

# Cultural Competence of Obstetric and Neonatal Nurses

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## Keywords

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## ABSTRACT

**Objectives:** To measure the cultural competence level of obstetric and neonatal nurses, explore relationships between cultural competence and selected sociodemographic variables, and identify factors related to cultural competence.

**Design:** Descriptive correlational study.

**Setting:** Online survey.

**Participants:** A convenience sample of 132 obstetric and neonatal registered nurses practicing in the United States.

**Methods:** Nurse participants completed the Cultural Competence Assessment (CCA) instrument, which included Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behaviors (CCB) subscales, and a sociodemographic questionnaire. Correlation and regression analyses were conducted.

**Results:** The average CCA score was 5.38 (possible range = 1.00–7.00). CCA scores were negatively correlated with age and positively correlated with self-ranked cultural competence, years of nursing experience, years of experience within the specialty area, and number of types of previous cultural diversity training. CCB subscale scores were correlated positively with age, years of nursing experience, years of experience within the specialty area, and number of types of previous diversity training. CAS subscale scores were positively correlated with number of types of previous diversity training. Standard multiple linear regression explained approximately 10%, 12%, and 11% of the variance in CCA, CAS, and CCB scores, respectively.

**Conclusion:** Obstetric and neonatal registered nurses should continue to work toward greater cultural competence. Exposing nurses to more types of cultural diversity training may help achieve greater cultural competence.

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The critical importance of delivering culturally competent nursing care has been well documented in the health care literature for decades and is universally recognized by the nursing profession. This need for cultural competence within nursing practice will only expand as the demographics of United States continue to become more culturally diverse. It is anticipated that by 2043, the non-Hispanic White population will no longer be the majority, and current minority groups (Hispanic, Asian, Pacific Islander, African American, and Native American) will compose more than half of the U.S. population (U.S. Census Bureau, 2012). The U.S. population is among the most diverse in the world, challenging health care providers to practice culturally competent care to promote health equity.

Culture affects all areas of health care, and its effects are particularly strong during critical life

events such as birth and death. Childbearing is imbued with cultural beliefs related to health, health care, reproduction, and the roles of women. Childbearing, as a cultural phenomenon, is experienced within the specific culture's customs and norms, which guide the behaviors of women and families during pregnancy, birth, and the postpartum period (Benza & Liamputtong, 2014).

Maternal mortality among African American/Black women is more than 3 times that of non-Hispanic White women (U.S. Department of Health and Human Services, 2013). Hispanic women born in the United States have greater pregnancy-related mortality rates than non-Hispanic White women, and this rate is more than 5 times greater in African American/Black women (Creanga et al., 2012), representing one of the largest racial disparities in public health indicators. Hispanic

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**To promote health equity, more research is needed to measure the cultural competence level of obstetric and neonatal registered nurses.**

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mothers are more likely to have diabetes, and African American/Black women have the greatest rate of hypertension during pregnancy (U.S. Department of Health and Human Services, 2011).

Disparities in neonatal mortality are also prevalent. From 2008 through 2010 the number of neonatal deaths per 1,000 live births was greatest among African American neonates, followed by Native American/Alaska Native, Hispanic, and White neonates (8.0, 4.3, 3.6, and 3.4 deaths, respectively; National Center of Health Statistics, 2014), and the infant mortality rate in African American/Black infants was more than twice that of White infants (Hoyert & Xu, 2012). This is not surprising, because African American/Black women have the greatest incidence of preterm birth and low-birth-weight births in the United States, and women of minority groups are less likely to receive first trimester prenatal care (U.S. Department of Health and Human Services, 2015).

### Cultural Competence

Health care provider cultural competence has been defined as possession and use of the cognitive, affective, and psychomotor skills needed to bridge the gaps that often occur when diverse individuals interact (Schim & Doorenbos, 2010). The incorporation of cultural competence into health care practice has been shown to have numerous benefits, including greater health equality (Browne et al., 2012), increased patient satisfaction (Davey, Waite, Nunez, Nino, & Kissil, 2014; Paez, Allen, Beach, Carson, & Cooper, 2009), enhanced communication (Weech-Maldonado et al., 2012), better pain control (Weech-Maldonado et al., 2012), greater medication adherence (Saha et al., 2013), and increased seeking and sharing of information during health care visits (Paez et al., 2009). Cultural competence may also decrease overall medical care expenditures (Bougie, 2013).

Cultural competence also affects the health behaviors of women related to pre- and postnatal care. For example, cultural competence has been reported to increase the incidence of breastfeeding (Riordan & Gill-Hopple, 2001), which

could potentially decrease the incidence of childhood obesity in Hispanic Americans (Hernandez, 2006). Benza and Liamputtong (2014) found that culturally sensitive care promoted prenatal clinic attendance and promoted positive outcomes for mothers and newborns. Culturally competent patient-centered care also has been shown to affect the amount of prenatal care received by Hispanic women and their ability to learn at prenatal appointments (Tandon, Parillo, & Keefer, 2005). Castro and Ruiz (2009) showed that Latina women in their study were more satisfied with providers who had undergone cultural competence training and were more likely to adhere to recommended treatments. Additionally, Chan, Wong, Lam, Wong, and Kwok (2013) found that postpartum women desired nurses who demonstrated cultural competence, which enhanced their childbirth experience and increased patient satisfaction.

No researchers have quantitatively measured the cultural competence of obstetric and neonatal registered nurses; however, several have explored the cultural competence of hospice and palliative care providers (Doorenbos & Schim, 2004; Schim, Doorenbos, & Borse, 2005, 2006), oncology surgeons (Doorenbos, Morris, Haozous, Harris, & Flum, 2016), and nurses in Italy (Cicolini et al., 2015). Cultural competence attitudes and knowledge have been positively associated with level of educational attainment (Cicolini et al., 2015; Schim et al., 2005, 2006) and receipt of prior cultural sensitivity training (Schim et al., 2005). An increase in cultural competence behaviors also has been associated with prior diversity training (Cicolini et al., 2015; Schim et al., 2005, 2006) and greater educational attainment (Cicolini et al., 2015; Schim et al., 2005). Age, race or ethnicity, years of health care experience, and number of racial and ethnic groups encountered have not been correlated with cultural competence in palliative care providers (Schim et al., 2005, 2006). Age also has not been found to correlate with cultural competence in oncology surgeons (Doorenbos et al., 2016). However, years of clinical experience has been associated with cultural competence behaviors and cultural competence attitudes and knowledge in Italian nurses (Cicolini et al., 2015).

Cultural competence has been discussed and described in nursing and health care literature for many years. Recently, Chan et al. (2013) found that most postpartum women in their qualitative

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