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A Gap Analysis of Nursing Systems and Practices in Malaysia: Culturally Appropriate Interventions to Advance Nursing

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With deepest appreciation
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Abstract

This project comprises a gap analysis of differences between American and Malaysian nursing programs, and additionally, proposes culturally appropriate interventions for Malaysian nursing to adopt American nursing models. The gap analysis was conducted on nursing systems and practices in Malaysia undertaken to identify the differences between Malaysian and American nursing, and the influences that affect Malaysian nursing. The aim is to facilitate the use of the American Nurses Credentialing Center (ANCC) Pathway to Excellence Practice Standard #4: Orientation Prepares New Nurses for the Work Environment, and #6: Professional Development is Provided and Used. The proposal of culturally appropriate interventions as a means to effectively introduce American nursing approaches to Malaysia for short and long term purposes was derived from the gap analysis data. The project is based on the framework that cultural understanding is necessary for the success of a cross-cultural project. Using Hofstede's national culture dimensions as the foundation, the main intervention focuses on cross-cultural training with the use of simulation to create cultural awareness.

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Gap Analysis of Nursing Systems and Practices in Malaysia:
Culturally Appropriate Interventions to Advance Nursing

Executive Summary

This project comprises a gap analysis of differences between American and Malaysian nursing programs, and additionally, proposes culturally appropriate interventions for Malaysian nursing to adopt American nursing models. The gap analysis was conducted on nursing systems and practices in Malaysia undertaken to identify the differences between Malaysian and American nursing, and the influences that affect Malaysian nursing. The aim is to facilitate the use of the American Nurses Credentialing Center (ANCC) Pathway to Excellence Practice Standard #4: Orientation Prepares New Nurses for the Work Environment, and #6: Professional Development is Provided and Used. The proposal of culturally appropriate interventions as a means to effectively introduce American nursing approaches to Malaysia for short and long term purposes was derived from the gap analysis data. The main intervention focuses on cross-cultural training with the use of simulation to create cultural awareness. This project was assumed for Johns Hopkins Medicine International (JHMI) with the proposed commissioning of Perdana University Hospital in 2014 which JHMI will be managing.

The paper is subtitled into five sections:

Section I	Covers the gap analysis and is the largest section as it entails literature reviews on the status and influences of nursing in Malaysia; visits to hospitals and schools of nursing; discussions with key informants; and observations of people and their perspectives on life in Malaysia. The findings are such that nursing in Malaysia has remained relatively unchanged for the past four decades, and cultural factors brought about by the complex racial and ethnic mix of Malaysians have contributed to the situation in nursing.
Section II	Discusses the intervention of cross-cultural training emphasizing simulation as a method that has been used in business for the past four decades.
Section III	As the project does not include the actual implementation of interventions, this section describes the proposed interventions covering orientation and

career development opportunities.

Section IV — Proposes evaluative measures for the interventions for the interventions of orientation and career development, and short and long-term goals of the JHMI-PUH partnership.

Section V — Addresses time and budgetary issues, practical implications of the project, and a conclusion.

Section I

Introduction

Malaysia, a small country in Southeast Asia of 27 million people, is a young nation. After five centuries of colonization by European powers, the country gained independence in 1957 from Great Britain. Having experienced 150 years under British rule, systems in Malaysia, from government to banking, from education to health care, are traditionally British. Under these systems, Malaysia has done relatively well practicing a constitutional monarchy with a fairly open economy that has enabled the provision of free education and free basic health care to her people. As a developing country, Malaysia has much to learn from developed countries. Britain, Japan, the United States, Germany, Taiwan, Korea, and Singapore have contributed much to Malaysia's economic growth (Thomas White Global Investing, 2012; Athukorala & Menon, 1996).

The American influence has gradually grown over the years especially in technology and information technology with the founding of American factories such as Intel, Advanced Micro Devices, and Motorola in Malaysia followed by Agilent and Dell later (Tye, 2002). As Malaysians were increasingly exposed to American technology, more Malaysians went to the U.S. to pursue higher education. It is expected that American influence can only grow stronger in Malaysia (U.S. Department of State, 2012).

Background

The opportunity for introducing Malaysia to the American approach to health care arose with the invitation to Johns Hopkins University School of Medicine (JHUSOM) to begin a medical school at Perdana University in Serdang, Malaysia. Chase Perdana Sdn Bhd (private limited company), an investment group with the support of the Malaysian government signed an agreement with JHUSOM in 2010. JHUSOM was to pioneer the first 4-year graduate medical degree program in Malaysia at Perdana University, "a public private project" with approval from the Malaysian Prime Minister's Department (Chase Perdana, 2012). Upon receiving the approvals from the Malaysian Ministry of Education, Malaysian Qualifications Agency, and the Malaysian Medical Council, Perdana University Graduate School of Medicine (PUGSOM) admitted its inaugural group of 24 students in September 2011 (Chase Perdana, 2012). Scholarships were provided by the Malaysian Public Service Department (Jabatan Perkhidmatan Awam) to all qualified students (Chase Perdana, 2012).

Chase Perdana plans for a 600-bed "Teaching Hospital of Perdana University" to be affiliated with Johns Hopkins Medicine International (JHMI). It will be the first private teaching hospital in Malaysia (Chase Perdana, 2012). JHMI is granted the right to design and manage all aspects of the hospital on its commission. This responsibility will include managing the department of nursing. Without a prior working history in Malaysia, JHMI has to learn about the Malaysian hospital and nursing systems and practices to facilitate the introduction of the American approach effectively.

Statement of the Problem

As little is known about Malaysian nursing, the purpose of this project is to analyze how different the two systems are, essentially identifying the "gap". The goal is to identify critical

factors that will influence proposed interventions to enable JHMI to succeed in implementing the American approach to nursing, or more specifically, the use of the American Nurses Credentialing Center (ANCC) Pathway to Excellence Practice Standard #4: Orientation Prepares New Nurses for the Work Environment, and #6: Professional Development is Provided and Used.

The Johns Hopkins Nursing evidence-based practice (JHNEBP) model provides a foundation to professional nursing. It calls for nursing leaders to "promote practice based on evidence, to cultivate a spirit of continuous learning, and to translate the highest quality evidence into practice" (Dearholt & Dang, 2012, p.33). In an environment where nurses are encouraged to ask questions to improve practice, JHNEBP expects nurses to be able to evaluate evidence for quality to support their practice. This inquiry requires teamwork and the appreciation of expert opinions as well as input from patients. External factors such as regulatory bodies and laws governing health care, and internal factors including the culture, values and beliefs as well leadership, support and resources of an institution, affect the practice of the model (Dearholt & Dang, 2012). JHNEPB is very much in line with the ANCC Magnet Model in which nurses are empowered in their practice to encourage professional satisfaction and retention both at their place of employment and in nursing (Dearholt & Dang, 2012).

The Magnet Model is applicable to an advanced professional practice of nursing. It is recognized that in many situations, the Magnet Model cannot be achieved due to circumstances of budgetary constraints and availability of qualified personnel (Frellick, 2011). The ANCC Pathway to Excellence is a less demanding model focusing on positive work environments for nurses and an environment based on EBP (Frellick, 2011). It is to the credit of the leaders at JHMI, in their short visit to Malaysia in June 2012, that the ANCC Pathway to Excellence

Standards #4 and #6 may be the appropriate place to start for nursing at Perdana University Hospital (PUH).

The second part to this project is to identify culturally appropriate interventions to begin the process of transformation of the Malaysian nursing system to the expectations set forth by JHMI for PUH. From the gap analysis, factors influencing nursing and work in Malaysia must be given due consideration for the interventions to be effectively implemented. The goals for the second part of the project are to ensure the proposed interventions will provide an effective commissioning of PUH, and promote sustainability of the hospital as well as the development of long-term American-Malaysian partnerships in nursing.

The undeveloped nature of this project presents itself with the inevitability that the gap analysis may command the biggest portion of this project. It is assumed that the gap analysis will provide substantial data to assist in the development of the culturally appropriate interventions. It is also assumed that culture will play a role in the interventions and in the development of the JHMI-PUH nursing partnership. Another limitation of this project is that the interventions will be a proposal, and the actual implementation and evaluation of the interventions may happen in the future outside the timeframe of the due date of this write-up. As such, the "evaluation" part of this project is also a proposal, and contents of the evaluation can be perceived as "suggestions" for probable utilization as seen fit in a future time.

Significance of the Project

In this global age where information sharing is a touch of a button away for many people, cross-cultural understanding and cooperation remains an elusive goal for many societies. As migration of peoples across borders increases with population growth, the inevitable crossings of paths of different cultures will also multiply. Cultural competency and advocacy are two

concepts in health care that have been given much attention in recent years. With globalization and changes in demographics, nurses everywhere are no longer immune to different cultural perspectives and needs. In 2011, the Joint Commission (2009) required that care given in the United States must be culturally competent to promote patient safety. Culturally competent care would recognize not only the importance of language, but also an understanding of cultural concepts and beliefs such as faith healing, diet, role of the family, and beliefs on causes of illnesses. It is thus reasonable to say that patient advocacy, an expectation of all nurses to uphold patient rights, must include appropriate cultural knowledge. The role of culture in health care and the need for cultural competency are captured in the Transcultural Nursing Society's Standards of Practice for Culturally Competent Nursing Care (Douglas et al., 2009). The twelve Standards nobly call for a commitment to learning and understanding the cultural differences based on the principles of social justice.

Campesino (2008) describes a traditional view of "cultures as distinct entities with clear separation from other groups" without consideration for the "permeable" nature of societies and individuals (p.301). She observed, as other educators of cultural competency have offered, that cultural competency cannot be learned from one course as traditionally been done in schools, or from attending one-time conferences and seminars teaching "monolithic and timeless representations of an entire group of people" (Campesino, 2008, p. 302). Teaching and learning cultures superficially can result in stereotyping which can harm patients even if the practice is done without ill-intent. It is observed that becoming culturally competent is a developmental process and not a static accomplishment (Brathwaite & Majumdar, 2006; Munoz, DoBroka, & Mohammad, 2009; and Brown, Warren, Brehm, Breen, Bierschbach, & Smith, 2008).

This development of "competency" in cross-cultural awareness has brought about curriculum changes in nursing education in the U.S. since the 1990's from texts describing generic aspects of culture to the more recent move towards global education (Kulbok, Mitchell, Glick, and Greiner; 2012; Parker, Locsin, and Longo, 2006; Schweer, 2004; Smith-Miller, Leak, Harlan, Dieckmann, and Sherwood, 2010). Nursing schools today conduct exchange programs for nursing students to obtain first-hand experience in cultural living and learning. Global experiences provide students with a wider perspective of life and healthcare (Smith-Miller et al., 2010). As Kulbok and her colleagues describe in their literature review on global exchange programs, by living in another culture, students reflect, learn humility, and to appreciate their own culture and other cultures in a deeper sense (Kulbok et al., 2012). Cultural relativism and pluralism make people less judgmental and more able to see the perspectives of others, and render better patient-centered care (Forsyth, O'Boyle, & McDaniel, 2008). Many of these projects have evolved into joint educational programs for information and knowledge exchange. The JHU School of Nursing Center for Global Nursing is one of these programs giving their students hands-on clinical experience worldwide (Johns Hopkins University School of Nursing, 2011). In establishing the nursing program at PUH, JHMI, in many ways, is helping to extend the work of the JHU School of Nursing Center for Global Nursing. There is opportunity in the future for the possibility of nursing exchange programs between PUH and the JHU School of Nursing, contributing to cross-cultural understanding and cooperation, international nursing knowledge exchange, and better patient care locally. Research opportunities also abound in cross-cultural care, healthcare in a developing country, and tropical medicine.

By conducting a gap analysis, JHMI is taking the first steps in understanding the differences in nursing systems and practices of the two countries, Malaysia and the U.S., and

identifying factors that will positively influence interventions for the use of the ANCC Pathway to Excellence Standards numbers 4 and 6. Cross-cultural understanding, as the foundation to successful cross-cultural work, is the underlying framework for this project. The development of culturally appropriate interventions is the beginning for many more opportunities between JHMI and PUH starting with nursing, and in a bigger context, between Malaysia and the U.S. in the healthcare industry.

Methodology

The gap analysis comprised of (a) literature searches and reviews on Malaysian nursing and the cultural influences on work in Malaysia; (b) visits to Malaysian hospitals and schools of nursing; (c) discussions with key informants—nurses and nursing leaders of the industry; and (d) observations of the culture in Malaysia as an "insider". Much of the initial assessment of Malaysian nursing systems and practices by Jane Shivnan, Executive Director, Clinical Quality and Nursing, Johns Hopkins Medicine International also contributed to this gap analysis. Answers are sought for the following questions:

1. What is the current state of nursing in Malaysia?
2. How are nurses educated and how do nurses practice in Malaysia?
3. What are the influences in nursing education and practice?
4. Why the influences?
5. How do the influences potentially affect the introduction of JHMI evidence-based nursing?
6. Based on the information gathered, how can JHMI most effectively facilitate their model of practice using the American Nurses Credentialing Center (ANCC) Pathway to Excellence Practice Standard #4 (Orientation Prepares New Nurses for the Work Environment), and #6 (Professional Development is Provided and Used)?

The interventions proposed are based on this author's understanding of American nursing as an American and British trained nurse, the expectations of JHMI, and her knowledge of the Malaysian culture having been brought up in this country with current familial ties, and the American culture having lived in the U.S. for most of her adult life.

I. Literature Review

As the subject matter of the project is undeveloped and underdeveloped, an initial search of Malaysian nursing was done using Google. While this might be considered unusual search strategy for an academic paper, a search using Google can provide an immediate judge on the maturity of a subject matter, and will provide topical information that might not yet be in journals. For example, a search for "American nursing" produced an immediate yield of professional nursing organizations with well-developed websites providing essential data such as the American Nurses Credentialing Center (ANCC) Pathway to Excellence. The search for Malaysian nursing brought few findings of significance: official government sites with limited data; a few academic theses; websites for nursing conferences, nursing schools, and nursing jobs; and a number of media reports on the nursing needs of the country and more recently, on the many unemployed and poorly prepared nursing graduates. The lack of quality and substance of these websites is a reflection of the immaturity of Malaysian nursing. The following is a summary of these sites:

1. Government sites on nursing and health care are of limited use for the purpose of information gathering. Kanchanachitra et al. (2011), in their regional study on health care workforce needs, noted that governments in Southeast Asia do not sufficiently collect data. For example, the Malaysian Nursing Board site does not provide any data on the numbers of nurses practicing in the country, the educational background of nurses, or any numbers on schools of nursing.
2. Government sites and websites of nursing schools and conferences are written in poor English with the exception of a few. The standard of English has dropped over the decades since Malaysia's independence from the British in 1957. There have been calls

by the government to improve English as indicated in the latest "education blueprint" (Chapman, K., Kulasagaran, P., & Kang, S.C., 2012).

3. There has been much media coverage on the reported shortage of nurses in Malaysia, the growth of nursing schools, and the quality of training provided. Much has been said about the lack of nurses in Malaysia causing ward closures and Malaysia not being able to meet the World Health Organization recommended nurse to population ratio of 1:200 by 2015 ("Happy Graduates," 2010; "Nation Faces Shortage," 2004; Then, S., 2006, December; "Nursing Profession," 2007; Edwards, 2008, July). In response to the nursing shortage, the government has promoted the opening of nursing schools from 24 in 2007 to a total of 106 in 2010, and encouraging high-school graduates to enter nursing ("Ensuring Quality," 2007; "More Nursing," 2004; Then, S., 2006, October; "Move to Stop," 2010; "Recommendation," 2006; Wong, L., 2010, May). The uncontrolled growth of private nursing education institutions and the lack of oversight of the schools have led to the recent negative media coverage on thousands of unemployed nursing school graduates and graduates who are reportedly ill-prepared ("Five Thousand," 2012; "Hire Local Grads," 2012; "Jobs in Nursing," 2012; "Nursing Job Woes," 2012; "System Needed," 2012). In response, the Ministry of Health has increased the entry requirement into diploma programs raising the 3-SPM (Sijil Pelajaran Malaysian or the Malaysian equivalent to the 'O' levels) credit criteria to 5-SPM credits (Choong, E.H., 2011, August; Mokhtar, L., Lean, L.P., & Noorazam, N. , 2012, March; "Nurse the Real," 2012), and imposed a moratorium on private nursing schools ("Five Thousand," 2010; "Nurse the Real," 2012; "System Needed," 2012). These actions have had an impact on

lowering nursing school enrolment and the enforcement of the Ministry on maintaining the higher entry criteria (Choong, E.H., 2011, August; "RM140,000 Compound," 2012).

Searches were run on the following academic nursing and health care search engines: CINAHL, OVID and PUBMED. The Boolean phrases of "nursing" and "Malaysia" on CINAHL yielded 99 articles ranging from 1948 to the present. Substituting "nurse" for "nursing" did not improve the yield. The limited availability and the types of articles on nursing in Malaysia can be perceived as an indicator of the professional level of nursing in this country. The dearth of material on nursing in Malaysia was also reported by Barnett, Navasivayam and Narudin (2009). Dr. Phil Hunt (personal communication, July 25, 2012) explained that he has had to use research articles from other countries and adapt them to Malaysia in his work.

Early articles were largely narratives of British and Australian nurses describing their nursing experience in Malaya (pre-independence Malaysia) and Malaysia. Limiting the search to the past 10 years of 2002-2012, the yield was 68 articles. A quick browse of the 68 articles indicated two main areas of interest--nursing education, and research related to disease management such as a patient's ability to cope with diabetes and medical management of ventilated patients. A further limitation was added to the search by adding the Boolean phrase of "education" which resulted in 35 articles of which 4 were non-academic articles in nursing newsletters; one was in Japanese; one was on physician education; and 15 were researches related to disease management.

