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs, 31*(11), 2501-2509.

A study by the University of Pennsylvania School of Nursing reported that nurses who worked 10 or more hours per shift were at a 2.5 times greater risk to experience burnout and job dissatisfaction as compared to those nurses who worked shorter shifts. As the proportion of hospital nurses working shifts more than 13 hours increased, the patients' dissatisfaction with care also increased.

Design and data

This study by Amy Witoski Stimpfel and her colleagues investigated the relationship between hospital nurses' shift length and three nurse outcomes: burnout, job satisfaction and intention to leave job. They used data from the Hospital Consumers Assessment of Health Care Providers and Systems Survey, a national standardized hospital-level data set that includes information about patients' assessment of overall care and nursing care in acute care hospitals. A secondary analysis was completed of cross-sectional data from the three outcomes by common hospital identifiers. The sample included 22,275 registered nurses (RNs), in 577 hospitals in California, New Jersey, Pennsylvania and Florida. The selection included only nurses working directly with patients in medical-surgical units and intensive-care units. The sample eliminated nurses in long-term care, outpatient or operative services. Shift length was calculated as the difference between start and end time of the most recent shift that the RN worked.

Results

While most nurses (80%) reported satisfaction with their work schedule, increased shift length was associated with increasing odds of burnout, job dissatisfaction and intention to leave the job. The odds of unfavorable outcomes were highest for nurses who worked shifts greater than 13 hours in length. The data demonstrates that patients were less satisfied with care when nurses worked shifts longer than 13 hours. In these situations, patients reported: (a) they would not recommend the hospital to friends and family and gave the hospitals lower overall ratings; (b) RNs sometimes or never communicated well; (c) pain was sometimes or never well-controlled; and (d) patients sometimes or never received help as soon as they wanted.

Implications

Given changes being implemented in reimbursement by the Centers for Medicare and Medicaid, hospitals will face reductions in reimbursement if they are not meeting national benchmarks on measures of patient care such as patient satisfaction. Attention to factors which affect patient satisfaction such as length of shift will become extremely important to the hospital's fiscal health.

In a 2011 "sentinel event" alert, the Joint Commission has recommended that hospitals take actions to monitor and address health care workers' risk for fatigue caused by extended shifts. Will this recommendation become part of the accreditation standards?

Current literature cites 12-hour shifts as a recruitment strategy. Most nurses are satisfied with their schedule. A possible explanation for the study findings is that nurses underestimate the impact of working long shifts because the idea of working three shifts instead of five sounds appealing.

Suggested actions by nurses to improve both nurse and patient outcomes:

1. Discuss the results of this study at staff meetings.
   Nurses are problem solvers. Brainstorm suggestions to address the staff shortages which may be leading to longer shift lengths. These may include voluntary call lists, per diem pools, etc.

   Identify barriers to the prompt departure of the RN at change of shift.

   Observe, ask staff to identify causes, patterns and trends.

   Is the assignment made by the charge nurse or head nurse from the prior shift? Delays may be occurring while the oncoming shift tries to create the assignment and decide which patients to assign.

   Is there an efficient and complete "hand-off" from the prior shift? Consider communication formats using situation, background, assessment, and recommendation (SBAR).

   Is there a floater list? This will reduce delays.

   Is the charting system cumbersome leading to delays in leaving the unit? Consider a team to evaluate possible changes in charting for more efficiency.

2. Lobby with professional nursing organizations.
   Focus on elimination of mandatory overtime.

   Consider policies limiting the number of consecutive hours worked by nurses. Similar policies are already in place to restrict resident physician duty hours.

Nursing shortages, coupled with a weak economy, have motivated nurses to work past the end of their scheduled shift or to work additional shifts. This study provides new and valuable insights into the relationships between shift length as well as patient and nurse outcomes. Nurses can help develop processes and policies that can contribute to a healthy nursing workforce, prepared to manage the complex care needs of our patients and their families.

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Effect of creative therapy on patients with dementia

Rylatt, P. (2012). The benefits of creative therapy for people with dementia. *Nursing Standard, 26*(33), 42-47.

