Ethnic and racial population growth is reshaping the face of the country. Recent U.S. Census Bureau estimates indicate that by the year 2042 the nation’s present ethnic/racial minorities will have become the majority (Flow- ers, 2004). In 2025, this demographic shift will be evident in people 18 years and younger. Within this shift, Latinos are the fastest growing minority population in the U.S. (Morales, King- ton, Valdez, & Escarce, 2002; Spector, 2004; U.S. Department of Commerce, 2001). According to the U.S. census, the number of Latinos has increased almost 60 percent in the last decade from 23 million (1990) to 35 million (2000) (Guz- man, 2001). By 2050 the Latino population is expected to reach 97 million, representing nearly one-quarter of the U.S. population (Day, 1996). In a recent article in the Oregonian, the headline read: “Hispanic Surge Is Reshaping Oregon” (Casey, 2009). In the Mid-Willamette Valley, a rural agricultural area that attracts immigrant and migrant workers and their families, Latinos are the fastest-growing segment of the population with 30-50% of communities comprised of Latino families.

These rapidly shifting demographics highlight the critical nature of ensuring that nurses


Abstract
The objective of this program was to evaluate an educationally based intervention in developing intercultural competence of postpartum nursing staff using a quality improvement (QI) framework. The method included eighty nursing staff participating in a cultural competence training program (CCTP) infused with Latino culture, including Spanish language/music, to highlight critical reflections, cross-cultural practice, and communication standards for culturally competent care. Perceptions of cultural sensitivity were evaluated via patient interviews, the Intercultural Development Inventory (IDI), and focus groups. The results included a staff level of understanding, comfort, and effectiveness in providing care to the Latino population improved from pre- to post-IDI scores. Despite heightened awareness, the team’s cultural orientation remained unchanged, indicating that staff overestimated their intercultural competence. While patients reported satisfaction with care, many Latina mothers shared moments in which care could have been more culturally sensitive.

Keywords
Latino culture, hospital staff, birthing experience, obstetrics

Impacting the Latino Birthing Experience with a Cultural Competence Training Program
Margo A. Halm, RN, PhD, ACNS-BC
Edward Wilgus, PhD
and other health care professionals are culturally competent. Becoming culturally competent is an ongoing process that involves seeking cultural knowledge, skills, and awareness so that care can be delivered effectively within the cultural context of an individual, family, and community (Campinha-Bacote, 2002; Eggenberger, Grassley, & Restrepo, 2006). Intercultural competence reflects the degree to which cultural differences and commonalities in values, expectations, beliefs, and practices are effectively bridged; an inclusive environment is achieved; and specific differences are addressed from a mutual adaptation perspective. Intercultural competence is the capacity to accurately understand and adapt behavior to cultural differences and commonalities (Campinha-Bacote, 2002; Flowers, 2004; Leninger 2002; Papadopoulos, 2006).

**Background and Setting**

As demographic changes have taken place in the Mid-Willamette Valley, our 454-bed regional medical center made a strategic commitment not merely to address but to significantly advance the cultural competence of the interdisciplinary health care team (Table 1). The need to nurture and develop cultural competence was especially evident within our Family Birth Center, not solely because of changing demographics. The Center delivers over 3,500 babies each year, a large proportion from the Latino culture. The major driving forces for change in this care setting included: (a) several recent, significant patient care events with Latino families during the birth experience; (b) objective patient data indicating a need to address culturally effective personalized care; (c) service excellence team members observing a need to focus on culturally competent nursing care; and (d) staff requesting opportunities for professional learning about cultural diversity.

