[](https://www.editorialmanager.com/net/viewRCResults.aspx?pdf=1&docID=10038&rev=1&fileID=195140&msid=fcf53dd3-c82a-4530-81e0-047b3c526650)

# Title: Inclusion of Cultural Competence and Racial Awareness in Nursing

1 **Education: An Exploration of the Nurse Educator Role**

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6 Keywords: Cultural competence, cultural safety, cultural awareness, racial

7 awareness, nurse education, decolonisation, nursing curriculum, global majority,

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9 health equity, racism, diversity, equality, inclusion, UK

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12 Contemporary global issues such as the war in Ukraine, COVID-19, and the Black Lives Matter

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14

15 (BLM) movement have catapulted nurse education to a crucial juncture. Consequently, there

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17 is now an urgent opportunity and need to reflect and consider how nurse educators

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20 are effectively preparing nursing students to be culturally competent and racially aware.

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23 This paper discusses how nurse educators can remain committed to developing cultural

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26 competence and racial awareness among nursing students. Cultural competence in nursing

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28 is the ability to provide holistic care that is non-judgmental and takes into

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31 consideration patients’ diversity i.e. their backgrounds, values, belief systems and behaviours

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34 and inclusive of any protected characteristics. It is concerned with valuing differences

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36 and other world views, as well as tailoring care delivery to meet the patients’ social, cultural

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38

39 and linguistic needs (Mitchell-Brown, 2020). In essence, cultural competence sits on the

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41 tenets of equity, diversity and inclusion.

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45 Cultural competence has been disaggregated to include cultural awareness, cultural skills,

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48 cultural knowledge and cultural desire (Betancourt et al., 2003). As a group of female

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50 educators of colour, we have observed gaps in undergraduate nursing students’ cultural

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53 knowledge, skills and awareness in both classroom and clinical practice. Essex et al. (2022)

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56 defines racism as interpersonal acts of discrimination and prejudice, maintained through

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58 policies and practices to maintain racial hierarchy. They advise that this can be addressed

through training . To be anti-racist in education is concerned with making systemic oppression

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2 visible, challenging any denial of involvement or complicity in this, and lastly contributing to

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5 transformation that guards against inequality (Arneback and Jamte, 2022).

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8 In this paper we view being anti racist in nursing care as part of cultural competence. One way

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10 of addressing cultural competence in nursing education is applying a decolonised curriculum

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13 approach.

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17 Decolonisation is the movement away from Eurocentric curricula which reinforces white,

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19 western dominance and privilege and may be full of stereotypes, prejudices and patronising

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22 views about people of colour. (Schucan Bird and Pitman, 2020). We have found a simple way

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24 of decolonising the curriculum in a UK context was by introducing reading lists that are more

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26

27 inclusive, diverse and representative. According to Gopal (2021) the term ‘decolonisation’

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30 means to eliminate the ways that our education and knowledge has been marginalised and

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32 removing the borders engaged by White educators. The aim of decolonising the nursing

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35 curriculum is to remove the privilege of ‘whiteness’ by asking the educators the vital

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37 question ‘where and how does racism manifest itself’? (Schroeder & DiAngelo, 2010) To

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40 decolonise the nursing curriculum is to place all cultures and ethnicities i.e. all people on an

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42 equal footing when it comes to delivering, accessing and receiving healthcare. By decolonising

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45 the nursing curriculum, we bring cultural competence and cultural safety to the forefront of

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48 everything we do as educators and care providers.

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53 The murder of Black American George Floyd and the subsequent resurgence of the ‘BLM’

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55 movement has led to increasing calls for decolonisation of curricula across the higher

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58 education system. Media coverage of Floyd's death demonstrated the need for critical and

uncomfortable conversations in relation to the disparities experienced by the global majority

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2 across the world. We use the term ‘global majority’, instead of ethnic minority, to identify

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5 people of colour who make up the majority of people in the world (Afuape et al., 2022).

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10 In the UK, there has been an uproar within the Black community concerning the case of Child

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13 Q. In 2020, Child Q, identified as ‘a black female child of secondary school age’ who, was strip-

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15 searched by police officers at her school, with the agreement of the teachers. The teachers

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18 reported concern that she smelt of cannabis and that she may be carrying drugs. The search

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21 took place on school grounds, with no appropriate adult being present, no parent being

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23 informed and while Child Q was menstruating. The search was conducted by female police

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26 officers, who exposed Child Q’s female body parts. No drugs were found (CHSCP, 2022). The

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28 abuse of power by the school, supported by the Metropolitan Police, cannot be ignored or

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31 minimised. Historically, we also highlight the case of the murder of Stephen Lawrence, a male

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33 Black teenager , who was murdered in a racist attack in, South London, 1993. The G Report

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36 (1999) identified the ‘institutional racism’ that exists within the Metropolitan Police and made

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39 reference to the use of, and need for, a cultural competence assessment tool. Institutional

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41 racism is not limited to the police force; it exists in all large institutions. As educators within

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44 health and social care, it is our responsibility to be the change for the future of nurse

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46 education. Educators, need to instigate a change in mindset, to reduce health disparities and

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49 inequalities born out of poor cultural competence and racial awareness.