Self-expression and motivation are compromised when neurological deterioration in the frontal lobe develops. Creative therapies can enable emotional release through communication, self-expression and evoking memories. Although the benefits of creative-based approaches in health care has been recommended, a holistic approach of combining a multitude of creative therapies has not been studied on patients with dementia. The purpose of the study was to examine the effectiveness

of movement, dance, music and drama on communication, pleasure and enjoyment, self-expression, and engagement in patients who have dementia.

All participants were attending inpatient and day-treatment services for Alzheimer's at a National Health Service organization. A sample of 37 patients was divided into two groups. Ethical approval was not required due to the categorization of a service-improvement project, but consent was obtained from patients/family members and anonymity was maintained. Over an 8-week period in 2010, creative therapy sessions were implemented at least three times per week for 30 minutes by professionally trained staff. Data was collected by staff members using an author-constructed tool on a scale of zero, slight, or marked improvement in each of the categories.

A total of 78 instances of attendance occurred on Unit A and 88 on Unit B. The data was collected from two staff members from each unit. Pleasure and enjoyment scored 97% marked improvement on Unit A and 99% on Unit B. Communication had marked improvement of 74% on Unit A and 98% on Unit B. Self-expression had a marked improvement of 60% on Unit A and 16% on Unit B and engagement had a 95% marked improvement on Unit A and 98% on Unit B.

The evaluation of the service-improvement project showed perceptible improvement in pleasure and enjoyment, communication and engagement. With more research, creative therapies have the potential to change the face of dementia care and create a more enjoyable, expressive and engaging life style.

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Study links nurse staffing, burnout and health care-associated infections — a call for action!

Cimiotti, J.P., Aiken, L.H., Sloane, D.M., & Wu, E.S. (2012). Nurse staffing, burnout, and health care-associated infection. *American Journal of Infection Control, 40*(6), 486-490.

When first reading the link to this article, I felt upset and angry. Yet again, nurses were being blamed for negative patient outcomes! In the past I have utilized Linda Aiken's study linking staffing with patient outcomes in order to advocate for improved nursing staffing levels.

As I read the entire study by Dr. Cimiotti and colleagues, as published in the *American Journal of Infection Control,* I recognized opportunities for all of us to take action to improve our workplace.

The study linked nurse survey data to the Pennsylvania Health Care Cost Containment Council report on hospital infections and the American Hospital Association Annual survey. They examined urinary tract infections and surgical site infections. The review of the literature noted that job-related burnout has been linked to suboptimal medical care and patient satisfaction with the key component of burnout being emotional exhaustion (Williams, Manwell, Konrad, & Linzer, 2007). The study examined job-related burnout in registered nurses (RNs) to determine whether it accounts in full or part for the relationship between nurse staffing and patient infections acquired during hospital stays.

Data from a 2006 survey of RNs working in 161 hospitals in Pennsylvania was analyzed. Job-related burnout was assessed with the Maslach Burnout Inventory – Human Services Survey. Emotional exhaustion was used as the key component of the burnout syndrome. The findings confirm an association between nurse staffing and health care-associated infection rates with fewer infections seen in hospitals in which nurses care for fewer patients. The higher rate of infections in hospitals in which nurses care for more patients seems to be related in part to the high nurse burnout associated with heavier patient caseloads. The researchers hypothesize that the cognitive detachment associated with high levels of burnout may result in inadequate hand hygiene practices and lapses in other infection control procedures among RNs. The study found that increasing a nurse's workload by one patient was associated with increases in both urinary tract infections and surgical site infections. Increases in both urinary tract infections and surgical site infections were largely attributed to differences in nurse burnout: every ten percent increase in nurse burnout revealed an increase in rates of infection.

For years we, as nurses, have argued that inadequate staffing harms patients. We now know that the work environment, when lacking teamwork and support from upper management, causes more stress to the RN, leading to burnout. How many of you can relate to stories of colleagues who experienced emotional and cognitive detachment from work as a way to cope with work demands?

