

## A Multifocal Education Strategy to Enhance Hospital-Based Cultural Competency in Professional Staff

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The Oncology Nursing Society (ONS) believes that cultural competence is a critical factor in providing quality cancer care to an increasingly diverse patient population (ONS, 1999). Nurses and their interdisciplinary colleagues should be educated comprehensively to foster sensitivity and responsiveness to issues of diversity.

ONS (1999) issued guidelines and identified four components of educational interventions designed to enhance cultural competence: promoting cultural self-awareness, disseminating cultural knowledge, developing cultural skill building, and facilitating cultural encounters. This article describes one institution's efforts to enhance the cultural competency of its staff by using multiple interventions over seven years. Although the effort ultimately resulted in a systemwide institutional initiative, the impetus for this novel offering originated from innovations within the institution's cancer program.

### Oncology Unit Identifies Concern

In 1995, the Cancer Center at Inova Fairfax Hospital in Falls Church, VA, undertook a quality-improvement project to identify how well the staff in the inpatient oncology unit was rendering care to dying patients and their families. Families who attended the center's "Good Grief" support group were asked to complete a survey assessing their perceptions of helpful care by the cancer team and unmet needs during their loved ones' dying experiences. To comprehensively evaluate the quality of care, staff members in the oncology unit also were surveyed about their impressions of deficits in the provision of terminal care in the hospital setting. Nurses were asked to identify clinical situations that they deemed difficult for themselves and their peers. A consistent theme evolved in the responses to the qualitative survey: Nurses said that one of the most challenging scenarios was when a dying patient and his or her family were immigrants to the United States and had limited English proficiency. Lack of knowledge about family norms based on ethnicity prompted the nursing staff to question their ability to provide optimum terminal nursing care.

As a result of the finding, a unit-based task force was developed to serve as the genesis for ongoing, innovative education planning for the oncology staff. As awareness of the program's successes grew, other specialty departments requested assistance with education on similar topics. For example, the intensive care unit requested help with educating its staff about cultural aspects of end-of-life care. The gynecology clinic asked for help with understanding culturally derived reticence to undergo biopsy for cervical cancer. The oncology unit's task force ultimately evolved into the core group for an institutional initiative supporting global education of professional staff about issues of diversity.

### Educational Interventions

Nursing staff who had acknowledged interest in transcultural nursing care or were of diverse ethnic backgrounds comprised the initial task force, which was chaired by an oncology clinical nurse specialist. Oncology social workers, representatives from chaplaincy, and the ethics consultation team also were active members of the initial task force.

The task force undertook a series of projects during its first year, starting with identifying the type and scope of diversity within the cancer center's population to determine what were the prominent subgroups by ethnicity and how they compared with the Caucasian majority. In collaboration with the cancer registry, the task force identified new cancer cases by ethnic group; that information was posted on the unit's education bulletin board. Summation of new cancer cases from 1992–1995 revealed that almost 12% of the patient base was of an ethnic minority; African Americans represented the largest number, followed by Hispanic, Korean, Vietnamese, Filipino, East Indian, and Chinese patients. The team further investigated the diversity of the geographic region in comparison to national statistics. Relevant data were disseminated whenever possible to share information about the center's unique diversity profile.

Acknowledgment of ethnic subgroups that the cancer center served helped the task force to focus efforts on increasing educational cultural awareness programs and on planning outreach efforts to the northern Virginia community. For example, the oncology nursing staff began to participate yearly in an African American health fair by developing materials and staffing an educational booth on cancer in African Americans. The oncology clinical nurse specialist also worked with local African American churches to coordinate lectures to several congregations on the critical problem of prostate cancer in their community. An application was submitted for external funding to promote awareness about breast cancer in older women with a specific focus on reaching groups of elderly women in ethnic minorities. In collaboration with community agencies, two offerings were made to elderly groups of Korean and Hispanic women. Educational materials were translated specifically for those audiences, and cancer center staff of Hispanic and Korean ethnicity taught programs.

Efforts to sensitize and educate cancer center staff were ongoing. A survey of the nursing staff's educational needs related to cultural aspects resulted in the identification of

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three prominent themes. The staff desired additional information about

- Perspectives on information disclosure and truth telling
- The family's role in hospital care
- Death rituals and practices.

A brown bag "Lunch 'n Learn" series for the inpatient oncology unit, outpatient infusion clinic, and radiation therapy staff was conducted. Task force members presented cultural overviews, including information about communication styles, family relationships, expectations from healthcare staff, reactions to symptom distress, and death rituals specific to prominent cultures within the patient population. Interdisciplinary colleagues from minority cultures were invited to attend the lunches and form a response panel to the information provided. Nurses, physicians, pharmacists, physical and respiratory therapists, chaplains, and social workers willingly participated in the series. During the series, the task force provided food specific to the cultures being discussed.

