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Research Article

Development and Psychometric Evaluation of the Korean Version of the Cultural Competence Scale for Clinical Nurses

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SUMMARY

Purpose: To develop and psychometrically test the Korean version of the Cultural Competence Scale for Nurses (K-CCSN).
Methods: A multi-phase questionnaire development method was used to develop the scale from November 2012 to April 2013. The item pool was generated based on literature review, existing scales and in-depth interviews. The content validity was evaluated twice by an expert panel. The scale validation was conducted with a convenience sample of 456 general hospital nurses recruited from five general hospitals and a nursing college in the Seoul Metropolitan Area of South Korea. The construct-related and criterion-related validity and internal consistency reliability of the scale were tested.
Results: The 33-item K-CCSN comprised four subscales—cultural awareness, cultural knowledge, cultural sensitivity and cultural skills—explaining 53.96% of the total variance. The criterion-related validity was supported by a known-group comparison. The reliability analysis showed an acceptable-to-high Cronbach's alpha in total and for subscales ranging from .879 to .932.
Conclusion: This preliminary evaluation of psychometric scale properties demonstrated acceptable validity and reliability. The K-CCSN is able to provide scientific and empirical data regarding the cultural competence of clinical nurses. However, further studies are needed to test the applicability of the scale in different settings and contexts.

Introduction

Cultural competence is a complex concept that has not reached a universal definition yet. Nursing scholars have mixed the term "cultural competence" with transcultural nursing, culturally congruent care and culturally sensitive nursing care (Suh, 2004). Leininger (1991) was a pioneer in the nursing discipline who gave attention to the cultural dimension in human caring. She coined the term "culturally congruent care" and developed the Culture Care Theory of Diversity and Universality. Leininger stated the purpose of the theory as to discover ways for providing culturally congruent care to promote the health and well-being of clients, families and cultural groups (Leininger, 1985, 1991). Following Leininger, nursing scholars such as Papadopoulos, Tilki and Taylor (1998), Purnell and Paulanka (1998), Campinha-Bacote (1999), and Schim, Doorenbos, Miller and Benkert (2003) defined and developed theoretical models for cultural competence.

Suh (2004, p. 96) conducted a concept analysis of cultural competence and concluded that, "Cultural competence is an ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities." The American Academy of Nursing (1992, p. 278) defined culturally competent care as being "sensitive to issues related to culture, race, gender, and sexual orientation". This demonstrates that the understating of cultural diversity has not been limited to culture or race but has broadened to more comprehensive inclusion of minority groups.

Although the existing literature has explained various definitions and subconstructs, cultural competence has generally been understood as a nursing capacity to promote the health and wellness of clients whose cultural backgrounds are different from that of the nurses. Also, four subconstructs of cultural competence, cultural awareness, cultural knowledge, cultural sensitivity and cultural skills, have been commonly recognized (Calvillo et al., 2009; Flowers, 2004; Galanti, 2005; Leonard & Plotnikoff, 2000).

The Korean version of the Cultural Competence Scale for Nurses (K-CCSN) was designed to measure the cultural competence of

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clinical nurses in Korea. It was viewed within the context of a modified "model for developing cultural competence" originally developed by Papadopoulos et al. (1998). Papadopoulos (2003, p. 5) defined cultural competence as "the capacity to provide effective healthcare taking into consideration peoples' cultural beliefs, behaviors and needs…The achievement of cultural competence requires the synthesis of previously gained awareness, knowledge and sensitivity and its application in the assessment of clients' needs, clinical diagnosis and other caring skills." Papadopoulos et al. presented a four-stage model of circulation: cultural awareness (first stage), cultural knowledge (second stage), cultural sensitivity (third stage) and cultural competence (fourth stage). In the current study, we replaced the cultural competence component with cultural skills. Figure 1 displays the conceptual framework of this study.

Until recently, Korea was a culturally and ethnically homogeneous society. Since the 1990s, the number of international marriages involving women immigrants and foreign workers has been continuously increasing in Korea (Nho & Kim, 2011). Also, foreign patients are becoming increasingly common along with a boom of the medical tourism industry, which combines medical service and tourism (Jin, Kim, Sung, Hwang, & Jung, 2010). In 2009, the Korean government declared that global healthcare was a new growth engine industry. Since then, the average annual growth rate of medical tourism has increased by 42.5% (Ministry of Health & Welfare, 2013). According to recent statistics, foreign residents account for 2.8% of the Korean population, while more than 150,000 patients visit Korea each year (Ministry of Health & Welfare; Ministry of Justice, 2012). As a result, the use of South Korea's healthcare services has expanded to include racially, ethnically and linguistically diverse clients, creating a growing need for developing the cultural competence of nursing professionals. Education and training based on scientific and empirical studies and using a reliable and valid scale are required to provide culturally appropriate nursing care to those diverse clients.