RNs must identify and implement strategies to enhance our work environment.

Strategies may include:

Discussing results of this study at a staff meeting with the unit manager and exploring with staff ideas to improve the work environment.

Working with physician colleagues for support with hospital administration to enhance unit staffing.

Learning more about the American Nursing Association's Magnet standards and its positive effects on the work environment (i.e., success of shared governance and quality councils).

Educating all nurses about burnout and strategies to prevent it.

Emphasizing appropriate infection control practices and closely monitoring unit-based infection rates. Utilizing the quality improvement process to ensure compliance and positive patient outcomes.

Participating in your professional nursing organization to educate the consumer about staffing levels and patient outcomes and lobbying for staffing-level legislation.

Registered nurses are in a perfect position to make a difference in our work environment and ultimately improve the quality of care to our patients. Let's respond to the call for action.

REFERENCES:

Williams, E.S., Manwell, L.B., Konrad, T.R., & Linzer, M. (2007). The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal care: results from the MEMO study. *Health Care Manage Rev., 32*(3), 203-12.

Carole McCue, RN, MS, CNE, Nursing Instructor, Cochran School of Nursing, Yonkers, NY

CE Activity: Provision of Culturally Competent Health Care: An Interim Status Review and Report

Thank you for your participation in Provision of Culturally Competent Health Care: An Interim Status Review and Report, a new 1.4-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

INSTRUCTIONS:

In order to receive contact hours for this educational activity, participants are to read the article presented in this issue of the *Journal*, complete and return the post-test, evaluation form, and earn 80% or better on the post-test.

This activity is free to NYSNA members and $10 for non-members. Participants can pay by check (made out to NYSNA & please include CE code 11WHD8 on your check) or credit card. The completed answer sheet and evaluation form may be mailed or faxed back to NYSNA; see the answer sheet for more information.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

GOAL:

To examine the current status of the nursing professions' initiative to integrate multicultural, diversity training into its educational programs and on the degree to which nurses' report on their preparedness to provide exemplary, culturally competent care following their educational training.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Define culture, cultural competence, culture care, culturally competent care, and cultural diversity.
2. Identify one theory and one conceptual model of cultural care.
3. Discuss nurses' currently reported levels of cultural competence as measured by tools that assess and measure cultural competence.

Please answer the questions below. Remember to complete the answer sheet by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer.

The 1.4 contact hours for this program will be offered until July 12, 2016.

1. The Expert Panel on Cultural Competence is charged with ensuring that measurable outcomes be achieved that reduce or eliminate health disparities found in all of the following populations, except:
   a) The uninsured.
   b) The underserved.
   c) The underrepresented.
   d) The racial minority living abroad.

2. The Office of Minority Health has required health care providers to offer health care services that are respectful of and responsive to all of the following, except:
   a) Health beliefs of diverse patients.
   b) Cultural practices of diverse patients.
   c) Musical practices of diverse patients.
   d) Spiritual needs of diverse patients.
   e) Linguistic needs of diverse patients.

3. Differences in definitions and foci have led to delayed advancements toward the provision of exemplary culturally competent nursing care in the United States.
   a) True
   b) False

CE Activity: Provision of Culturally Competent Health Care: An Interim Status Review and Report, continued

4. The definition of "culture" includes all of the following except:
   a) Morals
   b) Biological inheritance
   c) Custom
   d) Beliefs

5. The definition of "culture care" includes all of the following, except:
   a) Those assistive, supportive, enabling, and facilitative culturally-based ways to help people in a compassionate, respectful, and appropriate way to improve a human condition.
   b) The concept of care as a regimen.
   c) The concept of care as protection.
   d) The concept of care as respect.

6. The definition of "cultural diversity" includes all of the following, except:
   a) It is a concept that serves communities with little variations in socioeconomics or race.
   b) It is a construct that is variable in quantity and quality, across place and time.
   c) It is a concept that goes beyond the constructs of ethnicity and race.
   d) It is a concept that includes class, gender, sexual orientation, and physical abilities/disabilities.

