ARE ASSOCIATE DEGREE NURSING GRADUATES ADEQUATELY PREPARED TO MEET THE CULTURAL NEEDS OF THEIR PATIENTS AT THE END OF LIFE?

By

REBECCA LYNNE ELLIS

A thesis submitted in partial fulfillment of the
requirements for the degree of

MASTER OF NURSING

WASHINGTON STATE UNIVERSITY
Intercollegiate College of Nursing
May 2006

To the faculty of Washington State University

The members of the Committee appointed to examine the thesis of REBECCA LYNNE ELLIS find it satisfactory and recommend that it be accepted.

_____
Chair

_____

_____

ACKNOWLEDGEMENT

I would like to thank Dr. Renee Hoeksel the Chair of my research committee and committee members, Dr. Dawn Doutrich and Dr. Judy Meyers who have guided and assisted me in every phase of my research. I also would like to thank all the faculty of the Intercollegiate College of Nursing at Washington State University who have shared their knowledge and expertise during this wonderful and exciting educational journey.

ARE ASSOCIATE DEGREE NURSING GRADUATES ADEQUATELY PREPARED TO MEET THE CULTURAL NEEDS OF THEIR PATIENTS AT THE END OF LIFE?

Abstract

By Rebecca Lynne Ellis MNURS
Washington State University
May 2006

Chair: Renee Hoeksel

With America's rapidly aging and increasingly diverse population, culturally sensitive end-of-life care is becoming an important part of general nursing care. In order to provide the dying and their family members with a peaceful death, the nurse must recognize and honor differences in how diverse cultures view death, including rituals practiced and how communication about sensitive topics are handled within that particular culture. When the nurse is insensitive or unaware of a patient's cultural practices, added stress and turmoil will be placed on the dying and their families preventing a peaceful transition from life.

A quantitative non-experimental descriptive research method was used to study the cultural self-efficacy of second-year associate degree nursing students completing their sixth and final quarter at two large associate degree nursing programs in the Pacific Northwest. The study was conducted using the Transcultural Self-Efficacy Tool (TSET) developed by Dr. Marianne Jeffreys [unpublished instrument copyrighted by author, 1994].

Findings suggest a relatively high level of self-efficacy in caring for the general end-of-life cultural needs of these students' dying patients. These same students report relatively low self-efficacy in meeting these same needs of specific cultural populations within their local

geographic area. It is recommended that nurse educators find creative educational methods to teach culturally sensitive end-of-life care in order to better prepare their students to meet the end-of-life cultural needs of non-dominant cultures within their own particular geographic area.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

Dedication

This work is dedicated to my loving husband, John, without whose support this would not have been possible.

CHAPTER ONE

INTRODUCTION

Statement of the Problem

With America's rapidly aging and increasingly diverse population (United States Census Bureau, 2005); culturally sensitive end-of-life care is becoming an important part of general nursing care. With only 3% of nursing programs in the United States reporting having a course dedicated to end-of-life (EOL) issues in 2002 (Wells et al., 2003), graduates of both Baccalaureate (BSN) and Associate Degree Nursing (ADN) programs may not be adequately prepared to care for culturally diverse patients and their families experiencing end-of-life issues.

When asked, 70% of the populace wants to die peacefully at home, but in reality, only 24.9% actually die in the home (The Dartmouth Atlas of Health Care, 2005). The vast majority of deaths occur in acute care or long-term care facilities, attended by nurses and other members of the health care team (Last Acts, 2002). As our aging and culturally diverse population nears the end of life in greater numbers, nurses are increasingly called upon to care for the dying. With increasing frequency, nurses are required to refocus the direction of their care from that of using aggressive measures to save life, to one of providing comfort and palliation at the end of life. In order to provide the dying and their family members with a peaceful death, the nurse must recognize and honor differences in how diverse cultures view death, including rituals practiced and how communication about sensitive topics are handled within a particular culture. When the nurse is insensitive or unaware of a patient's cultural practices, added stress and turmoil can be placed on the dying and their families. This can prevent or disrupt a peaceful transition from life (American Association of Colleges of Nursing [AACN], 2005)

The majority of registered nurses report their initial preparation at the ADN level (The US Department of Health and Human Services, 2000). In 2000, forty three percent of nurses (1.1 million) reported completing their basic nursing education at the associate degree level, while only twenty-nine percent (739,000) graduated from a baccalaureate degree program. From this author's experience, the majority of ADN programs have end-of-life issues integrated throughout the curriculum which can result in little continuity or concentration of subject matter. Since most nursing curricula are already tight, in terms of content, there is very little time to add designated end-of-life care courses or allow for in-depth discussion of palliative care particularly for culturally sensitive palliative care (Institute of Medicine, 1997). Robinson (2004) makes an interesting observation about palliative care nursing education "Education on obstetrical care is contained in all nursing curricula even though less than 50% of the population will ever need obstetrical care. Everyone dies. End-of-life care needs to be given at least as much time" (p. 90).

Statement of the Purpose

The purpose of this study was to ascertain the quality and quantity of culturally sensitive EOL instruction that nurses receive during their primary ADN education. Two ADN programs were the focus of this study which examined how second-year student nurses perceived the quality and quantity of culturally sensitive EOL instruction received during their primary nursing education and how confident they are in their ability to care for culturally diverse dying patients and their families. Nursing students in the final quarter of their nursing program were selected as the target population. How comfortable are these student nurses in caring for dying patients from other cultures? Are they confident in meeting the needs of transcultural patients and families experiencing grief and loss? How confident are they in addressing life support and

resuscitation issues with patients from other cultures? This study sought answers to these questions.

There is little evidence in the literature addressing how well nurse educators are meeting this critical need. The results of this study can help guide future curriculum revisions to more adequately provide in-depth, culturally sensitive EOL educational needs in our nursing programs. "Cultural competence and sensitivity of nurses is important to achieve a "good" death for patients within the context of their belief system" (Matzo, Sherman, Mazanec &, Virani, 2002, p.271).

Theoretical Framework

Madeline Leininger's Theory of Culture Care Diversity and Universality was used as the theoretical framework for this study. In her theory, Leininger defines Culture Care as "a means to discover meanings and ways to give care to people who have different values and life ways" (Leininger, 2001, p. 7). Leininger believes cultural values cannot be separated from the concepts of health, wellness, and illness and that nursing care not congruent with beliefs and values of a patient's culture will lead to noncompliance and stress. The importance of transcultural nursing care arises from the belief that people have a human right and expectation to have their cultural values, beliefs, and needs met by nurses as professional caregivers (Leininger, 1995). Nurses must recognize, understand, and honor a patient's cultural practices in all circumstances, but particularly during the dying process. By doing this, the nurse can promote a peaceful death for the patient (AACN, 2005).

