

SENIOR NURSES' PERCEPTIONS OF CULTURAL SAFETY IN AN ACUTE CLINICAL PRACTICE AREA

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Abstract

Cultural safety is a concept that emerged within the New Zealand nursing context. The purpose is to ensure that nursing practice is congruent with the aims and objectives of the Treaty of Waitangi (the founding document between Maori and the Crown) and so facilitates the nursing of patients respectful of all that makes them unique and individual. While cultural safety has continued to develop since its inception in the 1980s, there remains relatively little research looking at its application in practice. This is due in part to the core element that recognises that only the recipient of care can determine if cultural safety has occurred. There are inherent difficulties in questioning patients about the quality of their care from a cultural safety perspective. One of these is the uncertainty around the public perception and understanding of cultural safety together with the implications of asking a vulnerable group to comment on this aspect of care. An alternative to asking patients to comment on whether they received culturally safe care is to consider the perceptions of health care professionals regarding this concept. This paper presents the results of a small study aimed at eliciting the beliefs and attitudes of a group of senior nurses with respect to the concept of cultural safety, and their perception of its role in clinical practice. It was undertaken as a preliminary to a wider survey.

Key Words: Cultural safety, attitudes and beliefs, senior clinical nurses, nursing perceptions.

Introduction

Much has been written outlining the evolution of cultural safety, and identifying its role in relation to New Zealand nursing (Benham, 2001; Meyst, 2005; Papps & Ramsden,

1996; Richardson, 2004; Richardson & Williams, 2007; Wepa, 2001). This article explores the views of a small group of senior nurses working in an

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acute clinical area, with regard to the perceived relevance of cultural safety in clinical practice. It is acknowledged that only the patient has the right to identify whether cultural safety is present in an interaction, yet there are ethical concerns with asking patients to comment on this. While approaching patients is a necessary step, other preliminary measures can be undertaken to examine the nursing context and environment. One such measure is to explore the beliefs and perceptions practicing nurses hold regarding cultural safety.

The cultural safety framework

The history of cultural safety is well established, from its emergence in the late 1980s in response to issues around Maori health disparities to its links to critical social theory, post colonialism and feminist standpoints (Anderson et al, 2003; Ramsden, 2000b; Wepa, 2004). Ellison-Loschmann and Pearce (2006) describe cultural safety as an 'educational framework' which acts to assess power relationships between health professionals and those they serve. The Nursing Council of New Zealand (the Council) also emphasises the educational focus associated with cultural safety, noting that it is "focused on the knowledge and understanding of the individual nurse" and that as a result "the nurse who can understand his or her own culture and the theory of power relationships can be culturally safe in any context" (Nursing Council of New Zealand (NCNZ), 2005, p. 4). This focus is mirrored in the literature which considers the challenges associated with teaching (Hughes & Farrow, 2006; Jeffs, 2001; Ramsden 1992;

Ramsden, 2000a; Richardson & Carryer, 2005; Thompson, 2002) and explores the perspectives of those being taught (Saxon, 1995; Warren, 2003). By comparison, there have been relatively few publications of research seeking to explore the impact of cultural safety in clinical practice (Bunker, 2001; Hughes & Farrow, 2006).

In order to provide care in a culturally safe manner, a nurse needs to be self reflective and evaluative of their own cultural beliefs, recognising his/her own unique culture. This includes recognition of the culture of nursing and the power gained as a result of professional knowledge and position. An understanding of the concept of cultural safety allows the practitioner to recognise cultural risk as well as cultural safety. Interactions incorporating recognition of the patient as an individual, and showing acknowledgement and respect of difference are foundational to cultural safety. Actions contributing to culturally unsafe practice are those which have the potential to demean, diminish or disempower the patient (Cooney, 1994; Wood & Schwass, 1993).

From a nursing perspective there are three concepts which can be used to guide practice. These are 'self recognition', 'situational assessment' and a 'solution focus'. Each nurse needs to undergo a process of self recognition, identifying facets of their own cultural makeup and identifying assumptions and generalisations that inform practice (De Souza, 2008; NCNZ, 2005). This creates the context within which cultural

safety can develop. Having raised the individual practitioner's awareness of their own perspectives as well as wider social issues it then becomes possible to identify areas of cultural risk – the 'situational analysis'. Without reflection and critical thinking, situations of risk are often 'invisible'. By shifting the nursing focus, areas of risk can be identified and the application of cultural safety can move from the theoretical to the practical. By taking a solution focused approach, the nurse seeks to address the situational factors identified, identifying the actual or potential outcomes from a culturally unsafe situation. The nurse practising in a culturally safe manner is able to act as a role model, mentor and advocate not only for patients, but also for colleagues and the wider profession. De and Richardson (2008) identify the importance of skills in communication, reflection and leadership (amongst others) as necessary to culturally safe practice.