As a result of these driving forces, the Diversity Manager partnered with the Director of Nursing Research to take advantage of a grant opportunity provided by the Nurturing Cultural Competence in Nursing (NCCN) program to create a demonstration project that would further the organization’s commitment to advancing cultural competence. The specific aim of this QI project was to address the following question: Can an educationally-based intervention develop the intercultural competence of nursing staff practicing in the Mother/Baby Unit (M/B Unit) who serve a culturally diverse population? Based on prior data from Latina patient and family experiences, the project focused on improving culturally sensitive care regarding respect for human dignity, management of pain, involvement of family, and self-care knowledge for after discharge. The ultimate goal of this

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
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<tr>
<td>2003</td>
<td>An assessment was conducted to initiate the integration of diversity and cultural competence.</td>
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<tr>
<td>2005</td>
<td>A Diversity and Cultural Competence Steering Committee was formed to focus on diversity-related issues and programming.</td>
</tr>
<tr>
<td>2007</td>
<td>A Diversity Manager was hired, reflecting the organization’s commitment to cultural competence.</td>
</tr>
<tr>
<td>2008</td>
<td>A Diversity and Cultural Competence Assessment Report was completed, which produced findings, observations, and an analysis of the organization.</td>
</tr>
<tr>
<td>2009</td>
<td>A Cultural Effectiveness Roadmap was approved to serve as a diversity action and accountability plan. A Nurturing Cultural Competence in Nursing grant was awarded by the Oregon Center for Nursing and the Oregon Community Foundation.</td>
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Table 1: Organizational Timeline: Commitment to Diversity and Cultural Competence
program was not only to improve the quality of care, but also to reduce health disparities for this minority population.

Methods

Design

A pre-post evaluation design was used to evaluate the impact of the cultural competence program. Pre-post assessment of cultural competence interventions are highly desired and commonly utilized designs that provide information not only about existing levels of cultural competence, but also about the effectiveness of training to the trainers and participants (Beach, Price, Gary et al., 2005; Papadopoulos, Tilki, & Lees, 2004). The foundation of this program was the Standards of Practice for Culturally Competent Nursing Care by the American Academy of Nursing Expert Panel on Global Nursing and Health along with the Standards of Practice for Culturally Competent Nursing Care (Douglas, Pierce, & Rosenkoetter et al., 2009). The standards reflect a set of universally applicable evidence-based principles for culturally competent nursing care around the globe. These principles include social justice, critical reflection, transcultural nursing knowledge, cross-cultural practice, health care systems and organizations, patient advocacy and empowerment, multicultural workforce, education and training, cross-cultural communication, cross-cultural leadership, policy development, and evidence-based practice and research. The application of these standards in the practice setting may radically reduce racial and ethnic inequalities in health outcomes of patient populations served. This project used the education and training standard as a vehicle to specifically target five of the 12 standards: critical reflection, transcultural nursing knowledge, cross-cultural practice, patient advocacy/empowerment, and cross-cultural communication.

In addition to cultural competence standards, this QI project was grounded in the best practice report of 60 hospitals, Exploring Cultural and Linguistic Services in the Nation’s Hospitals. This report advocates a “no one size fits all” solution to promoting organizational cultural competence (Wilson-Stronks, Lee, Cordeiro et al., 2008). The strategies and approaches are unique for each hospital based on its history, traditions, and staff, as well as the heritage and customs of the patient populations served. From this best practices research, four major themes for promoting cultural competence emerge: 1) building a foundation; 2) collecting and using data to improve services; 3) establishing internal and external collaboration; and 4) accommodating the needs of specific populations. The best practice report advocates systematic adoption of a range of practices that span all four themes and are aligned with patient needs and organizational resources. With the building blocks for cultural competence already in place within the organization’s diversity infrastructure (theme 1), as previously described, this project incorporated use of data to evaluate and improve nursing services (theme 2). In addition, internal and external collaborators with a vital interest in promoting cultural competence were utilized as key organizational stakeholders (theme 3). The core activity concentrated on delivering cultural competence training that targeted the five previously identified standards of culturally competent practice (critical reflection, transcultural nursing knowledge, cross-cultural practice, patient advocacy/empowerment, and cross-cultural communication) in order to assist nurses in attending to and meeting the needs of the Latino population (theme 4) and to promote safe, high-quality care in the M/B Unit.

