

# 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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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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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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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

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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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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

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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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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

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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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