Leininger describes the difficulties that schools of nursing have integrating transcultural nursing education into already tight curricula. Even when it is integrated throughout a curriculum, most faculty lack the expertise or even the interest to teach transcultural nursing care

to their students (Leininger, 1995). Addressing these issues is key in providing transcultural-nursing education in our schools of nursing.

Review of Literature

Much has been written about the need for nurses to be culturally competent and confident when caring for the dying patient and their families. Little has been written about how well we are accomplishing this critical aspect of nursing education.

Data from the Department of Health and Human Services indicates a rapidly aging, culturally diverse population. By the year 2030, the older minority population is projected to increase by 217 percent compared with 81 percent for the older white population. Minorities with the projected highest elder rates by the year 2030 are Hispanic Americans who will increase by 322 percent followed closely by Asian Americans who will increase by 301 percent (Department of Health and Human Services, Administration on Aging, 2005).

According to United States Census Statistics of 2005, minority elders comprise over 16.1 percent of all older Americans (65 years of age and older). In 1994, 1 in 10 elderly were a race other than White. In 2050, this proportion should rise to 2 in 10 (United States Census Bureau, 2005).

The International Council of Nurses (ICN) published a Policy Statement calling for the integration of respect for cultural values into nursing curricula, and for nurses to provide compassionate care that respects the cultural norms in death and mourning (ICN 2000). In April of 2004, the National Consensus Project for Quality Palliative Care published guidelines for palliative care. Guideline 6.1 states, “The palliative care program assesses and attempts to meet the culture-specific needs of the patient and family” (Meyer, p.31). In 2005, The American Association of Colleges of Nursing (AACN) published, on their web site, fifteen competencies

necessary for the nurse to provide quality end-of-life care. Competency 4 states "Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs. End-of-life care must be sensitive to diversity and provide for the spiritual and psychological well being of the dying patient and their family." In addition, the AACN's document suggests that faculty who teach end-of-life care incorporate teaching about the predominant cultures within the surrounding community into their curricula (AACN, 2005).

One study in the United Kingdom (UK) surveyed nurse educators (n=46) using a short questionnaire concerning the palliative care content in their curricula. The majority (82%) felt that palliative care should be core content in undergraduate curricula, but noted difficulties of incorporating added content into already full curricula. In addition, they noted a lack of qualified educators to teach the end-of-life content (Lloyd-Williams & Field, 2002). In 2001 White, Coyne &, Patel, surveyed Oncology Certified Nurses (n=2334) concerning their perspectives of how well they felt they were prepared to care for the dying patient. The vast majority (80%) reported a "good" to "excellent" level of preparation received from both their primary nursing education and continuing education. Yet, as expressed in their survey responses, religious and cultural perspectives of end-of-life care were core competencies about which they would like to have had more education. Kayser-Jones (2002) conducted an ethnographic study of how nursing home patients and their families perceive their end-of-life care. Over a period of 30 months, she observed and interviewed 35 nursing home residents, 52 family members, and 66 nursing staff. The findings showed the most predominant factors that influenced the experience of dying were lack of attention to cultural needs, cognitive status, inadequate staffing, and inappropriate and inadequate communication between health care providers and nursing home residents and their

families. Thirty-five percent of the residents were Asian and most unable to speak English. Those who did not have family were socially isolated (Kayser-Jones, 2002).

Research Questions

While there has been some research that addresses the adequacy of nurses' preparation for palliative care, in general, no research could be found that addressed specifically how well nurses are trained during their schooling to meet the cultural needs of the dying patient. With our rapidly increasing minority population who will be facing end-of-life issues, it is imperative that we educate our nurses to provide transcultural end-of-life care.

This study seeks answers to the following questions:

1. How confident are ADN graduates in addressing cultural aspects of dying and death, grief and loss, life support and resuscitation, and religious practices and beliefs?
2. How confident are ADN graduates in meeting the cultural needs of the dying patients from the dominant culture in their local geographic area?
3. How confident are ADN graduates in meeting the cultural needs of the dying patient from the non-dominant culture in their local geographic area?

Definition of Terms

For the purpose of this study, the following definitions are used.

Self-Efficacy – The individual's belief that he/she can perform or succeed at learning a specific skill, expend the necessary energy to competently learn/perform the skill, and persist at the skill despite any obstacles or hardships (Bandura, 2004).

Transcultural Self-Efficacy – The individual's perceived confidence performing or learning transcultural nursing skills. "The degree to which individuals perceive they have the ability to

perform the specific transcultural nursing skills needed for culturally competent and congruent care" (Jeffreys, 2000, p. 128).

Cultural Competence – "A process, not an endpoint, in which the nurse continuously strives to achieve the ability to work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background" (Campinha-Bacote, 1996, p. 60).

Peaceful Death – Peace of body, mind, and soul; evidenced when one is not troubled by turmoil, agitation, anxiety, or pain.

Significance for Nursing

The results of this survey offer a preliminary examination of how well second year students attending a 2-year nursing program believe they are being prepared to care for the transcultural dying patient. The survey results may assist nurse educators in developing culturally sensitive end-of-life instruction when developing curricula or nursing courses. Smatterings of transcultural care are often integrated throughout curricula, but there are no available studies that tell us how well this is meeting the needs of our students. The results of this study may help fine-tune curricula and courses in order to meet this critical need in a rapidly aging, culturally diverse society.

CHAPTER TWO

METHOD OF STUDY

Design of Study

This research was conducted utilizing a quantitative non-experimental descriptive method as described by Polit and Beck (2004).

Setting for Study

A survey was distributed to second-year ADN student nurses attending two large nursing programs in the Pacific Northwest.

Population and Sample

Forty-six senior ADN nursing students were surveyed during their last class in their respective nursing programs. The participants were informed that completing the survey would indicate their implied consent to participate in this research. In order to minimize social desirability response bias, the identities of the students remained confidential. Surveys were identified with a numerical numbering system. Participants were asked to not place their name or any other personal identifying data on the actual questionnaire that was returned to this researcher.

Instrumentation; Reliability and Validity

The Transcultural Self-Efficacy Tool (TSET), developed by Jeffreys (1994), was used to assess the study participants' self-efficacy in dealing with transcultural end-of-life issues. Jeffreys established content validity of the TSET by having a six-member panel of doctorally prepared experts in the field of transcultural nursing review the tool for clarity, appropriateness, and inclusiveness of response alternatives (Jeffreys & Smodlaka, 1996). In studies conducted to determine the TSET's reliability, it was found to be highly reliable with alpha coefficients of .97 to .98 on each administration of the TEST and has been deemed reliable in assessing student

nurses' self-efficacy in transcultural nursing matters (Jeffreys & Smodlaka, 1998). "The results support the conclusion that transcultural self-efficacy is a dynamic construct that changes over time and is influenced by previous health care experience and education" (Jeffreys & Smodlaka, 1999, p. 10). Dr. Jeffreys has given permission to use the TSET; in addition she has offered to act as a consultant for this study.