The same approach was used on OVID to yield 18 articles of which one was a repeat from the CINAHL search. One article on Asian nurses in the United States had minimal relation to Malaysian nursing as the article merely stated the U.S. is not a country to which Malaysian nurses traditionally go (Liou & Grobe, 2008). Sixteen articles were either research articles on

disease management or not related to Malaysia but with authors from Malaysia. The PUBMED search yielded 48 articles, 39 of which were articles on disease management or not related to Malaysian nursing. Seven articles were already cited in CINAHL; one was an abstract on assessing distance learning students using the objective structured clinical examination (OSCE) by Oranye, Ahmad, Ahmad, & Bakar (2012); and the last citation on PUBMED, an abstract on e-learning in nursing education by Syed-Mohamad, Pardi, Zainal, & Ismail (2006) could not be found as a full-text article. The authors summarized that e-learning is a powerful tool but recommended it is most suitably used in hybrid programs (Syed-Mohamad et al., 2006).

Fifteen articles were reviewed. These articles cover the following categories or topics: the nursing shortage; nursing motivation for continuing education; description of post registration nursing education; nursing training; one article on legal and ethical aspects of nursing which is of little value to nursing as it largely covered the issue from the medical perspective (Nemie, 2009). A majority of the articles, nine, were contributed by faculty of nursing programs of Australian universities. Of the eight articles covering nursing education, two were found to be of minimal value as they were descriptions of education seminars offered in Malaysia (Achike & Nain, 2005; Birks, 2011). Achike and Nain (2005) lent perspective to the slow process of change in Malaysia in their description of introducing problem-based learning (PBL) to schools of nursing in the country.

The description of shared values by Australia and Malaysia had little to contribute beyond the brief historical context of Malaysian nursing (Birks, Francis, & Chapman, 2009). The study on drug administration errors completed by Chua, Tea, and Rahman (2009) provided the first data on drug errors in Malaysia. The rate of errors, 11.4%, is compatible with developed countries. Of significance is that 10.4% of the errors were considered potentially life-

threatening. Doctors were found to contribute to more errors in administrating intra-venous medications and that may be an indication of the fact that Malaysian nurses do not administer bolus intra-venous medications (Chua et al., 2009). The letter to the editor by Shamsudin (2006), Professor and Head of the nursing program at University College Sedaya International, provided a perspective from a nursing leader on the need for Malaysia to progress beyond the diploma-level training for nurses with the growing complexities in health care.

As noted by Shamsudin (2006), Malaysia is late in transitioning to the degree level of nursing education. Diploma-based training has been so entrenched and remains so today that it is only within the past decade that research has been conducted to assess the motivation for Malaysian nurses to pursue post-registration education (Birks, Francis, & Chapman, 2009a; Chiu, 2005; and Chiu, 2006). Birks et al (2009a) and Chiu (2005, 2006) found that nurses were internally motivated to continue their education even though systems and society in general failed to appreciate the value of obtaining a degree in nursing. All three studies were conducted on students who pursued their bachelors when no recognition was given to nurses with degrees. The nurses had a thirst for knowledge, wanted to be recognized as professionals, and most went on to pursue career changes within nursing, feeling empowered by their education (Birks et al, 2009a; Chiu, 2005, 2006).

The cultural obstacles preventing nursing in Malaysia from moving forward in a timely manner cannot be overstated. Birks, Francis, and Chapman (2009b) described the influence of religion and tradition on women which comprised 99% of the nursing work-force according to their sources in 2006. Islamic societies share a low image of nurses, require low entry criteria into nursing, pay nurses poorly, and generally are behind in nursing education and practice (Birks et al., 2009b). Ahmad and Oranye (2010) also suggested that the lack of professional

recognition for nursing in Malaysia could be related to a traditionalist Islamic state. The lack of professional recognition may be a contributory factor to a low sense of job satisfaction among nurses in a public teaching hospital. In contrast, their English counterparts at a public teaching hospital felt more empowered at their place of employment and were more inclined to stay. The authors suggested that age may have a role to play in the sense of empowerment in traditional societies versus that of a developed society which valued freedom and flexibility as empowering (Ahmad & Oranye, 2010). Without knowing where these hospitals are, it is hard to conclude why the Malaysian nurses were more committed to stay at their place of employment. Siew, Chitpakdee and Chontawan (2011) found that marriage may be a factor in influencing freedom to move. Associated with the commitment to stay at their place of employment is years of service at the nurses' respective hospitals (Siew et al., 2011).

Ahmad and Oranye (2010) emphasized the need to appreciate cultural influences in shaping policies affecting nursing. Culture affects the understanding and definition of concepts. As presented by Siew et al. (2011), "professional status" is perceived to be appreciation by patients, physicians, and other health care providers--the nurses felt "treated as important persons in the hospitals" (p. 26). One could argue that this sense of "professional status" which affects the nurses' commitment to stay at their place of employment is not the same as the appreciation of nursing as a profession by society. It should be noted that the last two articles used samples from government owned public hospitals which largely comprised Malay nurses (87% and 93% respectively) and not representative of Malaysian nurses.

The effects of the slow adoption of new systems and approaches to nursing and nursing education, as indicated by the late adoption of the diploma in nursing in 1990 (Shamsudin, 2006), is seen clearly in how nursing is taught. Emphasis remains in achieving competency in

technical skills. Learning leans heavily on tutor or lecturer-led activities, not student-centered needs (Ooi & Barnett, 2012; Said, Rogayah, & Hafizah, 2009). A contributory factor in the inability to break away from the traditional approach may be a lack of qualified faculty, or "trained manpower" (Achike & Nain, 2005).

As for the much discussed shortage of nurses in Malaysia, Barnett, Namasivayam & Narudin (2010) and Kanchanachitra et al. (2011) shared concern for the lack of planning in managing the shortage. The government's method of opening new schools and producing new graduates is a symptomatic response instead of entailing wider workplace reform (Barnett et al. (2010). Kanchanachitra et al. (2011), providing a regional view of the health care personnel shortage and distribution, essentially called for better regulation of private institutions which has diluted the quality of training and contributed to an over-supply of nurses. They also called for governments to invest in the collection of "timely data that could improve understanding of the situation and inform policy" without which governments are unable to monitor the "production and employment" of health care workers (Kanchanachitra et al., 2011, p. 780). The authors noted that Malaysia exports nurses to the Middle East, United Kingdom, Australia, and Singapore, and imports nurses from India, Bangladesh, and the Philippines, a position shared by Matsuno (n.d.) in a report written on nurse migration in Asia. The fifteen articles reviewed are compiled in Table I, and they are noted to comprise largely of non-research articles.

In summary, the limited literature available and reviewed on nursing in Malaysia indicates the early developmental stage of nursing as a profession in Malaysia. Birks et al. (2009b) put Malaysian nursing in the first stage of "unexamined acceptance" based on Robert's 5-stages of rising against oppression which

> "…identifies a negative view of nursing and an unquestioning acceptance of the role of nurses, the power of the system, and

the dominance of physicians…." (p.121).

Several factors contribute to this stagnation: It is a woman-dominated vocation marked by low education, a lack of leadership, a lack of qualified manpower, poor government policies, and a culture which encompasses the political and the religious. While there are signs of rising awareness, the pace of change and the policies accompanying this change, especially in the promotion of private institutions to produce more nurses to meet the nursing shortage, have negatively affected nursing in Malaysia.

A search on "Malaysia," "work," and "cultural influences" using academic search engines Proquest and Academic Search Premier yielded eleven articles of relevance published between 2002 and 2012. The articles provided a look into the complex racial relations of the country and its effects on work. A further look into Hofstede's findings on culture, referenced by Bhaskaran and Sukumaran (2007); Noordin, Williams, and Zimmer (2002); Selvarajah and Meyer (2006); and Selvarajah and Meyer, (2008), offered five articles of relevance on the influence of culture on work.

Religion and ethnicity greatly influence work culture in Malaysia. The three main races--Malays, Chinese and Indians bring with them the influence of Islam, Confucianism, Taoism, Buddhism, and Hinduism to their work. Christianity and Western values, however, are of growing influence today (Bhaskaran & Sukumaran, 2007; Selvarajah & Meyer, 2006; Selvarajah & Meyer, 2008). The national culture of Malaysia, following Hofstede's model, can be summarized as generally hierarchical with high power distance; status conscious with a deep respect for elders and roles in society; paternalistic; relationship-based instead of task-oriented; largely collective in approaching work; and confrontation-averse emphasizing "harmony and

face-saving" (Bhaskaran & Sukumaran, 2007; Dooley, 2003; Noordin et al., 2002; Selvarajah & Meyer, 2006; Selvarajah & Meyer, 2008; Zainol & Ayadurai, 2010).

An appreciation of Hofstede's findings on national culture and its influence on work (Hofstede, n.d.a; Minkov & Hofstede, 2011; Triandis, 2004) can help facilitate better understanding between countries. Particularly in the modern world of multinational corporations where work is truly global, developing better working relationships among staff of different world views can literally make or break a company. Dooley (2003) and Condron, Thompson and Dove (2004) highlighted the importance of this subject in their writing describing the success and failure of American companies working in Malaysia. Hofstede's research is based on the five dimensions of culture: individualism-collectivism, power distance, masculine-feminine, uncertainty avoidance, and long-term orientation (Hofstede, n.d.). Of these five dimensions, the first two, individualism-collectivism and power distance have the most impact on Malaysian-American working relationship.

According to Hofstede's findings, the individualistic culture is best exemplified by Americans where independence, freedom, and self-reliance are valued (Dooley, 2003). Malaysians, collectivist in nature, value respect for elders and maintaining family and community harmony (Dooley, 2003). Americans have low power distance where people view themselves as somewhat equal; Malaysians have high power distance where titles and roles in society matter greatly (Dooley, 2003). These two dimensions affect the way people communicate. Because Malaysians value relationships, communication is "high context" in nature emphasizing politeness not only verbally but in body language and facial expressions (Condron et al., 2004, p. 51). From the perspective of a "low context" communicator where speech is direct and precise, the category into which Americans fall, Malaysians' style of

communication is ambiguous (Condron et al., 2004, p. 51). Spoken language can and is often misinterpreted either as rude or offensive by the high context communicator of the low context person, and untrustworthy or misleading by the low context communicator of the high context person (Dooley, 2003; Condron et al., 2004).

These two dimensions also influence how the societies perceive time. American view time as a resource and tend to be precise in reference to time whereas Malaysians view time, again, in the context of relationships where time cannot be precise as relationships take priority (Dooley, 2003; Condron et al., 2004). The example of a meeting is given where Americans will adjourn a meeting for the next task whereas Malaysians will give whatever time is needed to resolve an issue so as not to be perceived as rude to any participants (Dooley, 2003; Condron et al., 2004). This reference to time has been greatly affected by the industrialization of Malaysia; the rural population coming to work for task-oriented Multinational Corporation (MNC) has had to adjust to time-keeping with some difficulty (Elias, n.d.). Even so, the issue of "Malaysian time" still brings passionate opinions on how Malaysians should change for the country's future and to realize the country's goal to be a developed country ("High cost to," 2012; "'Malaysian time,'" 2012).

While Hofstede's dimensions explains much of the Malaysian culture and its influence on how her people work, other social institutions such as the government's role in economics, level of industrialization, model of education, and labor union activities also influence work culture (Parboteeah & Cullen, 2003). In Malaysia, the first three issues affect work culture, the most important being the governmental policy in economics which comes in the form of affirmative action. It is, however, a policy that is racially and culturally based adding to the complexity of Hofstede's findings.

The policies of affirmative action in education and employment since independence for the majority "Bumiputra" (comprising largely Malay Muslims) have contributed to tremendous progress in reducing poverty in the country but have also created disequilibrium in the already complex racial relations (Lee, 2005; Montesino, 2011). The share of wealth has not been equitable inter- and intra-racially; the rise in dissatisfaction has brought racial riots in recent years and the creation of a viable opposition to the government since 2008. The population has a fear for a further decline in race relations having experienced a violent riot in 1969. Affirmative action also contributed to the creation of a Malay middle-class though largely entrenched in the civil service and government owned businesses such as Petronas and Telekom Malaysia (Lee, 2005; Montesino, 2011). A sense of entitlement persists and is of concern to the government as it has stifled innovation (Lee, 2005; Montesino, 2011; Zainol & Ayadurai, 2010). A large bureaucracy has also slowed any pace of change (Lee, 2005; Montesino, 2011), and a lack of urgency, compounded by "Malaysian time," is experienced by foreign investors and expatriates (Tahir & Ismail, 2007; Condon et al., 2004). A lack of competition is tied to low work centrality or commitment (Parboteeah & Cullen, 2003), and job performance as indicated by the study completed by Bakar, Salleh, and Lee (2008) which found that a competitive corporate culture increases the job performance of employees in Malaysia.

Affirmative action has also created a lower standard of education as the government gradually lowered passing scores to enable "Bumiputra" students to meet the higher standards of the "non-Bumiputra" students (Lee, 2005). This lowered expectation has led to inadequately prepared students. Job expectations of new graduates in recent years are described by employers as "unrealistic", a finding that crosses industries (Jusoh, Simun, & Siong, 2011). A well-

structured orientation is essential to set expectations from the beginning of employment (Jusoh et al., 2011).

In summary, the two most important factors that influence the work culture in Malaysia are (a) Hofetede's dimensions of individualism-collectivism and power distance which stem from the religious and ethnic composition of Malaysian society, and (b) governmental policies in the form of affirmative action. Learning from MNC's, particularly American companies, it is crucial that cross-cultural training is made available to employees from all cultures at the very beginning of employment to facilitate learning and acceptance, and to set expectations (Dooley, 2003; Condron et al., 2004). Dooley (2003) shows that employer commitment to diversity and cross-cultural understanding can have an impact on job performance in Malaysia. Articles of significant contribution to the above topic of influences on work are summarized in Table II.

The literature search and review have uncovered that the influence of these two factors, Hofetede's dimensions and affirmative action on the work culture in Malaysia, may explain the status of Malaysian nursing. Considered feminine work in a society bound by religious and cultural traditions, nursing has been a safe choice of work for women in Malaysian. Accustomed to a subservient role in a culture that emphasizes harmony and face-saving, hierarchy, status, roles and titles, nurses in Malaysia do not challenge the status quo or question "orders" given to them by their parents or physicians. A combination of these cultural influences and affirmative action, which has seen the leadership of nursing in Malaysian confined largely to Muslim women, may have played a role in the slow pace of change in the nursing profession in this country.

II. Visits to Hospitals and Schools of Nursing

A total of four hospitals and five schools of nursing were formally visited: Penang Adventist Hospital (PAH) and School of Nursing (SON) in Penang; Mahokota Medical Center (MMC) and School of Nursing in Malacca; Assunta Hospital (AH) and School of Nursing; International Medical University (IMU); Lincoln University College (LUC); and Gleneagles Hospital Kuala Lumpur (GHKL), the last four institutions in Kuala Lumpur. Visits to Lam Wah Ee Hospital, Gleneagles Hospital Penang, and Pantai Hospital in Penang were unofficial as they were undertaken as a visiting family member of patients. It is noted that three hospitals in Penang alone are adding "new towers" to their sites, affirming the growth in the Malaysian health care industry, in particular, medical tourism ("Penang tops list," 2012). Medical tourism contributes a large number of the patient population of a hospital; for example, 45% of patients at PAH and 23% at MMC are foreigners (Lim Keat Hoon, personal communication, August 13 2012; Sally Tan, personal communication, September 4, 2102). Depending on the person accompanying the visits to the hospitals, information availability was reliant on the areas and time allowed by the hospitals and schools of nursing.

Of the five schools of nursing visited, IMU is the only school offering a nursing degree. Its entry criteria are the equivalent of 2 passes of the British "A" levels. The other four schools offer the diploma in nursing with the entry criteria of 5 "O" level credits. These entry criteria are standard for nursing schools in Malaysia. IMU will be purchasing Pantai Hospital School of Nursing after which IMU will be known as IMU College. It will start offering diploma level nursing. PAH and AS are not-for-profit institutions. Fluency in English at entry is required by all schools except LUC.

PAH and AH are well-established institutions and their schools of nursing have the reputation of being "good" nursing schools with high board passing rates and producing "good" nurses. There is a high demand for PAH and AH nurses locally and internationally. Both schools have stringent entry criteria into their programs, and produce a small number of nurses per year up to 50 each. There is a sense of pride among AH nurses to be identified as an "Assunta nurse." LUC, on the other hand, produces the largest number of graduates up to 500 a year. It was recently fined by the government for not meeting the basic entry requirements for its student nurses ("RM140,000 compound", 2012).

All schools emphasize technical skills and competency. PAH claimed the nursing process and care planning process is taught in their curriculum (Lim Gek Mui, personal communication, September 12, 2012) but the practice is not observed in the hospital clinical areas. MMC also stated the same (Sally Tan, personal communication, September 12, 2012) but a nurse of the hospital claimed otherwise stating that assessments are done only by physicians and nurses follow orders to complete their tasks:

> "We did [learn]… full assessment but not practicing it which [is]quite sad. ... they just focus and deliver the care [based on] what the doctor diagnosed. Kind of [robotic—carry] their routine [tasks], except for some [who] may have own [their] initiative to do more for the patient" (Kuan Yng Yng, personal communication, July 27, 2012).

MMC is the only school without a simulation laboratory. Low fidelity mannequins are widely used at the other schools. At IMU, the nurse consultant reported that simulation is not being used correctly as frequently, students are simply being observed for completion of tasks as presented on a checklist. Dr. Phil Hunt (personal communication, July 25, 2012) reported there is minimal interaction between the instructor running the simulation and the student, nor is there feedback in the form of a debriefing. Reflective learning is not part of the culture of learning. It

is of interest to this author that the word "scold" was frequently used by instructors at the schools of nursing in reference to managing students who are not performing to expectations. Two of the instructors referred negatively to the "scolding" approach and stated the "tradition" must change (Lim Keat Hoon & Lew Shuh Fang, personal communication, August 13 and August 29, 2012).

