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Cultural understanding reduces the barriers generated by prejudice and stereotyping, and can help health professionals provide person-focused care

Ensuring cultural safety in nurse education

In this article...

- Definitions of culture
- Why cultural diversity should be considered in nurse education
- The concept of cultural safety

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Abstract De D, Richardson J (2015) Ensuring cultural safety in nurse education. *Nursing Times;* 111: 39, 17-19.
Nursing courses now have a more culturally diverse mix of students and educators, and students need to consider how this influences learning and how their needs can be addressed. This article describes how the idea of "cultural safety" can promote professionally comprehensive and culturally coherent healthcare education in academic and clinical situations.

The student nurse population is increasingly culturally diverse as a result of growing access to nursing courses and increasing numbers of students from overseas. To deliver or receive effective and fair learning strategies, nurse educators and students need to address their intercultural competencies.

Although many universities run modules addressing cultural aspects of care, transcultural nursing and multicultural health needs, many nurse educators feel uncomfortable teaching the topic (Starr et al, 2011); this constitutes a growing challenge for nurse education. One approach that promotes comprehensive and culturally coherent healthcare education in both academic and clinical situations is that of "cultural safety". This is based on a broad definition of the term "culture" and on individuals' analysis of their cultural self and its potential impact on therapeutic encounters (De and Richardson, 2008).

Culture

Culture is an elusive idea with a diverse range of meanings. This article uses two definitions:

> *"beliefs and practices common to any particular group"* (Nursing Council of New Zealand, 2011)

and the broader:

> *"a set of guidelines... which an individual inherits as a member of a particular society and which tells him how to view the world and learn how to behave in relation to other people. It also provides him with a way of transmitting these guidelines to the next generation"* (Helman, 2007).

Culture as a risk factor

Locke (1992) realised that nurses need to recognise patients' culture and different cultural identities to provide effective healthcare strategies. Almost 10 years later Culley and Dyson (2001) emphasised this would need to be acknowledged in a non-biased "culturally safe" manner without any "recourse to crude stereotyping" that could be perceived as discriminatory or unsafe.

Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of any person using health or educational services (NCNZ, 2011). In health and social care settings, it may contribute to poor patient concordance/adherence, miscommunication or even mistrust (Fadiman, 1997). In education, failure to take culture into consideration may lead to inequality, negative stereotyping, homogenous generalisations, poor academic performance and increasing rates of attrition.

There should be no place in nurse education for cultural blindness, as an

5 key points

1. **Cultural diversity is increasing in students on pre- and post-registration nursing programmes**
2. **Nurse educators and mentors need to consider how diversity affects learning needs**
3. **Culture refers to the beliefs and practices common to any particular group**
4. **Unsafe cultural practice includes actions that diminish, demean or disempower the cultural identity and wellbeing of any person**
5. **The key feature of cultural safety is equality**

Students may have a different cultural background and this should be recognised

Alamy

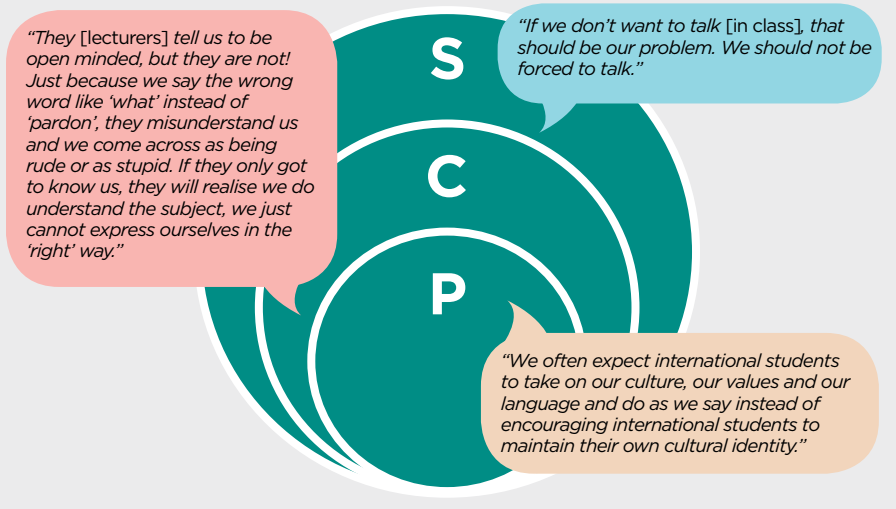
inability to appreciate cultural sensitivities could lead to compromised care – a risk that must be mitigated. Apart from Leininger and McFarland's (2002) transcultural nursing theory, other widely used UK nursing models, such as Roper et al's (1980) or Orem's (2001), have not tended to identify with the notion that culture and diversity could play a significant role in nursing care or risk-based assessment.