Measurement

Data collection for this QI project was multi-level. One level of focus was on the patient experience, while the second was on staff intercultural development. In addition, mixed methods were used for evaluation purposes (Qualitative + Quantitative). This project was exempt from the Institutional Review Board since a QI methodology was employed and no personal identifiable information was obtained.
Interviews with Latina mothers. Perceptions of culturally sensitive interventions were assessed from the perspective of Latina patients through face-to-face interviews. This method of getting data directly from the source is consistent with the “no one size fits all” best practice, since surveys have very low rates of return for populations with limited English proficiency. A semi-structured interview guide was used to assess patients’ perceptions of nursing care on the postpartum unit after their deliveries. Focused on the four chosen indicators, the interview guide asked mothers to tell a story or describe how the nursing team had respected their basic dignity as a human being, managed their pain, involved family in care, and taught them about post-discharge self-care. A final open-ended question asked if there was anything else the mothers would like to share regarding how the nursing staff was sensitive to their individual needs. All interviews with patients were conducted just prior to discharge by a bilingual/bicultural Latina senior nursing student, an individual not directly involved in their care in order to ensure confidentiality and open sharing.

Thirty patients were interviewed before and thirty after the Community-based Care Transition Program (CCTP) sessions (N=60). Detailed notes were taken during each interview using the interview guide. The constant comparison method (Richards, 2005) was used to extract themes in the human dignity, pain management, family involvement, and self-care categories. Themes from patients interviewed before the training (pre) were compared to those who received care from staff after the CCTP sessions (post). Although different patients were assessed at the two time-points, general inferences can be drawn by comparing patient reflections about the sensitivity of the nursing care.

Intercultural development of staff. The Intercultural Development Inventory (IDI) is a self-report measure of how deeply one understands culturally learned differences, recognizes commonalities between oneself and others, and acts on increased insight in culturally appropriate ways that facilitate performance, increase patient satisfaction, and reduce health disparities. The 50 IDI items are constructed on a 5-point Likert scale from disagree to agree (Hammer, Bennett, & Wiseman, 2003). Conceptually, the IDI differentiates between one’s perceived orientation and developmental orientation toward cultural differences and commonalities along the intercultural continuum. Perceived orientation is where an individual places him or herself along the continuum, whereas developmental orientation is the perspective most likely used in situations where cultural differences and commonalities need to be bridged. These orientations can be one of the following:

1. Denial: limited perceptions of other cultures based on stereotypes;
2. Polarization (Defense/Reversal): polarized perceptions focused on one’s own ways of doing things as superior to those of other cultures;
3. Minimization: perspective that recognizes some patterns of cultural difference, but emphasizes dealing with these through a commonality lens that masks underlying differences;
4. Acceptance: perspective that recognizes cultural patterns need to be understood from the perspective of the other culture; and
5. Adaptation: shifting perspective to another culture according to cultural context.

The ‘Orientation Gap’ is the difference along the continuum between the perceived and developmental orientations. A gap score of 7 or higher indicates a meaningful difference between the two orientations. As a result, by measuring an individual or group’s fundamental worldview orientation to cultural difference, the IDI gauges their capacity for intercultural development.
competence from a monocultural (ethnocentric) to an intercultural (ethnorelativist) mindset (Hammer, 2008).

Content validity of the original 60-item IDI was established through in-depth interviews with individuals from a variety of cultures. Evaluations by a panel of experts, followed by survey pilot testing, reduced the original scale from 60 to 50 items that cross five factors: denial/defense (DD), reversal (R), minimization (M), acceptance/adaptation (AA), and encapsulated marginality (EM). Reliability coefficients for all five scales ranged from 0.80-.085 (Hammer et al., 2003).

The IDI was administered via computer as a pre- and post-group measure of cultural competence. Pre-assessments were completed prior to the CCTP. Post-assessments were completed after the focus group sessions held five months after the CCTP. A group cultural competence score was calculated to assess the degree of change in cultural competence after the training sessions. A group score, rather than individual scores, reassured staff about the anonymity of their responses. Group scores were also the most appropriate unit of analysis, since the goal of this project was to determine how effective the CCTP was in heightening collective staff awareness and promoting cultural behavior change on the M/B unit.