Curricula are controlled by the Malaysian Nursing Board (MNB). Minimal changes in curriculum are allowed but any proposed changes of 30% of the established program must have the approval of the MNB. The process of curriculum change can take three to five years (Dr. Phil Hunt and Ng Kok Toh, personal communication, July 25, 2012). The three-year diploma programs essentially cover health sciences, behavioral sciences and nursing sciences, of which nursing sciences must comprise at least 60% of the curriculum (Nursing Board Malaysia, 2010). Forty-five to fifty-five percent of the diploma program must entail practical clinical work in a health care facility, 60% of which must be in medical-surgical nursing (Nursing Board Malaysia, 2010). As listed in the same guidelines, other areas to be covered or considered optional are

> "Orthopaedic; Paediatric; Obstetric; Gynaecology; Ophthalmology; Ear, Nose and Throat; Psychiatry; Oncology; Accident and Emergency; Operation Theatre Unit; Urology; Geriatrics; Nephrology; Community Health Nursing.
> Optional discipline
> □ ICU
> □ CCU
> □ Neurology
> * Note : minimum : 52 - 53 weeks of clinical placement
> * Medical nursing & Surgical nursing : 60% of total disciplines
> * Management practice : minimum 2 weeks
> * Old folk's home and retirement home are not to be used as clinical practice area (except for social responsibility and community activity" (Nursing Board Malaysia, 2010, p. 10).

There is no definition of "Nursing Sciences" beyond "Related Pathophysiology/Nursing Management" (Nursing Board Malaysia, 2010, p. 18). The curriculum defines "Health sciences [as] Anatomy & Physiology, Microbiology, Pharmacology, Parasitology, Epidemiology, Nutrition, Environmental Health … [and] Behavioral sciences [as] Psychology, Sociology, Soft

Skills / Professional Interaction" (Nursing Board Malaysia, 2010, p. 18). Specialty certificates are currently the most common path to a "career ladder" as degrees are still relatively rare but growing with the recent recognition of nursing degrees in the government public service (Ng Kok Toh, personal communication, July 25, 2012; Dato Dr. Bibi F. Abdullah, personal communication, July 26, 2012; Ong Bing Yok, personal communication, September 25, 2012). At present, few private schools have been approved to offer specialty certificates causing a backlog of nurses in need of training as government schools which offer the certificates give priority to government nurses (Ng Kok Toh, personal communication, July 25, 2012; Ong Bing Yok, personal communication, September 25, 2012). Please refer to Appendix A for the curriculum chapter of the Guidelines.

With the exception of self-paying students, all nursing students are bonded to serve 5 years at the institution that sponsored their training. While bonded, the nurses may be contracted by the sponsoring institution to serve at other hospitals, essentially a business transaction of "selling and buying" nurses.

Penang Adventist Hospital, Assunta Hospital, Mahkota Medical Centre, and Gleneagles Hospital Kuala Lumpur practice "task" nursing where units are divided into workable nurse-patient ratios; nurses are tasked with rounding, medication administration or providing treatment. Nurse-patient ratios are guided by the Private Healthcare Facilities and Services Act 1998. According to Ong Bing Yok, the common interpretation of the Private Healthcare Facilities and Services Act 1998 is such that the highest ratio is in the medical-surgical units where the ratio is 1:8 (personal communication, September 25, 2012). The lowest ratio of 1:1 is found in the intensive care and labor and delivery units for ventilated patients and patients in active labor (Ong Bing Yok, personal communication, September 25, 2012). The ratios are similar at

Mahkota Medical Centre as reported by Sally Tan (personal communication, September 4, 2102). PAH, AH and GHKL nurses wear white uniforms with caps; MMC nurses wear lavender uniforms without caps. Uniforms are provided by hospitals.

As observed, there was minimal communication between nurses and physicians at PAH; MMC had a more collegial environment. No physician-nurse exchanges were observed at GHKL or AH. Every nursing leader acknowledged the lack of assertiveness among nurses in Malaysia. Questioning is not encouraged; the physician-nurse relationship is paternalistic. The other issue hindering physician-nurse communication is language; the master of the English language among nurses is considerable low. Two nursing clinical instructors at PAH who had transferred from other hospitals relate the same task-oriented practices at Gleneagles Medical Center and Lam Wah Ee Hospital in Penang (Lim Keat Hoon & Lew Shuh Fang, personal communication, August 13 and August 29, 2012). They confirm that nurse-physician communication is minimal and staff nurses tend not to question physicians. Concerns are frequently escalated through the nursing chain of command.

All hospitals experience a shortage of experienced nurses or "senior" nurses as a large number go abroad, particularly to the Middle East due to a higher salary, reportedly as high as 500% of the pay scale in Malaysia (Ong Bing Yok, personal communication, September 25, 2012). This exodus has affected all hospitals in their ability to facilitate orientation of new graduates; "junior" nurses are orienting new graduates, a situation which is acknowledged as not optimal ((Ng Kok Toh, personal communication, July 25, 2012; Lim Keat Hoon, personal communication, August 13, 2012; Sally Tan personal communication, September 4, 2102; Ong Bing Yok, personal communication, September 25, 2012).

PAH and GHKL are Joint Commission International (JCI) accredited hospitals. MMC did not get accreditation two years ago and will reapply in 2013. All three hospitals have active quality assurance departments tracking JCI required patient safety goals such as hospital-acquired infections, falls, and medication errors. While all three hospitals claim to have a voluntary incident reporting system, only GHKL has an active program in place on the hospital intranet. None of three hospitals presently use computerized charting, however, MMC is in the process of buying a system.

Other non-clinical observations made are that MMC and GHKL emphasize world-class customer service. Both facilities were sparkling clean. MMC is designed to enhance the "5-senses" of patients and visitors (Sally Tan, personal communication, September 4, 2012). A bakery near the entrance welcomes visitors with the smells of fresh bread and pastry; outpatient departments have kitchenette areas serving free drinks and snacks; and patient menus allow for á-la-carte orders of food. Appointments do not work in Malaysia as many patients walk in expecting to be seen by physicians of their choice the same day, preferably at the time of their arrival. All hospitals have three "classes" of rooms: single, double and quads. Most rooms observed had family members with patients assisting the patients with daily activities of living, and acting as patient advocates. Two differing perspectives were given on room choices: Sally Tan (personal communication, September 4, 2012) reported patients liked the options of different "classes;" Ong Bing Yok stated patients attending Gleneagles "all prefer single rooms" (personal communication, September 25, 2012). This difference could be a reflection of the geography of the hospitals, one being in the capital city of the country where the population is more affluent and is able to afford the highest "class" of rooms.

The visits to the schools of nursing confirmed the findings in the literature that nursing education has not progressed far in the past 4-5 decades. Training is largely diploma-based and the curriculum emphasizes technical skills with checklists to ascertain "competency." This one-way approach of instructor-led education without reflective learning may contribute to the lack of assertiveness among nurses in hospitals. Unaccustomed to critical thinking or discussing issues, hampered by language, discouraged by a strict paternalistic physician-nurse relationship, and delegated to "task" nursing, the system does not encourage personal growth. The lack of professionalism may contribute to the cycle of nursing not being able to attract students of higher qualifications. The shortage of qualified nurses may become the incentive to increase salaries making nursing more attractive.

III. Discussions with Key Informants

The following nursing leaders shared their perspectives and knowledge on nursing in Malaysia:

1. Phil Hunt, RN, EdD, nurse consultant for PAH and IMU;
2. Siriporn Tantipoonwinai, RN, PhD, nurse consultant and professor emeritus, Asia-Pacific University Thailand;
3. Shanthi Solomon, RN, MSN, Assistant DON, PAH;
4. Ms Ng Kok Toh, RN, MSN, Principal of AH SON;
5. Dato' Bibi Florina Abdullah, honorary Doctor of Civil Law, University of Northumbria, Pro-Chancellor of LUC, formerly the Director of the MNB (the first director as the position was previously known as Chief Matron);
6. Madam Lee, RN, Principal, LUC SON;
7. Sally Tan, RN, MBA, General Manager, Patient Services, MMC;
8. Madam Tan, RN, Principal, MMC SON;
9. Noraidah Puah, RN, MSN, Lecturer, PAH SON;
10. Ms. Lim Keat Hoon, RN, MSN, Clinical Instructor, PAH SON;
11. Ms. Lew Shuh Fang, RN, Dip. in Nursing, Clinical Instructor, PAH SON.
12. Ms. Ong Bing Yok, RN, BSN, DON, GHKL.

Findings from discussions with the above leaders are generally supported by literature. Certain key points were unanimously shared by all of them which can be categorized into (a) the

state of nursing in Malaysia, (b) nursing leadership, and (c) the cultural complexities affecting nursing. The general acknowledgement is such that nursing has not changed for decades. Nursing is "archaic and entrenched' in Malaysia and the pace of change is "glacial." It may take another 30 years for Malaysian nursing to reach Magnet level of nursing (Dr. Phil Hunt, personal communication, July 25, 2012). Nurses are not in the position to question physician practice/orders from tradition (deemed inappropriate), hierarchy, lack of confidence/education, and lack of support from nursing administration (Shanthi Solomon, personal communication, July 15 and 16, 2012; Lim Keat Hoon & Lew Shuh Fang, personal communication, August 13 and August 29, 2012; Madam Lee, personal communication, July 26, 2012; Madam Tan, personal communication, September 4, 2012). Much of this slow pace of change and nursing practice can be attributed to nursing education in the country where technical skills are emphasized. Skill labs, competencies, licensing, and accreditation in Malaysia are conducted by the "check list method" but with checklists that have not been updated (Dr. Phil Hunt, personal communication, July 25, 2012). As mentioned previously, reflective learning is not used in the educational approach; learning is instructor-led with minimal contribution from students. The lack of fluency in English is unanimously identified as problem in advancing nursing.

Contributing to the lack of change and the lack of professional recognition of nursing in the country is the low qualification of nurse leaders in Malaysia (Dr. Siriporn Tantipoonwinai and Shanthi Solomon, personal communication, July 15 and 16, 2012). Only fifteen Malaysian nurses are known to be doctorally trained (Dato Dr. Bibi F. Abdullah, personal communication, July 26 2012). Nursing "professors" in universities mainly hold bachelor or masters degrees. The lack of qualified leaders limit the introduction of new ideas and vision thus the lack of courage to challenge the status quo and control of nursing by physicians. The majority of the

nursing leaders agree that the entry requirements into nursing should be raised to promote professionalism although there is one call for lowering the standards to promote two levels of nursing: the lower standards for the "hands-on nurse" and the higher standards for the "critical thinking nurse" (Dato Dr. Bibi F. Abdullah, personal communication, July 26, 2012). Dato Dr. Abdullah sees the need to maintain a lower level of entry to meet the needs of rural Malaysia where access to quality education is limited (personal communication, July 26, 2012). Other leaders see the need for better education opportunities from world-class institutions that will not compromise standards of excellence for profit purposes (Shanthi Solomon, personal communication, July 15 and 16, 2012; Dr. Siriporn Tantipoonwinai, personal communication, July 15 and 16, 2012; Dr. Phil Hunt, personal communication, July 25, 2012; Ng Kok Toh, personal communication, July 25, 2012; Ong Bing Yok, personal communication, September 25, 2012).

Another likely contributory factor to the state of nursing in Malaysia is the complex racial politics and affirmative action policies of the country. Race and ethnicity influence decision-making: Meritocracy is second to affirmative action and winning favors by "who you know," the relationship-based approach (Shanthi Solomon, personal communication, July 15 and 16, 2012; Ng Kok Toh, personal communication, July 25, 2012; Dr. Phil Hunt, personal communication, July 25, 2012). The political "who you know" approach in conducting business can make or break a business or institution (Dato Dr. Bibi F. Abdullah, personal communication, July 26, 2012). This approach is best described by Dr. Hunt, "It is not what you know but who you know that makes things happen" (personal communication Dr. Phil Hunt, personal communication, July 25, 2012). Appointments to leadership roles are thus politically-based. Another effect of racially-based politics is the existence of "ethnic enclaves" in nursing as in other industries (Lee,

2005, p. 216): Malays largely work at public hospitals; and Chinese nurses at private hospitals as acknowledged by every nursing leader met. This division causes staffing issues as the hiring manager has to be diligent on whom to hire to make sure the many ethnic holidays in Malaysia are adequately covered (Ong Bing Yok, personal communication, September 25, 2012).

The other cultural influence as discussed in the literature review is the collectivist relation-based approach to work and the high power distance among Malaysians. The society at large is not assertive; silence and quiet responses to instructors or speakers at conferences are the norm (Shanthi Solomon, personal communication, July 15 and 16, 2012; Noraidah Puah, personal communication August 13, 2012). The classrooms observed were quiet, instructor-led, and students only spoke when asked, sometimes after several prompts from the instructor. The same quietness was observed at an international nursing conference held at PAH where participants had few questions to ask of speakers, and applause was always lukewarm.

The issue of inadequately prepared new graduates at "shop-lot" (Dato Dr. Bibi F. Florina, personal communication, July 26, 2012) or "fly-by-night" (Ng Kok Toh, personal communication, August 25, 2012; Madam Lee, personal communication, August 26, 2012) schools was a topic of great concern to the nursing leaders. Recruitment of new graduates has become a challenge; many new graduates fail to succeed even with prolonged orientation of up to 6 months (Dr. Phil Hunt, personal communication July 25, 2012; Ng Kok Toh, personal communication July 25, 2012; Sally Tan, personal communication, September 4, 2012; Ong Bing Yok, personal communication, September 25, 2012). Every hospital has a list of "blacklisted" schools. The cause of this problem has been identified by these leaders as the ill supervision of private schools by the government. No one government agency has taken accountability for the problem but several schools are now closed. The students who had

attended defunct schools or who were ill-prepared are now being forced to go for remediation at other schools but at the cost to the students or assigned schools (Dr. Phil Hunt, personal communication, July 25, 2012; Ng Kok Toh, personal communication, July 25, 2012; Dato Dr. Bibi F. Abdullah, personal communication, July 26, 2012; Madam Lee, personal communication, July 26, 2012; Madam Tan, personal communication, September 4, 2012).

While attending the international nursing conference at PAH, this author had the opportunity to speak with nurses who were co-attendees. Faculty members of various schools shared similar views described by nursing leaders above, in particular, the lack of supervision by the Malaysian Board of Nursing contributing to the over-production of new graduates from "shop lot" schools; the poor standard of English among nurses today; and the need to increase the educational entry level into nursing. Staff nurses shared that it is very difficult to pursue further education in nursing due to the requirement to work full-time in Malaysia. No flexibility in scheduling is available and most hospitals still rotate nurses through all shifts. Clinical practice is confined to task nursing and assessments are conducted by physicians.

In summary, the nursing leaders confirmed the findings of the literature reviews that nursing has not changed for decades. Much can be done to advance the profession of nursing in Malaysia. The challenges in bringing about change, however, are complex, ingrained in the complicated cultural history and composition of the population. Because of these challenges, the pace of change has been slow, and will continue to be slow unless external factors such as a severe shortage of nurses will induce the profession to take steps towards modern nursing at a faster pace.

IV. Observations of Malaysian Culture

Being an "insider" of the local society allowed this author to be part of many discussions. Opinions of relatives, friends, acquaintances, and casual contact were gathered for information that may be of importance to the project. There is subjectivity in the process; however, the information shared is supported by literature. Much of the opinion concerns the racially-based politics and government policies especially those of affirmative action for the "Bumiputra" majority.

Race and ethnicity influence all aspects of life in the country. There is acceptance from all races of the necessity of the government policies but there are rumblings from all sides. For the "non-Bumiputras," much of their dissatisfaction stem from the fact that meritocracy is sidelined by affirmative action. Discontent among the Malays or "Bumiputras," stems from the economic power of the "non-Bumiputras," especially of the Chinese. Segregation or ethnic enclaves are very real and pervasive in everyday live. The lowering of standards in education to allow for the passage of Malays through higher education has caused concern and dissatisfaction. Concern comes in the form of local university and college graduates who are ill-prepared for professions of their choice. More disturbing is the mistrust among non-Malays for locally-trained doctors, especially Malay physicians practicing in public hospitals due to affirmative action and the perceived lack of standards in their qualification and lack of quality in their practice. Media reports of incompetent physicians do not help the situation (Lim, W.W., 2012). There is also concern over the explosion of private educational institutions in the past decade. As corruption is still pervasive in the country, questions of corruption arise in the context of the boom in private educational institutions with poor government regulations and minimal government oversight.

Several acquaintances who have had experiences in negotiations on behalf of foreign universities with the Malaysian government in the recent past, voiced great reservations about the affirmative action policies. Institutions have pulled out of negotiations or contracts have been broken when both sides fail to come to agreement on meritocracy and the recruitment of the most qualified persons to run the proposed projects (personal communication, Gaspar Torancher and Lim Ee Lin, July 20, 2012).

Opinions on the culture of the country concur that Malaysia is a status conscious society where roles and titles are emphasized. Preserving harmony and face-saving are two important guiding forces in how things are run in the country. Collective in nature with a preference for relationships over task, it is "who you know" that gets things done quickly. Teams versus individual successes are celebrated; self-promotion is generally frowned upon. This lack in individualism can manifest itself in long silences and lack of participation at meetings as observed at a nursing conference where there was minimal participation by those attending the conference.

The last observation that is of probable effect on the Perdana University Hospital (PUH) is that there has been much discussion on 2012 being an election year. Elections bring a sense of caution across the country. There is some hesitancy on proceeding with projects. Many friends, relatives, and acquaintances speculated that nothing will progress at PUH, known as "the Malaysian Prime Minister's baby," until it is known who will be in power after the elections.

The views of "the man on street" concur with the findings of the literature reviews and the perspectives of the nursing leaders. Nursing education is part and parcel of the country's educational system shaped by affirmative action. Nursing as a profession is also a component of

the society, sharing cultural norms and influences. A profession of women with low educational criteria, confined by cultural expectations, has stagnated nursing in Malaysia.

Summary of Findings

The findings from the research conducted through literature searches and reviews; visits to hospitals and schools of nursing; discussions with nurse leaders and nurses; and observations as an "insider", provide a clear picture that huge differences exist between the American and Malaysian nursing. The differences or gaps between American approaches versus the Malaysian can be summarized as follows:

- The prevalent model of Malaysian nursing education is hospital-based with diploma programs where technical competence is emphasized, whereas American nursing education has progressed to as high as the doctoral level with an emphasis on critical thinking and evidence-based practice.

- Accordingly, Malaysian nursing practice is task-oriented instead of nursing based on critical thinking and professional nurse accountability.

- Meritocracy is largely the American approach in education and business; affirmative action and the "who you know" approach rule Malaysian life.

- The nursing leadership in Malaysia, and nursing in general, reflect the lack of advanced nursing education, and the effects of affirmative action.