7. Madeline Leininger's *Theory of Culture Care Diversity and Universality* is unique in that:
   a) It is the only nursing theory focused explicitly on "culture care" as the dominant theme of nursing inquiry.
   b) It is a holistic, culturally-based care theory that incorporates broad humanistic dimensions about people in their cultural life context.
   c) It incorporates social structure factors, such as religion, politics, economics, cultural history, and philosophy of living.
   d) All of the above.

8. All of the following are true about Madeline Leininger's *Theory of Culture Care Diversity and Universality* except:
   a) It requires nurses to discover dominant care constructs and perform in-depth studies of cultures to identify the close relationship of care to culture.
   b) It is a theory that reinforces the medical and nursing ideology of focusing on diseases, symptoms, and pathological conditions.
   c) It is a theory that incorporates "caring" as its dominant focus.
   d) It is a theory that focuses on "emic" and "etic" care knowledge.

9. Fawcett, Newman and McAllister have added all of the following dimensions to Leininger's *Theory of Culture Care Diversity and Universality* for theory application in advance practice nursing, except:
   a) The theory should foster a focus on the illness.
   b) The theory should consider the patient's significant other's perception of the situation.
   c) The theory should facilitate autonomous nursing practice.
   d) The theory should encourage diverse ways of sociopolitical knowing.

10. Which of the following statements is not true of Campinha-Bacote's conceptual model of cultural competency:
   a) Cultural awareness involves a self-examination and self-assessment of one's own culture and its potential influence on one's way of thinking and behavior.
   b) Cultural knowledge involves obtaining information about the worldviews of different cultural groups, including how its members interpret illnesses.
   c) Cultural skill involves the ability to perform a physical examination that is measured by the prevailing standards of practice.
   d) Cultural encounters involve the process of engaging in direct encounters with patients from diverse cultural backgrounds in order to increase verbal and non-verbal communication skills.

11. The *Cultural Diversity Questionnaire for Nurse Educators* measures all of the following, except:
   a) Cultural awareness
   b) Cultural skills
   c) Cultural desire
   d) Cultural assessments

CE Activity: Provision of Culturally Competent Health Care: An Interim Status Review and Report, continued

12. *The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals* measures all of the following except:
    a) Cultural awareness
    b) Cultural skills
    c) Cultural desire
    d) Cultural encounters

13. *The Openness to Diversity and Challenge Scale* is most appropriate for use with:
    a) Nursing educators
    b) Minority nurses
    c) Practicing nurses
    d) Student nurses

14. Nursing practitioners report limitations related to their ability to maintain sustainable changes in practices following culturally specific curricula enhancements.
    a) True
    b) False

15. Transcultural nursing goes beyond the constructs of race and ethnicity and includes such subcultures as:
    a) Gay/Lesbian/Bisexual/Transgendered
    b) Blind/Deaf
    c) Mentally challenged
    d) All of the above

Answer Sheet

Please print legibly and verify that all information is correct.

First Name: _____ MI:_____ Last Name: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Daytime Phone Number (include area code): (_____)_____ E-mail:_____

Profession:_____ Currently Licensed in NY State? Yes / No (circle one)

NYSNA Member # (if applicable):_____ License #:_____License State:_____

ACTIVITY FEE: FREE for NYSNA members/$10 non-members

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Card Number: _____ Expiration Date: _____/_____/_____ CVV#_____

Name:_____ Signature: _____

Date:_____/_____/_____

The contact hours for this CE activity will be offered until July 12, 2016

Please print your answers in the spaces provided below. **There is only one answer for each question.**

Provision of Culturally Competent Health Care: An Interim Status Review and Report

1. _____	6. _____	11._____
2. _____	7. _____	12._____
3. _____	8. _____	13._____
4. _____	9. _____	14._____
5. _____	10. _____	15._____

Please complete the answer sheet above and course evaluation form on reverse.
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Mail to:
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11 Cornell Rd.
Latham, NY 12110

Or fax to:
(518) 782-9533

Course Evaluation

Provision of Culturally Competent Health Care: An Interim Status Review and Report