Although this tool is quite detailed and addresses many aspects of transcultural care, only the data related to end-of-life issues were analyzed. The areas of particular interest to this researcher were dying and death, grieving and loss, life support and resuscitation, and religious beliefs and practices. See appendix B for Transcultural Self-Efficacy Tool.

A demographic survey tool was developed by this author. It included questions related to gender, age, and ethnic background. In addition questions were asked concerning fluency in other languages, college degrees held, travel and residence outside the United States, and other transcultural education received. This author also developed a 10 point Likert Scale questionnaire consisting of 4 questions concerning the students' confidence in caring for dying patients from the dominant culture and their confidence in caring for dying patients from the Hispanic, Russian, and Vietnamese cultures in their local areas. The scale ranged from 1-10, with 1 being low self-confidence and 10 indicating high self-confidence. The United States Census statistics from 2000 indicate the Vietnamese population is the largest Asian group residing within the counties where the ADN programs are located (US Census Bureau, 2005). This researcher elected to ascertain the students' self-efficacy in caring for this particular Asian population.

Data Collection Procedure

After receiving permission of the course instructor, the researcher explained the purpose of the survey and how students' confidentiality would be maintained. The survey consisted of demographic questions and utilized a 10-point Likert Scale survey to ascertain the students' overall confidence level in their ability to care for the transcultural dying patient and family. Demographic data included age, gender, and ethnicity. The students were asked to complete the entire 83 question survey. Since the survey was confidential, no written consent was required. A container for the completed surveys was left at the front of the classroom. After the class, this researcher collected the completed surveys and transferred them to a locked file cabinet in this researcher's office. Implied consent was inferred from the participants' return of the survey. Please see Appendix A for the survey cover letter.

Data Analysis

Once the completed surveys were returned, the demographic data were coded then logged for future reference. Demographic data were examined using descriptive statistics and frequency distribution.

This researcher maintained all data in a locked file cabinet. Surveys were assigned a number prior to the distribution; this number was placed on the upper right corner of the survey. No identifying personal data were elicited from the participant for placement on the actual survey form. Data were referenced using the above-described numerical numbering system. The principle investigator will maintain surveys and analysis results in a locked file cabinet for three years.

All analyses were performed using SPSS for Windows (SPSS14.0, SPSS Inc., Chicago, IL). Both descriptive and inferential statistical methods were employed. All testing was based

on determining statistical significance at a two-sided alpha level of 0.05. The study sample was described using frequency and percentage for categorical variables and mean and standard deviation for continuous variables. Pearson's correlation coefficient was used to compare continuous scaled variables with age.

The Likert Scale questions were scored using descriptive statistics, two sample t-tests and Pearson's Correlation Analysis. Numerical values were assigned to the ten possible response choices. Two sample t-tests were used to compare the TSET Likert Scale responses to questions 21, 22, 23, and 37 with all 8 continuous variables from the demographic data survey form. Two sample t-tests were also used to compare each of the four Likert Scale EOL questions (1, 2a, 2b, and 2c) on the demographic survey form to the 8 continuous demographic variables.

Human Subjects Considerations

Approval was obtained from the Washington State University Institutional Review Board (IRB). In addition IRB approval was obtained from both community colleges involved in the study.

CHAPTER THREE

Findings

Sample Characteristics

There were a total of 46 senior nursing students from two Associate Degree Nursing Programs in the Southwest Washington geographic area surveyed on their last day of their basic nursing program. Of the 46, 40 were females. The average age was 32, with the oldest being 53 and the youngest 21. Ninety-three percent of the respondents reported their ethnicity as White. Of the remaining three respondents, there was one American Indian, one Asian, and one Pacific Islander. There were four respondents (8.7%) who were fluent in another language other than English. Of the 4 fluent in another language, two were fluent in Russian, one in Spanish, and one in Filipino [*sic*]. It's interesting to note that both of the Russian students responded to the ethnicity demographic question as "White" rather than Eastern European. One lived in Ukraine and one is from Belarus.

Of the 46 study participants, all but three were of Caucasian ethnicity. Thus, it was not possible to make statistical comparisons among different ethnic groups because the non-Caucasian sample size was too small. Table 1 illustrates the frequency distribution for all the categorical variables that include gender, ethnicity, language fluency, other college degrees held, traveled or lived outside the United States, and other transcultural education. There were 40 females (87%) and 6 males (13%), with ages ranging between 21 and 53 with a mean of 32.87. Only 8.7 percent (n=4) were fluent in another language other than English. A large percentage of respondents held other college degrees, 41.3 percent. In addition there was a large percentage that had traveled or lived in another country, 52.2 percent. The majority 63 percent (n=29) of

respondents had not received any transcultural education other than their basic nursing education (Table 1).

Gender				
	Frequency	Percent	Valid Percent	Cumulative Percent
Female	40	87.0	87.0	87.0
Male	6	13.0	13.0	100.0
Total	46	100.0	100.0	

Ethnicity				
	Frequency	Percent	Valid Percent	Cumulative Percent
American Indian or Alaskan Native	1	2.2	2.2	2.2
Asian	1	2.2	2.2	4.3
Native Hawaiian or Pacific Islander	1	2.2	2.2	6.5
White	43	93.5	93.5	100.0
Total	46	100.0	100.0	

Language Are you fluent in another language other than English?				
	Frequency	Percent	Valid Percent	Cumulative Percent
No	42	91.3	91.3	91.3
Yes	4	8.7	8.7	100.0
Total	46	100.0	100.0	

Degree Do you hold other college degrees?				
	Frequency	Percent	Valid Percent	Cumulative Percent
No	27	58.7	58.7	58.7
Yes	19	41.3	41.3	100.0
Total	46	100.0	100.0	

Country Have you traveled or lived in a country other than the United States?				
	Frequency	Percent	Valid Percent	Cumulative Percent
No	22	47.8	47.8	47.8
Yes	24	52.2	52.2	100.0
Total	46	100.0	100.0	

Transcultural Have you ever received transcultural education in another program or setting?				
	Frequency	Percent	Valid Percent	Cumulative Percent
No	29	63.0	63.0	63.0
Yes	17	37.0	37.0	100.0
Total	46	100.0	100.0	

Table 1: Frequency distribution of all categorical variables

Research Question 1

How confident are ADN graduates in addressing cultural aspects of dying and death, grief and loss, life support and resuscitation, and religious practices and beliefs?

The average response to question 21 (knowledge and understanding of cultural factors that may influence nursing care in "dying and death") was 6.7 with a Standard Deviation (SD) of 1.8. This question had a range score of 1-10, with 10 indicating high self-efficacy and 1 indicating low self-efficacy. Questions 22, 23, and 37 all had similar means and Standard Deviations, 6.6 (SD 1.8), 6.5 (SD 1.7), and 6.7 (SD 1.9) respectively.