For a game titled "Cultural Jeopardy," staff members formed teams to compete on knowledge of cultural topics. Resource manuals on culture-based nursing care (Geissler, 1994; Lipson, Dibble, & Minarik, 1996) were purchased and placed in clinical areas for reference. However, the staff was cautioned against expecting "cookie-cutter" behaviors after reading the manuals about cultural norms. After the intensive and highly focused schedule of educational events, quarterly "Culture Grand Rounds" were planned, and all cancer center staff members were invited to the ongoing events.

As mentioned previously, other services and units became aware of the success of the educational interventions. Task force members were invited more often to speak to other clinical areas, the institutional ethics committee, and other hospitals in the community and to make daily house staff rounds. Clearly, education and an innovative forum to disseminate information in a more timely and systematic manner to clinical staff was in demand. Subsequently, a hospitalwide culture task force was formed. A needs survey was distributed to all nursing units to assist with planning of future efforts.

### Diversity Education Web Site

The hospital and its sister organizations had an expanding, internal, Web-based communication network (i.e., the Inova Health System Intranet) that was identified as a potential vehicle to provide clinical staff with a resource base about culture. The information provided had to be timely, comprehensive, and practical; however, the volunteer efforts of the task force were not sufficient to develop such a program. A proposal asked the hospital system's foundation to support the creation of an internal, Web-based resource on culture for the staff. The foundation provided \$4,000, which covered the costs of a research assistant

to develop and write templates for the 17 cultures described on the Web site. Task force members researched and wrote other elements of the Web site.

The ultimate result of the initiative was the creation of an internal Web site called Culture and Religious Education (CARE). Information specialists assisted with the development and production of the novel program and were critical to its successful launch in February 2000. To date, Inova Health System staff members have visited the CARE Web site more than 4,000 times. It receives about 10 requests for information daily. The site consists of eight major components.

- An introduction to the program describes what users will find when accessing the Web site. It offers special emphasis for nurse users and lists key American Nurses Association position statements about the importance of cultural diversity education and expertise.
- A section designed to promote introspection by users, titled "Health Care Provider—Know Thyself," is provided so that users can understand the universal concept of culture. This section also outlines queries promoting self-assessment.
- A cultural snapshot of Virginia reinforces the importance of diversity understanding relative to the geographic uniqueness of northern Virginia. Key demographics are described.
- Culture and religion templates help users gain increased understanding of patients' beliefs, attitudes, and behaviors; 17 cultures and 14 religions are described (see Figure 1).
- The site provides a monthly calendar of cultural and religious days.
- "Key Questions to Ask" are outlined to help healthcare professionals understand how people's cultures and faiths may affect their hospital or illness experiences (see Figure 2).
- A section titled "Individual Considerations in Cultural Assessment" establishes important criteria to undertake a personalized inventory, which may influence responses to health crises (see Figure 2).
- Resources include a list of translator services; advance directives brochures translated into Spanish, Farsi, Korean, and Vietnamese; a list of information resources in the health sciences library; and key translation phrases in Spanish, Farsi, Korean, and Vietnamese.

Specific translated phrases were identified based on a survey of priority questions and communication needs of nurses representing intensive care, medical, surgical, maternal, and pediatric settings. The phrases were formatted so that a "yes" or "no" answer or a simple nod of the head is all that is required of patients. A phrase in English followed by the translation allows users to locate a query in English and then identify the adjacent translation. Categories of phrases include

### Cultures Described (n = 17)

Arab, Cambodian, Chinese, Colombian, Dominican Republic, East Indian, Ethiopian and Eritrean, Filipino, Guatemalan, Iranian, Korean, Laotian, Nicaraguan, Nigerian, Pakistani, Salvadoran, Vietnamese

### Culture Subheadings

- Background information (e.g., country of origin, typical prominent religion(s))
- Communication (e.g., body language, eye contact, use of interpreters, prominent language(s), social amenities, tone of voice, touch)
- Healthcare issues (e.g., abortion, bathing and hygiene, birth control, birthing, decision making, disease risk, family roles, food practices, health and illness beliefs, medical procedures, medicine and drugs, mental health issues, modesty and privacy, pain management, traditional healing)
- End-of-life issues (e.g., dying and death, death rituals, organ donation, autopsy, burial)
- References

### Religions Described (n = 14)

Baha'i, Buddhism, Catholicism, Christian Scientist, Greek Orthodox, Hinduism, Islam, Jehovah's Witness, Judaism, Mormon, Protestantism, Quaker, Seventh Day Adventist, Sikh

### Religion Subheadings

- Basic beliefs (i.e., core elements of the spiritual belief system)
- Attitudes toward medical interventions and personnel (e.g., beliefs about illness, medical procedures and medications, drugs, blood and vaccines, loss of limb, transplants, symptoms and pain management, birth control, abortion, birthing and maternal care)
- End-of-life issues (e.g., termination of life, death rituals, autopsy, burial practices, afterlife)
- Religious lifestyle (e.g., dietary and modesty requirements, rituals and worship, sacraments, religious organization)
- References

### Figure 1. Culture and Religion Templates

- General introduction: Good morning. You are in the hospital. This is the bell to call the nurse. I am going to listen to your heart.
- Patient history: Do you have any allergies? Is your stomach upset? Are you thirsty? Are you cold?
- Symptom assessment: Are you in pain? Did you see any blood? Have you vomited? Are you dizzy?
- Functional status: Do you use a hearing aid? Did you fall at home? Is there someone to help you at home?