**Focus groups with staff.** Approximately five months after the CCTP sessions, two focus group sessions were held to obtain staff feedback. This time lag allowed nursing staff time to assimilate the new knowledge and reflect on their cultural awareness, as well as to experience how the training had impacted their delivery of culturally based interventions in practice. A Latino consultant group with expertise in focus group methodology facilitated the sessions using the following standard script:

1. Since the training, identify any critical incidents related to working with Latino and/or second language patients.
2. What did you notice? What did you become aware of? What feelings, thoughts, and behaviors resulted from these incidents? How did you share these insights with your colleagues?
3. Since the training, what are your perceptions about the relationship between cultural effectiveness and service excellence?
4. How did or how might your practice change as a result of any type of learning that occurred throughout the course of the grant program (training session, readings, experiences, reflections, journaling)?
5. If you could pinpoint your greatest learning, what might that be?

The trained focus group facilitators also inquired about prior cultural diversity training; the nursing staff’s background in cultural differences; perceptions regarding what is most interesting and/or challenging in working with people from other cultures, as well as key responsibilities in which cultural differences need to be successfully navigated; and examples of cultural differences needing to be addressed. The facilitator encouraged staff to tell stories about how the CCTP impacted them personally and how it changed their professional practice with Latino families. Focus group sessions were tape-recorded and transcribed to allow the facilitators to identify critical themes.

**Intervention**

Baseline IDI results exposed that the group as a whole believed their perceived orientation was at the level of acceptance. However, group results indicated their developmental orientation was more realistically at the level of minimization. Because the group overestimated
their intercultural competence, a number of strategies listed below (accompanied by the type of learning targeted based on Bloom’s taxonomy [Anderson & Krathwohl, 2001]), were developed as components of the intervention:

1. Presentation of demographic data that portrayed a shifting Latino population in the region (cognitive learning).
2. Experiential cultural skits and role-playing to foster first-hand experience (cognitive, affective, and psychomotor learning): The CCTP was facilitated by a knowledgeable and thoughtfully trained professional Latino theater production group who incorporated birthing themes infused with Latino cultural beliefs and traditions, Spanish language, and original music. This creative arts intervention engaged the hearts and minds of potentially distrustful participants by allowing them to experience the realities of the Latino birth experience. For instance, participants were asked to introduce themselves in Spanish and then share what the experience of not being able to speak another person’s language was like.
3. Engagement in addressing cultural assumptions and stereotypes about Latinos (affective learning): The theater group facilitated an exercise where participants safely called out their main assumptions about the Latino culture. The assumptions were then challenged openly in an effort to dispel the many myths and stereotypes, giving participants a new lens with which to view their Latino patients/families (Earle & Church, 2004; Papadopoulos et al., 2004).
4. Facilitated conversation about the Latino experience in the U.S. (cognitive and affective learning): In an interactive dialogue, a bilingual/Latino pediatrician was invited to share his experience and knowledge of the culture, especially related to the key focus areas (respect for human dignity, pain management, involvement of family, and post-discharge care).
5. Involvement of a Latino family who shared their emotionally charged birthing experience within the health care/hospital context (affective learning): The experience highlighted cultural moments where staff could have demonstrated more intercultural sensitivity.
6. Staff-created scenarios that presented cross-cultural challenges (cognitive, affective, and psychomotor learning): Role-playing was integrated as a learning technique to help participants act out real-life clinical experiences faced by Latina mothers and families. Then, based on learning related to the Latino birth experience, staff re-enacted these scenarios as to how they could better approach these same experiences in their future practice (Figure 1).
7. Selection of evidence-based readings on culturally competent care with Latinos (cognitive and affective learning): At the conclusion, staff were provided with a series of evidence-based readings on cultural competence topics and asked to engage in dialogue and critical reflection related to their practice. For instance, the pamphlet Culture Whispers: Understanding Latino Families was developed to dispel myths and to present cultural beliefs and birthing practices of the Latino population. Journals were also provided to encourage participants to use individualized forms of self-expression.
The intervention integrated three conceptual approaches to training cultural competence: attitudes, knowledge and skills. Betancourt (2003) likened these conceptual components to a three-legged stool in that each is crucial but cannot support any weight when not fully supported by the other two.