- Americans are linear thinkers with a direct and precise way of communication, usually addressing "the task at hand;" Malaysians, as with most Asian populations, are generally cyclical thinkers where communication is subtle and complicated by relational priorities of "preserving harmony and saving face."

- Americans are individualistic and view everyone in society as equal. Malaysians are status conscious. This cultural subtlety, combined with the cultural emphasis on harmony, has affected nursing by emphasizing and preserving tradition and the status quo, keeping a largely female workforce under the control of physicians who are perceived highly in Malaysian society.

- Malaysians have a low awareness of time where time interpretation is more relaxed; Americans have high awareness of time where time is considered a commodity of value that can be measured and should not be wasted.

- Complicated race, ethnicity, and religion issues color the way of life in Malaysia with an intensity not experienced in the United States. For example, there are public service advertisements daily on television reminding Malaysians on the importance of living harmoniously.

These findings can be further summarized into these three major points: (a) nursing in Malaysia has remained relatively unchanged for four decades and the status can be explained by the country's culture and work culture; (b). culture and work culture in Malaysia are integral parts of each other influenced by ethnicity and complex racial issues including affirmative action; and (c). Americans and Malaysians have very different cultural influences and needs. With this information, JHMI can develop an effective plan to promote American nursing at PUH. Starting with the ANCC Pathway to Excellence Standards numbers 4 and 6, the three key points above will be addressed by the interventions for both orientation and career development opportunities. With culture established as having an influential role on nursing, the proposed interventions must emphasize a cultural approach to facilitate an effective commissioning of PUH, and promote sustainability of the hospital as well as the development of long-term American-Malaysian partnerships in nursing.

Leadership in Malaysia requires an understanding and acceptance (or at least, tolerance) of the many social and political subtleties. To ensure the success of JHMI at PUH in the context of the complex Malaysian culture, the joint Malaysian-American leadership of the hospital must, from the very beginning of the partnership, share the same mission, vision, and goals. Dooley aptly found,

> "…the more diverse the set of cultures working together within the organization, the more urgent the need for a shared set of articulated operating principles" (Dooley, 2003, p. 60).

With a strong foundation, differences can be overcome. It is in this context of a strong partnership that the following interventions are proposed. A strong partnership extends beyond

simply the joint Malaysian-American leadership of hospital. “Buy-in” and support of a shared mission, vision, and goals with a shared set of operating principles from all stakeholders, particularly the physicians, would be crucial to the success of the interventions proposed below.

Section II

Culturally Appropriate Interventions: Creating the “Perdana Nurse”

In light of the above findings, the opportunities to promote the advancement of nursing according to the American model/s of nursing exist but within the cultural context of Malaysia. For the purposes of this project which is to use the ANCC Pathway to Excellence Standard #4 and #6, providing orientation and career development opportunities as the starting point for introducing American nursing to Malaysia by way of PUH, proposed interventions will be organized using the PEST (Political, Economical, Social, and Technological) model. Hofstede’s dimensions of national culture will be the guiding force of the interventions. The two dimensions of collectivism-individualism and power distance will be emphasized due to the differences between the two countries involved. The main goals are, again, to ensure an effective commissioning of PUH, promote sustainability of the hospital, and develop long-term American-Malaysian partnerships in nursing with the introduction of the American approach to nursing specifically patient-centered care with evidence-based practice.

The right personnel to conduct the orientation would be critical. If the personnel are Americans, the staff members conducting the orientation must be provided cultural training on Malaysian cultural needs and subtleties. Similarly, if Malaysian, the staff members must be trained on American cultural expectations particularly those in nursing. The important key to grasp is that a unilateral introduction of American methods by American personnel to Malaysian nursing staff is likely to fail if there is little appreciation of the differences between the two

national cultures, or four cultures as Dooley would argue (Dooley, 2003). Similar to what Condron et al. (2004) described in the exchange of an American-Malaysian high-technological project, a silent group of staff members may induce a sense of doubt in an American personnel that the Malaysians have understood the contents of what was shared, whereas the outright seeking of confirmation by the American/s by asking direct questions may be deemed rude by the Malaysian participants.

Dooley's convincing article on the successful use of simulation and role playing in cross-cultural training between Americans and Malaysians provided the incentive to use the approach as an intervention for this project. A search on academic search engines such as Proquest and Academic Search Premier on cross cultural training quickly illustrates that the importance of intercultural training or cross cultural training has been acknowledged and provided in the business world for at least four decades. While cultural competency has been addressed in health care education for a decade or so, the industry has only taken on this aspect of education in earnest with the Joint Commission recommendation for culturally appropriate care for patient safety (The Joint Commission, 2009). Similarly, a search adding "simulation" as a Boolean phrase indicated that simulation in cultural awareness training has been advocated and used by Hofstede since the 1970's (Hofstede, de Caluwé, and Peters, 2010; Hofstede and Pederson, 1999). Much of the simulation for creating cultural awareness in business training has used synthetic cultures for role playing in games involving business negotiations in addition to didactic or lecture-based components (Chin, Dukes & Gamson, 2009; Hofstede, de Caluwé, and Peters, 2010; Hofstede and Pederson, 1999; Hurn, 2011; Johnston & Burton, 2009; Lewis, 2005). Research articles on the use of simulation specifically in cross-cultural training, however, are rare; an observation shared by Chin et al. (2009).

Hofstede and Pederson (1999) presented a detailed description on how cross-cultural simulation training should be conducted. They provided examples of several popular games such as "BaFa BaFa," "After Nafta" and "Windmills of Your Mind" which show participants the difficulty in not evaluating another culture from one's point of view. These games also incorporate Hofstede's national culture dimensions and can be manipulated to represent all the dimensions for practice or game playing. The authors provided strengths of simulation and also discussed challenges associated with the method.

Hofstede et al. (2010) explained why simulation works in creating cultural awareness by citing 40 years of observations from creators and facilitators of simulation. Cross cultural simulation is a complicated process of learning, encompassing many influences and factors which can be grouped into four essential aspects--knowledge, practice, emotion and social aspects. Of these, the emotion and social aspects are deemed the most important by the authors, which can be lost in the didactic approach. Hofstede et al. (2010) went on to emphasize that cross-cultural simulation can be unpredictable but it is crucial to learn from unexpected outcomes due to different participants and facilitators of each simulation. The authors stressed the importance of a culturally appropriate facilitator, one open to learning, and the debriefing process in simulation which is the most important part in facilitating learning. In this sense, simulation reflects real life. This strength of simulation is also its weakness for the unpredictability can make assessment and evaluation of simulation sessions difficult.

Chin et al. (2009) shared the same concerns in their review of articles on simulation as a learning tool over forty years. While qualitative "evidence" abound, there has been little quantitative evidence to show that simulation or experiential learning actually work. Several factors might have contributed to the lack of assessment; these include the negative connotation

associated with the word "assessment" which was perceived as grading, but more importantly, the unpredictability of simulation sessions whereby a facilitator must react to the unplanned directions a scenario can take, does not lend simulation to the "controlled" environment of research. The authors provided suggestions on how to assess or evaluate the effectiveness of simulation favoring the pre-test post-test approach (Chin et al., 2009).

Hurn (2011) described the five methods of simulation can be used for cross-cultural training: culture capsules and clusters; critical incidents; culture assimilators; role playing; and case studies. Beyond stating that simulation has proven effective in creating cross-cultural awareness, Hurn did not cover the issue of assessment or evaluation. Lewis (2004) also did not discuss assessment or evaluation in writing of her own experience as student and teacher of simulation in cross-cultural training in business school. She shared her perception on why simulation works as a tool to create cross-cultural awareness, noting that simulation stresses the process and has no predetermined outcome reflecting the reality of life. Simulation helps learners connect knowledge from books and lectures to real life.

While the use of simulation to create cultural awareness has been well-developed in the business world, the method of training has not been widely used in other fields such as the foreign service or non-profit organizations with international dealings (Hurn, 2011). The use of simulation to develop cultural awareness in health care is also not well developed with only five articles found to describe the use of standardized patients in training (Fors, Muntean & Botezatu, 2009; Haas, Seckman, & Rea, 2010; Parkhurst & Ramsey, 2006; Rutledge, Garzon, Scott, & Karlowicz, 2004; Schitai, 2004), and one with the actual use of the cross cultural simulation game of "BaFa BaFa" adapted to the healthcare environment in medical school (O'Connor, 2002). O'Connor was of the belief that "most of the identified elements in medical cultural

competence fall in to the realm of skills and attitude – qualities best promoted through experiential learning…and personal experience" (O'Connor, 2002, p. 1102). The evaluation completed by O'Connor was of the effectiveness of the simulation as perceived by participants at the end of the session. Of the five articles describing the use of standardized patients, Schitai (2004) provided an evaluation of the program from the perspective of the participants, whereas Parkhurst and Ramsay (2006) reported qualitative effectiveness of their program. While the use of standardized patients in simulation can contribute to gaining knowledge on patients of particular cultures, the method runs the risk of taking the traditional approach of what Campesino described as the "monolithic" description of groups of people from the "all-White" perspective creating a potential for stereotyping (Campesino, 2008).

Inglis et al. (2004), one of three research articles on simulation in cross-cultural training, studied the effect of the method on a group of university students also by using an adapted version of "Bafa Bafa." Following the simulation protocol, students were thoroughly debriefed. Evaluations of the program effectiveness came in the form of student written reflections, student evaluations of the program, and measuring pre and post cultural diversity scores. Evaluations were positive, and cultural diversity scores improved post intervention (Inglis et al., 2004). Johnston and Burton (2009) tested a simulated negotiation game to raise cultural awareness between Brazilians and Americans. Crucial to the effectiveness of a simulation, insufficient time was allocated for the training and the participants of the session felt rushed to learn the game, participate in it, and debrief in two hours. Assessment of the program was minimal and limited to participant perspectives (Johnston & Burton, 2009).

Mills and Smith (2004) provided the most rigorous article as they describe the study conducted by the Australian Department of Defence in using simulation to train soldiers in cultural awareness in preparation for duties overseas. The study addressed the concerns on

effectiveness measures of simulation in cross-cultural training by including the following criteria:

- "Comparison between control and experimental groups
- Pre- and post-training measures of changes to variables of interest
- Assignment of participants to treatment and control on a random basis
- Longitudinal measures of variables of interest. Notably, measures of training effectiveness may show greater effects longer term as participants have had time to assimilate what they have learnt…
- Measures of immediate results and longer-term effects that are more objective than self-reports
- Multiple outcome measures" Mills and Smith, 2004, p. 6).

The study was piloted prior to being conducted using Hofstede's simulation game, "The Trade Mission." As stated above, the main study met the criteria for rigor. The results demonstrated an increase in cultural understanding in cultural relativity scores, and in multicultural acceptance. There was no change in cultural values indicating that the participants understood their own culture but became more accepting of other cultures. The tool used by the authors to measure cultural awareness based on Hofstede's dimensions was that of the Cultural Awareness Scale by Jung (Mills and Smith, 2004). Eight pretests involving more than 1000 participants were conducted to ensure validity and reliability of the survey prior to the use of the scale on over 600 respondents in his actual study among American and Korean business managers (Jung, 2002). Questions in the survey measure ethnocentrism, individualism, collectivism, power distance, achievement orientation, and uncertainty avoidance. The scale includes measures for ethical judgment, ethical relativism and behavioral intentions. Mills and Smith (2004) used the scale three times—prior to the cross-cultural training, immediately after the training, and 12 weeks after the training. Table III summarizes the articles reviewed for the use of simulation in cross cultural training.

The lack of "evidence" in the form quantitative data does not mean that simulation is not an effective method in introducing cultural awareness. As stated above, the cultural context in scenarios makes simulation sessions unpredictable, giving researchers a lack of control over the direction of how sessions can go. The authors describing their simulation experiences above are all firm believers that simulation is an effective tool in creating cultural awareness. However, as Hofstede et al. (2010) warn, simulation for developing cultural awareness should not be taken lightly and scenarios must be developed carefully. Good facilitation is of upmost importance. They cite an expert facilitator of the cultural game, "So Long Sucker" being thrown off by unwritten cultural rules when she facilitated the game in Taiwan, outside the norm of the United States. The simulation, supposedly to last no more than a few minutes, took four hours to complete in Taiwan as the students tolerated "suckers" and allowed them to stay in the game (Hofstede, 2010). This case proves that simulation is a tool for continuous learning for all involved, and a culturally competent facilitator is crucial in running simulations with cultural issues. The difficulty in obtaining quantitative data needs to be overcome but one must acknowledge that any quantitative measurement cannot be perceived with high validity due to the very nature of subjectivity involved in each and every cultural simulation. Taking that into consideration, written reflections and evaluations from participants become the core of "evidence" in simulation to created cultural awareness.

Figure 1 provides a visual on the importance of cultural awareness training as part of the process in cultural awareness development in cross-cultural work or projects. The different components in the cross-cultural training can be assembled into a "toolkit" (Figure 2). While the toolkit is specific to the needs of this particular American-Malaysian exchange, the contents can be changed to reflect Hofstede's national culture dimensions of other countries. For example,

the articles provided for class reading and reflection should reflect the countries of which a particular project involves, and the simulation scenario must be written to capture the important national culture dimension differences of the countries involved.

It would be prudent to acknowledge that prior to the orientation process the importance of hiring the "right person for the right fit" cannot be overstated. Considering the all-encompassing influence of hospital-based diploma training for nurses in Malaysia, the interview process must be clearly articulated to identify the critical elements of a staff nurse's "qualifications"--what are the characteristics of the "Perdana nurse", and what screening processes and questions will be used to assist in the selection process. English has to be established as the common language and fluency should be made a criterion for recruitment. It is also assumed that the hospital would have established the timeline for implementing the nursing plan; instituted its nursing mission, vision and goals, and policies and procedures, as well as standards of practice, by the time orientation is conducted. As this is a population of learners culturally not familiarized to change or to small tests of change in continuous improvement, a solid foundation of expectations would be crucial. The reality of work at PUH must be driven home as giving only positive features of a job would create false impressions (Josuh et al., 2011); introduction of new ideas must be paced as the nurses mature. From day one, it would be vital to inculcate the identity of the "Perdana nurse" to instill a sense of pride of being selected for an interview and/or selected to work at the hospital. Such recognition, associated with a premier institution, can be interpreted as a "team" versus an "individual" call to attention, adhering to the cultural tradition of prioritizing community over self. Being "part of the best" would be more palatable than "I am the best" according to Malaysian cultural expectations.

Section III

I. Orientation of Staff

A well-structured orientation is the first step to "committing" a newly hired staff member to the expectations and organizational culture of an organization. The on-boarding process establishes the mission, vision and goals, policies and procedures, and standards of practice of an institution. Comprehension of expectations and "buy-in" to a system will make the ensuing process of enculturation and change in practice smooth and meaningful (Cawood, 2011). It is also vital to the success of a new organization that strong leadership exists to guide the new "vessel" through uncharted waters. Thus orientation must start with selecting the right nursing leaders and providing them with a well-structured orientation.

The objectives to consider for the orientation program with the short-term goal of a successful commissioning of the hospital are:

- Improved cultural awareness survey scores before and after cultural awareness training for personnel providing orientation for staff, and all staff members being oriented, measured for significance using the repeated measures analysis of variance (RM-ANOVA);
- Improved mean scores of at least 5% of the adapted Hospital Survey on Patient Safety Culture (or HSPSC; see Appendix B) at beginning of employment, and after orientation; and
- Attrition rates of less than 10% of recruited nurses by the end of orientation period including the preceptorship period for new graduates.

For long-term goals, objectives for sustainability of the hospital and long-term JHMI-PUH nursing cooperation should be considered. Potentially, these objectives may include the following:

- Improved mean scores of at least 5% of the modified Hospital Survey on Patient Safety Culture from the scores after orientation compared to scores in a year;

- Acceptable patient satisfaction scores (measuring tool to be selected and acceptable scores to be established); and
- Acceptable staff satisfaction scores (measuring tool to be selected and acceptable scores to be established).

To begin, cross-cultural training, the toolkit proposed above, will be mandatory for all staff, and should be the initial step. Cross-cultural awareness will be key in developing some understanding, and cross-cultural training should be taken as the opportunity to introduce "a shared set of articulated operating principles" (Dooley, 2003, p. 60). A "method" of conducting the orientation must be established. Top-down, one-way communication should be discouraged and new employee participation in the orientation process must be encouraged and made an expectation (Josuh et al., 2011; Kennedy, Nichols, Halamek, & Arafeh, 2012). Reflective learning should be introduced at orientation where participants are taught the importance of reflection and sharing what they have learned from an orientation session or activity. Physician involvement in joint orientation sessions would benefit the organization by promoting a safe culture of open communication. Many audio-visual resources are also available today to share the importance of intra- and inter-professional teamwork. It is assumed that by covering such issues as open communication among professions, the hospital would have established policies and procedures for a safe environment where retaliation, harassment or abuse is not to be tolerated.

Many of the suggested orientation items above fall under Quality and Safety Education for Nurses (QSEN) which came about from the Institute of Medicine's competencies for nursing (Cronenwett et al., 2007). While QSEN was originally meant to address pre-licensure education, nurses' education in Malaysia would not have covered these important components of patient safety. It would make much sense to introduce QSEN at the nursing orientation at PUH.

Essentially, QSEN promotes (a) patient-centered care, (b) teamwork and collaboration, (c) evidence-based practice, (d) quality improvement, (e) safety, and (f) informatics (Cronenwett, et al., 2007) which coincide with the expectations of JHNEBP. Knowledge, skills and attitudes (KSA), also known as competencies (Cronenwett et al., 2007) for each of the above components can be introduced, taught and evaluated at orientation. As Jarzemsky, McCarthy & Ellis (2010) recommend using simulation to share these KSA's, QSEN can be incorporated into the simulation part of the toolkit. With the many KSA's such as recognizing a change in patient status; incorporating patient or family in care planning; exploring ethics in clinical care; communicating critical information; questioning inappropriate orders; using evidence to support change in care; understanding the importance of procedural checklists; etc., scenarios can be written to address them to facilitate understanding of knowledge on patient safety within the Malaysian cultural context. An excerpt from a scenario written by this author is attached as Appendix C.

