

Fall 12-2018

Developing Cultural Competency in Anesthesia through Student Registered Nurse Anesthetists

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DEVELOPING CULTURAL COMPETENCY IN ANESTHESIA
THROUGH STUDENT REGISTERED NURSE ANESTHETISTS

by

Emma To

A Capstone Project
Submitted to the Graduate School,
the College of Nursing
and the Department Advanced Practice
at The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Nursing Practice

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December 2018

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2018

Published by the Graduate School



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ABSTRACT

Certified Registered Nurse Anesthetists (CRNAs) are the main anesthesia providers in over 70% of rural hospitals providing anesthesia. Each year, over 2,000 student registered nurse anesthetists (SRNAs) graduate and continue as licensed CRNAs. This Doctor of Nurse Practice (DNP) project emphasizes the importance of developing culturally competent providers in anesthesia by promoting early outreach in cultural competence education of SRNAs. Cultural competence is described as possessing characteristics of congruent attitudes, awareness, and conduct that provides and enables effective skills in cross-cultural encounters. Encompassing cultural competency education early in the SRNAs profession may provide valuable lifelong cultural skills that will benefit the provision of culturally competent care to growing diverse populations.

For this DNP project, SRNAs were presented with the opportunity to develop cultural competency in anesthesia with cultural competency education which consisted of four modules. The goal of this DNP project was to increase cultural awareness, sensitivity, and enhance culturally competent communication skills in SRNAs progressing through clinical education. There were 20 participants who were SRNAs in the first year of clinical rotation. After the four modules were presented the participants were given a post-evaluation survey to complete. After the cultural competency education, the participants were allowed 6-weeks before a descriptive qualitative survey was administered to evaluate if the cultural competency education influenced cultural awareness and sensitivity in clinical setting.

The total average for the overall scores for the sample of 20 participants was 23.65, which indicated that cultural competency education was successful after the educational intervention to the SRNAs. Six weeks after the cultural competency education was provided, SRNAs were given a 6-Week Qualitative evaluation that emphasized a notice in an increase in cultural awareness, sensitivity, and ability to recognize different cultural needs among patients of different cultural backgrounds. There was a 75% notice in clinical practice change since the educational intervention was provided, and 25% did not notice a change in practice due to no cultural encounters after the educational intervention. Overall, there was 100% in agreement that the educational intervention made a difference and will be useful in practice for the SRNAs and future practice beyond graduation.

ACKNOWLEDGMENTS

I would like to give my appreciation to my committee chair and committee members, Drs. Bonnie Harbaugh, Michong Rayborn, and John Nagelhout for their invaluable patience and guidance throughout my doctoral project. Thank you to the anesthesia faculty for their dedication and investment into seeing their student registered nurse anesthetists succeed.

DEDICATION

I would like to thank God for blessing me with the ability to reach this achievement. For my valiant loving parents, I would like to dedicate this entire doctoral project to you both. I will never truly understand my parents' plights as Vietnamese refugees but I will forever be grateful for their sacrifices for me to be an American today. Lastly, I would like to express sincere gratitude to Dr. John Nagelhout from Kaiser Permanente, for allowing me to go forth with this project and applying it at The University of Southern Mississippi's Nurse Anesthesia Program.

TABLE OF CONTENTS

ABSTRACT ii

ACKNOWLEDGMENTS iv

DEDICATION v

LIST OF TABLES ix

LIST OF ABBREVIATIONS x

CHAPTER I – INTRODUCTION AND PROBLEM 1

 Background and Significance 2

 PICOT 3

 Purpose Statement..... 4

 Project Model..... 4

 Doctorate of Nursing Practice Essentials..... 5

 Synthesis of Evidence 6

 Search Strategy 6

 Cultural Competence 7

 Cultural Competence in Healthcare 8

 Culturally Competent Nurse Anesthesia Care 9

 Summary 10

CHAPTER II - METHODOLOGY 11

 Population and Sample 11

Instrument	12
Procedures and Educational Intervention	12
Analysis.....	13
Summary	14
CHAPTER III – RESULTS	15
Data Analysis	15
Overview.....	15
CHAPTER IV– DISCUSSION.....	20
Limitations	20
Dissemination	21
Future Directions	21
Conclusion	22
APPENDIX A – Literature Matrix	23
APPENDIX B – Logic Model.....	25
APPENDIX C – SWOT ANALYSIS	26
APPENDIX D – Doctor of Nursing Essentials.....	27
APPENDIX E – Letter Seeking Permission for Tool.....	28
APPENDIX F – Permission Letter	29
APPENDIX G – Instrument.....	30
APPENDIX H – Post Evaluation Survey.....	31

APPENDIX I – 6 Week Qualitative Survey	33
APPENDIX J – IRB Approval Letter	34
REFERENCES	35

LIST OF TABLES

Table 1 Knowledge and Valuing Scores (N = 20).....	18
Table 2 Descriptive Reports for 6 Week Qualitative Data	19

LIST OF ABBREVIATIONS

AANA	American Association of Nurse Anesthetists
CCT	Cultural Care Diversity and Universality Theory
DNP	Doctor of Nurse Practice
KP	Kaiser Permanente
SRNAs	Student Registered Nurse Anesthetists
TCNS	Transcultural Nursing Society
USM	The University of Southern Mississippi

CHAPTER I – INTRODUCTION AND PROBLEM

The population in the United States is accelerating in culture and ethnicity; with this increasing direction, over 47 million people speak a language other than English (Wright, 2008). Moreover, culture involves far more than ethnicity or race but is also determined by age, gender, education, religion, socioeconomic status, geographic region, and occupation (Cai, 2016). Delivering culturally competent care requires the provider to understand the multifaceted determinants of culture. With the growing diversity in the United States, the importance of having culturally competent providers is vital to providing quality and congruent care.