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56 Disparities including mortality, morbidity, race, and other social determinants of health

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58 (Exworthy et al., 2006) have been perpetuated by the structures connected with accessing

services. As health and social care academics and practitioners, we are privileged by the very

1

2 nature of our roles to exercise the opportunity to engage with diverse populations who are

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5 seeking advice and care. Therefore, as educators from the global majority, we have a

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8 responsibility to address the inequities of culturally incompetent care. However, before this

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10 can start, there is a need for the individual (the academic and the student) to embrace the

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13 cultural practices of racially diverse groups and move away from the assumption that

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15 everyone fits into the same category, acknowledging that multiple categories exist, and that

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18 these intersect to give rise to individual culture, which contains all their practices and beliefs

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21 (Moorley et al., 2020).

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26 Limited research exists on the racial cultural competence learning needs of UK nursing

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29 students, which makes this paper important. In this article we discuss and identify ways to

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32 apply evidence-based teaching methods in the pre-registration nursing curricula. Despite the

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34 National Health Service (NHS) and the UK having a late response to addressing cultural

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37 competence (Papadopoulos et al., 2004), cultural competence is drawn from the transcultural

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39 nursing models such as Leininger (1991), Geiger and Davidhizar (1995); Papadopoulos et al.

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42 (1998). Models such as Campinha-Bacote (2002); and Purnell and Paulanska 2003), provide

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44 approaches to nursing practice in the UK but lack the integration of race as an element of

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47 cultural competence.

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56 There are key benefits to cultural competence in nursing education that are well recognised,

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59 including health equity, holistic health assessments and improved health outcomes (Gebru &

Willman, 2009). Cultural competence places health and health care in a social, cultural and

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2 historical context (Kumagai and Lypson, 2009). This context, coupled with a recognition of

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5 inequalities in society, allows us to work together to find appropriate solutions to those

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8 inequalities. Cultural competence needs to be embedded in the skillset of nurses and, as

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10 educators, we have a significant role to play in this. The nurse educator facilitates the student

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13 nurses’ awareness of their own cultural values and beliefs, as well as those of their patients,

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15 service users and their families or support network. By instilling the realisation that learning

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18 cultural competence is ongoing, the student nurse is then able to appropriately assess,

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21 communicate with and interact with individuals from racially diverse backgrounds (Tedam,

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23 2021).

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30 Three steps to teaching racially-aware cultural competence:

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## 32 1. Connecting with students and service users

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35 We advocate the necessity for care providers to start referring to and connecting with their

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37 contemporaries, students, and service users, who may already understand cultural

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39

40 competency and racial awareness. This could help to build upon the models that already

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42 exist. For example, Tedam (2021) highlights that cultural competence can be viewed as a

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45 continual process, a method to promote anti-oppressive practice in the

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47 workplace, undertaken with individuals from different cultural backgrounds than

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50 us. Therefore, working in collaboration with learners and service users can help to

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53 redistribute the power invested in our roles as educators, supporting the promotion of

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55 inclusive and accessible learning opportunities. This can assist in remedying the

disconnection between the patient and the nurse, generated by the lack of

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2 effective training in cultural diversity (Leininger, 1991).

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## 10 2. Cultural competence is everyone’s business

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14 Large teaching institutions may assume that the teaching of cultural competence should be

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16 left to the global majority. Addressing racism should not solely be the concern of the global

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19 majority. Srivastava and Mawhinney (2022) points to allyship as central to achieving equity

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22 and social justice. Moorley (2022) describes white allyship to include inviting others to the

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24 table, confronting racism when it occurs and building relationships with people of colour as

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27 well as white people, challenging their thinking about race where appropriate.

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37 Our experience as a group of Black female academics is quite different. Daily, we relive the

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39 trauma of oppression or unidimensional events, such as single mandatory training days on

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42 matters of race and equality. Our experience has taught us that nurse educators need to be

43

44 bold and start the dialogue about the issue of cultural competence, working together with

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47 authentic allies in creatively examining how we can incorporate the concept into the

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49

50 curriculum design, as well as what learning can be obtained from our colleagues in the field

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52 of social care.

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It is not sufficient, to talk about a consistent trickling down of information to impact

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2 change (Smith, 2018). There is a need to provide a parallel process which includes saturation

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5 and the leaking of information related to cultural competence to learners on a regular basis.

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8 This in turn will support the students who are engaging with patients and service users to

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10 examine and change the perceptions and assumptions they hold, which can result in them

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13 developing the knowledge and skills needed to become anti-racist/anti-

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15 oppressive practitioners. To support learners, academics will need to create regular safe

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18 reflective spaces where students can bring and discuss the issues they struggle with in terms

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21 of race and differences. Within these spaces, learners should expect to gain support

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23 from educators and their peer group to make sense of the unconscious processes that

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26 present themselves when working with individuals that are dissimilar to them .