**Major Findings**

**Patient Perspectives**

Themes from the Latina mother interviews were categorized with respect to the four focus areas (respect for human dignity, involvement of family/friends, management of pain, and post-discharge care). These themes were derived for three populations: (a) Spanish-speaking mothers, (b) Spanish-English-speaking mothers, and (c) English-speaking mothers. As themes were similar for pre- and post-interviews, key themes were collapsed into the main areas of satisfaction and those in need of improvement (Table 2).

**Staff Perspectives**

**Training reactions.** Eighty staff from the M/B Unit participated in two 7-hour CCTP sessions (56 RNs/ LPNs and 24 support staff, including certified nursing assistants and unit clerks). Thus the goal of 100% staff involvement and participation was met. Both training sessions were conducted in the same manner and incorporated the intervention components previously described.

In program evaluations, staff shared an overwhelmingly high level of satisfaction with components of the CCTP. Program evaluations also revealed the CCTP was successful in impacting cognitive, affective, and psychomotor learning, as shown on Table 3. Some examples of staff training reactions include:
- “I will do my best to greet my patient in Spanish.”
- “I will introduce myself to everyone in the room and teach the family as a whole.”
- “I can’t wait to ask my patients where they come from.”
- “This training reminded me how important it is to slow down and truly listen … and by listening I can better understand how to best care for my patients.”
- “It is important to include the family members in communication and patient care, especially the patient’s mother.”
- “I will try not to make assumptions (positive, negative, or neutral) regarding what my patient might want or need, even with my knowledge of cultural norms.”
- “I won’t assume all Latino families want to use formula. I will educate my patients and their families about breastfeeding.”

**IDI findings.** The group profile revealed a number of characteristics. The vast majority of staff were not from an ethnic minority and had lived their formative years in North America. Two-thirds had never lived in another country. At baseline and five months post-CCTP, acceptance was the perceived orientation, indicating the group recognized and appreciated patterns of cultural difference and commonality in their own and others’ cultures. On the other hand, minimization was the group developmental...
orientation at both time periods. Minimization means that the group had a tendency to highlight commonalities across cultures that can mask important cultural differences in values, perceptions, and behaviors.

As shown in Table 4, the group’s orientation gap between perceived and developmental orientation was greater than seven points. This means the leading orientation for both time periods was acceptance through adaptation, a range focused on increasing cultural self-awareness by learning culture-general and culture-specific frameworks in order to more deeply understand patterns of difference that emerge in interactions with people from other cultures. As a result of this leading orientation, the group is well positioned to look for ways to shift cultural perspective and adapt behavior around cultural differences as its members begin to more fully recognize and appreciate cultural differences. The only secondary orientation, reversal trailing orientation, was seen after the CCTP, indicating that cultural differences were viewed by the group in terms of “us” and “them,” including an overly critical view of one’s own cultural values and practices and an uncritical view of other cultural values and practices. Last, in terms of cultural disengagement, the group was resolved at both time periods. This finding means that individuals were not experiencing a sense of being disconnected from their primary cultural group as a whole.

**Focus group themes.** As indicated by the major focus group themes, the CCTP increased overall staff awareness of perceptions, practices, and cultural beliefs of Latina patients related to the birthing process and infant care. Participants reported adjusting their paradigm related to the importance of family, la familia, as indicated by: (a) the presence of family members during the birthing process, (b) building confianza as a tool to develop trust, (c) inclusion of significant others in decision-making, and (d) engagement of the family in treatment and follow-up. Participants also recognized the role of language in providing effective care.

