Nurse Education in Practice 15 (2015) 218–224

Contents lists available at ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/nepr

Learning and teaching in clinical practice

eSimulation: A novel approach to enhancing cultural competence within a health care organisation

Astrid Perry [a, *], Lisa Woodland [b, 1], Scott Brunero [c, 2]

[a] Multicultural Health Service, South Eastern Sydney Local Health District, PO Box 1614, Sydney NSW 2001, 301 Forbes Street, Darlinghurst, NSW 2010, Australia
[b] Learning and Workforce Development, Multicultural Health Service, South Eastern Sydney Local Health District, PO Box 1614, Sydney NSW 2001, Level 1, 301 Forbes St, Darlinghurst, NSW 2010, Australia
[c] Mental Health Liaison, Prince of Wales Hospital, Level 1 East Wing, Edmund Blackett Building, High Street, Randwick 2031, Australia

ARTICLE INFO

Article history:
Accepted 19 November 2014

Keywords:
Cultural competence education
Educational modules
Transcultural health
Culturally competent health care
Diversity
eLearning
eSimulation

ABSTRACT

The need for Australian health care organisations to deliver culturally competent and safe care to its increasingly diverse population provided the impetus for the development of an interactive eSimulation module "Communicating with Patients from Culturally and Linguistically Diverse Backgrounds, Case Study: Ms Shu Fen Chen". This article discusses the rationale, development and implementation of the module. Feedback from sixty nurses and allied health professionals indicated the module was highly engaging and had a positive impact on learners' confidence, knowledge and clinical practice. It is concluded that eSimulation modules can contribute to the uptake of cultural competency training and create a foundation for further initiatives to enhance the provision of culturally competent health care.

Introduction

Cultural diversity in Australia

Australia is a multicultural country whose cultural and linguistic diversity has been shaped over many years by a strong migration program (Australian Bureau of Statistics [ABS], 2012). Since 1945, the proportion of people born in an overseas country has steadily increased with an additional one million migrants arriving in each subsequent decade (Department of Immigration and Citizenship [DIAC], 2011).

The 2011 population census (ABS, 2011) identified that, of Australia's 22.3 million people, 19% were born in non-English speaking countries with the same percentage speaking a language other than English at home, with these figures rising to 31% and 37% respectively in major metropolitan areas such as Sydney (ABS, 2013). Australia is becoming increasingly more diverse with the most rapid population growth (average annual increase) for the ten years since 2001 for persons from Nepal (27%), Sudan (17.6%), India (12.7%), Bangladesh (11.9%) and Pakistan (10.2%) (DIAC, 2011). Of the migrants settled in Australia for more than ten years, almost half spoke a language other than English at home, most commonly Mandarin (4.3%), Cantonese (4.2%), Italian (3.7%) and Vietnamese (3.2%) (ABS, 2013). Of the more recent arrivals (less than ten years), 67% spoke a language other than English at home, most commonly Mandarin (10.8%), Punjabi (3.7%), Hindi (3.3%) and Arabic (3.0%) (ABS, 2013).

The provision of safe, high quality health care relies on health services responding appropriately to this cultural and linguistic diversity. This article discusses the rationale, development and implementation of an eSimulation module on cultural competency. The module was designed for nurses and allied health professionals employed through the health care organisation. An eSimulation approach was chosen to promote the uptake of cultural competency training and to create a foundation for further initiatives to enhance the provision of culturally competent health care.

Cultural competence

The Australian National Health and Medical Research Council (NHMRC) has promoted the following definition of cultural competence: "a set of congruent behaviours, attitudes, and policies

* Corresponding author. Tel.: +61 2 9382 8676; fax: +61 2 9382 8651.
E-mail addresses: astrid.perry@sesiahs.health.nsw.gov.au (A. Perry), lisa.woodland@sesiahs.health.nsw.gov.au (L. Woodland).
[1] Tel.: +61 2 9382 8670; fax: +61 2 9382 8651.
[2] Tel.: +61 2 9382 2797; fax: +61 2 9383 3035.

http://dx.doi.org/10.1016/j.nepr.2014.11.013
1471-5953/

that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (NHMRC, 2006 p. 10, based on Cross et al. 1989). Achievement of cultural competence requires a multifaceted approach targeting structural and systemic aspects of the health system as well as developing a culturally competent workforce (Alexander, 2008; NHMRC, 2006). Differing terminology is noted in the international literature when describing minority populations, with a strong focus on under-served racial and ethnic groups in the United States (US), minority ethnic or culturally diverse groups in the United Kingdom and non-English speaking background (NESB) and/or culturally and linguistically diverse (CALD) populations in Australia (Roberts et al., 2014; NSW Ministry of Health, 2012; Long, 2012; Bhui et al., 2007). Despite differences in terminology, there are consistent strategies recommended to address the multiple socio-cultural barriers to health care to these target populations. These include the recruitment of people from target communities into the health workforce, routine use of interpreter services and translated health education materials for people with limited English language proficiency (LEP), cultural tailoring of health care programs and cultural competency training for health professionals (Gari et al., 2013; Alexander, 2008).