Research Question 2

How confident are ADN graduates in addressing the end-of-life cultural needs of the dying patient from the dominant culture in their local geographic area?

The EOL (end-of-life) question, "Right now, how confident are you in providing end-of –life care for the dominant culture in your geographic area", showed a mean of 7.0 (SD 2.0).

Research Question 3

How confident is the ADN graduate in addressing the end-of-life cultural needs of the non-dominant cultures within their local geographic area?

EOL (2a), which asks about confidence in providing end-of-life care to the Hispanic population, had a mean of 5.4 (SD 2.5). EOL (2b) asks about confidence in caring for the Russian population and had a mean of 4.1 (SD 2.1). The last end-of-life question, EOL (2c), asks about confidence in providing end-of-life care for the Vietnamese population and had a mean of 3.9 (SD 2.0) (Table 2).

Responses to EOL Cultural Self-Efficacy							
	N		Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing					
Q21 Dying and death	46	0	6.70	7.00	1.750	2	10
Q22 Grieving and loss	45	1	6.60	7.00	1.750	3	10
Q23 Life support and resuscitation	46	0	6.52	7.00	1.709	3	10
Q37 Religious practices and beliefs	46	0	6.70	7.00	1.884	2	10
Age	46	0	32.87	32.00	8.318	21	53
EOL (1) Right now, how confident are you in providing end-of-life care for the dominant culture in your geographic area?	46	0	6.96	7.50	2.076	1	10
EOL (2a) Right now, how confident are you in providing end-of-life care for the Hispanic culture in your geographic area?	46	0	5.37	5.50	2.462	1	10
EOL (2b) Right now, how confident are you in providing end-of-life care for the Russian culture in your geographic area?	46	0	4.11	4.00	2.121	1	10
EOL (2c) Right now, how confident are you in providing end-of-life care for the Vietnamese culture in your geographic area?	46	0	3.89	4.00	1.980	1	9

Table 2: Descriptive Statistics for all continuous variables

A comparison was made between gender and all 8 continuous variables using the Two Sample t-test. The results showed no statistical significance in the average responses to questions 21, 22, 23, 37, EOL (1), EOL (2a), EOL (2b), and EOL (2c) (Table 3).

Independent Samples Test			
	t-test for Equality of Means		
	t	df	Sig. (2-tailed)
Q21 Dying and death	.791	44	.433
Q22 Grieving and loss	.647	43	.521
Q23 Life support and resuscitation	1.059	44	.295
Q37 Religious practices and beliefs	1.452	44	.154
EOL (1) Right now, how confident are you in providing end-of-life care for the dominant culture in your geographic area?	-1.112	44	.272
EOL (2a) Right now, how confident are you in providing end-of-life care for the Hispanic culture in your geographic area?	-1.399	44	.169
EOL (2b) Right now, how confident are you in providing end-of-life care for the Russian culture in your geographic area?	-.895	44	.375
EOL (2c) Right now, how confident are you in providing end-of-life care for the Vietnamese culture in your geographic area?	-.582	44	.564

Table 3: Two sample t-tests to compare all 8 continuous variables between males and females.

Pearson's Correlation Analysis was used to compare all 8 continuous variables with age. No statistically significant correlation with age was found (Table 4).

Correlations		
		Age
Q21 Dying and death	**Pearson Correlation**	-.068
	Sig. (2-tailed)	.651
	N	46
Q22 Grieving and loss	**Pearson Correlation**	.130
	Sig. (2-tailed)	.396
	N	45
Q23 Life support and resuscitation	**Pearson Correlation**	-.050
	Sig. (2-tailed)	.742
	N	46
Q37 Religious practices and beliefs	**Pearson Correlation**	-.133
	Sig. (2-tailed)	.378
	N	46
EOL (1) Right now, how confident are you in providing end-of-life care for the dominant culture in your geographic area?	**Pearson Correlation**	.101
	Sig. (2-tailed)	.503
	N	46
EOL (2a) Right now, how confident are you in providing end-of-life care for the Hispanic culture in your geographic area?	**Pearson Correlation**	.203
	Sig. (2-tailed)	.176
	N	46
EOL (2b) Right now, how confident are you in providing end-of-life care for the Russian culture in your geographic area?	**Pearson Correlation**	-.106
	Sig. (2-tailed)	.482
	N	46
EOL (2c) Right now, how confident are you in providing end-of-life care for the Vietnamese culture in your geographic area?	**Pearson Correlation**	-.040
	Sig. (2-tailed)	.792
	N	46

Table 4: Pearson's Correlation Analysis comparing all 8 continuous variables with age.

Two Sample t-tests were done to compare all 8 continuous variables between those who are, and are not, fluent in a language other than English. Table 5 illustrates that the group that is fluent in a language other than English was statistically significantly more confident in providing end-of-life care to the Hispanic culture than the group that was not fluent in a language other than English. The average response to EOL (2a) was 5.1 (SD 2.4) for the group that was not fluent, versus 7.8 (SD 2.6) for the group that was fluent in a language other than English, $t = -2.1$; $df = 44$; $p=0.042$. The remaining 7 continuous variables showed no statistical significance when compared with language fluency (Table 5).

Independent Samples Test				
		t-test for Equality of Means		
		t	df	Sig. (2-tailed)
Q21 Dying and death		.529	44	.600
Q22 Grieving and loss		.714	43	.479
Q23 Life support and resuscitation		.635	44	.529
Q37 Religious practices and beliefs		-.060	44	.953
EOL1 Right now, how confident are you in providing end-of-life care for the dominant culture in your geographic area?		.206	44	.838
EOL (2a) Right now, how confident are you in providing end-of-life care for the Hispanic culture in your geographic area?		-2.099	44	.042
EOL (2b) Right now, how confident are you in providing end-of-life care for the Russian culture in your geographic area?		-2.493	44	.017
EOL (2c) Right now, how confident are you in providing end-of-life care for the Vietnamese culture in your geographic area?		-2.032	44	.048

Table 5: Two sample t-tests to compare all 8 continuous variables between those who are, and are not, fluent in a language other than English.

Two Sample t-tests were done to compare all 8 continuous variables between those who do and do not hold another college degree, those who have and have not traveled or lived in a country other that the United States, and those who have and have not, received transcultural education in another program or setting. There were no statistically significant findings with any of these questions.

CHAPTER FOUR

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Discussion

Analysis of the correlation between 7 of the 8 continuous variables showed no statistical significance. There was statistical significance (p=0.042) between the group of students fluent in a language other than English when compared with those English only speaking students in providing end-of-life care for patients of the Hispanic culture (Figure 1).