Overall, focus group feedback echoed the training evaluations. Staff relayed that education is power. Through the education and training process provided by this grant, participants felt empowered to offer better care to Latina and Spanish-speaking patients. Staff reported feeling better prepared and thus believed they had the information needed, relative to how culture impacts healthcare decisions, to assist them in providing effective care to Latina maternity patients. At the close of each focus group, staff was asked to think of one word or simple phrase that would sum up their overall experience in the grant training experience. The following responses were obtained: enlightening, energizing, engaging, eye opening, and heightened

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<table>
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<tr>
<th>Domain of Care</th>
<th>Satisfiers</th>
<th>Dissatisfiers</th>
</tr>
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</table>
| Respect for Human Dignity | - Attentiveness  
- Respect for privacy & cultural preferences | - Lack, of explanations  
- Communication style (impatience, frustration) |
| Management of Pain      | - Frequent pain assessment  
- Prompt medication administration | - Lack of medication teaching  
- Pain not adequately managed |
| Involvement of Family   | - Nurtured presence / accomodated needs  
- Involved family in care | - Family not involved in care |
| Post-Discharge Care     | - Demonstration on care of baby  
- Informative class / questions answered | - Distracting environment with infants  
- Ineffective style of class presenter |

*Table 2: Themes of Latina mothers’ regarding four domains of care: Pre- (n=30) and Post-Interview (n=30) (N=60)*
awareness. Staff reported that the CCTP should be replicated for all hospital staff, including new hires. The M/B Unit staff relayed that as a result of this experience they are now in need of similar and additional cultural competency training related to other diverse ethnic communities they serve, such as the Russian, Pacific Islander, Middle Eastern, Asian, and African cultures.

Discussion

Latina Patient Experiences

At the patient experience level, the pre- and post-patient interviews (although conducted...
with different Latina mothers) revealed both positive aspects of the four priority areas (respect for human dignity, management of pain, involvement of family/friends, and post-discharge care of self and baby) and continued opportunities for improvement. While these preliminary findings reinforce that CCTPs may impact patient satisfaction (Beach et al., 2005), true improvement could only be identified through interviews with Latina mothers who experienced care before and after the program. Thus, this data collection method was one of the main limitations of this project. Regardless, the patient interview findings underscore the continual work required on the journey towards becoming culturally competent. For instance, Latina mothers continued to express that family were not actively involved in their care after the time period that staff had participated in the cultural competence program. Eggenberger and colleagues (2006) reinforce the significance of the concept of familism, the intergenerational helping networks that include both the nuclear and extended family group in the Latino social organization system. Other sources of Latina mothers’ dissatisfaction that possibly had cultural undertones were the communication styles of some nurses, who displayed impatience and frustration.

Impact on Staff Experiences

From the vantage point of the nursing staff, the collective data revealed that the knowledge, attitudes, and skills of the staff in providing care to the Latino population were enhanced by the intervention. Perceived understanding of the Latino culture more than doubled, from 27% to 57%, rating understanding as good. Perceived comfort and effectiveness in providing care to the Latina mother also increased, but in smaller degrees: from 34% to 43%, rating comfort as good, and from 16% to 29%, rating effectiveness as very good. Indeed, a systematic

<table>
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<th>Baseline Score</th>
<th>Post Score</th>
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<tr>
<td>Perceived level of understanding of Latino culture rated as ‘good’</td>
<td>27%</td>
</tr>
<tr>
<td>Perceived comfort in providing care to Latino population rated as ‘good’</td>
<td>34%</td>
</tr>
<tr>
<td>Perceived effectiveness in providing care to Latino population rated as ‘very good’</td>
<td>16%</td>
</tr>
</tbody>
</table>

**Table 4: Intercultural Developmental Inventory (IDI) Results**

* ‘Leading Orientation’ are those orientations that are immediately in front of the ‘Developmental Orientation’, or ones next step in intercultural development. For example, if one’s Developmental Orientation is Minimization, then the Leading Orientations would be Acceptance and Adaptation.

** ‘Trailing Orientation’ are those orientations that are in back of the ‘Developmental Orientation’ on the continuum that are not resolved, which may pull an individual back from their development orientation when dealing with cultural differences and commonalities.