Cultural competence is described as having the characteristics of congruent attitudes, knowledge and behaviors of providers that enables effective skills in cross-cultural encounters (Cai, 2016). Each cultural group comes with specific health disparities that require cultural knowledge and skills to aid in providing culturally competent care. Wright (2008) mentioned that ignorance of the differences in cultural disparity consequently interrupts the equality of care and improvement in health disparity in the people of our nation.

Nurses form one of the largest groups in the healthcare workforce and are in constant contact with culturally diverse patients. With nurses' direct interaction at the forefront in healthcare, congruent care necessitates student registered nurse anesthetists (SRNAs), whose anesthesia education is in progress, to be trained in cultural competency. Cultural competency in anesthesia providers can benefit their practice by improving the quality of care delivered, patient satisfaction, and health outcomes.

Building cultural competency skills to utilize during the preoperative evaluation and perioperative period is invaluable to providing safe, effective, and quality anesthesia care to patients. Most importantly, cultural competency education can help assist SRNAs in incorporating attitudes, skills and behaviors, and policies that will provide effective recognition and response to health-related needs in cross-cultural situations. The cultural competency skills acquired can then be further utilized in the profession of anesthesia as a certified registered nurse anesthetist (CRNA) upon completion of the SRNAs' education. Although this project's educational intervention design is not typical for direct practice change, its intent is to instill cultural competency in SRNAs who will be future anesthesia professionals.

Background and Significance

For over a century in the United States, CRNAs have been delivering quality anesthesia care (Gibbs & Waugaman, 2004). Gibbs and Waugaman (2004) mention that CRNAs are the primary anesthesia providers in over 70% of rural hospitals providing anesthesia. More than 2,000 SRNAs graduate each year and become certified, as CRNAs (American Association of Nurse Anesthetists [AANA], 2016). With diversifying demographics catapulting in the United States, a growing problem in health disparities is also increasing. These disparities are linked to unique genetic variation, environmental factors, health behaviors, and factors related to healthcare services delivered (Wright, 2008).

Changing demographics in the United States require healthcare providers to have a basic understanding of knowledge and issues regarding cross-cultural communication, health beliefs, and practices in culturally diverse populations (Chong, Elisha, Maglalang,

& Koh, 2006). Even though culture is frequently perceived as only race and ethnicity, other antecedents such as age, gender, socioeconomic status, geographic region, and occupation should be considered (Cai, 2016). For this reason, it is necessary that anesthesia providers, such as students who are progressing in anesthesia education, are trained for the demand in population diversification and concepts relating to culture.

Although there is no universally effective approach to building cultural competency training, preparing SRNAs to have an open cultural approach through awareness and sensitivity is a starting place to begin closing the gap in provider-patient misunderstanding in cross-cultural encounters. With a foundation to an open approach and awareness of other cultures, cultural competency training can enhance SRNAs to provide holistic, therapeutic, high-quality anesthesia care that enhances awareness, sensitivity, and respect for cultural differences and similarities unique to each patient that may positively impact health outcomes.

PICOT

Cultural competency is an invaluable skill to have as an anesthesia provider to establish safe, equitable, and quality care to the diverse populations encountered. In SRNAs at The University of Southern Mississippi (USM), will cultural competency training increase the knowledge of cultural competency versus before the SRNAs' exposure to cultural competency training? An anesthesia provider prepared with cultural competency skills can reduce patient anxiety and bridge the gap to patient interaction to provide quality care.

Purpose Statement

Cultural boundaries encountered can hinder the quality of care provided. As an anesthesia provider, understanding the patients' cultural background, circumstances, and needs can facilitate in providing safer quality anesthesia care. The purpose of this project was to determine if the SRNAs' level of understanding increased after the cultural competency training had been implemented.

Project Model

Madeleine Leininger's Cultural Care Diversity and Universality Theory (CCT) was used as the foundation to this Doctor of Nurse Practice (DNP) project. The CCT's central theme is to be holistic and explain culture as the certain pattern of behavior that distinguishes any society from one another and allows the human expression of care (Purnell, 2015). Understanding the behaviors, patterns, and practices of people aids in the delivery of congruent care. Leininger's emphasis on care and culture has brought much light to the importance of both essences combined to provide culturally congruent care. As mentioned in McFarland and Wehbe-Alamah (2015) the CCT's purpose is to recognize, record, acknowledge, and demonstrate the affiliation of care and culture phenomena with differences and similarities between and among cultures.

The DNP project's goals were to help the SRNAs discover self-awareness in personal bias and stereotypes and to incorporate an open approach to those who come from different cultural backgrounds. At times, it is nearly impossible to know every culture's values or beliefs. However, training the SRNAs to realize and examine his or her own beliefs and how it may affect care for cross-cultural situations may establish an initial

bridge to overcome cultural barriers in anesthesia care for those of different cultural backgrounds.

Doctorate of Nursing Practice Essentials

The DNP eight essentials are the foundational competencies required to fulfill the DNP objectives to obtain the DNP degree by the American Association of Colleges of Nursing (American Association of Colleges of Nursing [AACN], 2006). All eight essentials are met in this project. Nonetheless, three were applicable to this DNP project the most. The depth and focus of these three competencies are discussed in further details below.

Essential II is the organizational and system leadership for quality improvement and systems thinking. This project assessed the changing diverse demographics and goes deeper into the meaning of culture. Furthermore, it correlated the need for cultural competency and the need for delivery of safe, quality congruent care in providers within systems that leads to greater patient satisfaction.