Several scales, such as the Inventory of Assessing the Process of Cultural Competence Among Health Care Professionals (IAPCC; Campinha-Bacote, 1999), the Cultural Competence Assessment (CCA; Schim et al., 2003), Caffrey Cultural Competence in Healthcare Scale (Caffrey, Neander, Markle, & Stewart, 2005), Cultural Self-Efficacy Scale (Bernal & Froman, 1987) and Transcultural Self-Efficacy Tool (TSET; Jeffreys, 2000) have been developed and used in nursing researches. These scales are intended to measure nursing students (Caffrey et al.; Jeffreys), community health nurses (Bernal & Froman), healthcare professionals (Campinha-Bacote) or more inclusive healthcare workers (Schim et al.). The Cultural Self-Efficacy Scale and TSET were based on Bandura's social cognitive theory (Bandura, 1977), while the IAPCC and CCA were guided by their own theoretical models. The number of items vary from 25 items (CCA) to 83 items (TSET). Response scales are Likert-type scales that vary from 4 points (IAPCC) to 10 points (TSET). The internal consistency was most widely used to test reliability and Cronbach's alpha was more than .70 in most studies, which is considered acceptable (Nunnally, 1978). Additionally, split-half or test–retest reliability methods were reported in limited studies (Campinha-Bacote; Jeffreys). Most of them reported content and construct validity. However, except for the TSET and CCA, the validity was tested in few studies only. Of all scales, IAPCC is the most commonly used in nursing studies.

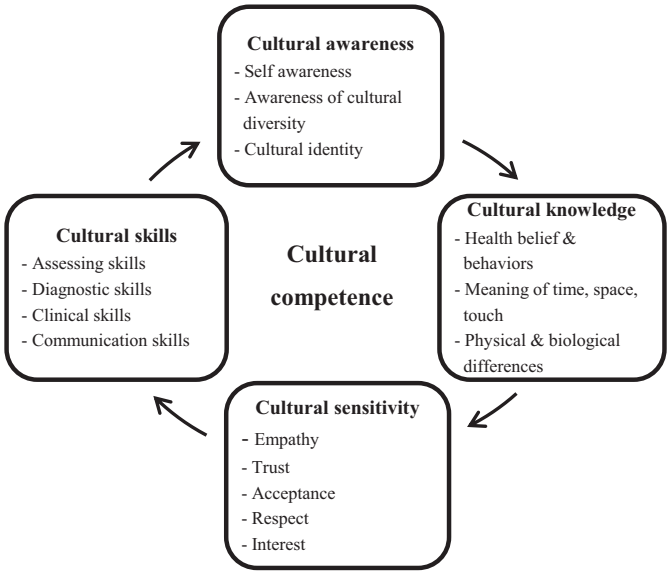

Figure 1. Modified conceptual framework of Papadopoulos, Tilki, and Taylor (1998), a model for developing cultural competence.

The most research on cultural competence in nurses was conducted in the United States, Canada, the UK and Australia with long histories of multicultural societies. Globalization increases the need to develop the cultural competence of nurses among those who have lived and cared for clients in a homogeneous society until recently. In the last few years, translated versions of the IAPCC were used in research in countries other than North America, such as Sweden (Henriksson, 2006; Olt, Jirwe, Gustavsson & Emami, 2010), Japan (Kawashima, 2008) and Taiwan (Ho & Lee, 2007).

However, in these studies, the study participants expressed their difficulties in understanding some items and perceived meaning differently from that of the original tool (Kawashima, 2008; Olt et al., 2010). For example, the term "cultural competence" was especially difficult for Swedish and Japanese nurses to understand (Henriksson, 2006; Kawashima; Olt et al.) because cultural competence is a relatively unfamiliar issue and the knowledge of cultural competence is limited in these countries (Jirwe, Gerrish, Keeney & Emami, 2009; Kawashima). Swedish and Japanese nurses perceived the culturally or ethnically diverse client as a foreign patient. Nonetheless, the IAPCC was based on expanded conceptions of cultural diversity, including socioeconomic status, education, religion and sexual orientation. Thus, no cultural and construct equivalence was established between the original and translated scales. For these reasons, studies from Japan, Taiwan and Sweden reported weak reliability and validity (Henriksson; Ho & Lee, 2007; Kawashima; Olt et al.).

Like in Japan, Taiwan and Sweden, the academic interest on nurses' cultural competence is at a very early stage. The same is the case in Korea. Since 2011, three studies (Chae, Park, Kang & Lee, 2012; Lee, Kim & Lee, 2012; Yang, Kwon & Lee, 2012; Kim, 2013) have been reported in peer-reviewed journals. They used a scale that was originally developed for social workers (Yang et al.) or nursing students (Kim). In addition to this, they composed a new scale using a part of previous instruments (Chae et al.; Lee et al.). Although Kim reported a translation process and obtaining content validity of the translated scale, an appropriate validation process of the translated scales has not been sufficiently addressed in these studies.

Recently, two cultural competence scales (Choi, 2010; Nho & Kim, 2011) were developed in Korea to measure the cultural competence of human service workers, mainly social workers. Although these scales have an acceptable validity and reliability, they are not appropriate for measuring the cultural competence of clinical nurses. This may be because the nurse and culturally or ethnically diverse client interaction occurs with different care expectations as well as in different situational contexts. Thus, the