*** ‘Cultural Disengagement’ signals perceptions relating to connection or disconnection toward one’s own cultural community.
review of educational programs that promote the cultural competence of health care professionals found such interventions to have a positive impact on the intermediate outcomes of knowledge, attitudes, and skills. The impact on these intermediate outcomes is promising in that they may ultimately impact patient outcomes. As Beach and colleagues (2005) suggest, health care professionals who are more knowledgeable, have a more positive attitude toward their patient’s cultural backgrounds, and practice communication skills in a patient-centered manner will likely provide better patient care. Additionally, the systematic review found that short and long duration cultural competence interventions were both effective, as were programs that focused on either general cultural or culture-specific concepts, or used either experiential or non-experiential learning methods (Beach et al., 2005).

While actual IDI scores and intercultural competence levels did not change significantly from pre- to post-data, a likely explanation for this finding is the short time period between the completion of the CCTP and post-IDI assessment at five months. Significant change in IDI scores along the cultural competence continuum likely takes a longer period of time, involving sustained focus and critical reflection. Further study is needed to identify the training components (including sequence and timing) that are most effective in evoking change in the worldview of clinicians at both the group and individual levels of analysis. Serial measurement of intercultural competence over time would also strengthen the design of these projects.

The central challenge of the cultural competence intervention occurred early in the grant cycle. The baseline IDI assessment told us that the group’s cultural competence was not advanced and that staff actually overemphasized their level of competence. This perception proved to be a challenge early on, evidenced by staff wondering what the project was about and why they needed to learn about the Latino culture.

As Papadopoulos et al. (2004) point out, requiring mandatory attendance can lead to resistance and superficial participation, due to participant perceptions of performance inadequacies. Resistance was lessened by meeting with the Mother/Baby specialty practice team (SPT) prior to the CCTP sessions to engage the team in the process and outcomes to be achieved, including the benefits for patients and for the greater organization. An additional factor that reduced resistance was the experiential nature of the intervention, including the non-threatening and collaborative learning environment that was created. The program was extremely relevant to nursing in that it took the issue of cultural competence to the level of the bedside clinician. The CCTP, as well as self-paced learning and critical reflection activities, reminded clinicians about the importance of quality patient-provider communication, since it is through this interaction that clinicians can best understand a patient’s cultural values, nuances, behaviors, and preferences and how these come into play in meeting their healthcare needs.

Many lessons were learned along the journey towards developing cultural competence in our Family Birth Center. These lessons may be summarized as follows:

1. Clinicians learn in different styles (hands-on, visual, auditory): Multiple learning styles need to be addressed through the process of the CCTP.
2. Focusing on cultural competency is a process: This grant was a seed that has been planted; the true challenge is building and sustaining the capacity to continually focus on patient care across cultures.
3. Collaboration is crucial: Success can be measured by the involvement of numerous parties in both the implementation and follow-up phases of the project.
4. Exposing new staff to diversity and cultural competency training should
take place immediately upon entry into the organization.

5. The more we know about a culture, the more we do not know: The more staff became aware of what they did not know about Latino culture, the more they recognized that additional training was needed for other diverse communities served (e.g., Russian, Pacific Islander, Middle Eastern, African-American).

As the program evolved over time, a major success of the collaboration with staff and other internal/external partners was the growing recognition that service excellence and cultural competency training go hand in hand. Concrete consequences of the cultural competence program include a pictorial essay of the training, along with concepts learned, displayed in a public place within the hospital. Also to promote continual learning and reflection, the Diversity Manager wrote a staff educational brochure, Latina Voices, that highlights what it means to provide culturally competent maternity care to Latina patients and their families. Individual concepts learned have been attached to diversity bracelets and made available to anyone within the hospital. A final product video tells the story of the learning process of the staff along the cultural competence continuum journey. Another unintended consequence was recognition of the need not only to revamp the discharge education video for English-speaking patients, but also to create a Spanish-language version. Concepts and practices related to intercultural competence have been presented at service excellence/patient satisfaction meetings, in addition to being integrated into the MBU SPT, a micro-system that meets monthly to work on quality issues related to professional practice. The M/B Unit SPT made a commitment to advancing and sustaining this work by convening a diversity cohort to address issues related to cultural competence. The team was so enthusiastic that a diversity subcommittee was formed that now meets monthly as well. One of the first activities the group undertook was the development of a brochure, Communicating with Your Spanish-speaking Patients, that lists common English phrases in Spanish. A Latina RN then volunteered to offer brown-bag sessions over lunch to help nurses learn how to say some of these phrases in Spanish when caring for their patients.