Essential III is the clinical scholarship and analytical methods for evidence-based practice. Nursing knowledge of cultural competency education in SRNAs from Kaiser Permanente Nurse Anesthesia Program was the inspiration to implement nursing knowledge of cultural competency training at The University of Southern Mississippi (USM) Nurse Anesthesia Program. Application and translation of the cultural competency training and evidence was implemented to deliver the project at USM.

Essential V is healthcare policy for advocacy in healthcare. Health policy addresses cultural competency as essential to delivering safe, quality, and equitable care is

covered in this project. Providing safer, quality, and more equitable healthcare is provided through an established rapport with patients with different cultural background with a provider who has been trained in cultural awareness and sensitivity.

Essentials II, III, and V were the key essentials focused upon in this project. All eight essentials were carried out in the DNP project. These essentials and their relationships to the project can be found in Appendix D.

Synthesis of Evidence

Cultural competency is important for anesthesia providers such as SRNAs to deliver safe and quality anesthesia care to patients of different cultures. The goal of cultural competency education in SRNAs is to build self-awareness to enhance realization and appreciation for the differences of patients from different cultural backgrounds. For CRNAs to provide culturally competent and holistic patient care, therapeutic relationships must be developed with his or her patients (Sassoon et al., 2008). Opportunities to develop therapeutic relationships increase when anesthesia providers can understand and are culturally sensitive to cultural beliefs and practices of patients of different cultural backgrounds (Sassoon et al., 2008).

Search Strategy

For this project, the evidence was located by using searches for peer-reviewed journal articles in multiple databases. The databases utilized for this search were EBSCOhost, MEDLINE, CINAHL with full text, Google Scholar, Cochrane Database of Systematic Reviews, PUBMED, and SAGE Journals. Publications were limited to between January 1, 1998 and May 1, 2017. There were minimal studies completed for cultural competency in nurse anesthesia. The initial searches resulted in 12,402 cultural competence

articles. However, there were 3,843 articles related to cultural competency in nursing and further results of 425 for cultural competence in nurses. Although the articles were related to other healthcare professions other than nurse anesthesia, they did provide relevance to cultural competency in overall healthcare. Search terms used were cultural competence and nursing, transcultural, multicultural, cultural competence and nurse anesthesia or anesthesiology, cultural awareness and cultural sensitivity, cultural competence in anesthesia, cultural competence in education, cultural competence in advanced practice nursing, cultural competence in certified registered nurse anesthetists, culture care and universality theory, and health disparities. After critically evaluating the evidence most informative for this project, five articles were evaluated. For a literature matrix of the evidence, see Appendix A.

Cultural Competence

Ihara (2004) stated that, “Cultural competence is defined as the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of patients” (para. 1). Cultural competency is an integral component of delivering culturally congruent and sensitive care to the growing diverse population. An increasingly diverse population further leads to an increase in need for knowledge in health disparities that are population specific. Cultural competence allows the provider to respond to cultural beliefs, views, and practice that are different from his or her own in cross-cultural encounters and establishes the bridge to patient-provider relationship. The Institute of Medicine (IOM), in its report *Unequal Treatment* recommended ways to address the issue (Wright, 2008). These include increasing awareness

among providers regarding the healthcare gap that has an impact on cultural groups, increasing the diversity in hospital staff, and incorporating cultural competency training for healthcare professionals (Wright, 2008).

Cultural Competence in Healthcare

Increasing diversity of the nation comes with opportunities and challenges for healthcare providers, healthcare systems, and policy makers to deliver culturally competent care (Ihara, 2004). Cultural competence can improve quality of care and health outcomes in the growing demographic healthcare system. Most importantly, racial and ethnic minorities suffer from greater morbidity and mortality from chronic diseases (Ihara, 2004). In African Americans and Latinos, chronic conditions are considerably higher compared to Whites. Many of the chronic conditions include—asthma, cancer, heart disease, diabetes, high blood pressure, obesity, or anxiety and depression (Ihara, 2004). Those individuals with chronic illnesses require more healthcare services (Ihara, 2004).

One of the positive impacts of cultural competency in healthcare providers is a reduction in malpractice liability. By promoting interventions to language barriers with the usage of language lines or interpreters, providers are able to deliver a true, thorough, informed consent. Language barriers can affect the quality of healthcare received if the patient does not fully comprehend directions, explanations, or patient education. Ihara (2004) mentioned that in non-English speakers who needed an interpreter during medical care visits, less than 48% reported having one. Low literacy also affects healthcare. Those individuals affected are the elderly and racial and ethnic minorities who have

lower levels of literacy and access to formal education (Ihara, 2004). A low socioeconomic background, even in those who speak English, should also be considered in cultural sensitivity education.

Access to healthcare and how it differs between races and ethnicities is also an issue. Without appropriate access to healthcare, patients are not participating in services to prevent or treat diseases in early stages and can lead to poor health outcomes. Culture affects every patient differently in experiences of illness, responses to diseases, access to healthcare, usage of healthcare services, and interactions with medical providers (Sassoon et al., 2008). Cultural competency training should provide a framework for sensitivity, awareness, and knowledge of health disparities to appropriately address each population's specific health needs.

Culturally Competent Nurse Anesthesia Care

The United States has 2.2 million nurses (Sassoon et al., 2008). However, only 9% of the nation's nurses are ethnic minorities, such as African Americans, Hispanic Americans, and Native Americans (Sassoon et al., 2008). In the United States, CRNAs administer anesthetics to almost two-thirds of 2.6 million anesthesia cases delivered annually (Gibbs & Waugaman, 2004). CRNAs have become essential in delivering safe and quality anesthesia care. Even more, with the increasing diversity in demographics, CRNAs are encountering a demand in more than just delivering anesthesia but also in providing culturally sensitive and appropriate care to patients during preoperative evaluation and perioperative care.