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32 Educators can also discern the learning needs of students where students are open and

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35 transparent about areas where there is lack of knowledge, experience or skill. This is critical

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37 to ensuring that the teaching delivered is congruous with the specific learning needs of

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40 students. This has been evidenced through the lived experience of one of the authors. For

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43 example, students may demonstrate that they have some knowledge however they are

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45 unsure of how to utilise this knowledge in patient assessment. An accurate and complete

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48 assessment of the patient requires the practitioner to possess and operationalise a culturally

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50 competent skillset. Therefore, nursing students should be equipped to gain knowledge as

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53 well as consistently put this to use in caring for patients. Therefore, theoretical teaching

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56 should be adequately complemented by practical application.

Resistance to include cultural competence teaching is evident from academics for several

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2 reasons. Ranzijn et al. (2008) found a lack of support from academic peers and/or HEI

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5 leadership; a lack of experience in delivering the topic; the number of topics already included

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8 in the existing nursing programme/curricula and the viewpoint that cultural competence is an

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10 ‘optional extra’. A safe space approach should be encouraged by institutions to support staff

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13 to start these crucial conversations. This will facilitate the examination of one’s personal bias

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15 and those of our counterparts. Within these spaces there is a need to draw upon reflective

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18 and reflexivity techniques to understand where the individual sits concerning the issue of

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21 difference. The actions may take the student to uncomfortable and vulnerable places, where

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23 we as the educators are no longer the experts, allowing them to be in control. As they reflect,

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26 this may broaden their understanding of the importance of cultural awareness.

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## 38 3. Teaching cultural competence

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40 Cultural competence is complex in nature and as a result can be challenging for nurse

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43 educators to teach. This is complex because there are difficulties in observing cultural

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46 competence in the classroom. Challenges include setting the threshold for the improvement

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48 in competence and being able to describe what this would look like (Mokel & Canty, 2020).

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51 Challenges include reaching a consensus around whether this skill should be observed,

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53 described, demonstrated or a combination of all of these. These challenges can also extend

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56 to assessing the application of knowledge and understanding in cultural competence. A

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59 solution to some of the challenges of teaching cultural competence can be the utilisation of a

repository for information and materials. This would promote the currency and quality of

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2 student nurses learning and knowledge acquisition. This may also reduce the

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5 apprehensiveness that some staff may feel in executing competency-based teaching on

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8 cultural competence. A repository can also allow nurse educators to identify existing learning

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10 resources as well as gaps.

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17 A repository of relevant content can allow for material to be set out across the years of the

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19 nursing course and this is relevant for teaching cultural competence, as this learning needs to

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22 continue throughout the student’s training and the practitioner's career. The learning should

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25 be mapped across the years, with key learning outcomes, and the repository should

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27 be shared by the academics to ensure that learning is done in a developmental and spiral

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30 curriculum. This collaboration between educators contributes to consistency in teaching and

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32 assessment. It can also bolster confidence in academics for whom cultural competence is

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35 outside of their comfort zone. Educators need to remain updated on the meaning of the

36

37 term cultural competence to ensure congruence with teaching content. There should be

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40 consideration of which culturally competent attributes result in the successful engagement

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43 and care of patients. A forum where educators can talk about their successes and failures in

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45 teaching cultural competence is also invaluable to improving their capabilities in this area.

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48 Academics may also grow in their confidence in delivering this content without being

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51 concerned by developing new material independently that does not have the benefit of being

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54 peer reviewed.

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Conclusion

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6 This paper has provided an exploration of how to include cultural competence and racial

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9 awareness in nursing education and the role of nurse educators in executing

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12 this. Discrimination in any form is ubiquitous in nature and the reality of this underpins the

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14 need for cultural competence to feature consistently throughout the curriculum. In our

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17 experience, we have found that while students' knowledge around cultural competence is

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19 lacking, they are keen to learn and embed it into their practice. While they may lack the

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22 understanding of how and where to apply the knowledge that they possess in this area, we

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25 have found that, once taught, they become better equipped to deliver culturally

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27 competent care. When included in the nursing assessment, cultural competence enables the

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30 nursing student to build a holistic picture of their patient/service user, including who they are

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32 and what is important to them. A holistic assessment without the inclusion of cultural

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35 competence is incomplete. Students who have received teaching on cultural

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37 competence have improved attitudes towards patients and families of differing

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40 cultures, are better equipped at delivering culturally appropriate nursing care and health

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43 outcomes are improved as a result (Mokel & Canty, 2020). Building the subject of cultural

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45 competence into entire programmes and curricula can lead to students becoming

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48 knowledgeable and caring. Cultural competence content should be threaded through the

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50 curriculum ensuring consistency. It can be delivered yearly to students as part of an annual

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53 update which encourages continued development of cultural competence across the years of

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56 their course and into registered nursing practice. Cultural competence is relevant in a world

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58 that is increasingly globalised, and in a health and social care system that continues to

become more demographically diverse. Healthcare professionals who are not trained to be

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2 culturally competent and racially aware can remain restricted in their ability to provide care

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5 that is truly holistic and meets the person centred needs of each patient. While clinically

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8 based skills are important, cultural competence, cultural safety, and racial awareness

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10 should be seen as instrumental to addressing the complex needs of patients.

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