Figure 1: Error Bar Graph showing 95% Confidence Interval of providing end-of-life care for the Hispanic culture compared with fluency in a language other than English

When asked about their confidence in providing end-of-life care for the Russian population, the mean score was 4.1, Vietnamese 3.9, and Hispanic 5.37 (Figures 2, 3, 4).

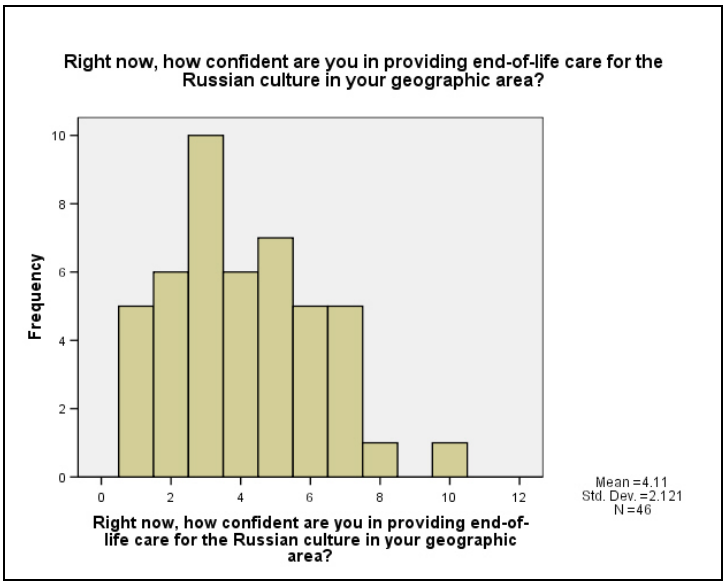

Figure 2: Response frequency to EOL (2b), Russian Culture

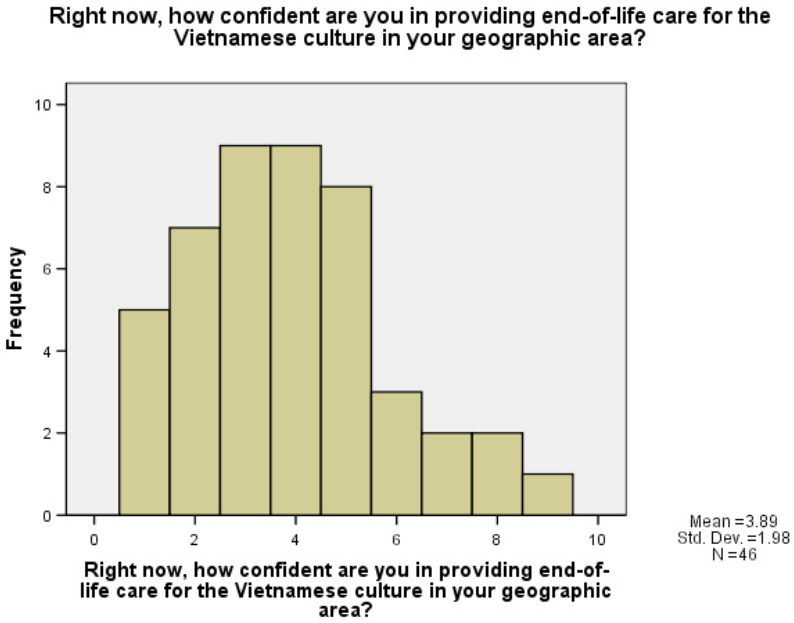

Figure 3: Response frequency to EOL (2c) Vietnamese Culture

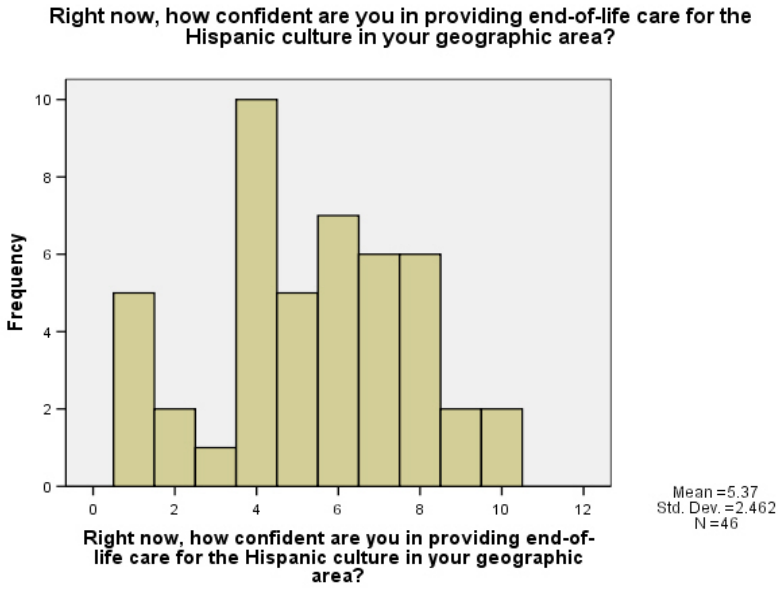

Figure 4: Response frequency to EOL (2a) Hispanic Culture

The mean score was higher, 7.0, when responding to the question that concerned providing end-of-life care to the dominant culture within their geographic, area (Figure 5).

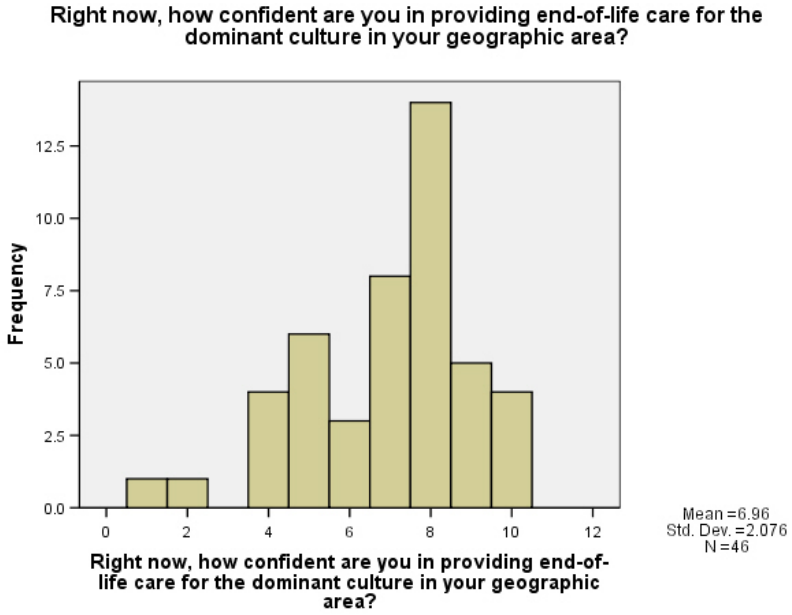

Figure 5: Response frequency to EOL (1) Dominant Culture

Limitations

A limitation of self-report surveys is the risk of response bias on the part of the participant. Response bias includes social desirability response bias and extreme responses (Polit & Beck, 2004). Knowing this risk, the researcher utilized a confidential survey instructing the participants that their participation is confidential, only the principle researcher will have access to the completed survey forms, and they should feel free to answers questions honestly.