Informed consent is when an understanding of the nature of the procedure, choices available for patient, and risks and benefits and all other alternatives are disclosed

to complete understanding for the patient (Sassoon et al., 2008). CRNAs provide services not only in anesthesia, but also must include consideration for linguistic and cultural issues into his or her planning (Minority Nurse Staff [Minority Nurse], 2013). How can true informed consent be delivered if the patient does not comprehend the language or excessive medical jargon is used during informed consent? A thorough interview must be completed to assess if the patient has other cultural needs such as a limited English proficiency, low literacy to understand information in consent, cultural health practices, or alternative medicine performed at home that can interfere with treatment. Regardless of language or literacy barrier, a patient has the right to be truly informed about what will be done for treatment and the risks before undergoing any type of procedure.

Importantly, meeting the cultural needs of patients by providing a language line or speaking in simple terms so the patient does not feel intimidated, gives the patient the right to understand medical treatment and risks thoroughly and to ask questions. Knowledge in specifics of the area of cultural differences is paramount in providing culturally congruent care to those of diverse population.

Summary

In highlight of the evidence, having more culturally competent providers led to greater patient satisfaction and outcome. Patients who understood the healthcare treatments and education provided were more satisfied with the care received. For this reason, training future nurse anesthetists to be more culturally aware and sensitive of patient specific needs is the start for a more congruent healthcare.

CHAPTER II - METHODOLOGY

In this section, the project's methods will be explained. A SWOT analysis and logic model were created to assist in development of the project's process. See Appendices B and C.

Population and Sample

The population for this project was SRNAs in nurse anesthesia programs. The University of Southern Mississippi's (USM) nurse anesthesia program (NAP) is a 36 month, 9 semesters total program which results in a Doctor of Nursing Practice (DNP) degree. Didactic work is completed in the first 12 months. The sample size were 20 students who completed his or her first 12 months of the NAP and entered his or her first year of clinical experience, which is the junior year of the program. Inclusion criteria for the project were SRNAs who had completed the first 12 months of the NAP and had started his or her first year of clinical experience. Exclusion criteria were SRNAs who did not complete 12 months of didactic and those who were beyond the first year of clinical experience in the NAP. A sample size of 20 was chosen for this project because that was the maximum number of students accepted into the program per cohort. If there were students who did not pass his or her didactic courses and did not continue into the junior year or if the students in the cohort decided not to participate in the DNP project, it may have reduced the sample size to less than 20. However, the project design can still be completed with a sample of less than 20.

Instrument

The authors granted permission to use the *Cultural Competence Checklist: Personal Reflection* for this project through the American Speech-Language-Hearing Association (ASHA). ASHA created the self-assessment tool to determine cultural competency, in order to improve and increase service delivery to culturally/linguistically diverse populations. The ASHA tool was part of the educational intervention in this project as a self-evaluation prompt to ready the participants for the intervention. This project used a post-test evaluation only, and the ASHA tool was used to help capture baseline cultural competency before educational intervention was applied. The post-test evaluation's questions were worded to capture self-perceived change as a result of the educational intervention. A 6-week Qualitative Assessment of usage and practice change were given to determine whether the SRNAs used the information provided from the educational intervention in clinical practice. Please see Appendix E, F, G, H, and I for the instrument letter seeking permission, permission granted reply, and instrument sample, post-test evaluation, and 6-Weeks Qualitative Assessment.

Procedures and Educational Intervention

Inspiration for the development of the cultural competency training at USM NAP was from Kaiser Permanente (KP) NAP's cultural competency education program. Permission to utilize KP's cultural competency training structure as a guide for the application at USM was requested and approved by Dr. John Nagelhout, my project mentor. Approval to implement the cultural competency project was requested and approved by the USM NAP director.

Upon approval of the USM Institutional Review Board (IRB), SRNAs were notified via email of the cultural competency training opportunity and informed participation is optional. The IRB approval form will be in Appendix J. Consent forms were provided stating all results from tools and evaluation will only be used to analyze the results and no student identification will be disclosed. Students were given a 1-hour cultural competency training that included four modules. The ASHA tool was given before the modules as a self-assessment baseline in cultural competency for the participants. Module 1 was the introduction to diversity and culturally competent care that consisted of PowerPoints and definitions of what culture is and how it affects the anesthesia profession. Module 2 was cultural knowledge and focuses on Mississippi demographics and how essential cultural competency is in the anesthesia profession for the state of Mississippi. Module 3 was the cultural awareness session where students participated in exercises with informed consent that identified personal biases and stereotypes and how it affects the preoperative evaluation and perioperative care. Module 4 consisted of cultural skills. An experienced CRNA guest speaker provided insight on strategies to handle cultural encounters as an anesthesia provider and how to use cultural skills when providing culturally competent anesthesia care.

Analysis

Upon completion of the cultural competency training, the SRNAs received a post-evaluation (Developing Cultural Competency in Anesthesia through SRNAs) to measure his or her experience and whether there was an increase in knowledge about cultural competency than before training. The ASHA tool used before the intervention was helpful for participants to gauge their baseline of cultural competency and the self-perceived

change after the educational intervention was applied. See Appendix H for post-evaluation. To further explore indication of practice change, a qualitative evaluation was given to the SRNAs at 6 weeks after the educational intervention to determine if the information was useful in clinical practice.