A cultural shift in nurses' thinking is crucial if the profession is to better address the needs of Britain's diverse service user and student populations. The Nursing and Midwifery Council's Code (NMC, 2015) recognises the need for mutual respect as well as holistic, inclusive, non-judgemental and culturally sensitive person-centred care. This much-anticipated Code builds on the cultural foundations laid down by Leininger and McFarland (2002) and puts greater emphasis on the importance of individual choice for those trying to access health and social care services.

Although there have been areas of progress and development, increasing internationalisation and diversity still cause difficulties, misinterpretations and a certain degree of often unwitting discrimination and oppression in educational systems, as they do in wider society. Fig 1 illustrates the use of Thompson's (1997) Personal Cultural Structural model to analyse a number of comments on cultural difficulties from international students. It provides a graphic illustration of the dimensions of potentially discriminatory behaviour. The comments formed part of two studies investigating increasing internationalisation and diversity in Welsh higher education and their impact in the classroom (De, unpublished; Lau et al, 2012). They exemplify Thompson's (1997) theory of the various levels of discrimination that may co-exist in society. Culturally safer practice could be introduced at all levels, helping to eradicate widespread discernment and marginalisation.

Classroom examples, as in Fig 1, show that some nurse educators have a somewhat ethnocentric approach to learning. An excessive emphasis on negatively labelling students as needy or problematic could be considered disempowering and disabling (Hemingway et al, 2012). Academics have a responsibility to widen participation and inform practice by creating and sharing learning opportunities. They are equally responsible for ensuring moral justice and fairness in participation, as well as ensuring that individuals progress and leave their studies better equipped, rather than marginalised and disillusioned (Shen, 2004).

FIG 1. **THE PERSONAL CULTURAL STRUCTURAL MODEL: EXPLORING ANTI-OPPRESSIVE PRACTICE**



The fact that our uniqueness as human beings cannot be reduced to a list of characteristics (Hemingway et al, 2012) is slowly being recognised, as demonstrated by the growing interest in health literacy (Kickbusch et al, 2013). Cultural mediation is also based on mutually devised goal setting (Kleinman, 1978), and educators could use these principles with students or when teaching colleagues to promote inclusivity within curricula, thereby ensuring cultural safety. For example, considering a number of aspects of culture such as age, gender, professional background and life experiences could help nurse educators involved in recruitment develop a sense of the holistic components that make up individuals. This could involve considering their students' beliefs, values and customs when assessing learning needs (Thompson, 1997).

Cultural safety

The extent to which learning or care feels safe can only be judged by the recipient, as the experience is subjective. Creating a safe or effective encounter in a healthcare/classroom environment, supervision session or teaching situation is a responsibility for the nurse or educator. Promoting cultural safety involves regular evaluation, awareness of oneself and of others.

Recognising through reflection that our actions have an impact on other's healthcare or learning outcomes is a key principle of cultural safety. It is only possible for individual educators or nurses to appreciate other people's differences and cultures when they gain a detailed understanding of our own culture, identity and sense of belonging. Only then can they forge strong, trusting therapeutic relationships with their students or service users.

Framework

The development of a cultural safety framework in education originated from New Zealand (Ramsden, 1996). The key feature of cultural safety is that of equality and promoting the idea of a power relationship shifting from a person perceived as an authority figure, such as a health professional or nurse educator, to the patient or student. This creates a notion of equilibrium and is secured on a mutually agreed set of health-promoting, quality-of-life-improving, clinical or theoretical learning objectives for which both parties are accountable. Only those participating in an encounter will be able to measure or judge whether their professional relationship feels culturally safe (Box 1).