Cultural competency training

Education and training of health professionals in cultural competence has been identified as a necessary strategy to developing culturally sensitive, congruent and responsive clinical practice (Alexander, 2008). There is a significant emphasis on cultural competency in undergraduate nursing training in the international literature (Roberts et al., 2014; Long, 2012). In Australia there is particular emphasis on its inclusion in nurse education in the clinical environment (NSW Ministry of Health, 2012). Various approaches to cultural competency training have been described in the literature over the past ten years (Long, 2012; Alexander, 2008). Cultural awareness and cultural sensitivity approaches have preferenced cultural briefings on the traditions and customs of ethno-specific groups (Leishman, 2004), however, concerns have been raised about the promotion of stereotypes (Betancourt, 2006; Beach et al., 2005). Johnstone and Kanitsaki (2006) have emphasised training in the use of professional interpreters, arguing that culture, language and safety are interlinked. Patient centred approaches have focused on the social, cultural and economic influences on individuals' health related values, beliefs and behaviours (Renzaho et al., 2013; Betancourt, 2006; Beach et al., 2005) while systems approaches have emphasised organisational cultural competence (Johnstone and Kanitsaki, 2006; NHMRC, 2006; Stewart, 2006), where training is seen as a strategic approach to improving organizational performance (Roberts et al., 2014; Alexander, 2008; Curtis et al., 2007).

There is mounting evidence from Australia and the US that cultural competency training can improve the attitudes, knowledge, skills and behaviours of health professionals and impact positively on patient satisfaction (Renzaho et al., 2013; Betancourt and Green, 2010; Beach et al., 2005). The use of professional interpreters has been linked with reduction in lengths of stay (Flores, 2005) and reduction of medical errors (Cohen et al., 2005) for patients with LEP. However, there are few research studies that have linked increased cultural competence with improved health outcomes, and health disparities for racial minorities and people with LEP remain (Long, 2012; Beach et al., 2005).

eSimulation as an educational approach

In a review of the impact of the on-line learning environment for practicing nurses, Gerkin et al. (2009) noted that the eSimulation format is both a satisfactory and effective learning medium, the benefits of which include convenience, flexible program design, incorporation of adult learning principles and accommodation of multiple learning styles. While promoting self efficacy in learners (Docherty et al., 2005), eSimulation has also been identified as a cost effective method of delivering professional education, promoting the uptake of training through reduced training time, travel time, reliance on trainer's availability and the ease of delivering to large numbers of geographically dispersed learners (Ward et al., 2008).

eSimulation is an eLearning approach informed by a constructivist pedagogical perspective in which the learner is placed in an interactive environment for knowledge building and is presented with scenarios that encourage experimentation and discovery of principles (Joint Information Systems Committee, 2004). It authentically recreates experiences in real world situations to enable the development of knowledge, skills and attitudes (Guise et al., 2012). eSimulation has been positively evaluated in the areas of critical care nursing competencies, blood transfusion practices, undergraduate surgery training, pharmacological training, difficult nurse-patient relationships and mental health education for generalist nurses (Brunero et al., 2012). eSimulation is argued to have a positive effect on knowledge, attitude and skill level, with most users describing advantages beyond these, suggesting that the simulated 'real life' experience and the availability of the resource are key to the success of this type of learning (Lamont and Brunero, 2013a).

Development of the eSimulation module

Organisational context

The module was developed within a metropolitan Local Health District (LHD) in Sydney, New South Wales (NSW), Australia. The LHD employs over 13,000 staff across seven hospitals and 25 community health settings and approximately 55% of the workforce are nurses. The LHD provides care for a population of 840,000, of whom 23% were born overseas in a non-English speaking country and 37% speak a language other than English at home (South Eastern Sydney Local Health District [SESLHD], 2013). Issues within the LHD, common across the Australian health care system, include increasing patient diversity, increasing demands on clinical services and decreasing opportunities for staff to be released from clinical work to attend face to face education and training. The organisation has adopted a range of approaches to meet the needs of its culturally and linguistically diverse population which include (1) policies mandating routine collection of each patient's country of birth and language spoken at home and need for professional interpreters for patients with LEP; (2) employment of dedicated bilingual health professionals across a range of clinical settings; (3) annual reporting of services and programs targeting people from CALD backgrounds; (4) a specialist Multicultural Health Service; (5) a Multicultural Health Advisory Committee; and (6) a range of workforce development initiatives. However, uptake of cultural competency training has been limited, the use of professional interpreters for patients with LEP is less than 50% (SESLHD, 2014a) and the provision of culturally competent care to culturally diverse patient groups has remained inconsistent.

Content development

The development of the content for the module "Communicating with Patients from Culturally and Linguistically Diverse Backgrounds – Case Study: Ms Shu Fen Chen was informed by research with the local Chinese community. The patient's cultural