Data analysis was a univariate statistical approach with means for each question per participants. The post-test evaluation provided after the educational intervention were ranked on a 5-point Likert scale from 1 (strongly disagree), 2 (disagree), 3 (undecided), 4 (agree), and 5 (strongly agree) on whether the participant found the cultural competency intervention useful, educational, valuable, and enhancement in cultural awareness and sensitivity. A comprising score for each participant's post-test evaluation was added between all participant's question and a total average was obtained for all 20 participants. A score of 20 to 25 demonstrated a heightened experience from cultural competency training for that individual question, and a score of 5 to 15 represents no gain from the cultural competency training specific to that question and requirement for improvement in that area of cultural competency training is needed. The goal was to determine if SRNAs perceived gains in cultural competency and thus will more likely to utilize his or her new knowledge in clinical practice.

Summary

The univariate statistical approach was easy to use in a sample of 20 SRNAs. However, the data analysis was not rigorous in focus on specific cultural competency skills gained for each SRNA after the intervention application. The data analysis only measured self-perception of general cultural competency skills gained.

CHAPTER III – RESULTS

Data Analysis

This DNP project explored whether implementing a cultural competency educational intervention to SRNAs would increase cultural knowledge, awareness, sensitivity, and influence change in practice. A post-test evaluation was given to the participants after the educational intervention, and the scores generated were based on how cultural competency education impacted each participant and how useful the information provided would change the SRNAs practice in a clinical setting. This analysis is presented in Table 1. To further explore the development of cultural competency in SRNAs, a 6-week qualitative evaluation was given to determine changes in clinical practice for SRNAs who received the educational intervention, and a descriptive qualitative report presented in Table 2, was created to determine the educational intervention's impact.

Overview

The inclusion criteria used were SRNAs who completed the first 12 months of the NAP and started his or her first year of clinical experience. Exclusion criteria were SRNAs who did not complete 12 months of didactic and those who were beyond the first year of clinical experience in the nurse anesthesia program. A sample size of 20 SRNAs was successfully obtained. The SRNAs were provided the educational intervention and a post-test evaluation was given to assess the change in cultural competency and practice change. The post-test evaluation is in Appendix H.

The data gathered were from a sample of 20 participants. Data gathered from Table 1 and 2 measured the educational intervention's impact on SRNAs and how likely the SRNAs were to use the information provided and change practice in clinical. The post-

test evaluation provided after the educational intervention were ranked on a 5-point Likert scale from 1 (strongly disagree), 2 (disagree), 3 (undecided), 4 (agree), and 5 (strongly agree) on whether the participant found the cultural competency intervention useful, educational, valuable, and enhancing in cultural awareness and sensitivity. Overall, the mean to each question yielded greater than 4 out of 5 possible, which was a positive indication that the SRNAs agreed the educational intervention was beneficial. Questions 6 and 7 were commentary and resulted 40% favorable to the CRNA testimonial used in Module 2 to capture the importance of cultural competency in the rural population of Mississippi demographics. About 35% positive reviews were reported Module 3, which was the case scenario interactive session on the importance of cultural needs in the non-English speaking population, and 25% of participants left the commentary section blank for question 6. For question 7, there was one comment that expressed the length of the presentation being the least favorable part about the presentation; however, the answer was ambiguous and did not thoroughly explain whether the educational intervention length was too long or too short.

A summative score of 5 to 15 for each participant questions per post-test evaluation would indicate the educational intervention was not successful in increasing cultural competency, and a total score of a 20 to 25 would indicate that the educational intervention was successful in increasing cultural competency in SRNAs. The total average for the overall scores for the sample of 20 participants was 23.65, which indicated that cultural competency education was achieved after the educational intervention to the SRNAs. The SRNAs generated scores for the response highlighted the usefulness and value of cultural competency education.

Further analysis of responses from SRNAs were determined by a 6-Week Qualitative post-evaluation. The 6-Week Qualitative evaluation questions emphasized the SRNAs perception of personal practice change after the educational intervention. Responses included noticing an increase in cultural awareness, sensitivity, and ability to recognize different cultural needs among patients of different cultural backgrounds. In Table 2, for the descriptive data for Question 1, 100% of participants agreed the cultural competency educational intervention made a difference in practice change. For Question 2, a 75% increase was noticed in clinical practice change since the educational intervention was provided, and 25% did not notice a change in practice due to no cultural encounters after the educational intervention. The participants who answered no to Question 2 (25%) had additional comments on the educational intervention and a notice in change of practice. "I have not had a chance to take care of someone who does not speak English yet." "I have not but also I have not had an experience where culturally an issue as far as patient care goes." "N/A, Opportunity hasn't arise." "Not at this moment but where the opportunity presents itself I will keep it in mind." For Question 3, there was 100% in agreement that the overall educational intervention made a difference and will be useful in practice for the SRNAs and future practice beyond graduation.

Table 1

Knowledge and Valuing Scores (N = 20)

Questions	Average (min 1, max 5)
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Compared to what you knew BEFORE about cultural competency, please note the following: </div>	
Question 1: This information was useful for my practice.	4.85
Question 2: I learned a lot from the information provided to me today.	4.70
Question 3: I now value this information	4.75
Question 4: How likely are you to change practice after this information today?	4.70
Question 5: I feel more culturally aware and sensitive after this information provided to me today.	4.65
Total Average	23.65 (5 - 25)

(Table 1 continued)

Commentary Questions

Questions	Results
Question 6: What did you like most about the information provided to you today on cultural competency?	Module 2: 40% (n = 8) responded Module 3: 35% (n = 7) responded No response: 25% (n = 5) responded
Question 7: What did you like least about the information provided to you today and how can we improve?	Length: 5% (n = 1) No response: 95% (n = 19)