- Event anticipation: I need to take your temperature. I need to start an intravenous line in your arm. I am going to clean your breathing tube. Your doctor is coming soon. You are going for a special test.
- Instructions: Please stand up slowly. Squeeze my hands if you can hear me. Do not pull at your tube. Please do not get up without the nurse; we are worried you may fall.
- Medical, surgical, and intensive care: Wiggle your toes. You are in the recovery area after your surgery. We are going to put a bandage on.
- Maternal and child health: Did the baby wet? Has the baby been eating well?
- Medication: When did you last take your medication? Here is the medicine to help you breathe better. Take this medicine after you eat.

## Recommendations and Conclusion

Cultural awareness and synthesis of learning are ongoing requirements for the delivery of optimum patient-centered care. Diversity education should not be an isolated event but rather a continual process that supports enhancement of quality care. Successful endeavors to improve organizational cultural competence must be interdisciplinary and practical in nature. The following recommendations will help influence and sustain innovation in this area.

First, identify potential champions and drivers of the initiative. Enlisting the support, enthusiasm, and innovation of committed colleagues is imperative to success. An interdisciplinary planning group is critical; this group can be made up of colleagues who have firsthand knowledge of the importance of cultural competency or who have professional experience in integrating awareness and skill in healthcare settings. Professionals that the authors have found to be instrumental in planning cultural sensitivity endeavors in hospital settings include nurses, social workers, chaplains, librarians, patient advocates, educators, information and quality-improvement specialists, and dietitians from a variety of specialties and settings. Second, gather information about the cultural mosaic specific to the institution's setting (i.e., What are the cultural demographics?). Dissemination of such information captures colleagues' attention. Third, provide practical information that will help health professionals in their daily provision of culturally sensitive care. Surveying the needs of staff will facilitate prioritization of interventions (Peterson, Whitman, & Smith, 1997). For example, the task force's work with the Patient Relations Department in translating advance directives brochures was a highly successful intervention that had immediate, hands-on implications. Fourth, whenever implementing a new program, use numerous reminder cues because new behavior needs reinforcing over time. When

## Key Questions to Ask

- In what country were you born?
- How long have you been in the United States?
- Do you practice a specific religion?
- Have you or your family member been ill or hospitalized in the past? What was your experience? How did this differ from what you expected?
- What do you fear most about being sick?
- How bad do you think your illness is?
- What can I do to make you more comfortable?
- Who makes the decisions in your family? Do we need to speak to him or her first?
- What do you want your family to know?
- What do we need to know about you or your family member who is sick?
- What important customs should we know about?
- What is worrying you the most right now?

## Individual Considerations in Cultural Assessment

- What generation does a patient identify with?
  - Has he or she been in the United States months, years, or decades?
  - Who are his or her peers, and what are the generation's common characteristics?
- What is the predominant language of the patient?
  - How much does he or she rely on the native language versus that of the host country (e.g., English)?
  - Does he or she understand only key words or have full comprehension of the English language?
- What is the patient's normal social network?
  - Is his or her social network mixed with English-speaking friends and colleagues or is it reserved to those of the native country of origin?
  - How much has the patient and family attempted to acculturate themselves to American society?
- What is the patient's educational background?
  - What might you expect based on the individual's experience with a formal educational system?
  - Is literacy an issue to consider?
- What is the patient's economic status?
  - Is the patient's and family's financial situation compromised?
  - If yes, how will this affect the response to the healthcare issue of concern?
- Does the patient have an urban or rural origin in his or her native country?
  - Are the patient and family accustomed to using formal hospital-based care in time of need?

## Figure 2. Strategies to Individualize Culturally Sensitive Nursing Assessment

the CARE Web site first became available, the task force realized that reminders were critical to encourage its use. A sticker was affixed to all computer screens in patient-care areas to remind staff of the new resource. Finally, the timely provision of literature and new information helps to raise and maintain awareness of the importance of culturally competent health care. This information can be outlined in updated reference lists, copies can be made available to staff in clinical areas, or the information can serve as the basis for journal club discussions. The authors have provided a current listing of recent publications (see inset).

Meleis (1996) wrote that providing culturally competent care no longer is a luxury, but a necessity. Attempts to offer staff accurate, timely, and practical information about transcultural care facilitates nursing excellence within the realm of highly customized, patient-centered interventions. Some aspect

of cultural sensitivity *must* be integrated into all healthcare settings as the global heterogeneity of patients is appreciated and acknowledged.

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