	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	❑	❑	❑	❑	❑
2. The content fulfills each of the course objectives.	❑	❑	❑	❑	❑
3. The course subject matter is current and accurate.	❑	❑	❑	❑	❑
4. The material presented is clear and understandable.	❑	❑	❑	❑	❑
5. The teaching/learning method is effective.	❑	❑	❑	❑	❑
6. The test is clear and the answers are appropriately covered in the course.	❑	❑	❑	❑	❑
7. How would you rate this course overall?	❑	❑	❑	❑	❑

8. Time to complete the entire course and the test? _____ Hours (enter 0-99) _____ Minutes (enter 0-59)

9. Was this course fair, balanced, and free of commercial bias? Yes / No (circle one)

10. Comments: _____

_____

11. Do you have any suggestions about how we can improve this course?

_____

CE Activity: Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms

Thank you for your participation in Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms, a new 1.0-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

INSTRUCTIONS:

In order to receive contact hours for this educational activity, participants are to read the article presented in this issue of the Journal, complete and return the post-test, evaluation form, and earn 80% or better on the post-test.

This activity is free to NYSNA members and $10 for non-members. Participants can pay by check (made out to NYSNA & please include CE code W06TNG on your check) or credit card. The completed answer sheet and evaluation form may be mailed or faxed back to NYSNA; see the answer sheet for more information.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

GOAL:

To increase education about women's knowledge of myocardial infarctions (MI) and heart disease.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Identify the importance of MI education in women.
2. Describe the research method and procedure.
3. Name the two acronyms and what they stand for.

Please answer the questions below. Remember to complete the answer sheet by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer.

The 1.0 contact hour for this program will be offered until July 12, 2016.

1. The *Matters of Your Heart* instrument was considered valid in this study with validity determined by:
   a) A factor analysis.
   b) A review by other researchers.
   c) Cronbach's alpha.
   d) Descriptive.

2. Cronbach's alpha was conducted to:
   a) Describe the validity of the instrument.
   b) Protect the rights of human subjects.
   c) Model the best acronym to use in teaching women about female heart attack symptoms.
   d) Describe how internally consistent the items in the instrument performed.

3. A Cohen's d is calculated to:
   a) Identify the effect size between pre- and post-test scores on the *Matters of Your Heart* instrument.
   b) Show the best acronym to use in teaching women about female heart attack symptoms.
   c) Show the least effective acronym to use in teaching women about female heart attack symptoms.
   d) Identify the effect size of difference between scores of the experimental and control groups.

CE Activity: Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms, continued

4. A large effect size in this study means:
   a) All women should be educated on female heart attack symptoms.
   b) All men should be educated on female heart attack symptoms.
   c) Even though there was a small sample, the differences in knowledge after the education should be detectable.
   d) The sample was too small to be able to measure large differences in knowledge after the educational program.

5. In this study, each subject:
   a) Attended two presentations.
   b) Served as own control.
   c) Served as control for a group of men who were educated on female heart attack symptoms.
   d) Was under the age of 18.

6. Limitations of this study included:
   a) An experimental design.
   b) Too large an effect size.
   c) Only women who had not had heart attacks in the sample.
   d) A small and homogenous sample.

7. What are the typical prodromal MI symptoms in women?
   a) Crushing chest pain, radiating pain, fatigue, and anxiety.
   b) Crushing chest pain, radiating pain, light headed, and anxiety.
   c) Fatigue, anxiety, chest discomfort, shortness of breath, and sleeping difficulties.
   d) Indigestion, fatigue, crushing chest pain and light headed.

8. What are the typical acute MI symptoms in women?
   a) Chest pain, unusual fatigue, radiating pain, and breathing difficulties.
   b) Crushing chest pain, radiating pain, and anxiety.
   c) Fatigue, anxiety, and sleeping difficulties.
   d) Indigestion, fatigue, crushing chest pain and light headed.