As a result of these learning experiences, the M/B nursing staff expressed strong beliefs that the CCTP should be replicated for all employees within the organization. This perception was likely tied to the fact that staff believed the training was successful in improving their cultural awareness of the Latina patient’s cultural norms, customs, and values related to the maternity experience. As a result of this recommendation, the Diversity Program, in collaboration with the Family Birth Center, trained an additional 200 clinical and support staff within the Labor and Delivery and Neonatal Intensive Care Units. Collaboration with the theater group was so successful that the Diversity Program partnered with this team to utilize their services in further training of staff teams.

The local and regional relevance of this project rests on the fact that the organization is creating ways to meet the changing demographic health care needs of the populations served. Accordingly, the organization will hopefully be seen as a leader and provide a model to be emulated by other health care facilities not only in the Mid-Willamette Valley but also in the Pacific Northwest. The project itself conveyed a message that has permeated numerous areas of the hospital: the nation’s health care needs are becoming as diverse as its population. Hospital staff in other specialties is seeking professional opportunities to explore cultural competence in their own practice. Staff is talking about cultural competence and how they want to be more directly involved in Diversity Team meetings. In addition, this project has communicated a message to both the Latino community and hospital
employees that the Latino voice and culture are gifts to be celebrated.

As a result of this work, the team partnered with the Medical-Surgical Oncology Unit to create best practices for culturally sensitive end-of-life care. This project was recently awarded a national seed grant from The Beryl Institute entitled Caring for Patients at the End of Life: One Size Doesn’t Fit All. The Beryl Institute is passionate about supporting research that positively impacts the patient experience. This project is focused on educating the interdisciplinary team on an evidence-based end-of-life protocol that incorporates the culturally mediated beliefs, practices, and preferences of the Latino, Russian, and Micronesian populations in our area.

Recommendations for Replication

Based on the local experience, several components of the CCTP were integral to its success and therefore are recommended as promising practices for replication and further testing. These elements include:

1. Focus on cultural assumptions/stereotypes to encourage nurses to confront their biases.
2. Personal sharing of real-life cultural moments and stories.
3. Utilization of a creative arts theater approach to engage staff in more fully experiencing and embracing Latino birth events.
4. Incorporation of experiential learning techniques to promote informal dialogue among nurses about insights and lessons learned as new information is acquired and applied in practice.

Systematic testing will be useful to identify specific training activities that assist individuals and teams in moving along the intercultural development continuum.

Several factors are critical for successful replication. Foremost, a project of this nature cannot succeed without solid leadership support. A key ingredient for the success of the program was the full support of the CEO, Board of Trustees, and other top executives, which enabled the project team to creatively move forward to educate and the mentor staff to become better equipped to meet the needs of diverse patient/family groups. Replication would also be extremely challenging without creative ingenuity in training techniques, the presence of a learning culture/organization, and the engagement and involvement of staff in recognizing the importance of the journey.

Conclusion

While the cultural competence intervention did not significantly change the intercultural development level of the staff, it did increase staff knowledge, awareness, and understanding of how to effectively serve Latina patients by attending to cultural norms, customs, and values during the birthing experience. Further studies are needed to systematically test cultural competence interventions and identify training activities that are successful in assisting individuals and teams in moving along the intercultural development continuum. Experiential learning activities are promising practices, as they promote informal dialogue and sharing among staff while advancing cognitive, affective, and psychomotor learning related to becoming culturally competent.

Despite beginning successes, a key message of this cultural competence QI project is that individuals often overestimate their level of cultural competence. It is ever important that clinicians pay close attention to what patients
and families say, because a disparity often exists between the customer’s level of perceived satisfaction and the level of satisfaction the clinician perceives the patient has experienced. In other words, one of the fundamental perspectives needed to grow and become culturally competent is to recognize the limits of our knowledge. Undeniably, the more we know, the more there is to learn about a culture.

References

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