Implications

This study indicates that students graduating from both of the ADN programs studied had a lower perceived self-efficacy in meeting the needs of the non-dominant cultures within their local area. These results indicate that there may not be sufficient time spent in educating our students concerning the cultural needs of those from non-dominant cultures within the local geographic area.

Recommendations

Although students reported a relatively high level of confidence in providing end-of-life care for the dominant local culture, they were not as confident in providing for these same needs within the non-dominant cultures. Leininger's Theory of Culture Care Diversity and Universality states that in order to provide culturally sensitive nursing care the nurse is expected "to know and respect cultural differences and similarities of clients in order to provide culturally effective and safe care" (Leininger, 2002, p. 529). If, as nurse educators, we are not addressing the diverse needs of the non-dominant cultures in our local communities within our curricula, we are doing a disservice to our students and to our local communities. Not addressing this need with our nursing students can result in poor and potentially destructive patient outcomes. The results of this study indicate that while we are doing an effective job teaching culturally sensitive

end-of-life care in general, we are not effectively preparing students to meet the specific end-of-life needs of the non-dominant cultures within our own geographic area. We need to keep in mind the AACN's recommendations that nursing faculty include end-of-life teaching about the predominate cultures within their surrounding community in their curricula (AACN, 2005). As nurse educators, there are several ways we can address this important aspect of instruction. One way would be to have guest speakers from the predominant cultures come to our classrooms and speak about the cultural end-of-life needs related to that particular culture. These speakers could be drawn from the culture's local religious leaders or local community members who would be willing to share their culture's end-of-life beliefs, rituals, and customs. Another method would be to offer culturally sensitive end-of-life seminars, twice a year, where a panel of speakers from each of the predominant cultures would share their cultural practices. All students and faculty would be encouraged to participate in at least one end-of-life seminar each year. These changes could easily be incorporated into our already full curricula.

There was a statistically significant relationship between a student's perceived cultural self-efficacy and fluency in a language other than English. It is recommended that future research be done to investigate this relationship.

Conclusions

Senior nursing students in both of the ADN programs surveyed reported a relatively high level of confidence in providing for the general end-of-life cultural needs of their patients related to areas of dying and death, grieving and loss, life support and resuscitation, religious practices and beliefs (means = 6.5-6.7 on the 10 point TSET Likert Scale.). In providing care for the dominant culture in their geographic area, the mean score was 6.9. While these students reported a relatively high level of confidence in the areas described above, there was a significant drop in

their perceived confidence in caring for the non-dominate cultures, Hispanic (5.4), Russian (4.1), and Vietnamese (3.9), within their geographic area. It is possible that while the faculty is indeed, addressing end-of-life cultural care in general terms throughout the nursing curricula of both schools, they are not addressing the end-of-life needs of the specific cultures that their students will be caring for within their local geographic area.

It is also interesting to note that there is a significant correlation between fluency in another language and a student's perceived confidence to provide culturally sensitive end-of-life care to patients from the Hispanic culture ($p=.042$). Within this study's geographic location, there is a large Hispanic population. One student reported fluency in Spanish, while two reported fluency in Russian, and one reported fluency in Filipino [*sic*]. It is possible that fluency in any language other than English allows the student to perceive him or herself as more culturally sensitive and confident in providing end-of-life care to other cultures, particularly the non-dominant cultures within the geographic area.

These results indicate that we, as nurse educators, are not fully meeting the needs of our students in teaching culturally sensitive end-of-life care as indicated in Leininger's Model of Culture Care Diversity and Universality. She clearly states "our students are keenly aware of culturally diverse communities in which they live and they must develop competency skills with clients, families, and diverse groups" (Leininger 2002, p. 530).

Through making these small changes, we have the potential to advance our students' self-efficacy in meeting the needs of the varying cultures within our own geographic areas, thus allowing our graduates to provide a peaceful death for their terminally ill patients.

References

American Association of Colleges of Nursing (2005). *Peaceful death: recommended competencies and curricular guidelines of end-of-life nursing care.* Retrieved February 19, 2005, Http://www.aacn.nche.edu/Publications/deathfin.htm

Bandura, A., (2004). Health promotion by social cognitive means. *Health Education & Behavior 32(2),* 143-164.

Campinha-Bacote, J., Yahle, T., & Langenkamp, M., (1996, March/April). The challenge of cultural diversity for nurse educators. *The Journal of Continuing Education in Nursing. 27,* 59-64.

Department of Health and Human Services, Administration on Aging (2005). *Statistics on aging and diversity.* Retrieved April 8, 2005, http://www.aoa.dhhs.org/

Institute of Medicine (1997, January 1). *Approaching death: Improving care at the end of life.* Retrieved July 15, 2005, http://www.iom.edu

International Council of Nurses (2000). *Nurses' role in providing care to dying patients and their families.* Retrieved February 24, 2005, Http://www.icn.ch/pscare00.htm

Jeffreys, M. R. (1994). *Transcultural Self-Efficacy Tool (TSET).* Unpublished instrument copyrighted by the author.

Jeffreys, M. R. & Smodlaka I. (1996, November/December). Steps of the instrument design process: An illustrative approach for nurse educators. *Nurse Educator, 21 (6),* 47-52.

Jeffreys, M. R. & Smodlaka, I. (1998). Exploring the factorial composition of the transcultural self-efficacy tool. *International Journal of Nursing Studies, 35,* 217-225.

Jeffreys, M. R., & Smodlaka, I. (1999, May). Construct validation of the transcultural self-efficacy tool. [Electronic version]. *Journal of Nursing Education, 38 (5),* 222-227. Retrieved, July 25, 2005.

Jeffreys, M. R., (2000, April). Development and psychometric evaluation of the transcultural self-efficacy tool: A synthesis of findings. *Journal of Transcultural Nursing, 11 (2),* 127-136.

Kayser-Jones, J. (2002). The experience of dying: An ethnographic nursing home study. *The Gerontologist, 42,* 11-19.

Last Acts (2002). Means to a better end: A report on dying in America, Retrieved May 10, 2005, www.lastacts.org [you will be redirected to the archives of the RWJF website.]

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research and practices* (2nd ed.). New York, NY: McGraw-Hill, Inc.

Leininger, M. M. (2002). *Culture care diversity & universality: a theory of nursing*. Sudbury, MA: Jones and Bartlett Publishers.