Table 2

Descriptive Reports for 6 Week Qualitative Data

Questions	Results (N = 20)	n	%
1. How did the cultural competency educational intervention make a difference in your practice? Please, briefly explain.	Difference in practice No difference in practice	20 0	100 0
2. Since the Educational Intervention, have you notice a change in your practice since the educational intervention? Please, briefly explain.	Change in practice No change in practice	15 5	75 25
3. Overall, did the educational interventional make a difference in your practice as a SRNA in clinical and future practice?	Difference in clinical/future practice No difference in clinical/future practice	20 0	100 0

CHAPTER IV– DISCUSSION

The objective of this DNP project was to increase cultural awareness and sensitivity in SRNAs through cultural competency education. Madeleine Leininger's CCT guided this DNP project's objectives in distinguishing the patterns and behaviors in culture that not only pertained to ethnicity but also patient background characteristics such as socioeconomic status, age, gender, and occupation. The CCT focused on recognizing and appreciating the differences and resemblances in culture by emphasizing awareness and sensitivity as the beginning of closing the gap to cultural barriers. The SRNAs were presented with four modules that introduced problematic situations in cultural encounters and exercised solutions in cross-cultural encounters. As seen in Table 2, the SRNAs stated the educational intervention was useful and made a difference in personal anesthesia practice. The results, for this sample, supports cultural competency education was successful.

Limitations

The DNP project required SRNAs to think about and openly discuss personal bias and stereotypical beliefs that have been conditioned from life experiences and environment. Some participants were reluctant to discuss personal beliefs and how he or she has handled cultural encounters. However, after Module 2 and 3 were presented students felt more comfortable to discuss how he or she felt and the idea of cultural competency in anesthesia became more relatable in clinical practice. Although the educational intervention resulted positively, some participants still did not respond to the comment section. No response to the commentary section can be contributed to the habit of not answering

evaluations completely or the discomfort of discussing cultural concept in a group setting.

Another limitation for this DNP project was insufficient time to fully assess the long-term impact of the educational intervention. The participants were given a 6-Week Qualitative evaluation to determine the usefulness of the intervention after and 25% stated in Question 2 of Table 2 that he or she did not have the opportunity in clinical practice for cultural encounters. In future implementation of the cultural competency education, SRNAs can be exposed to the intervention earlier in the program to evaluate the impact of the cultural competency education early in the NAP.

Dissemination

This DNP project has been presented as an in-progress presentation at the Trans-cultural Nursing Society (TCNS) Annual Conference in Clinton, MS. My goal was to present the final results of the DNP project at the TCNS International Conference. Other plans to disseminate results is to incorporate the education intervention into the NAP at USM so each class can benefit from the training. Last, I would like to publish an article in the American Association of Nurse Anesthetists (AANA) to share the project's results in Mississippi demographics to inspire others to incorporate cultural competency training into other NAPs to improve diverse patient care for the future of the anesthesia profession.

Future Directions

Dissemination of the DNP project can be furthered by integrating the educational intervention into the NAP and other health related professional programs. A folder cre-

ated containing the educational intervention, which includes the cultural competency assessment, modules, student post-test evaluation, and 6-week descriptive data will be provided to the College of Nursing so that the continuation of the cultural competency development is available. Also, a presentation of the completed DNP project at conferences such as the Transcultural Nursing Society (TCNS) will help disseminate the project so that other professionals may be aware of the educational intervention and the applicability in early professional exposure.

Conclusion

There is limited research completed on cultural competency in the profession of anesthesia. However, with CRNA providers being the majority providers to rural communities and the future of SRNAs graduating and entering the workforce annually, the benefits of having culturally competent providers is paramount to the profession of anesthesia. Educational intervention provided during SRNAs' clinical education experience can be the initiation of developing cultural competency skills that is carried through life-long future practice beyond graduation. Preparing culturally competent anesthesia providers will be beneficial in the future improvement of delivery of care, patient satisfaction, and health outcomes in the profession of anesthesia.

APPENDIX A – Literature Matrix

Author/Year/Title	Level/Grade	Design	Sample/Data Collection	Findings	Recommendations
Minority Nurse Staff. Culturally competent nurse anesthesia care. (2013).	Level 3 Grade C	Commentary/ expert opinion	N/A	Cultural competency includes providing the best service for patients with limited English proficiency in when informed consent is needed. Recognition of cultural practices is important and can prevent misinterpretation.	Hospitals that do not provide language lines or interpreters should have another solution to providing quality care for patient with a culturally different background. This leads to equity and congruence in care and providing true informed consent.
Gibbs, D. M., & Waugaman, W. R. (2004). Diversity behind the mask: Ethnicity, gender, and past career experience in a nurse anesthesia program.	Level 3 Grade A	Meta-analysis	Findings from a five-year study at Barry university was compared to statistics published by the American Association of Nurse Anesthetists and also a national sample in a study by Waugaman and Lu in 1999.	Diverse students should be recruited into nurse anesthesia programs to prepare for the growing diverse population and to facilitate cultural competent care.	Nurse anesthesia programs should implement a diversity program to recruit and retain diverse students.
Ihara, E. (2004). Cultural competence in healthcare: Is it important for people with chronic conditions?	Level 4 Grade D	Commentary	N/A	Recognizing that racial and minorities have higher comorbidities than any other population and how understanding access to healthcare, language and communication barriers, low literacy, and lack of cultural competence can lead to	More hospitals should provide continuing education to healthcare workers. However, education for cultural competence training should also start in school when healthcare providers in training to go into the field.