9. The subjects' knowledge of MI symptoms in women answers improved from pre-to post-test.
   a) True.
   b) False.

10. Why is it important to educate women about heart disease?
    a) Women are usually the care givers.
    b) Women know less about heart disease than men.
    c) So women will know to call their healthcare providers if they have symptoms of an MI.
    d) Heart disease is the number one cause of mortality in women.

Answer Sheet

Please print legibly and verify that all information is correct.

First Name: _____ MI:_____ Last Name: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Daytime Phone Number (include area code): (_____)_____ E-mail:_____

Profession:_____ Currently Licensed in NY State? Yes / No (circle one)

NYSNA Member # (if applicable):_____ License #:_____License State:_____

ACTIVITY FEE: FREE for NYSNA members/$10 non-members

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Card Number: _____ Expiration Date: _____/_____/_____ CVV#_____

Name:_____ Signature: _____

Date:_____/_____/_____

The contact hours for this CE activity will be offered until July 12, 2016

Please print your answers in the spaces provided below. **There is only one answer for each question.**

Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please complete the answer sheet above and course evaluation form on reverse.
Submit both the answer sheet and course evaluation form along with the activity fee for processing.

Mail to:
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11 Cornell Rd.
Latham, NY 12110

Or fax to:
(518) 782-9533

Course Evaluation

Education to Increase Women's Knowledge of Female Myocardial Infarction Symptoms

	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	❑	❑	❑	❑	❑
2. The content fulfills each of the course objectives.	❑	❑	❑	❑	❑
3. The course subject matter is current and accurate.	❑	❑	❑	❑	❑
4. The material presented is clear and understandable.	❑	❑	❑	❑	❑
5. The teaching/learning method is effective.	❑	❑	❑	❑	❑
6. The test is clear and the answers are appropriately covered in the course.	❑	❑	❑	❑	❑
7. How would you rate this course overall?	❑	❑	❑	❑	❑

8. Time to complete the entire course and the test? _____ Hours (enter 0-99) _____ Minutes (enter 0-59)

9. Was this course fair, balanced, and free of commercial bias? Yes / No (circle one)

10. Comments: _____

_____

11. Do you have any suggestions about how we can improve this course?

_____

CE Activity: Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing

Thank you for your participation in Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing, a new 1.0-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

INSTRUCTIONS:

In order to receive contact hours for this educational activity, participants are to read the article presented in this issue of the Journal, complete and return the post-test, evaluation form, and earn 80% or better on the post-test.

This activity is free to NYSNA members and $10 for non-members. Participants can pay by check (made out to NYSNA & please include CE code UA6QKD on your check) or credit card. The completed answer sheet and evaluation form may be mailed or faxed back to NYSNA; see the answer sheet for more information.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

GOAL:

To acquaint readers with the role that baccalaureate nursing education plays in the transformation of the nursing workforce called for by landmark documents and critical research. The article outlines the essential elements of baccalaureate nursing education developed by the American Association of Colleges of Nursing that develop new expanded roles and enhanced practice focused outcomes for the nurse of the future.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Discuss the landmark documents and critical research calling for the transformation of the nursing workforce.

2. Discuss the nine curricular elements essential to baccalaureate nursing education outlined by the American Association of Colleges of Nursing (AACN).

3. Discuss the roles of the nurse of the future as outlined by landmark documents and key stakeholders.

Please answer the questions below. Remember to complete the answer sheet by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer.

The 1.0 contact hour for this program will be offered until July 12, 2016.

1. The roles of the nurse of the future outlined in the 2011 *Institute of Medicine (IOM) Future of Nursing* report include:
   a) An expanded role in global maternal child health.
   b) An expanded role as provider, manager and designer of care.
   c) An enhanced role that allows practice across state and national boundaries.

2. The *IOM Future of Nursing Report* recommends that by 2020:
   a) Entry into RN practice should be at the baccalaureate level.
   b) Associate degree granting programs should prepare LPN's at a new level of competence.
   c) Eighty percent of the RN workforce should be baccalaureate prepared.