Preparing our future workforce

The nursing profession must continue to meet the needs of its own increasingly diverse population and those of wider communities (Hinshaw, 2000). Consideration is already being given to addressing the health and social care needs of the growing population of older people, but how do we equip student nurses with the skills they need to care specifically for cultural subgroups (such as older people from black or minority ethnic communities) and meet their health and social care needs?

Relating this to diverse student populations, we need to ensure adequate, inclusive support systems are in place for pre-registration students. Students on return to practice programmes may need support using technology, while students from overseas may need help adjusting to the supervised practice placements required to gain registration. For example, pressures on placement providers mean some

BOX 1. CHARACTERISTICS OF CULTURAL SAFETY

A cultural safety framework was devised to meet the needs of Maori healthcare users in New Zealand who were experiencing poor health outcomes linked to the cultural inappropriateness and insensitivity of the health services (Ramsden, 1996; 1992). It:

- Is based on the health professional's analysis of their own cultural self and the impact it can have on therapeutic encounters
- Rejects the idea of learning by rote the cultural characteristics of recognised groups and stereotypically applying this information to individuals
- Recognises the power gradient between professionals and service users
- Allows service users to judge whether the professional relationship feels culturally safe
- Is based on a set of skills that can be learned and applied by professionals
- Can be used to address the needs and relationships of a wider range of social groups (Grant-Mackie, 2007) that differ by age, gender (including transgender individuals), sexual preference (lesbian, gay, bisexual), socioeconomic status, ethnicity, religion, abilities (Nursing Council of New Zealand, 2011).

Source: De and Richardson (2008)

are placed in nursing homes rather than hospitals; this is an unfamiliar concept to many who may be accustomed to older relatives being cared for in the family home.

If these students are to be respected and feel welcomed, common ground rules are needed, with sound rationales that are not based on tacit assumption and cultural norms; power must be shifted away from the authority figure (whether that be an academic or a clinician) and result in shared expectations and learning outcomes. A more equal partnership would create the right support package for each individual student (or even service user) and forms part of cultural safety.

Guidance for nurse educators

The Quality Assurance Agency's (2012) six key principles are fundamental to ensuring international students have an enjoyable, rewarding and effective experience in British higher education. They include:

- An inclusive environment;
- Continuous improvement;
- Student engagement;
- Clear and accessible information;
- Shared responsibility;
- Staff development.

These same factors could be expanded to include other diverse learner or service user groups. Overseas students raise several issues of difficulties acclimatising to the UK university environment, including the need for cultural safety, and joint working between support services and students. Other key issues are summarised below.

Communication and clarity – explicit expectations not implicit assumptions

Sometimes our expectations are left unsaid as we think others understand them; this is not always so for international students. An example of this might be punctuality: students are expected to turn up for sessions on time and British students generally do so without being reminded but this may not be the case for international students who may then be surprised when lecturers object to their arriving late.

Information needs – clarity

Educators think they know what students need to know about their course but this might not be the case. They should ask students what they want and need to know about their course.

Respect and equality, equity

The point of welcome to the university is crucial and is the moment international students remember. If they are received in a warm, respectful manner, this creates the atmosphere for the foundation of constructive, open working relationships.

Pedagogy – assessment formats and accommodating various learning styles

A creative, student-centred approach to learning is vital. Preferred learning styles should be taken into account when working with international students and new learning strategies carefully introduced.

Conclusion

Better cultural understanding reduces the barriers generated by prejudice and stereotyping and can help to provide person-focused care. Like their clinical mentor colleagues, contemporary nurse educators must serve as cultural brokers or mediators helping vulnerable clients and diverse student groups engage with "cultural others" or become "cultural champions" (The Press Association, 2014). It is up to educators as "cultural ambassadors" to help others who may be finding the experience daunting and overwhelming. We all have a duty to provide care that is culturally safe. **NT**

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