				poor patient outcomes and dissatisfaction.	
Sassoon, E., Nagelhout, J., Gupte, S., Koh, K., Maglalang, M., & Chong, N. (2008). A successful partnership to help reduce health disparities: The institute for culturally competent care and the Kaiser Permanente school of anesthesia California State University Fullerton.	Level 3 Grade C	Cross-sectional	Currently, there are not statistical data stated in the journal; however, there are open-ended answers from the students that participated in the modules.	Some students appreciated the self-reflection on personal bias but also some students were resistant to the necessity of cultural competency training in anesthesia care because of the belief that anesthesia providers only sedate patients.	The modules could be more focused on perception of anesthesia providers rather than patient specific cultural populations. There is a large diverse population that the modules can become overwhelming for students. Perhaps if the modules focused on the student's bias and deciphering approaches with patients to be open rather than cultural specific.
Wright, S. M. (2008). Cultural competency training in nurse anesthesia education.	Level 4 Grade D	Commentary	N/A	CRNAs should provide care that is based on AANA Scope and Standards practice. Anything less provided may hinder the quality of care to patients. Patients have the rights to be informed of procedures and process and this can be done by thoroughly facilitating a language that is understandable to the patient.	More hospitals should provide staff with the access to language lines, interpreters, and cultural competency training. The more that is provided and trained to the CRNAs the possibility of health quality outcomes can improve.

APPENDIX B – Logic Model

Inputs	Activities	Outputs	Long-Term Outcomes
<p>Evidence with articles/statistics emphasizing the need for more cultural competency education</p> <p>Kaiser Permanente’s cultural competency modules setup (permission granted)</p> <p>Proof of successful cultural competency educational programs that have been implemented at other institutions/hospitals/facilities.</p> <p>Involvement of Students, Instructors, Director of program to participate in modules and presentation.</p> <p>Approval for presentation of modules through the director of the nurse anesthesia program</p> <p>Volunteers who are in the anesthesia field or medical field that have encounter with a diverse demographic to participate in presentation exercises</p>	<p>Cohorts 2016 will meet for a 1-hour module presentation.</p> <p>Presentation/Module will be from Kaiser Permanente’s modules that have been successfully applied:</p> <p>Power point that will explain definitions on what is culture, cultural competency, cultural sensitivity, and emphasize on empathy.</p> <p>Schedule time presentation for self-assessment tool to be given</p> <p>Schedule post-presentation evaluations on usefulness of cultural competency modules</p>	<p>Power-points/handouts/cultural competency videos ready for use post evaluation forms designed for student specific measurement in cultural competency knowledge.</p> <p>Evaluation forms to measure the module’s impact, process, and usefulness.</p> <p>General policy or procedure obtained from local hospital to discuss steps in cultural approaches provided.</p> <p>Kaiser Permanente notified of cultural competency module implemented at the University of Southern Mississippi SRNAs module training completed.</p>	<p>Patients of different cultural background will benefit from the new knowledge and cultural skills providers gained from cultural competency education</p> <p>More patient of different cultural background will receive medical care d/t the influence of trust in the cultural community</p> <p>Cultural competency training can be used in other nursing programs.</p>

APPENDIX C – SWOT ANALYSIS

Strength	Weakness	Opportunities	Threats
<p>The strengths of the DNP project are with more culturally competent providers it can improve quality in delivery of healthcare, patient satisfaction, and positive health outcomes. Cultural awareness and sensitivity will be a useful skill to respond to each patient specific need. Lastly, an increase in therapeutic provider-patient relationship.</p>	<p>The weakness of the DNP project is it is impossible to know every culture’s health needs and practices. For this reason, it is important to treat every patient encounter as a cultural encounter and to be aware and open to each patient’s needs. Age, gender, socioeconomic status, and religion are all a form of culture that should be considered.</p>	<p>Opportunities are success in cultural competency training at USM in SRNAs can further lead to the training to remain as part of the program for SRNAs. Also, it can be applied to other programs of the school of nursing.</p>	<p>The major threat to the DNP project is resistance in SRNAs to cultural competency training. It can be frustrating to understand the importance of cultural competence in anesthesia because of the stereotype that CRNAs only sedate patients and have no interaction to build a therapeutic relationship with patients.</p>

APPENDIX D – Doctor of Nursing Essentials

Doctor of Nursing Essentials	How the Essentials is Achieved
I. Scientific Underpinnings for Practice	By implementing a successful cultural competency training from KP nurse anesthesia program and emerging the nursing theory from Leininger’s CCT cultural competency training was applied to enhance SRNAs skills in cultural awareness and sensitivity.
II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking	The aim of the DNP project is to increase cultural competency knowledge to allow SRNAs to develop an open cultural approach in cross-cultural situations.
III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice	Evidence in improvement in health outcomes and patient satisfaction when providers are culturally competent was reviewed to meet this essential.
IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care	Utilization of language-line interpreters as a resource for cultural skills meets this essential for the DNP project.
V. Health Care Policy for Advocacy in Health Care	Health policy in cultural sensitivity and quality of care delivery is addressed in the DNP project to fulfill this essential.
VI. Interprofessional Collaboration for Improving patient and Population Health Outcomes	The DNP project includes CRNAs, SRNAs, faculty, and anesthesiologists to participate to enhance level of training in cultural competency is cross-cultural encounters.
VII. Clinical Prevention and Population Health for Improving the Nation’s Health	The goal of the DNP project was to improve in communication and understand can lead to reducing health disparities.
VIII. Advanced Nursing Practice	The evaluation of evidence based and usage of data, the application for practice change, and utilization of knowledge in clinical are all part of the future of advanced practice nursing.