Professional and legal expectations

The Health Practitioners Competence Assurance Act (HPCA) replaced the previous professional regulatory statutes governing 13 separate health related professions, including nursing (Ministry of Health, 2007). The Act's central aim is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions" (HPCA, 2003 section 1:3). The regulatory body responsible for ensuring these standards for nurses is the Council.

New Zealand nurses are required to hold an annual practising certificate which, following application and declaration of competence and fitness to practise, is issued by the Council. An additional process allows for up to five percent of registered nurses to be randomly selected for audit, which then requires that they present evidence in support of their application. Whether by means of the declaration of fitness to practise or through the audit process, nurses need to demonstrate their ability to maintain the 'competencies for registered nurses' (NCNZ, 2007). This includes competency 1.5, "*Practises nursing in a manner that the client determines as being culturally safe*" (p. 9). This is further defined by the inclusion of seven specific indicators that clarify how safety can be demonstrated. These include the ability to apply the principles of cultural safety in practice and recognition that nursing has its own culture which impacts on client care. The nurse is expected to practise in a way that respects each client's identity and rights to hold personal beliefs, values and goals, to assist the client to access support and representation and to consult with members of cultural and other groups as requested by the client. In terms of personal characteristics, the nurse is expected to be self reflective, recognise his/her own values and their impact on client care and to use this information to avoid imposing prejudice on others (NCNZ, 2007, p. 9). These indicators involve recognition and reflection on an individual's practice. The questions asked in the present study have the potential to illustrate these requirements.

In addition to the legal requirements, there is an ongoing professional expectation that cultural safety competence will continue to be developed. Increasing numbers of nurses are pursuing post registration education. This includes postgraduate study and involvement in Professional Development Recognition Programmes (PDRP). PDRPs developed in response to the need for pathways for nurses who wished to advance while remaining in clinical practice. These programmes use the Council's competency criteria as the framework against which to demonstrate practice, with a range of possible levels based on Benner's novice to expert framework (Benner, 2001). One PDRP programme lists the Council indicators for cultural safety as requirements for the 'competent' level nurse, building on these with the expectation that the nurse "*Recognises the impact of the organisational culture and the culture of nursing on client care and endeavours to promote the client's wellbeing within this culture by role-modelling cultural responsiveness and culturally safe care*" (Canterbury District Health Board, 2007, p. 15) to reach the 'proficient' level of attainment. At the 'expert' level, the previous indicators need to be met, with two further criteria aimed at demonstrating leadership and reflective practice in regard to cultural safety.

Method

Sample

Ten senior nurses working in an acute care area were approached to take part in a study aimed at identifying perceptions, attitudes and beliefs around the application of cultural

safety to practice. These participants were a convenience sample purposively selected, and therefore not presumed to be representative of any wider population. Data generated are specific to the experiences of these participants. The participants formed a discrete subset within a specific acute care setting. They comprised what was termed 'the senior nursing team' in that area. As the opinions of practising nurses in senior positions has not previously been identified, senior nurses recognised by their peers as 'experts' were specifically sought for this study. The determination of 'expert' status was based on their having been included in the organisation's designated 'senior nursing team' and their continued contribution to clinical practice.

Nine of the ten participants invited to take part completed the questionnaire. Participants were advised that their involvement was voluntary, that no personal identifiers would be used and that there were no implications with regard to employment as a result of completing the questionnaire. They gave verbal permission for non identifiable data to be used in publications and presentations. While the participants completing the survey were known to the researchers, none of the researchers had direct line authority over these people, so the risk of coercion (either implied or explicit) was minimised. Approval to undertake the study was gained from the departmental nurse manager and the Clinical Director.

Participants included six females and three males. Six of the respondents had more than 16 years nursing experience,

one between 11 and 15 years, and two between six and ten years. Six identified as being of NZ European ethnicity, two of other European ethnicity and one as NZ European/Maori ethnicity. For six participants, original nursing education had been through a hospital based School of Nursing, for three it was through a Polytechnic. Six of the participants had completed university based post graduate nursing education.