Individual clinical preceptorship or mentorship is a crucial part of orientation (Butt et al., 2002; Kennedy et al., 2012; Oermann & Garvin, 2002). Preceptors or mentors are experienced nurses who should have been given education on adult learning, and who are clinical experts motivated to learn and teach (Butt et al., 2002). These criteria may prove difficult to meet for PUH as senior nurses are in short supply in Malaysia, and senior nurses recruited would, most likely, not have clinical American healthcare experience. These senior nurses must be ensured a solid education on American nursing expectations.

In summary, the orientation program must start with cultural awareness training for all staff, American and Malaysian. Structurally, the program comprises of two phases: the first for those conducting the orientation who must culturally trained and use materials adapted to

cultural needs; and the second, for the recipients of the orientation program. The cross-cultural training should incorporate Hofstede's cultural dimensions of collectivism-individualism and power distance and QSEN KSA competencies. Especially important is communication styles which affect teamwork and patient safety as outlined in QSEN's KSA competencies. Simulation with carefully developed scenarios can be an effective tool to teach these competencies and create cultural awareness. The right orientation clearly has short term and long term consequences for the hospital and American nursing in Malaysia; it is imperative that orientation is conducted with cultural sensitivity without compromising American nursing practices that may be uncomfortable to Malaysian nurses.

Tables IV and V provide a break-down of the interventions at two levels, nursing leadership and nursing staff, according to the PEST model. Due to the strong influence of political and social factors in Malaysian life, the two categories are grouped together for ease of presentation.

II. Career Development Opportunities

Career ladders reduce poverty by promoting educational opportunities to increase access to work (Donley & Flaherty, 2008). The availability of career development opportunities has become synonymous with organizations which embrace curiosity and live-long learning. One way of promoting a workforce that is knowledgeable, committed to improvement, and innovative, is by way of providing career development opportunities such as continuing education and career ladders (Nelson, Sassaman, & Phillips, 2008; Pollitt, 2010; Troia, 2006). Providing such opportunities show the commitment of the employer to their workforce. Careful selection of educational opportunities to fit a company's mission, vision and goals also supports a sustainable future for the company (Nelson et al., 2008; Troia, 2006). In the United States,

career ladders have linked "academic progression to the development and demonstration of clinical and professional competence and to advancement in the workplace" (Donley & Flaherty, 2008, Phase Three: Professional Advancement in Nursing, para. 1.). Career ladders in nursing have evolved to an advanced state where it is now recognized that non-traditional approaches, such as bridging programs in education, promote retention of nurses and draw mature candidates into nursing during times of nursing shortages (Donley & Flaherty, 2008). Participation in career ladders has shown a higher commitment to excellence as well as to advancing the profession of nursing by way of clinical work, supervision and teaching, and participating in quality assurance (Bjork, Hansen, Samdal, Torstad, & Hamilton, 2007).

In Malaysia, American companies such as Intel and Motorola pioneered the concept of developing a knowledgeable workforce by starting their own educational mediums, Intel University and Motorola University. At these institutions, employees are certified internally to work with new technology and management tools or are given the opportunity to become certified in internationally recognized programs such as Six Sigma (Peter Green & Foong Kok Fong, personal communication, August 18, 2012). Japanese multinational corporations operating in Malaysia such as Sony, Toshiba, and Sanyo promote the same opportunities through their educational institutions located outside Malaysia. JHMI, affiliated with Johns Hopkins University (JHU), a premier academic institution, is primed to provide similar continuing education and career ladder opportunities.

Beyond being in the position as a great resource of continuing education activities such as seminars, conferences, courses and online training, JHMI, through JHU, is in the position to offer tertiary education in nursing and mentorship in the development of a quality graduate nursing program at PUH. By way of career ladders, JHMI can also encourage the development

research, quality assurance and improvement, evidence-based practice, and nursing governance by mentoring nurses to participate in these activities which will have long-term consequences to the profession of nursing in Malaysia. In providing these opportunities, JHMI through PUH will be contributing towards the World Health Organization (WHO)-Malaysia Country Cooperation Strategy, 2009-2013, items 2.4.1.3: Strategic Planning and Coordination for Human Resources Development and 2.4.1.5 Evidence Based Policy, Decision Making and Research (World Health Organization, n.d.):

- Item 2.4.1.3 emphasizes "the importance of human resource development" (p.22) "as human resource projections for… health professionals for the period 2005-2010 indicated shortfalls in all the categories" (p.27).
- Item 2.4.1.5 promotes further use of research as the foundation to policy making (World Health Organization, n.d.).

Similarly, JHMI and PUH will contribute to the World Health Assembly call for "a massive increase in education and training of health workers, as part of a systematic effort to build up health systems in developing countries" (Gawanas & Sharp, 2008, para. 3).

Career development is longer-term compared to orientation. Its objectives should relate to the long-term goals for sustainability of the hospital and long-term JHMI-PUH nursing cooperation:

- A minimal of 10% level of participation by all nursing staff in the hospital career ladder program in two years; and
- A minimal of 5% of nursing staff enrolled in degree education programs in five years.

Similar to orientation, the faculty providing continuing education opportunities and teaching of degree courses for JHU should receive cultural awareness training to enable effective sharing of knowledge. As emphasized above, educational activities must be conducted with cultural sensitivity without compromising American nursing practices that may be uncomfortable

to Malaysian nurses. With time and exposure to a consistent message, nurses at PUH should be able to function to the expectation of American nursing just like the engineers and technology workers described by Dooley and Condron et al., as living bicultural lives, the collectivist one for home and the individualistic other for work (Dooley, 2003; Condron et al. 2004). With the ability to adopt American nursing approaches, the goals of sustainability of the hospital and continued cooperation between American and Malaysian nurses can be realized. This should reflect in a reasonable rate of participation of staff nurses in career development opportunities, better safety awareness, and increasing patient and staff satisfaction scores.

Table VI summarizes the potential challenges of, as well as opportunities and interventions for, offering career development at Perdana University Hospital.

Section IV

Evaluation, Continuous Quality Improvement (CQI), and Benchmarking

The developing nature of this project is such that the possibilities are open for defining objectives and evaluations of objectives. Evaluations can include the ongoing evaluation of processes and evaluation of specific objectives. Process evaluation is a continuous process of participants evaluating a project or program otherwise known as process improvement (Nelson, Batalden, & Godfrey, 2007), also akin to continuous quality improvement. From the proposed interventions above, many possible evaluation methods are easily identified.

For purposes of this project, however, only evaluation of the toolkit of cross-cultural training using simulation is addressed in this paper to measure the following objective:

- Improved cultural awareness survey scores (modified CAS) before and after cultural awareness training for personnel providing orientation for staff, and all staff members being oriented, measured for significance using the repeated measures analysis of variance (RM-ANOVA);

While there is much discussion in nursing about measuring cultural competency, the measurement of cultural sensitivity or awareness is not well-developed or tested (Carpenter & Garcia, 2012; Perng & Watson, 2012). Rew et al., (2003) developed a scale on cultural awareness but it was written to assess nursing students within the context of nursing schools. Dooley (2003), in her detailed description of cross-cultural training did not provide a measure for cultural awareness although the outcome of the training is clearly substantiated in the employees' recommendation of activities that led to increased efficiency in the company. The Cultural Awareness Scale (CAS) used by Mills and Smith (2004) is not well known. It is selected as the measurement test of choice specifically because it was developed based on Hofstede's dimensions of national culture, and used to measure change after a simulation-based cross-cultural training. The CAS is a 49-item scale which uses a Likert scale to assess an individual's awareness of culture (see Appendix D). It can be modified to only reflect the two dimensions of importance for this project, that is, collectivism-individualism and power distance. The scale is given before and after orientation, and once again at a later time (Mills and Smith retested participants for the third time 12 weeks after their cross-cultural training). Differences in scores can be calculated by using the repeated measures analysis of variance (RM-ANOVA). The RM-ANOVA is the most appropriate statistical test to compare significance for the repeated mean scores of the CAS by the same sample (dependent group).

As previously discussed in the review of assessments for simulation in cross-cultural training, the quantification of assessing the effectiveness of the training must be taken with caution. Due to the inherent limitation of "control" in cross-cultural simulation, the approach of using multiple measures can be used as advocated by Mills and Smith (2004) to improve validity of the intervention. Two surveys described by Mills and Smith are the Rokeach Dogmatism

Scale and the Quick Discrimination Index which can be modified for use in the American-Malaysian context. Written reflections and evaluations from participants are also important and will be given equal consideration as a measure of effectiveness. Participant evaluations, however, come with the caveat--culturally, Malaysians may not be "honest" in their assessments and will provide a positive assessment simply out of not wanting to be rude. In that sense, any results from assessment tools given to Malaysians must be taken with caution.

The larger orientation program objectives,

- Improved mean scores of at least 5% of the modified Hospital Survey on Patient Safety Culture (HSPSC) at beginning of employment, and after orientation; and
- Attrition rates of less than 10% of recruited nurses by the end of orientation period including the preceptorship period for new graduates,

can also be affected by the cross-culture awareness training. The modified Hospital Survey on Patient Safety Culture (HSPSC), validated by the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2004) will measure appreciation for patient safety before orientation based previous work experience using questions that can cross time and place. The modified survey can be given before and after orientation. For example, question number 8. "Staff feel like their mistakes are held against them" under the hospital section can be used to reflect previous work experience and awareness after a simulation scenario on mistakes. Under the communication section, question number 4. "Staff feel free to question the decisions or actions of those with more authority" can also be adopted to test awareness after a simulation scenario on nurses questioning a physician.

A high attrition rate for nurses can be indicative of a wrong fit for individuals or a failure of the orientation program to set realistic expectations or provide adequate training. Ongoing evaluations of the orientation program by staff should be conducted during orientation to assess

the effectiveness of the program. Exit interviews would be important to conduct to assess reasons for staff leaving. For the long-term, the best measurement of effectiveness of the cross-cultural training will come in meeting long-term goals and objectives.

Level of participation in career development opportunities can reflect effectiveness of the opportunities provided. As in the orientation program, every career development opportunity must be evaluated by participants. A reasonable level of participation in career development programs should impact productivity and commitment to an institution or profession which should in turn positively influence attitudes towards safety, and patient and staff satisfaction scores.

Other evaluations of the orientation and career development programs can come in the form of meeting budgetary plans and timeline, and benchmarks such as for the Joint Commission patient safety goals including medication administration error rate, hospital acquired infection rate, and falls; number of degree and specialty certificate holders among nurses; and other benchmarks of clinical pathways such as stroke or acute coronary syndrome care.

As the recruitment of nursing leadership and staff are of significant importance to the proposed orientation interventions, evaluations should be conducted on the recruitment process. Is the recruitment process going according to the larger plan of PUH? Examples of items to evaluate include

- The right personnel: Are candidates meeting the criteria set forth for the positions as described? Are candidates diverse and represent all major races in Malaysia in the right percentage?

- Tools: Are the screening/interview questions culturally appropriate and reliable? Do the questions reflect the characteristics sought for a candidate? If testing is conducted, for example, in mathematics and/or English, is testing fair, consistent and appropriate?

- Process: Are the right people who are culturally sensitive involved in screening candidates and interviews?

The above items should be continuously evaluated for improvement and appropriateness especially if a process or tool is adopted from the U.S. and may not meet the needs of the recruitment process, for example, interview questions related to managing conflict may have to be reworded so as not to intimidate Malaysian nurses not used to addressing physician-nurse interactions. Similarly, as emphasized before, all tools, measures and methods to be introduced to Malaysia, be it for orientation, continuing education, care pathways, etc. must be reviewed for cultural appropriateness. Without the right cultural component, a joint project such as this can easily take the path of failed American-Malaysian projects before when cultural misunderstandings and miscues created obstacles (Condron et al. 2004). Or it can have cultural congruency and be successful as described by Dooley (2003).

Section V

Orientation Timeline and Financial Considerations

Considering the challenges presented and the proposed commissioning of the hospital in 2014, the planning process for workforce development should begin as soon as possible. Recruitment of the "right fit" of nursing leadership may post the greatest challenge for the hospital, from its successful commissioning through its growth and development to a successful, sustainable and profitable enterprise. With the few Malaysian nurses exposed to American nursing, recruitment of the chief nurse, mid-level managers, and educators may take 3-6 months. Upon recruitment, local orientation may take 2-4 weeks before a 2-4 week stint in Baltimore. The recruitment and orientation of nursing leadership alone may take 5-8 months.

On completion of their formal orientation, managerial work of completing policies and procedures, standards of care and nursing documentation standards must begin. The process

may take 6 months depending on the level of adoption from other facilities or systems. Nursing staff recruitment follows. Recruitment of staff nurses may take 8-12 weeks. Orientation of staff nurses may take 1 to 6 months depending on level of expertise and experience.

Table VII provides a summary of the probable time needed to begin the process of staff recruitment and orientation. Considering the time that may be needed to recruit the nursing leadership and staff for the hospital, the groundwork should begin as soon as possible, using as much of the time left in 2012 to begin the search for nursing leaders. Providing these leaders with timely orientation can affect the rest of the timeline.

Cost of hiring and orienting nurses will depend on the decision to allow flexible scheduling and pro-rated benefits. Nursing leaders are expected to be working full-time at a minimum of 40 hours a week. With unconfirmed reports that a nurse executive base pay in Malaysia ranges from RM$8,000 to RM$15,000 per month (the US$-RM$ exchange rate has been stable at about 1:3), and experienced nurse managers and educators receiving a base pay of RM$5,000 to RM$8,000 depending on responsibility and place of employment, a monthly expense of RM$33,000 to RM$55,000 in base pay is estimated for nursing leadership. This number is based on 6 fulltime equivalent positions (FTE's) assuming a chief nurse and a manager each starting with medical-surgical nursing, critical care including the emergency department, operating services, obstetrics and gynecology inclusive of neonatal and pediatric care, and an educator, are hired.

Base salaries for new graduate nurses in Malaysia start at RM$1,200; in Kuala Lumpur, base salaries for new graduates start at RM$1,500 (Dato Dr. Bibi F. Abdullah, personal communication, July 26, 2012; Sally Tan, personal communication, September 4, 2012, Ong Bing Yok, personal communication, September 25, 2012). With allowances and differentials, a

total of RM$1,800 to RM$2,700 is estimated per new graduate per month. Experience nurses can expect base salaries from RM$1,500 to RM$6,800 depending on job roles (Ministry of Health Malaysia, 2011).

Table VIII summarizes the budget for orientation and the cost of orientation for nursing leaders in Baltimore. It does not include the cost of staff required to provide orientation in Baltimore to the nursing leaders nor the additional FTE's that may be needed to conduct the orientation and provide mentorship for new graduates.

Project Implications

As this project comprises proposals that may or may not be implemented, implications are difficult to predict. If cultural needs are prioritized, and the interventions are acted upon and implemented successfully, PUH has the potential of being a premier hospital using the American nursing model. With the prestige of John Hopkins associated with PUH, the implications for the future of American nursing in Malaysia based on this success are great: it will impact the nursing practices and systems in Malaysia changing nursing from a technical job to a profession. The success of the hospital is imperative to the progress of nursing in Malaysia; it may be the instigation for change, from the nursing leadership of the country influencing all nursing calling for progressive practice and education, one based on curiosity, EBP, and life-long learning, all in the interest of better patient care. By increasing expectations of and for nursing, it can also change the view of Malaysians towards the profession, with the perspective that it is a career not only for women and those who cannot make it to university to pursue degrees.

The potential for joint knowledge exchange abound between Malaysian and American nursing particularly in the areas of cross-cultural studies and global nursing. While there is much for Malaysian nursing to learn from the American, Malaysia can contribute to American

culturally competent or congruent care from the perspective of ethical relativism and pluralism being a society absorbed in relativity and plurality everyday balancing the needs of three major cultures, not to forget the tens of tribes of aboriginal people. Americans can learn about the subtleties of collectivism, the importance of filial piety and honoring seniors in family life, the construct of "preserving harmony and face-saving" and apply the knowledge to the care of patients coming from collectivist cultures. American nurses may learn that bioethics as it is practice in America based on the Abrahamic traditions may have limitations, that concepts such as autonomy, justice, non-malfeasance, patient rights, respect, informed consents, etc. can be interpreted quite differently outside the norms of absolute rights and wrongs.

A successful JHMI-PUH model on education based on excellence may even influence government agencies to advocate for a higher level of education instead of allowing compromised standards for purposes of profit-making. Meritocracy may actually be encouraged in health care education contributing to improved outcomes for all patients. Just as American informational technology (IT) has changed the work environment in Malaysia, American health care knowledge can contribute to the culture here in calling for continuous learning, leading to better patient care and to the improvement of the health of the people.

Conclusion

As this project indicates, there are huge differences between Malaysian and American systems and practices, nursing included. Opportunities abound for cross-cultural learning, and for Perdana University Hospital to play a role in the introduction of American nursing to Malaysia. Considering the gap between Malaysian and American nursing and with the proposed opening of Perdana University Hospital in 2014, there is much for JHMI to do in facilitating the transition of nurses from the Malaysian model to the American. The process must be done

within the cultural context of Malaysia. The ANCC Pathway to Excellence Standards number 4 and 6, providing orientation and career development opportunities are excellent places to start.

Armed with the understanding of Hofstede's cultural findings, the interventions brought by the Americans must be adapted to the cultural sensitivities in Malaysia. Research and previous attempts at joint projects have shown that cross-cultural training for all staff, American and Malaysian, is needed to facilitate an effective transfer of knowledge. Done correctly, the interventions can have long term implications on cross-cultural understanding and continued cooperation between Malaysian and American nurses affecting practice, education and research.

Considering the complexity involved in recruiting and orienting staff, time is of the essence; the introduction of American nursing at Perdana University Hospital must begin as soon as possible if the hospital is to be commissioned as scheduled.