Lloyd-Williams, M. & Field, D. (2002). Are undergraduate nurses taught palliative care during their training? *Nurse Education Today, 22,* 589-592.

Matzo, M. L., Sherman, D. W., Mazanec, P. & Virani, R. (2000) Teaching cultural considerations at the end of life: End of life nursing education consortium program recommendations. *Journal of Continuing Education in Nursing, 33,* 270-278.

Meyer, M. L. (2004, April). *Introducing clinical practice guidelines for quality palliative care.* Retrieved February 24, 2005, http://www.nationalconsensusproject.org/

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia, PA: Lippincott Williams and Wilkins.

Robinson, R. (2004). End-of-life education in undergraduate nursing curricula. *Dimensions in Critical Care Nursing, 23*, 89-92.

The Dartmouth Atlas of Health Care (2005). Retrieved July 15, 2005, http://www.dartmouthatlas.org

US Department of Health and Human Services (2000, March). *The national sample survey of registered nurses* retrieved on March 10, 2000, http://bhpr.hrsa.gov/healthworkforce/reports/rnsurvey/

US Department of Health and Human Services (2001, spring). The health care workforce in ten states: education, practice, and policy survey, http://bhpr.hrsa.gov/healthworkforce/reports/states02/default.htm

United States Census Bureau (2005). Retrieved April 8, 2005, http://www.census.gov/

Wells, M. J., Wilkie, D. J., Brown, M. Corless, I. B., Judge, M. M., & Shannon, S. E. (2003, January/February). Technology survey of nursing programs: Implications for electronic end-of-life teaching tool development. *Computers, Informatics, Nursing, 21*, 29-36.

White, K. R., Coyne, P. J., & Patel, U. B. (2001). Are nurses adequately prepared for end-of-life care? *Journal of Nursing Scholarship, 33*, 147-151.

Appendix A

COVER LETTER

Dear Student Nurse,

I am a graduate student at Washington State University and am conducting research to examine how confident soon to be graduates of 2-year nursing programs are in meeting the end-of-life needs of the culturally diverse patient. Information obtained with this study will be used to improve our 2-year nursing curricula to better meet the needs of our graduates in this crucial area of our practice.

The questionnaire is completely anonymous, so you are not asked to put your name on it or to identify yourself in any way. I therefore, hope that you will feel comfortable about giving your honest opinions. If you prefer not to answer any particular question, please feel perfectly free to leave it blank. Please do answer the questions if you can and if you have any comments or concerns about any question just write you comments in the margin.

By completing and returning the enclosed survey, the participant is consenting to take part in this research. I hope that you will take a few minutes to complete and return the questionnaire to me - it should take only about 15-20 minutes of your time.

This study has been reviewed and approved for human subject participation by the Washington State University Review Board and the Clark College Human Subjects Review Board.

If you have any questions or concerns regarding the study, you can contact me at the above address and if you have questions or concerns regarding your rights as a participant, you can contact the WSU IRB at 509-335-9661 or irb@wsu.edu or Susan Maxwell with Clark College's Office of Planning and Advancement at 360-992-2506.

Thank you very much for your cooperation and assistance in this endeavor.

Sincerely,
Becky Ellis RN, BSN

Appendix B

Date: June 1, 2005

This letter is to grant permission to Becky Ellis, RN, BSN

For your use of the Transcultural Self-Efficacy Tool (TSET) in your research study. The questionnaire may be reproduced, however please be sure that all respondents return the questionnaire. I do request that you send me a copy of: a) any published work resulting from use of the TSET; and b) any further reliability and validity test results.

Please acknowledge Dr. Marianne R. Jeffreys as TSET creator and owner of copyright.

Best wishes in your research endeavors and commitment to cultural competent care. I would be happy to discuss the TSET with you and maintain correspondence as a consultant.

Sincerely,

Marianne R. Jeffreys

Marianne R. Jeffreys, EdD, RN
Professor, Nursing
Jeffreys@mail.csi.cuny.edu
(718)-982-3825

Throughout your nursing education and nursing career, you will be caring for clients of many different cultural backgrounds. These clients will represent various racial, ethnic, gender, socioeconomic, and religious groups.

Cultural difference exists in health care needs, caring, and curing practices. Knowing and understanding cultural factors related to client care helps establish a theoretical foundation for providing cultural-specific nursing care.

Part I

Among clients of **different** culture backgrounds, how knowledgeable are **YOU** about the ways cultural factors may influence nursing care? Please use the scale below and mark your response accordingly.

	Not Confident									Totally Confident
	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

You know and understand the ways **cultural factors** may influence **nursing care** in the following areas:

1)	health history and interview	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
2)	physical examination	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
3)	informed consent	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
4)	health promotion	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
5)	illness prevention	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
6)	health maintenance	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
7)	health restoration	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
8)	safety	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
9)	exercise and activity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
10)	pain relief and comfort	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
11)	diet and nutrition	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
12)	patient teaching	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
13)	hygiene	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
14)	anxiety and stress reduction	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
15)	diagnostic tests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
16)	blood tests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
17)	pregnancy	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
18)	birth	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
19)	growth and development	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
20)	aging	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
21)	dying and death	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
22)	grieving and loss	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
23)	life support and resuscitation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
24)	sexuality	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
25)	rest and sleep	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Part II

The most effective way to identify specific cultural factors that influence client behavior is to conduct a cultural assessment of each client. This is best done by interview.

Right NOW, how confident are **YOU** about **interviewing client of different cultural backgrounds** to learn about their values and beliefs?

Rate your degree of confidence or certainty for each of the following **interview topics**. Please use the scale below and mark your response accordingly.

	Not Confident ①	②	③	④	⑤	⑥	⑦	⑧	⑨	Totally Confident ⑩
Interview clients of different cultural backgrounds about:										
26) language preference	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
27) level of English comprehension	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
28) meaning of verbal communication patterns	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
29) meaning of nonverbal behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
30) meanings of space and touch	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
31) time perception & orientation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
32) racial background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
33) ethnic background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
34) socioeconomic background	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
35) religious background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
36) educational background & interests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
37) religious practices & beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
38) acculturation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
39) world view (philosophy of life)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
40) attitudes about health care technology	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
41) ethnic food preferences	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
42) role of elders	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
43) role of children	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
44) financial concerns	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
45) traditional health & illness beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
46) folk medicine tradition & use	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
47) gender role & responsibility	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
48) acceptable sick role behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
49) role of family during illness	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
50) discrimination & bias experiences	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
51) home environment	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
52) kinship ties	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
53) aging	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Part III

As a nurse who will care for many different people, **knowledge of yourself** is very important.

Please rate **YOUR** degree of confidence or certainty for each of the following items. Use the scale below and mark your response accordingly.