CE Activity: Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing

3. The call for reform in nursing education is in response to studies that demonstrate:
   a) An increase of 10% in unit staffing leads to better patient outcomes.
   b) Higher numbers of baccalaureate-prepared nurses at the unit level are associated with higher satisfaction with the work environment reported by the interdisciplinary team.
   c) An increase in failure to rescue events.

4. The *Essentials of Baccalaureate Education for Professional Nursing Practice* developed by the American Association of Colleges of Nursing:
   a) Lists recommended competencies for all entry level RN graduates.
   b) Compares and contrasts 2-, 3-, and 4-year RN preparation.
   c) Provides an educational framework for 4-year pre-licensure and degree-completion programs.

5. Course work in the liberal arts and sciences that are part of a baccalaureate nursing program:
   a) Provide students with the science course work needed to complete a Bachelor of Science degree.
   b) Substitute for the clinical practice hours provided by associate degree and diploma nursing programs.
   c) Provide the basis for the multidisciplinary perspective that BS-prepared nurses integrate into practice.

6. *Essential III* directs the evolution of nursing practice based on:
   a) The use of rigorous data to drive decision making.
   b) Assisting students to develop heuristic models of excellence.
   c) Honoring the traditions of the past.

7. Students need to be introduced to the political process and lobbying because:
   a) As a licensed profession, nursing practice is shaped by governmental policy and regulation.
   b) It is a requirement for membership in professional nursing organizations.
   c) Knowledge on current health policy and lobbying skills are identified as required competencies by the National Council of State Boards for Nursing and other professional accrediting bodies.

8. Models of interdisciplinary education allow students to:
   a) Compare their curricula and practicum experiences.
   b) Learn and practice established hierarchical roles in traditional health care settings.
   c) Develop a beginning understanding of shared accountabilities.

9. *Essential VII* acknowledges that all professions exist:
   a) To protect and advocate for their membership.
   b) To respond to a social mandate to promote societal well-being.
   c) To foster the professional development of their members.

10. As the profession of nursing moves forward in the transformation of its education models, the *Essentials of Baccalaureate Education for Professional Nursing Practice* document:
    a) Makes a convincing argument that an associate- or diploma-prepared graduate can choose any degree completion program grounded in the liberal arts and sciences to gain the enhanced knowledge and skills required for advancement of the profession.
    b) Identifies that the synthesis of knowledge, competencies and attitudes outlined in the identified curricular elements best prepare graduates to assume professional roles.
    c) Predicts that graduate level preparation in advanced practice will become the preferred credential for licensure and practice in the future.

Answer Sheet

Please print legibly and verify that all information is correct.

First Name: _____ MI:_____ Last Name: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Daytime Phone Number (include area code): (_____)_____ E-mail:_____

Profession:_____ Currently Licensed in NY State? Yes / No (circle one)

NYSNA Member # (if applicable):_____ License #:_____License State:_____

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Name:_____ Signature: _____

Date:_____/_____/_____

The contact hours for this CE activity will be offered until July 12, 2016

Please print your answers in the spaces provided below. **There is only one answer for each question.**

Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing

1. _____ 6. _____
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Course Evaluation

Transforming the Nursing Workforce in New York: The Value of Baccalaureate Preparation in Nursing

	Poor	Fair	Good	Very Good	Excellent
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2. The content fulfills each of the course objectives.	❑	❑	❑	❑	❑
3. The course subject matter is current and accurate.	❑	❑	❑	❑	❑
4. The material presented is clear and understandable.	❑	❑	❑	❑	❑
5. The teaching/learning method is effective.	❑	❑	❑	❑	❑
6. The test is clear and the answers are appropriately covered in the course.	❑	❑	❑	❑	❑
7. How would you rate this course overall?	❑	❑	❑	❑	❑

8. Time to complete the entire course and the test? _____ Hours (enter 0-99) _____ Minutes (enter 0-59)

9. Was this course fair, balanced, and free of commercial bias? Yes / No (circle one)

10. Comments: _____

_____

11. Do you have any suggestions about how we can improve this course?

_____

New York State NURSES ASSOCIATION

11 Cornell Road, Latham, NY 12110