APPENDIX E – Letter Seeking Permission for Tool

Letter Seeking Permission to Use Cultural Competence Checklist Tool

October 14, 2016

Emma Phuong To
University of Southern Mississippi
School of Nurse Anesthesia
40 Lasalle Street
Hattiesburg, MS 39402

Dear Sir/Madam:

I am a Student Registered Nurse Anesthetist in progress of my Doctor of Nurse Practice degree from The University of Southern Mississippi conducting my DNP project titled *Developing Cultural Competency in Anesthesia through Student Registered Nurse Anesthetists* under the direction of my project committee chaired by Dr. Harbaugh, who can be reached at Bonnie.Harbaugh@usm.edu.

I would like your permission to use and modify for student registered nurse anesthetists the Cultural Competence Checklist: Personal Reflection in my DNP project. I would like to use and print your survey under the following conditions:

- I will use the tool only for my DNP project and will not sell or use it with any compensated or curriculum development activities.
- I will include the copyright statement on all copies of the instrument.
- I will send a copy of my completed DNP project to your attention upon completion of the project.

If these are acceptable terms and conditions, please indicate so by replying to me through e-mail: Phuong.to@usm.edu

Sincerely,


Emma Phuong To

APPENDIX F – Permission Letter



Permissions Asha <Permissions@asha.org>
To: Emma Phuong To

Oct 17, 2016 at 10:06 AM ★

Dear Ms. To:

Thank you for the additional information. Permission is granted to reprint and use the Cultural Competence Checklist: Personal Reflection, found at <http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf#search=%22cultural%22>, in your forthcoming DNP project. Please cite ASHA as the source and include a link back to the original instrument on the ASHA site.

Should your work be published at a later time, additional permission to reprint would be needed in that case.

I have cancelled your order through the Copyright Clearance Center as this e-mail is an official grant of the permission you seek.

Sincerely,

Libby

Libby Bauer

Associate Director of Serial Publications

American Speech-Language-Hearing Association

APPENDIX G – Instrument



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Cultural Competence Checklist: **Personal Reflection**

Ratings:
1 Strongly Agree
2 Agree
3 Neutral
4 Disagree
5 Strongly Disagree

This tool was developed to heighten your awareness of how you view clients/patients from culturally and linguistically diverse (CLD) populations.

*There is no answer key; however, you should review responses that you rated 5, 4, and even 3.

- I treat all of my clients with respect for their culture.
- I do not impose my beliefs and value systems on my clients, their family members, or their friends.
- I believe that it is acceptable to use a language other than English in the U.S.
- I accept my clients' decisions as to the degree to which they choose to acculturate into the dominant culture.
- I provide services to clients who are GLBTQ (Gay, Lesbian, Bisexual, Transgender, or Questioning).
- I am driven to respond to others' insensitive comments or behaviors.
- I do not participate in insensitive comments or behaviors.
- I am aware that the roles of family members may differ within or across culture or families.
- I recognize family members and other designees as decision makers for services and support.
- I respect non-traditional family structures (e.g., divorced parents, same gender parents, grandparents as caretakers).
- I understand the difference between a communication disability and a communication difference.
- I understand that views of the aging process may influence the clients'/families' decision to seek intervention.
- I understand that there are several American English dialects. I recognize that all English speakers use a dialect of English.

I understand that the use of a foreign accent or limited English skill is not a reflection of:

- Reduced intellectual capacity
- The ability to communicate clearly and effectively in a native language

I understand how culture can affect child-rearing practices such as:

- Discipline
- Dressing
- Toileting
- Feeding
- Self-help skills
- Expectations for the future
- Communication

I understand the impact of culture on life activities, such as:

- Education
- Family roles
- Religion/faith-based practices
- Gender roles
- Alternative medicine
- Customs or superstitions
- Employment
- Perception of time
- Views of wellness
- Views of disabilities
- The value of Western medical treatment

I understand my clients' cultural norms may influence communication in many ways, including:

- Eye contact
- Interpersonal space
- Use of gestures
- Comfort with silence
- Turn-taking
- Topics of conversation
- Asking and responding to questions
- Greetings
- Interruptions
- Use of humor
- Decision-making roles

*While several sources were consulted in the development of this checklist, the following document inspired its design:
Goode, T. D. (1989, revised 2002). Promoting cultural and linguistic competence self-assessment checklist for personnel providing services and supports in early intervention and childhood settings.

Reference this material as: American Speech-Language-Hearing Association. (2010). *Cultural Competence Checklist: Personal reflection*. Available from www.asha.org/unloadedFiles/practice/multicultural/personalreflections.pdf

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APPENDIX H – Post Evaluation Survey

Developing Cultural Competency in Anesthesia through SRNAs

Compared to what you knew BEFORE about cultural competency, please note the following:

1. This information was useful for my future practice

- 1 - Strongly disagree
- 2 - Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly agree

2. I learned a lot from the information provided to me today:

- 1- Strongly Disagree
- 2- Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly Agree

3. I now value this information:

- 1 - Strongly Disagree
- 2- Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly Agree

4. How likely are you to change practice after this information today?

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly Agree

5. I feel more culturally aware and sensitive after this information provided to me today:

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly Agree

6. What did you like MOST about the information provided to you today on cultural competency?

7. What did you LEAST like about the information provided to you today and how can we improve?

APPENDIX J – IRB Approval Letter



INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 17062605
PROJECT TITLE: Developing Cultural Competency in Anesthesia through Student Registered Nurse Anesthetists
PROJECT TYPE: New Project
RESEARCHER(S): Emma Phuong To
COLLEGE/DIVISION: College of Nursing
DEPARTMENT: Advanced Practice
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 06/27/2017 to 06/26/2018
Lawrence A. Hosman, Ph.D.
Institutional Review Board

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