	Not Confident ①	②	③	④	⑤	⑥	⑦	⑧	⑨	Totally Confident ⑩
A) About yourself, you are **AWARE OF:**										
54) **YOUR OWN** cultural heritage and belief systems	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
55) **YOUR OWN** biases and limitations	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
56) differences within **YOUR OWN** cultural group	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
B) **Among clients of different cultural backgrounds,**										
You are **AWARE OF:**										
57) insensitive and prejudicial treatment	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
58) differences in perceived role of the nurse	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
59) traditional caring behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
60) professional caring behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
61) comfort and discomfort felt when entering a culturally different world	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
62) interaction between nursing, folk, and professional systems	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
You **ACCEPT:**										
63) differences between cultural groups	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
64) similarities between cultural groups	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
65) client's refusal treatment based on beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
You **APPRECIATE:**										
66) interaction with people of different cultures	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
67) cultural sensitivity and awareness	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
68) cultural-specific nursing care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
69) role of family in providing health care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
70) client's world view (philosophy of life)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

	Not Confident									Totally Confident
	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Among clients of different cultural backgrounds,

You **RECOGNIZE:**

71) inadequacies in the U.S. health care system	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
72) importance of home remedies & folk medicine	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
73) impact of roles on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
74) impact of values on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
75) impact of socioeconomic factors on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
76) impact of political factors on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
77) need for cultural care preservation/maintenance	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
78) need for cultural care accommodation/negotiation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
79) need for cultural care repatterning/restructuring	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
80) need to prevent ethnocentric views	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
81) need to prevent cultural imposition	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

You **ADVOCATE:**

82) client's decisions based on cultural beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
83) cultural-specific care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Appendix C

Demographic Questionnaire

Please answer the questions below. Your answers will remain confidential and will help with the statistical interpretation of your responses to the Transcultural Self-Efficacy questionnaire.

What is your gender?
a. Female
b. Male

What is your birth year?
19_____

What is your ethnic background?
a. American Indian or Alaskan Native
b. Asian
c. Black or African American
d. Native Hawaiian or other Pacific Islander
e. Eastern European
f. Hispanic
g. White

Are you fluent in another language other than English? If so, what language?
_____

Do you hold other college degrees? If so, in what area?
_____

Have you traveled or lived in a country other than the United States? If so, where?
_____

Have you ever received transcultural education in another program or setting? If so, describe below.
_____

Survey Questions Related to Transcultural End-of-Life Care

1. Right now, how confident are you in providing end of-life care for the dominant culture in your geographic area? Please circle your response

Not Confident Totally Confident
1 2 3 4 5 6 7 8 9 10

2. Right now, how confident are you in providing end-of-life care for the non-dominant cultures within your geographic area? Please circle your response

a. Hispanic
Not Confident Totally Confident
1 2 3 4 5 6 7 8 9 10

c.Russian
Not Confident Totally Confident
1 2 3 4 5 6 7 8 9 10

d.Vietnamese
Not Confident Totally Confident
1 2 3 4 5 6 7 8 9 10

Appendix D

WASHINGTON STATE UNIVERSITY

Research Compliance Office

MEMORANDUM

TO: Becky (Lynne) Ellis
Nursing, WSU, Vancouver

FROM: Malathi Jandhyala (for) Cindy Corbett, Chair, WSU Institutional Review Board (3140) MJ

DATE: 31 August 2005

SUBJECT: Approved Human Subjects Protocol - New Protocol

Your Human Subjects Review Summary Form and additional information provided for the proposal titled *"Are Associate Degree Nursing Graduates Adequately Prepared to Meet the Cultural Needs of Their Patients at the End of Life,"* IRB File Number **8696**-a was reviewed for the protection of the subjects participating in the study. Based on the information received from you, the WSU-IRB **approved** your human subjects protocol on **31 August 2005**.

IRB approval indicates that the study protocol as presented in the Human Subjects Form by the investigator, is designed to adequately protect the subjects participating in the study. This approval does not relieve the investigator from the responsibility of providing continuing attention to ethical considerations involved in the utilization of human subjects participating in the study.

This approval expires on 30 August 2006. If any significant changes are made to the study protocol you must notify the IRB before implementation. Request for modification forms are available online at http://www.ogrd.wsu.edu/Forms.asp.

In accordance with federal regulations, this approval letter and a copy of the approved protocol must be kept with any copies of signed consent forms by the principal investigator for THREE years after completion of the project.

Washington State University is covered under Human Subjects Assurance Number FWA00002946 which is on file with the Office for Human Research Protections.

If you have questions, please contact the Institutional Review Board at (509) 335-9661. Any revised materials can be mailed to the Research Compliance Office (Campus Zip 3140), faxed to (509) 335-1676, or in some cases by electronic mail, to *irb@mail.wsu.edu*.

Review Type: NEW
Review Category: XMT
Date Received: 25 August 2005

OGRD No.: NF
Agency: NA

PO Box 643140, Pullman, WA 99164-3140 • 509-335-9661 • Fax: 509-335-1676
iacuc@wsu.edu • ibc@wsu.edu • irb@wsu.edu • www.research-compliance.wsu.edu

WASHINGTON STATE UNIVERSITY

Research Compliance Office

MEMORANDUM

TO: Becky Lynne Ellis
Nursing, WSU, Vancouver

FROM: Malathi Jandhyala **(for)** Kris Miller, Chair, WSU Institutional Review Board MJ

DATE: 28 November 2005

SUBJECT: Review of Protocol Modification - Modification

Your proposal to modify the protocol titled ***"Are Associate Degree Nursing Graduates Adequately Prepared to Meet the Cultural Needs of Their Patients at the End of Life,"*** IRB File Number **8696-**b was reviewed for the protection of the subjects participating in the study. Based on the information received from you, the IRB has **approved** your modification request on **28 November 2005**. This modification includes replacing anonymous with confidential on the cover letter and revised demographic data form.

IRB approval indicates that the modifications described to the previously approved study protocol are designed to adequately protect the subjects participating in the study. This approval does not relieve the investigator from the responsibility of providing continuing attention to ethical considerations involved in the utilization of subjects participating in the study.

The approval for this protocol expires 30 August 2006. If any more changes are made to the study protocol you must notify the IRB and receive approval before implementation.

If you have questions, please contact the Institutional Review Board at OGRD (509) 335-9661. Any revised materials can be mailed to Research Compliance Office (Campus Zip 3140), faxed to (509) 335-1676, or in some cases by electronic mail, to *irb@wsu.edu*.

Review Type: MOD
Review Category: XMT
Date Received: 10 November 2005

OGRD No.: NF
Agency: NA

PO Box 643140, Pullman, WA 99164-3140 • 509-335-9661 • Fax: 509-335-1676
iacuc@wsu.edu • ibc@wsu.edu • irb@wsu.edu • www.research-compliance.wsu.edu