Table I: Summary of Articles on Nursing in Malaysia

Theme	Author/s	Type of Article	Methodology	Results/Discussion
Description of educational seminars	Achike, F. & Nain, N. (2005)	Description of workshop held in Malaysia on problem-based learning (PBL)	N/A	Provides insight into the conservative approach to nursing education in Malaysia and the difficulty in trying to bring change to academic staff not attuned to more liberal approaches in education. The article also addressed the lack of qualified nursing education faculty.
	Birks, M. (2011)	Description of a two-day seminar on conducting nursing research and evidence-based practice (EBP)	N/A	Describes introducing research and EBP to nurses in East Malaysia without any background in research or EBP
Legal/ ethical	Nemie, J. (2009)	Expert perspective on legal and ethical issues in health care.	N/A	Describes changing nursing responsibilities in nursing today. While persuasive in the need for nurses to adopt a more progressive attitude towards legalities in their profession, the author resorted to medical cases as examples losing the nursing perspective.
Historical	Birks, Francis, & Chapman (2009)	Historical description of Australian-Malaysian nursing journey, and the future of nursing from a global perspective.	N/A	Very good historical context to nursing in Malaysia with the roles of Australian nurses. Futuristic perspective is generic, calling for improved education and practices.
Medication Errors	Chua, Tea, & Rahman (2009)	Prospective study on medication administration	Direct, undisguised observation of all drug administration for 15 days on	Rate of errors, 11.4%, is compatible with developed countries; 10.4% of the errors were considered potentially life-threatening. Of

		errors in a Malaysian public hospital, the first ever conducted in the country.	a ward. IRB approved.	interest is the higher rate for intra-venous (IV) drug errors by physicians as nurses are not allowed to give bolus IV medications.
Degree education in Malaysia	Birks, Francis, & Chapman, (2009a)	Qualitative study on students' experience enrolling in bachelor level education in the mid 1990's	Grounded theory: 10 individual interviews and 5 focus groups. IRB approved.	Degrees in nursing were not recognized in Malaysia for practice at the time the nurses enrolled. The study found that the impetus to pursue further education is largely internal although many were encouraged by families and seniors. Nurses wanted to discover learning, pursue knowledge and hoped that continuing education would lead them to better career paths.
	Chiu (2005)	As above	Partial grounded theory of 12 participants comprising in-depth interviews and one focus group. IRB approved.	Similar to the above study, participants were bored with their nursing careers and were seeking new knowledge while faced with the lack of support from physicians and the government.
	Chiu (2006)	Qualitative study to see how a degree has impacted the lives of nurses in the 1990's	Exploratory, single-case study in-depth interviews and focus group of 12 participants. IRB approved.	The study found that the nurses who had obtained their degrees in nursing developed self-confidence and were more assertive; found different ways of practice; improved on their communication skills; learned to question physician management of patients; and many moved up in their careers to undertake management roles.
Influences of nursing in Malaysia	Birks, Francis, & Chapman (2009b)	Review	NA	Describes the influences of culture, race, religion and politics on nursing in Malaysia. Authors found Islam, the official religion in Malaysia, as a significant factor in holding the

				profession back due to its control over the lives of women.
Organizational commitment	Ahmad & Oranye (2010)	Research: descriptive correlational survey of Likert scale questionnaire	Nurses from two teaching hospitals, one in Malaysia and one in England, were surveyed. Survey tool compiled from four established scales; Internal consistency and validation of the tool was performed. Study had IRB approval.	Study found job satisfaction and empowerment were interpreted differently by culture. The more traditional sample, Malaysian nurses were older, felt more empowered, and they were more committed to staying in their jobs. The English sample reported higher job satisfaction. The authors surmised that the English sample valued flexibility and freedom affecting their sense of empowerment, and autonomy in practice influenced their job satisfaction. Teamwork, a cultural practice emphasizing relationships was felt to be a contributory factor among Malaysian nurses in their commitment to stay.
	Siew, Chitpakdee, & Chontawan (2011)	Research: survey using Likert scale questionnaire	Nurses at 4 public hospitals in Malaysia were surveyed with established tools to study the effect of organizational support, job satisfaction and years of experience to organizational commitment. IRB approved.	The authors found a high level of commitment among nurses to their places of work which could be explained by a high sense of pride of their nurses of their hospitals; very good government benefits; and teamwork from shared values and emphasis on community. Age, years of employment, and marriage were identified as factors contributing to nurses staying at their place of work.
Learning environments	Ooi & Barnett, (2012)	Research: descriptive design; self-administered survey on perceptions of learning environments.	Sampling at a private hospital with school of nursing: 142 nursing students, 54 staff nurses and 8 tutors surveyed using Likert scale tool which was tested for reliability and validity. IRB approval	Students reported difficulty in the theory-practice gap; they felt a lack of opportunity to learn skills quickly in the clinical environment as expected of them while not being given the support by staff nurses on clinical units. Staff nurses found the students slow and not self-motivated to learn. Students experienced high

			obtained.	peer support.
	Said, Rogayah, & Hafizah, (2009).	Research: descriptive with survey	The Dundee Ready Educational Environment Measure (DREEM) survey was administered to 105 Bachelor of Nursing students at an Islamic university. IRB approval obtained.	Students reported a low student-centered approach to teaching at the university. Scores for teaching innovation and student satisfaction were inversely related to years of enrollment.
Nursing shortage	Barnett, Namasivayam & Narudin (2010)	Review	N/A	The authors reported the lack of planning in managing the nursing shortage in Malaysia. The government's method of opening new schools and producing new graduates is a symptomatic response instead of entailing wider workplace reform.
	Kanchanachitra, et. al. (2011	Report	N/A	A report by experts in Southeast Asia on health care human resource shortages in the region. The authors found data collecting and reporting by governments to be very poor. There is no workforce or labor planning. Poor supervision of private schools has contributed to output of ill-prepared graduates. Very good discussion on each Southeast Asian country; growth of medical tourism; and migration of health care providers including nursing.

Table II: Summary of Articles on Influences on Work

Theme	Author/s	Type of Article	Methodology	Results/Discussion
Influence of Hofstede's national culture dimensions	Bhaskaran & Sukumaran (2007)	Study on influence of culture on management in Malaysia	Literature review, informal key discussions with key informants and use of survey: 376 usable responses from systemic sampling. Questionnaire adapted from validated resources from previous cultural studies. No mention of IRB.	Very detailed description of cultures in Malaysia. Authors use Hofstede's national culture dimensions as foundation. Significant cultural differences were found across the three major races in how companies were run, however, authors warn of stereotyping. Also of significant importance are government policies that affect the values of the different races or "national" cultures.
	Noordin, Williams, & Zimmer (2002)	Study comparing two cultures, the collectivist and individualist and impact on career commitment	Systemic sampling in Malaysia and Australia with 327 surveys returned by middle managers of companies in both countries. Surveys were adapted from established tools.	Although Hofstede's national culture dimension is the basis of this study, there is no racial breakdown. The study found that while Malaysians reported more collectivist values, individualist values were found in business competition. The authors suggest that Malaysians, in adopting Western economic ideals, are becoming more individualist or adapting their collectivist values.
	Selvarajah & Meyer (2006)	Study on ethnicity and leadership	Thirty organizations in the Klang Valley were targeted with 292 surveys returned. Surveys were used, again, adapted from established tools.	Study based on Hofstede's national culture dimensions. Authors acknowledge skewed sample of 69% Chinese respondents and sampling is not generalizable due to small geographic area studied. The significant findings of the study are that keeping up with technological progress and global issues were the deemed most important for leadership. Low priority is put on multi-culturalist orientation suggesting a sample bias or a low appreciation of cultural needs.

	Selvarajah &Meyer, (2008)	Study on ethnicity and leadership	Similar to the above study but with wider sampling of 512 respondents from several states in Malaysia.	Very detailed description of cultural composition in Malaysia. Again based on Hofstede's dimensions, the study found differences in leadership across ethnicities. Although "collectivist" in nature as a whole, the three major races in Malaysia view leadership through their own cultural lenses. The Chinese are managerial and delegators; the Malay emphasize personal qualities, and the Indians, view consultative leadership as most important.
	Zainol & Ayadurai (2010)	Ethnicity and entrepreneurship	Stratified proportionate random sampling of 162 Malays survey respondents in small geographic area.	Non-significant finding of ethnicity and entrepreneurship but ethnicity was found to be a predictor towards firm performance. Detailed description of factors that may influence Malay businesses in the country. Limitations of study acknowledged including sampling bias, cultural hesitancy to share personal views, and possible lack of validity of tools in this sample.
	Dooley (2003)	Review/report	Description of cultural awareness workshop and influence of cultural awareness on job performance	Based on Hofstede's cultural dimensions. A very good description on how an American company conducted a cultural awareness workshop for all its employees covering four cultures: American, Malay, Chinese and Indian, to successful improvement in work performance.
	Condron, Thompson, & Dove (2004)	Case description	Provides a case review on a joint American-Malaysian high-tech project.	A good learning experience for companies expanding globally on the need to understand "national" cultures. The failure of the project

				stemmed from poor appreciation of cultures from style of communication to appreciation of time which led to critical misunderstandings.
Other influences on work culture	Parboteeah & Cullen (2003)	Exploration/discussion on work centrality beyond national culture	N/A	Authors argue that Hofstede's dimensions are insufficient in explaining work centrality. Other social institutions such as model of education, level of industrialization, government policies and union activity influence work.
	Lee (2005)	Expert opinion/review	N/A	Author describes in detail the historical use of racially-based affirmative action in Malaysia and its impact on work culture. Affirmative action has induced a sense of entitlement, and created a huge base of civil servants. Both factors contribute to a lack of urgency in approaching work.
	Montesino (2011)	Expert opinion/review	N/A	As above.

Table III: Summary of Articles on Simulation in Cross-Cultural Training

Theme	Author/s	Type of Article	Methodology	Results/Discussion
Use of simulation in cross cultural training (business/ negotiations)	Chin, et al. (2009)	Review	N/A	Article reviews of the use of simulation in the last 40 years. Authors describe the challenges in assessing the effectiveness of simulation in particular the inability to "control" simulation. Suggestions are made on including assessment in the creation simulation scenarios to ensure real world validity, the use of pre and post-tests, and reflection learning.
	Hofstede and Pederson (1999)	Description of a simulation program	N/A	Authors provide an in depth description and analysis on the use of synthetic cultures in simulation emphasizing Hofstede's national cultural dimensions. Essentially a step-by-step "how to" manual with processes from introduction to evaluation, tools, and created cultures are shared.
	Hofstede, et al. (2010)	Critique/review	N/A	A critical analysis on the use of simulation in cross-cultural training addressing the strengths of simulation in reflecting the real world. The authors also share the challenges related to assessing simulation, and the possibility of failure if the simulation is not approached correctly, for example, a wrong fit for a facilitator or forgoing debriefing can devastate an educational experience.
	Hurn (2011)	Review	N/A	A review of the different approaches in using simulation in cross-cultural training.

	Lewis (2005)	Viewpoint	N/A	A personal perspective on simulation in cross-cultural training as a lecturer ad student in business school. Author describes the benefits and challenges in using simulation to reflect real world cultural-based exchange.
	Johnston & Burton (2009)	Study	Purposive sampling of American and Brazilian participants.	Participants were involved in 2-hour simulation on negotiating the sale of high-tech equipment. Session was rushed. Evaluations from participants on the effectiveness were mixed based on a post-intervention survey of Likert scale items.
	Dooley (2003)	See above (Table II)		
Simulation in cross-cultural training (health care)	Fors, et al. (2009)	Program description	N/A	States the need for cultural awareness and competence in health care. Describes a pilot program to train health care providers in cross-cultural awareness using virtual patients (standardized patients). The authors shared the importance of language proficiency in using the program.
	Haas, et al. (2010)	Program description	N/A	Use of simulated patients to create awareness of nursing students of three ethnic patients. Scenarios are simple and run the risk of stereotyping.
	Parkhurst & Ramsey (2006) [Abstract]	Program description	N/A	Use of standardized patients to train physician assistant students. Observations of students show qualitative improvement.

	Rutledge, et al. (2004) [Abstract]	Program description	N/A	Describes use of standardized patients to train nurse practitioner students on raising cultural awareness.
	Schitai, 2004	Program pilot	Evaluation of pilot included expert review; trials; focus group; and questionnaire on the use of the program	Author describes the development of a computer program using standardized Hispanic patients to train allied health professionals. Initial evaluation of the program indicates highly positive responses.
	O'Connor (2002)	Brief description of study	Sampling not discussed but evaluations (Likert scale) were submitted by 26 attendees of a pediatric conference who participated in the simulation.	Use of BaFa Bafa adapted to health care needs. Evaluations were largely positive on usefulness of the simulation.
Simulation in cross-cultural training (education)	Inglis, et al. (2004)	Qualitative and descriptive quantitative study	Purposive sampling of students in a social science course in a university	Use of the modified BaFa Bafa. Detailed description given on the validity of the modified game. Rigor maintained by capturing details of the simulation and how the students performed and reacted. Written reflections and debriefing were indicated. Students found the simulation far more educational than traditional didactic approaches. Scores in cultural diversity also improved post intervention and two years after the study.
Simulation in cross-cultural training (military)	Mills & Smith (2004)	Quantitative study	Volunteers of the Australian military branches recruited via email; potential sampling bias of those interested in cross-cultural issues although participants were	Study on the effectiveness of simulation in cross cultural training in the military. Strict criteria were set for the pilot. Rigor was maintained by piloting the study and feedback obtained to improve on the study. Main study used Hofstede's "The Trade

			randomly assigned to study and control groups.	Mission," and evaluations were done measuring multiple aspects of the study. Results indicate longitudinal improvement in scores in cultural relativity and multicultural acceptance.

Table IV: PEST Assessment of Orientation Needs of Nursing Leadership

PEST categories	Challenges	Opportunities	Interventions	Goals
Political and Social	1. Affirmative action places pressure on JHMI to hire a Malay or "Bumiputra" to be the chief nurse of the hospital. 2. The chief nurse must be a Malaysian citizen according to the Nurses Act of 1950. 3. Unfamiliarity with the American system. 4. Low level of education. 5. Challenges in the fluency of the English language.	1. A Malay or "Bumiputra" chief nurse will win the favor of key government agencies (for example, the MNB and the Ministry of Health) and assist in facilitating the commissioning of the hospital. 2. A Malaysian nurse familiar with the cultural practices and subtleties of the country may be more effective in communicating the expectations of the hospital. 3. A contract can be agreed upon at which this chief nurse and mid level managers will undertake further education to obtain a BSN or MSN from an American University of JHMI approval if they have a diploma at start of employment. This will allow for personal and professional growth with potential for influencing the future of	1. The Malaysian chief nurse, mid-level managers and educator/s should be sent to Johns Hopkins University Hospital for practical experience in American nursing. 2. Provide intensive English tutoring on writing and spoken skills may be necessary. 3. The services of American nurse consultants and educators can be acquired on a short-term basis to guide the Malaysian chief nurse allowing for the transfer of knowledge akin to the "technology transfer" during the industrialization of Malaysia. 4. An option to overcome the legal requirement of having a Malaysian as chief nurse of the hospital is to create the position of Vice President or General Manager, Patient Care Services to whom the chief nurse will report.	1. Effective commissioning of the hospital. 2. Professional nursing and workforce development 3. Knowledge development from research. 4. Development of hospital reputation. 5. Build on long-term sustainability and profitability. 6. Long-term American-Malaysian nursing cooperation.

PEST Categories	Challenges	Opportunities	Interventions	Goals
Political and Social (Continuation)		nursing. 4. Develop a foundation of and reputation for American nursing emphasizing critical thinking and evidence-based practice. 5. Facilitate the creation of the "Perdana nurse" according to the mission, vision, and goals of the institution. 6. Potential for research measuring aspects of leadership knowledge pre and post orientation or educational opportunity.		
Economic and Technological	1.High cost of orientation 2. Unfamiliarity with American systems, in particular, computerized charting if Perdana University Hospital will acquire a system in time for the opening of the hospital.	1. Investing at the onset will facilitate a smoother and more effective transition of systems and enculturation of staff. 2. Return of investment may be measured in the longer term by way of safe and excellent patient care, patient satisfaction scores, institutional reputation, and profit in the long run.	1. Facilitate "buy-in" of the nursing plan by other stake-holders particularly investors and physician decision- makers. 2. Provide cultural orientation to American nursing prior to clinical orientation in Baltimore to ensure effective learning and productive time. 3. Ensure plan to include an evaluative process and continuous improvement.	1. Effective commissioning of the hospital. 2. Cost effective investment. 3. Professional nursing and workforce development. 4. Knowledge development from research.

PEST Categories	**Challenges**	**Opportunities**	**Interventions**	**Goals**
Economic and Technological (Continuation)		3. Research opportunities measuring topics such as knowledge acquisition, staff attitudes, awareness, competencies, etc.		5. Development of hospital reputation. 6. Build on long-term sustainability and profitability. 7. Long-term American-Malaysian nursing cooperation.

Table V: PEST Assessment of Orientation Needs of Nursing Staff

PEST categories	**Challenges**	**Opportunities**	**Interventions**	**Goals**
Political and Social	1. Challenges in the fluency of the English language. 2. Unfamiliarity with the American system. 3. Low level of education. 4. Due to a shortage of experienced nursing staff in the country, recruitment may have to concentrate on hiring new graduates. 5. Inconsistent level of education/training calls for careful screening of applicants.	1. Opportunity to build workforce of diversity based on merit in hiring "the best and the brightest". 2. Ability to shape and influence the future of nursing as a profession. 3. Develop a foundation of and reputation for American nursing emphasizing critical thinking and evidence-based practice. 4. Facilitate the creation of the "Perdana nurse" according to the mission, vision, and goals of the institution.	1. Provide intensive English tutoring on writing and spoken skills may be necessary. 2. Provide well-structured orientation to communicate expectations early, and to ensure meaningful and smooth transition into clinical work. 3. Utilize simulation in teaching and in assessing competencies. 4. Use American educators to share knowledge on American nursing expectations. 5. Select and train early in the nursing plan preceptors and future educators for the hospital. 6. An early consideration: sponsor students for training at reputable schools for future workforce needs and utilize the practice of bonding sponsored students for five years post graduation.	See Nursing Leadership above
Economic and Technological	1.High cost of orientation 2. Time commitment	1. Nurses' wages are relatively low in Malaysia which will help in tempering cost.	1. Facilitate "buy-in" of the nursing plan by other stake-holders particularly investors and physician decision- makers.	See Nursing Leadership above

PEST Categories	**Challenges**	**Opportunities**	**Interventions**	**Goals**
Economic and Technological (Continuation)	3. Financial investment in technology e.g. simulation laboratory, computer-based educational materials.	2. Investing at the onset will facilitate a smoother and more effective transition of systems and enculturation of staff. 3. Return of investment may be measured in the longer term by way of safe and excellent patient care, patient satisfaction scores, institutional reputation, and profit in the long run. 4. Research opportunities measuring topics such as knowledge acquisition, staff attitudes, awareness, competencies, etc	2. Invest in technology. 3. Ensure plan to include an evaluative process and continuous improvement.	