This study involved a mixed methods approach to gaining descriptive data relating to nurses' perceptions of cultural safety. A questionnaire using a range of open ended questions was designed to gather qualitative data. Six questions were presented to participants, asking them to offer their personal definition of cultural safety. The questions also sought to identify sources and degree of formal education relating to the concept, asking for perceptions relating to the usefulness of cultural safety and for examples of the application of cultural safety to the participants' own practice.

In addition, demographic data, using structured questions and pre set response options, were obtained. This information related to gender, years of nursing practice, type and country of registration together and also data relating to sources of formal cultural safety education. This questionnaire was developed to be part of a pilot study, with a view to carrying out further data collection at a later date, with a wider range of nursing professionals.

Data collection

Questionnaires were distributed to each of the participants, completed individually and returned to the researchers. The responses were then transposed onto an excel data sheet, simple descriptive statistics relating to demographic information undertaken, and thematic analysis of the free text responses commenced.

Results

In the questionnaire participants were asked to give their personal definition of cultural safety. While responses varied, all included reference to recognising the cultural needs of the recipient of care, two included specific reference to principles from the Treaty of Waitangi and five identified the need to reflect on their own culture and beliefs. Examples of the nurses' definitions include the following:

It's about respecting all that makes a person unique (values, religion, gender etc etc) and working in partnership with them to ensure that nursing/health care does not disempower them, also acknowledging own beliefs etc and how they impact...

Delivery of nursing care that the patient and family deems is culturally safe. Nurses need to consider the historical, social, political, spiritual influences and acknowledge the contribution these factors have to health outcomes. Nurses have a position of power they need to work in partnership with patients and their families.

Participants were then asked to describe the source of their cultural

safety knowledge. For most this was identified as undergraduate or postgraduate formal nursing education, but additional sources identified included knowledge of the Council competencies, involvement in the Professional Development Recognition Programme, Council Cultural Safety Guidelines (NCNZ, 2005), colleagues, Maori health workers, specific education on Maori Health following employment in NZ and through caring for patients/families from other cultures. While all participants identified a range of sources for their cultural safety knowledge, three indicated that they had not received formal education in cultural safety.

The participants were then asked whether they thought an understanding of cultural safety was important in clinical practice. Eight of the nine respondents felt that cultural safety had a role in clinical practice, with the ninth stating that in an emergency setting, this was only in relation to issues around death and dying. Specific issues related to the unique nature of emergency care were also identified by another participant who stated:

Yes – however exactly whether it is important in emergency care is debatable. In this setting relationships tend to be superficial or if the patient is critically unwell then the ‘therapeutic relationship’ is put on the sideline whilst the physical aspects of care are tended to.

Other respondents identified cultural safety as being an expected part of their care, and acknowledged the

potential benefits to patients, family/whanau and to the practitioner him/herself. Examples of comments included:

Cultural Safety is important to enable minority groups to feel safe when accessing healthcare. A negative experience can lead to rejection of care, reluctance to access future care...

Nurses are very powerful. We need to work with patients and families to provide care that acknowledges not only their ethnic background, but also gender, sexual orientation, occupation, religion. I don't think cultural safety is just about being / nursing Maori.

A further question asked participants to consider whether they consciously used cultural safety principles in their area of work, and if they were able to remember a specific example illustrating this. The purpose of this was to move beyond the theoretical and to identify whether the skills and knowledge associated with cultural safety were used and recognised as such in the routine provision of patient care. All but two of the participants provided an example of where they had used cultural safety in their own practice. The following examples were given:

Accepting a patient's religious belief that prevented them from having blood products and not promoting my own beliefs that the blood product would be more beneficial than the religion.

Difficult to identify one specific instance. The nature etc of ED

work means that we are faced with a huge range of 'cultural' diversity and nursing care is individualised to meet the needs of specific cultures / patients.

A detailed exemplar was given by one respondent, who asked that the specifics of the situation remain confidential. As part of this example the culture of poverty and issues around access to and equity of care opportunities were discussed, together with the need to look beyond the superficial. The significance of recognising own role and the use of self reflective practices was identified.