Table VI: PEST Assessment of Career Development Needs

PEST categories	Challenges	Opportunities	Interventions	Goals
Political and Social	1. Traditionally not supported as nursing is viewed as a "labor" and not a profession 2. Lack of motivation 3. Lack of information 4. Inflexible nursing schedule i.e. nurses required to work full-time and rotate through all shifts.	1.Raise nursing awareness and expectations. 2. Ability to shape and influence the future of nursing as a profession. 3. Develop a foundation of and reputation for American nursing emphasizing critical thinking and evidence-based practice. 4. Facilitate the creation of the "Perdana nurse" according to the mission, vision, and goals of the institution. 5. Research opportunities to study culturally appropriate education, care, marketing, etc. 6. Utilize and promote JHU as a source of world-class education. 7. Develop hybrid educational opportunities with JHU.	1. In-house training, courses and seminars. 2. Consider pay differentials degreed nurses and those with specialty certification 3. Flexible scheduling 4. Tuition reimbursement 5. Open training, courses and seminars to nurses outside the facility. 6. Longer term: offer JHU degrees locally.	1. Promote knowledgeable workforce of curious staff and whose practice is evidence-based. 2. Promote live-long learning. 3. Advance professionalism. 4. Promote excellence: safe and quality patient care. 5. Develop reputation of hospital. 6. Longer term profitability and sustainability of hospital. 7. Long-term American-Malaysian nursing cooperation.

PEST Categories	Challenges	Opportunities	Interventions	Goals
Political and Social (Continuation)		8. Advance nursing as a profession affecting the country and region.		
Economic and Technological	1. Cost of providing career development opportunities 2. Lack of availability of technology	1. Potential for income from offering training, courses, degrees to nurses outside of the Perdana family. 2. Lead the region in providing the best technologically-based education. 3. Enhance hospital reputation as regional/international research and educational center.	1. Facilitate "buy-in" of the nursing plan by other stake-holders particularly investors and physician decision- makers. 2. Invest in technology. 3. Invest in marketing. 4. Ensure plan to include an evaluative process and continuous improvement.	See "Political and Social" above

Table VII: Probable Timeline for Recruitment and Orientation

Issue/Time	2012	1st Q 2013	2nd Q 2013	3rd Q 2013	4th Q 2013	1st Q 2014	2nd Q 2014	3rd Q 2014	4th Q 2014
Establish Mission, Vision and Goals									
Work on Nursing P&P's, Standards of Care, Nursing Documentation Standards, etc.									
Recruitment of Chief Nurse, Managers and Educator/s									
Orientation of Nursing Leadership									
Recruitment of Staff									
Orientation of Staff									
Opening of hospital									

Table VIII: Estimated Cost of Orientation

Cost Item				
1-month Base Pay for Nursing Leadership (median)				
• 1x FTE Chief Nurse	RM$	11,500		
• 4 x FTE Nurse Managers	RM$	26,000		
• 1 x FTE Educator	RM$	6,500		
Total		44,000		
2-week Orientation in Baltimore				
• Transportation	RM$	45,000		
• Housing	RM$	32,000		
• Expenses	RM$	10,000		
Total		87,000	Rolling Total	131,000
3-month Base Pay for New Graduates (RM$1,500/nurse/month in the Kuala Lumpur area)				
• 180 x FTE	RM$	810,000		
			Rolling Total	941,000
1-month Base Pay for Experienced Nurses (median)				
• 120 x FTE	RM$	498,000		
			Rolling Total	1,439,000
Estimated allowances, differentials and benefits at RM$ 650/nurse/month				
• New graduates 180 x FTE x 3	RM$	351,000		
• Staff nurses 120 x FTE	RM$	78,000		
Total		429,000	Cumulative Total	1,868,000

Figure 1: Developing Cultural Awareness

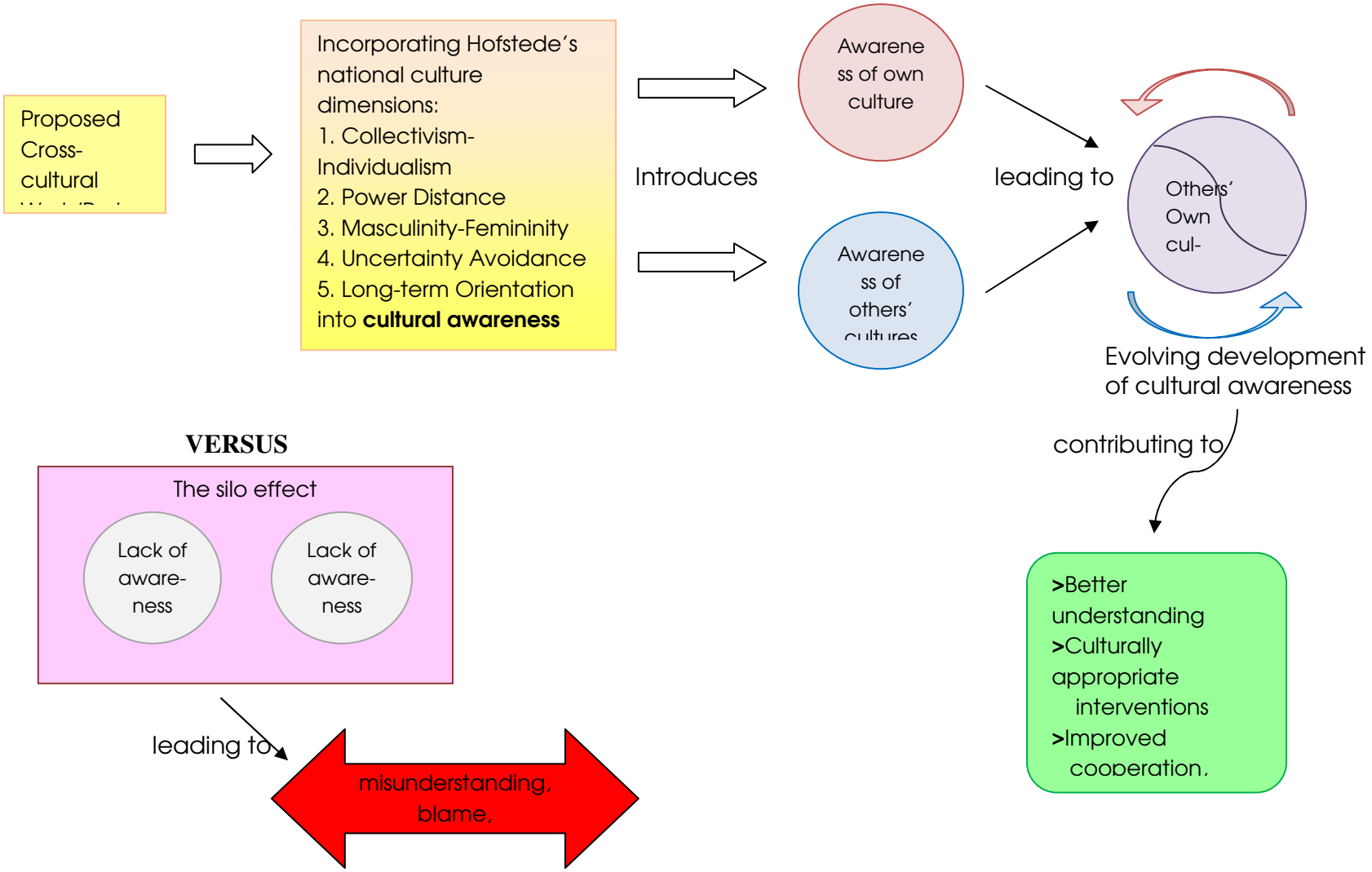
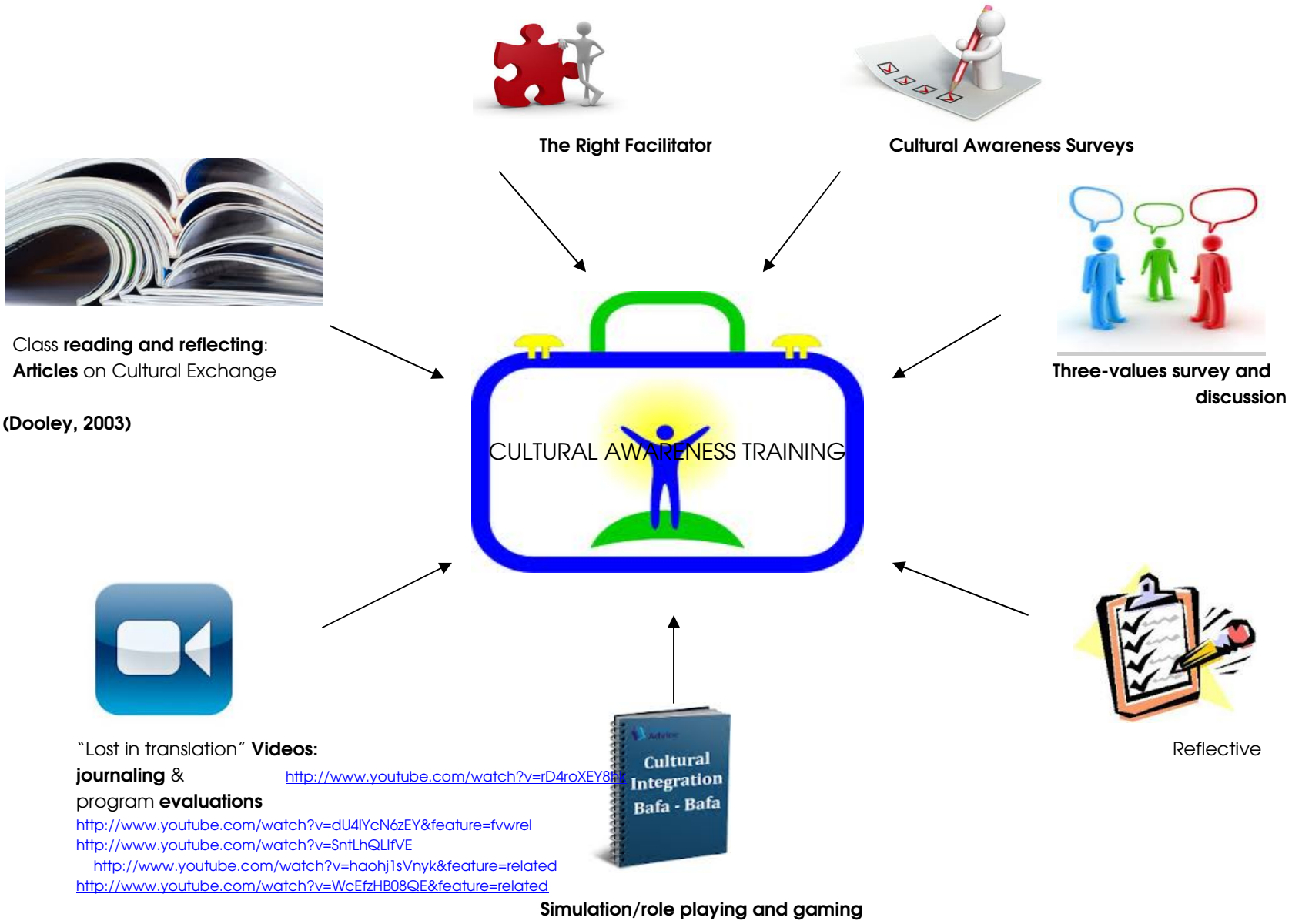


Figure 2: Components of the American-Malaysian Cultural Awareness Training Toolkit



with **debriefing**

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Appendix A:
"Guidelines on Standards and Criteria for Approval/Accreditation for Nursing Programmes"
(Nursing Board Malaysia, 2010, p. 18-23)

Standard 4: Curriculum

4
STANDARD FOUR :
THE CURRICULUM
The content of the curriculum must be designed to prepare the students to:
- *Assume the responsibility and accountability that registration confers.*
- *Apply knowledge, skills and demonstrate the right attitudes to meet the nursing needs of individuals and families in wellness or in sickness in the area of practice.*
- *Be a competent and safe nurse practitioner.*

CRITERIA

4.1 **The curriculum must comprise the 3 core sciences:**
4.1.1 Health sciences (Anatomy & Physiology, Microbiology, Pharmacology, Parasitology, Epidemiology, Nutrition, Environmental Health)
4.1.2 Behavioral sciences (Psychology, Sociology, Soft Skills / Professional Interaction)

4.1.3 Nursing Sciences

Core Sciences	**Minimum (%)**	**Maximum (%)**
Basic Degree/ Diploma / Certificate		
Health Sciences	10	20
Behavioral Sciences	10	20
Nursing Sciences	60	80
Specialty/ Post Basic/ Advanced Diploma		
Health / Behavioral Sciences	10	20
Nursing Sciences (Related Pathophysiology / Nursing Management	80	90

Post Registration	**Minimum %**	**Maximum %**
Degree		
Health / Behavioral Sciences	10	20
Nursing Sciences	80	90

Post Graduate Studies :		
1) Masters		
Behavioral Sciences (Research Components)	20	50
Nursing Sciences	50	80
2) Doctorate		
Behavioral Sciences (Research Components)	50	70
Nursing sciences	30	40

4.1.4 Duration of study must be within the timeframe as below	
Certificate	2 - 4 years
Diploma programme	3 - 5 years
Specialty / Post Basic	6 months - 1 year
Advanced Diploma	1 – 2 years
Basic Degree programme	4 - 6 years
Post Registration Degree	2 - 4 years
Masters	2 - 4 years
PhD / Doctorate	3 - 5 years (Full Time) 4 - 8 years (Part Time)

4.1.4 Total credit hours (core Sciences) should be within the range of: Certificate	60 - 85 credits
Diploma	90 - 100 credits
Post Basic	20 - 40 credits
Advanced Diploma	40 – 60 credits
Basic Degree	120 – 140 credits
Post Registration Degree	80 credits
Masters	40 credits
PhD / Doctorate	no given credit value or 50 – 70 credits (coursework and dissertation)

4.2 The organization must define its semester system and conceptual framework, the credit hours for theory and practice and the number of hours in a week that is being used. The institution is allowed to implement either a 2 or 3 semesters system.

Calculation of credit hours:
4.2.1 **Theory:**
4.2.1.1 1 credit hour of lecture = 1 hour X 14 to 16 weeks
4.2.1.2 1 credit hour of tutorial = 1.5 hours X 14 to 16 weeks
4.2.1.3 1 credit hour of clinical skills = 2 hours X14 to 16 weeks (skills laboratory)
4.2.1.4 Tutorial and clinical skills are computed as theoretical components.
4.2.2. **Practical:**
4.2.2.1 2 weeks of clinical posting is equivalent to 1 credit hour of clinical experience (84 to 96 hours)
It is calculated as:
1 week of Clinical Posting =
Number of hours x 14 to 16 weeks = 3 x 14 to 16 = 42 to 48 hours.
Therefore 2 weeks of Clinical Posting = 84 to 96 hours.
(Refer Table 2)

TABLE 2 : CALCULATION OF CREDIT HOURS

(BASED ON 16 TEACHING-LEARNING WEEKS) Components	**Calculations**
Lectures	1 hour lecture per week for 16 weeks is equivalent to 1 credit. 16 hours lecture = 1 credit hour.
Tutorial	1 ½ hours of tutorial per week for 16 weeks is equivalent to 1 credit. 24 hours of tutorial = 1 credit hour.
Clinical Skills	2 hours of clinical skills session per week for 16 weeks is equivalent to 1 credit hour- 32 hours of clinical skill practice = 1 credit
Practical (Clinical Experience)	7-8 hours of activities continuously for 2 weeks is equivalent to 1 credit. 2 weeks of clinical experience (clinical posting) = 1 credit hour.

4.2.2.2 Supervised experience in simulated ward using Human Patient Simulator (High fidelity mannequin) should not exceed 20% of total clinical practice and must be approved by Nursing Board Malaysia.
4.3 The total credits per semester should not exceed 20 credit hours. Each subject should not exceed 4 credit hours in a semester.

4.4 In a modular programme the credit weightage per module should be within 10 credits only.
4.5 The ratio between theory of nursing science and practical:

Components	**Certificate**	**Diploma/ Basic Degree**	**Post Basic/ Advanced Diploma**	**Post Registration Degree**	**Post Graduate Studies**
Theory	30 – 40%	45 – 55%	40 – 50%	45 – 55%	70 – 85%
Practical	60 – 70 %	45 – 55%	50 -60%	45 – 55%	15 – 30%

4.6 There must be evidence of integration between theory and practice components.
4.6.1 Each semester must demonstrate evidence of theory followed by practice.
4.6.2 Learning outcomes of clinical posting must be congruent with the theory of current semester.
4.7 Selection, organization and sequence of learning experiences including the clinical practice **must** facilitate student achievement of course objectives.
4.8 There must be a variety of teaching methods that promotes creativity and life long learning.
4.9 There should be sufficient clinical experiences in the various disciplines as required by Nursing Board Malaysia with 60% emphasis in Medical and Surgical Nursing. The remainder will be used for exposure to specialized areas.
4.10 Emphasis on skills and attitudes necessary for effective communication and provision of safe nursing care:
4.10.1 The curriculum must have course objectives emphasizing on the psychomotor and effective domains to ensure the ability to communicate effectively, provide safe, competent and holistic nursing care.
4.10.2 The curriculum must define the level of achievements of procedures in the clinical practice record (Nursing Skills Log Book) according to the semesters and for exit of course.
4.11 Review of curriculum every 3 - 5 years to address the professional and health needs of the country.
4.12 The curriculum should illustrate the content sequence, breadth, depth and extent.
4.13 The Curriculum Committee should consists of stakeholders, academic staff, nursing personnel, graduates / regulatory / accreditation bodies.
4.14 Any review or changes to the curriculum must be notified to the NBM.
4.15 Reviews or changes of more than 30% to the curriculum must be endorsed by the NBM.

Appendix B:
Hospital Survey on Patient Safety
(Agency for Healthcare Research and Quality, 2004).

Hospital Survey on Patient Safety

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- *An **"event"** is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.*
- ***"Patient safety"** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.*

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

- ☐ a. Many different hospital units/No specific unit
- ☐ b. Medicine (non-surgical)
- ☐ c. Surgery
- ☐ d. Obstetrics
- ☐ e. Pediatrics
- ☐ f. Emergency department
- ☐ g. Intensive care unit (any type)
- ☐ h. Psychiatry/mental health
- ☐ i. Rehabilitation
- ☐ j. Pharmacy
- ☐ k. Laboratory
- ☐ l. Radiology
- ☐ m. Anesthesiology
- ☐ n. Other, please specify:

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit…	**Strongly Disagree** ▼	**Disagree** ▼	**Neither** ▼	**Agree** ▼	**Strongly Agree** ▼
1. People support one another in this unit	☐1	☐2	☐3	☐4	☐5
2. We have enough staff to handle the workload	☐1	☐2	☐3	☐4	☐5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done	☐1	☐2	☐3	☐4	☐5
4. In this unit, people treat each other with respect	☐1	☐2	☐3	☐4	☐5
5. Staff in this unit work longer hours than is best for patient care	☐1	☐2	☐3	☐4	☐5
6. We are actively doing things to improve patient safety	☐1	☐2	☐3	☐4	☐5
7. We use more agency/temporary staff than is best for patient care	☐1	☐2	☐3	☐4	☐5
8. Staff feel like their mistakes are held against them	☐1	☐2	☐3	☐4	☐5
9. Mistakes have led to positive changes here	☐1	☐2	☐3	☐4	☐5
10. It is just by chance that more serious mistakes don't happen around here	☐1	☐2	☐3	☐4	☐5
11. When one area in this unit gets really busy, others help out	☐1	☐2	☐3	☐4	☐5
12. When an event is reported, it feels like the person is being written up, not the problem	☐1	☐2	☐3	☐4	☐5
13. After we make changes to improve patient safety, we evaluate their effectiveness	☐1	☐2	☐3	☐4	☐5
14. We work in "crisis mode" trying to do too much, too quickly	☐1	☐2	☐3	☐4	☐5
15. Patient safety is never sacrificed to get more work done	☐1	☐2	☐3	☐4	☐5
16. Staff worry that mistakes they make are kept in their personnel file	☐1	☐2	☐3	☐4	☐5
17. We have patient safety problems in this unit	☐1	☐2	☐3	☐4	☐5
18. Our procedures and systems are good at preventing errors from happening	☐1	☐2	☐3	☐4	☐5

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.

	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	☐1	☐2	☐3	☐4	☐5
2. My supervisor/manager seriously considers staff suggestions for improving patient safety	☐1	☐2	☐3	☐4	☐5
3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	☐1	☐2	☐3	☐4	☐5
4. My supervisor/manager overlooks patient safety problems that happen over and over	☐1	☐2	☐3	☐4	☐5

SECTION C: Communications

How often do the following things happen in your work area/unit?

Think about your hospital work area/unit…	Never ▼	Rarely ▼	Some-times ▼	Most of the time ▼	Always ▼
1. We are given feedback about changes put into place based on event reports	☐1	☐2	☐3	☐4	☐5
2. Staff will freely speak up if they see something that may negatively affect patient care	☐1	☐2	☐3	☐4	☐5
3. We are informed about errors that happen in this unit	☐1	☐2	☐3	☐4	☐5
4. Staff feel free to question the decisions or actions of those with more authority	☐1	☐2	☐3	☐4	☐5
5. In this unit, we discuss ways to prevent errors from happening again	☐1	☐2	☐3	☐4	☐5
6. Staff are afraid to ask questions when something does not seem right	☐1	☐2	☐3	☐4	☐5

SECTION D: Frequency of Events Reported

In your hospital work area/unit, when the following mistakes happen, *how often are they reported?*

	Never ▼	Rarely ▼	Some-times ▼	Most of the time ▼	Always ▼
1. When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?	☐1	☐2	☐3	☐4	☐5
2. When a mistake is made, but has *no potential to harm the patient*, how often is this reported?	☐1	☐2	☐3	☐4	☐5
3. When a mistake is made that *could harm the patient*, but does not, how often is this reported?	☐1	☐2	☐3	☐4	☐5

SECTION E: Patient Safety Grade

Please give your work area/unit in this hospital an overall grade on patient safety.

☐	☐	☐	☐	☐
A	**B**	**C**	**D**	**E**
Excellent	Very Good	Acceptable	Poor	Failing

SECTION F: Your Hospital

Please indicate your agreement or disagreement with the following statements about your hospital.

Think about your hospital…	**Strongly Disagree** ▼	**Disagree** ▼	**Neither** ▼	**Agree** ▼	**Strongly Agree** ▼
1. Hospital management provides a work climate that promotes patient safety	☐1	☐2	☐3	☐4	☐5
2. Hospital units do not coordinate well with each other	☐1	☐2	☐3	☐4	☐5
3. Things "fall between the cracks" when transferring patients from one unit to another	☐1	☐2	☐3	☐4	☐5
4. There is good cooperation among hospital units that need to work together	☐1	☐2	☐3	☐4	☐5
5. Important patient care information is often lost during shift changes	☐1	☐2	☐3	☐4	☐5
6. It is often unpleasant to work with staff from other hospital units	☐1	☐2	☐3	☐4	☐5
7. Problems often occur in the exchange of information across hospital units	☐1	☐2	☐3	☐4	☐5
8. The actions of hospital management show that patient safety is a top priority	☐1	☐2	☐3	☐4	☐5
9. Hospital management seems interested in patient safety only after an adverse event happens	☐1	☐2	☐3	☐4	☐5
10. Hospital units work well together to provide the best care for patients	☐1	☐2	☐3	☐4	☐5
11. Shift changes are problematic for patients in this hospital	☐1	☐2	☐3	☐4	☐5

SECTION G: Number of Events Reported

In the past 12 months, how many event reports have you filled out and submitted?

- ☐ a. No event reports
- ☐ b. 1 to 2 event reports
- ☐ c. 3 to 5 event reports
- ☐ d. 6 to 10 event reports
- ☐ e. 11 to 20 event reports
- ☐ f. 21 event reports or more

SECTION H: Background Information

This information will help in the analysis of the survey results.

1. How long have you worked in this hospital?

- ☐ a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 to 15 years
- ☐ e. 16 to 20 years
- ☐ f. 21 years or more

2. How long have you worked in your current hospital work area/unit?

- ☐ a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 to 15 years
- ☐ e. 16 to 20 years
- ☐ f. 21 years or more

3. Typically, how many hours per week do you work in this hospital?

- ☐ a. Less than 20 hours per week
- ☐ b. 20 to 39 hours per week
- ☐ c. 40 to 59 hours per week
- ☐ d. 60 to 79 hours per week
- ☐ e. 80 to 99 hours per week
- ☐ f. 100 hours per week or more

SECTION H: Background Information (continued)

4. What is your staff position in this hospital? Select ONE answer that best describes your staff position.

- ☐ a. Registered Nurse
- ☐ b. Physician Assistant/Nurse Practitioner
- ☐ c. LVN/LPN
- ☐ d. Patient Care Asst/Hospital Aide/Care Partner
- ☐ e. Attending/Staff Physician
- ☐ f. Resident Physician/Physician in Training
- ☐ g. Pharmacist
- ☐ h. Dietician
- ☐ i. Unit Assistant/Clerk/Secretary
- ☐ j. Respiratory Therapist
- ☐ k. Physical, Occupational, or Speech Therapist
- ☐ l. Technician (e.g., EKG, Lab, Radiology)
- ☐ m. Administration/Management
- ☐ n. Other, please specify:

5. In your staff position, do you typically have direct interaction or contact with patients?

- ☐ a. YES, I typically have direct interaction or contact with patients.
- ☐ b. NO, I typically do NOT have direct interaction or contact with patients.

6. How long have you worked in your current specialty or profession?

- ☐ a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 to 15 years
- ☐ e. 16 to 20 years
- ☐ f. 21 years or more

SECTION I: Your Comments

Please feel free to write any comments about patient safety, error, or event reporting in your hospital.

THANK YOU FOR COMPLETING THIS SURVEY.

Appendix C:

Excerpt of a Simulation Scenario on Cultural Issues

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES				
Initiation of Scenario: Report information **S-** 85-year old **non-English** speaking Asian male, awaiting admission for pneumonia and pleural effusion. Newly diagnosed with lung CA. Patient lives with his daughter, a professor of law at the local university. **B-** After two weeks of a cough and URI symptoms, patient developed shortness of breath yesterday. The daughter brought the father to the physician. The daughter has acted as translator and has made all decisions for the father. Patient is unaware of diagnosis. Daughter is insisting the patient should not be told of diagnosis. The physician has spoken to the patient's oldest son who is a cardiologist in Penang who also insisted the patient should not be told of his diagnosis. The patient's treatment team comprises the admitting physician, a fourth year medical student, a resident, and nurses. The fourth year student and resident would like to inform the patient of his diagnosis. The daughter is threatening to leave AMA if they do so. **A-** Vitals on admission 108, 32, 140/79, 102.6. His O2 sat is 86% on RA; 95% with 4L via NC. Pain only 1-2/10, Alert Oriented x3 Labs unremarkable except for an elevated white count. CXR shows bilateral basal pleural effusion with multiple scattered nodes of 1mm to 5mm in size **R-** The admitting physician would like to tap the patient to drain the effusion and to send the fluid for testing. He is also recommending a lung biopsy. The daughter has agreed to all the procedures on the condition that her father is only informed of the pneumonia and fluid in his lungs.				
STATE	**PATIENT STATUS**	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline MS patient	**SOB** **After antipyretic, fluid bolus of 500ml, IV antibiotic, and on O2 at 4L via NC:** **02 sat 94%**	**Learner Actions:** **Respiratory Assessment** **Set-up for chest aspiration**	**Operator: Set up parameters for new case** **Triggers: Obtaining**	**Teaching Points:** **Complete Respiratory Assessment** **Increase the Oxygen delivery** **Medicate for pain if needed**

	BP 126/72 **HR 98** **R 26** **T 101.1** **Patient A&O x 3**		**consent with daughter as "decision maker"**	
STATE	**PATIENT STATUS**	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
2. Keeping information from patient	**Stable. Maintenance fluid at 125ml/hour.**	**Learner Actions:** **1. Recognize ethical principles in situation.** **2. Recognize inappropriateness of physicians discussing situation in patient room** **3. Involves assistance of social worker, case manager, bioethicist if available.** **4. Recommends family-team meeting with bioethicist.**	**Operator:** **Continues Scenario, Increase team frustration with daughter's insistence to keep diagnosis from the patient** **Triggers: call for team to continue discussion in conference room**	**Teaching Points:** **Team Communication; patient comfort** **Examine Principalist approach of Autonomy, Non-maleficience, Beneficience and Justice vs Values approach of community and family rights over the individual; preservation of familial harmony; protection from harm; respect for elders.** **Identify and discuss "surrogate" decision maker issues such as language and cultural differences, and previous health care wishes.**
3.Patient Aspiration proceeds with patient consent but without patient knowledge of CA diagnosis	**No "time out" conducted.** **Resident informs nurse "time out" is not necessary**	**Learner Actions:** **1. Communicate with daughter about tapping. Translated to patient.** **2. Recognize failure of physician**	**Operator: Continues Scenario** **Triggers: call resident to conduct "time out"**	**Teaching Points:** **Assist with chest aspiration set-up and with procedure.** **Assess need for pain control and/or sedation**

	During chest aspiration with increase in respiratory work: P 111 BP 145/92 R 36 O2 sat on 4L NC: 90% Nurse switches patient over to NRB. R continues to increase; O2sat drops; patient restless	to call "time out" 3. Recognize respiratory work 4. Reassess respiratory status	Triggers: call resident on importance of "time out" Triggers: call for resident attention to dropping O2sat Ignored by resident who says to give patient more oxygen Triggers: call for resident attention who gives the same answer to increase O2. Triggers: call colleague to contact admitting physician STAT; obtain crash cart	Managing change in respiratory status: anxiety versus pathology. Team communication—address physician on "time out" and changing patient status Psychological support for patient and daughter. Recognizing physician who is not responsive to clinical data; recognizing change in patient status requiring intervention.
STATE	**PATIENT STATUS**	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
5. Translation of patient wishes	Stable post aspiration: P 89 BP 132/76 R24 O2 6L via mask: 98%	Learner Actions: 1. Reassess respiratory status 2. Social worker speaks with daughter to resolve issue of patient's right to information, and self-determination. Ensure patient's wish is such that his family makes all decisions for him	Operator: continues scenario Triggers: Patient confirms that his daughter and son	Teaching Points Acceptance of patient's wish even though it may contradict one's own beliefs.

			are to make all decisions for him as he does not wish to be burdened by "difficult news"	
SCENARIO END POINT: **TREATING TEAM ACCEPTS PATIENT'S WISH.**				
SUGGESTIONS TO INCREASE OR DECREASE SCENARIO COMPLEXITY: 1. ADD RESIDENT WHO INSISTS ON SPEAKING WITH THE PATIENT WITHOUT THE PRESENCE OF THE DAUGHTER. 2. WRONG SIDE OF LUNG ASPIRATED				

Appendix D:
Cultural Awareness Scale
(Mills and Smith, 2004).

Cultural Awareness Scale

Anonymity Number: _____

Please indicate the extent to which you AGREE with the statement, circling the appropriate number.

	Strongly Disagree						**Strongly Agree**
1. We should block imports of foreign products that may affect our culture	1	2	3	4	5	6	7
2. A person should make certain that their actions never intentionally harm another even to a small degree	1	2	3	4	5	6	7
3. What is ethical varies from one situation and society to another	1	2	3	4	5	6	7
4. Acting as an individual is more appealing to me than acting as a member of a group	1	2	3	4	5	6	7
5. Achievement is synonymous with recognition and wealth	1	2	3	4	5	6	7
6. Ethical considerations in interpersonal relations are so complex that individuals should be allowed to form their own individual codes	1	2	3	4	5	6	7
7. I always believe that one should interpret things from the perspective of his/her own culture	1	2	3	4	5	6	7
8. I believe that group harmony is more important than personal satisfaction	1	2	3	4	5	6	7
9. Moral standards should be seen as individualistic; what one person considers to be moral may be judged to be immoral by another person	1	2	3	4	5	6	7
10. One should never psychologically or physically harm another person	1	2	3	4	5	6	7
11. I dislike unpredictable situations	1	2	3	4	5	6	7
12. I often do my own thing	1	2	3	4	5	6	7
13. I would not be satisfied until people recognize my name in my professional career	1	2	3	4	5	6	7

14. I enjoy being unique and different from others in many ways	1	2	3	4	5	6	7
15. I feel stressful when I cannot predict consequences	1	2	3	4	5	6	7
16. I find it hard to disagree with authority figures	1	2	3	4	5	6	7
17. I'd rather depend on myself than others	1	2	3	4	5	6	7
18. I tend to conform to the wishes of someone in a higher position than mine	1	2	3	4	5	6	7
19. I tend to get anxious easily when I don't know an outcome	1	2	3	4	5	6	7
20. I would never adopt the ideas that originated from other countries	1	2	3	4	5	6	7
21. I will sacrifice my self-interest for the benefit of the group I am in	1	2	3	4	5	6	7
22. I tend to give priority to the opinions of people in authority	1	2	3	4	5	6	7
23. I don't like to go into a situation without knowing what I can expect from it	1	2	3	4	5	6	7
24. I would prefer more salary to shorter working hours	1	2	3	4	5	6	7
25. It is important to me to respect decisions made by the group	1	2	3	4	5	6	7
26. I don't like situations that are uncertain	1	2	3	4	5	6	7
27. I would rather be known for who I am than as a member of an organization to which I belong	1	2	3	4	5	6	7
28. Risks to another should never be tolerated, irrespective of how small the risks might be	1	2	3	4	5	6	7
29. It is difficult for me to refuse a request if my superior asks me	1	2	3	4	5	6	7
30. It is important to maintain harmony within my group	1	2	3	4	5	6	7
31. If an action could harm an innocent other, then it should not be done	1	2	3	4	5	6	7
32. It is not worth spending time learning another country's culture	1	2	3	4	5	6	7

33. Maintenance of economic growth should have highest priority in a society	1	2	3	4	5	6	7
34. It is sad to see some people adopting foreign ideas or doctrines	1	2	3	4	5	6	7
35. I find it difficult to disagree with someone in a higher position than mine	1	2	3	4	5	6	7
36. Material success is more important than relationship maintenance	1	2	3	4	5	6	7
37. Moral standards are simply personal rules which indicate how a person should behave, and are not to be applied in making judgments of others	1	2	3	4	5	6	7
38. I believe that it is my duty and obligation to observe the norms set by the group to which I belong, even if personal costs outweigh personal benefits	1	2	3	4	5	6	7
39. My country's culture is superior to those of other countries	1	2	3	4	5	6	7
40. My personal identity, independent of others, is very important to me	1	2	3	4	5	6	7
41. I dislike it when a person's statement could mean many different things	1	2	3	4	5	6	7
42. One should not perform an action which might in any way threaten the dignity and welfare of another individual	1	2	3	4	5	6	7
43. Questions of what is ethical for everyone can never be resolved since what is moral or immoral is up to the individual	1	2	3	4	5	6	7
44. It is difficult for me to express my opinions to superiors	1	2	3	4	5	6	7
45. The existence of potential harm to others is always wrong, irrespective of the benefits to be gained	1	2	3	4	5	6	7
46. The value system that my fellow countrymen hold is superior to those in other countries	1	2	3	4	5	6	7
47. To me, "big and fast" is more attractive than "small and slow"	1	2	3	4	5	6	7
48. To me, the interests of the group are generally more important than my personal interests	1	2	3	4	5	6	7

49. Different types of moralities cannot be compared as to "rightness" 1 2 3 4 5 6 7

Note: Items in italics make up the cultural relativity subset.