The final question asked of participants was whether they believed cultural safety information should form a routine part of ongoing nursing education. Responses varied, with a range of rationale provided. Two respondents felt that the nature of emergency department care was such that cultural safety was not a high priority in terms of educational needs. One respondent stated that it was an *"extremely low priority we are unable to teach our core business properly"* while another suggested that there were limited opportunities to establish the necessary partnership. The comment was made about cultural safety that *"... its abstract nature and lack of practical application in everyday nursing practice will always be a barrier to its acceptance"*. Other participants saw an active and positive role for cultural safety education and in particular comment was made about the increasing numbers of international nurses working in the New Zealand health care setting, and the specific benefit to this group of

ongoing education in cultural safety. The links to the PDRP programme were made by several of the nurses, as well as Council requirements. Comments made in support of the inclusion of cultural safety in emergency department education included that:

I think cultural safety should be part of ED education. It should be considered for all patients who attend the department. Patient's who attended ED are already under a state of anxiety, recognition of their beliefs, practices may ease / provide a more comfortable experience for them. It is providing a holistic approach and well being for the individual.

Cultural Safety is essential to all aspects of Nursing, however with the high incidence of "European Origin" staff working in ED it would be of benefit for those new to New Zealand to be aware of the local significance of Cultural Safety. This should be related in particular to the Tangata Whenua of New Zealand and the bi-cultural partnership forged by Te Tiriti o Waitangi. This base knowledge can be utilized and principles applied when dealing with other cultures.

Reference was made to the cultural diversity of presenting patients and also to the diverse cultural representations among staff.

Discussion

The findings from this study suggest that cultural safety is a concept that is recognised by nurses working

at a senior level in an acute care environment. It is acknowledged as being a requirement in terms of Council competencies, and definitions given show an understanding of the wider application of cultural safety in terms of the nursing context. Cultural safety appeared to be valued by this group of senior nurses, with respondents acknowledging a link to clinical outcomes and patient well being. Comments were made identifying that cultural safety “... *enhances our practice, [provides] better outcome for patient and family..*”; “...*any individual who feels safe and supported may respond better to treatment*” and “... *patient’s who attend ED are already under a state of anxiety, recognition of their beliefs, practices may ease/provide a more comfortable experience for them. It is providing a holistic approach and well being for the individual*”.

Where concerns with the concept were identified, these were in relation to the difficulty of incorporating it into an acute area with associated issues of limited patient interaction, workloads and increasingly complex care requirements. When the participants were asked to identify situations where they had applied the principles of cultural safety to practice, a range of areas of cultural risk were identified. These were reflective of the Council categories of risk and again reinforced the scope of the cultural safety principles (NCNZ, 2005). Specific categories discussed by the participants included ethnicity, disability, socio-economic status, gender and age.

Concern was raised with regard to the

increasing workloads, staff shortages and the difficulty for nurses in meeting ‘core outcomes’. The need to prioritise care and nursing time was identified by participants. It has been recognised by other authors that this focus on prioritisation has the potential to marginalise the importance of cultural safety (Lake, 2005). The increasing tendency to focus on ‘essentials’ (often defined in terms of life preserving actions) is apparent in NZ healthcare, as the effects of staff and resource constraints continue to impact on the ability to provide quality care. The difficulty for nurses lies in identifying the essential elements that make nursing care unique and finding ways to ensure that these are supported (Erlen, 2001). We would suggest that cultural safety is one such core element of nursing – that it has helped to define the NZ approach to providing quality care. Cultural safety could be seen as nursing ‘taonga’ and as such needs to be protected, promoted and incorporated as of right into everyday practice.

There is a need to continue and build on the legacy left by Irihapati Ramsden, the architect of cultural safety and to continue to focus on the role and contribution of cultural safety to NZ nursing. This requires a clear understanding of the role that cultural safety plays in clinical practice. It is also important to identify the relative value nurses give to this concept. Further research into the understanding of nurses (and other health professionals) around cultural safety is necessary, and an ethically and culturally safe manner of assessing the views of patients needs to be developed.

Conclusion

Cultural safety is a core concept of nursing in New Zealand. It is associated with legislative, professional and competency standards. This small study involving senior nurses was undertaken to gauge the responsiveness of nursing practitioners to the concept of cultural safety. The

findings demonstrate a high level of awareness and knowledge related to cultural safety and a commitment to utilising this in everyday practice. Cultural safety continues to be a valuable tool at senior nursing levels. However further research is essential to understand how widely practitioners conceptualise and rationalise its application in clinical practice.

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