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NURSING BEST PRACTICE GUIDELINES PROGRAM

Healthy Work Environments Best Practice Guidelines

Embracing Cultural Diversity in Health Care: Developing Cultural Competence

Ontario

Greetings from Doris Grinspun, Executive Director Registered Nurses' Association of Ontario

It is with great pleasure that the Registered Nurses' Association of Ontario releases "Embracing Cultural Diversity in Health Care: Developing Cultural Competence Guideline." This is one of a series of six Best Practice Guidelines (BPGs) on Healthy Work Environments (HWE), developed to date by the nursing community. The aim of these guidelines is to provide the best available evidence to support the creation of thriving work environments.

Evidence-based HWE BPGs, when applied, will serve to support the excellence in service that nurses are committed to delivering in their day-to-day practice. RNAO is delighted to be able to provide this key resource to you.

We offer our endless gratitude to the many individuals and organizations that are making our vision for HWE BPGs a reality. To the Government of Ontario and Health Canada for recognizing RNAO's ability to lead this program and for providing generous funding. To Donna Tucker, program director from 2003 to 2005, and to Irmajean Bajnok – RNAO Director, Centre for Professional Nursing Excellence and the program's lead since 2005, for providing wisdom and working intensely to advance the production of these HWE BPGs. To each and all HWE BPG leaders and in particular, for this BPG, Panel Chair Rani Srivastava and Panel Coordinator Dianna Craig, for providing superb stewardship, commitment and above all exquisite expertise. Thanks go also to the amazing panel members who generously contributed their time and knowledge. We could not have delivered such a quality resource without you!

We thank in advance the entire nursing community, committed and passionate about excellence in nursing care and healthy work environments, who will now adopt these BPGs and implement them in their worksites. We ask that you evaluate their impact and tell us what works and what doesn't, so that we continuously learn from you, and revise these guidelines informed by evidence and practice. Partnerships such as this one are destined to produce splendid results – learning communities – all eager to network and share expertise. The resulting synergy will be felt within the BPG movement, in the workplaces, and by those who receive nursing care.

Creating healthy work environments is both a collective and an individual responsibility. Successful uptake of these guidelines requires the concerted effort of nurse administrators, nursing staff and advanced practice nurses, nurses in policy, education and research, and health care colleagues from other disciplines across the organization. It also requires full institutional support from CEO's and their Boards. We ask that you share this guideline with all. There is much we can learn from each other.

Together, we can ensure that health organizations including nurses and all other health care workers, build healthy work environments. This is central to ensuring quality patient care. Let's make health care providers, their organizations and the people they serve the real winners of this important effort!

[redacted]

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Background to the Healthy Work Environments Best Practice Guidelines Project

In July of 2003 the Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, (MOHLTC) working in partnership with Health Canada, Office of Nursing Policy, commenced the development of evidence-based best practice guidelines in order to create healthy work environments[G] for nurses.[G] Just as in clinical decision-making, it is important that those focusing on creating healthy work environments make decisions based on the best evidence possible.

The Healthy Work Environments Best Practice Guidelines[G] Project is a response to priority needs identified by the Joint Provincial Nursing Committee (JPNC) and the Canadian Nursing Advisory Committee.[1] The idea of developing and widely distributing a healthy work environment guide was first proposed in *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario*[2] submitted to MOHLTC in 2000 and approved by JPNC.

Health care systems are under mounting pressure to control costs and increase productivity while responding to increasing demands from growing and aging populations, advancing technology and more sophisticated consumerism. In Canada, health care reform is currently focused on the primary goals identified in the Federal/Provincial/Territorial First Ministers' Agreement 2000,[3] and the Health Accords of 2003[4] and 2004[5]:

- the provision of timely access to health services on the basis of need;
- high quality, effective, patient/client-centered and safe health services; and
- a sustainable and affordable health care system.

Nurses are a vital component in achieving these goals. A sufficient supply of nurses is central to sustain affordable access to safe, timely health care. Achievement of healthy work environments for nurses is critical to the safety, recruitment and retention of nurses.

Numerous reports and articles have documented the challenges in recruiting and retaining a healthy nursing workforce.[2, 6-10] Some have suggested that the basis for the current nursing shortage is the result of unhealthy work environments.[11-14] Strategies that enhance the workplaces of nurses are required to repair the damage left from a decade of relentless restructuring and downsizing.

There is a growing understanding of the relationship between nurses' work environments, patient/client outcomes and organizational and system performance.[15-17] A number of studies have shown strong links between nurse staffing and adverse patient/client outcomes.[18-28] Evidence shows that healthy work environments yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational health care costs,[29] and costs arising from adverse patient/client[G] outcomes.[30]

Achievement of healthy work environments for nurses requires *transformational change*, with "interventions that target underlying workplace and organizational factors".[31] It is with this intention that we have developed these guidelines. We believe that full implementation will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. It is anticipated that a focus on creating healthy work environments will benefit not only nurses but other members of the health care team. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation.

The project will result in six Healthy Work Environments Best Practice Guidelines

- Collaborative Practice Among Nursing Teams
- Developing and Sustaining Effective Staffing and Workload Practices
- Developing and Sustaining Nursing Leadership
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Professionalism in Nursing
- Workplace Health, Safety and Well-being of the Nurse

> *A healthy work environment is…*
>
> *…a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance and societal outcomes.*

Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

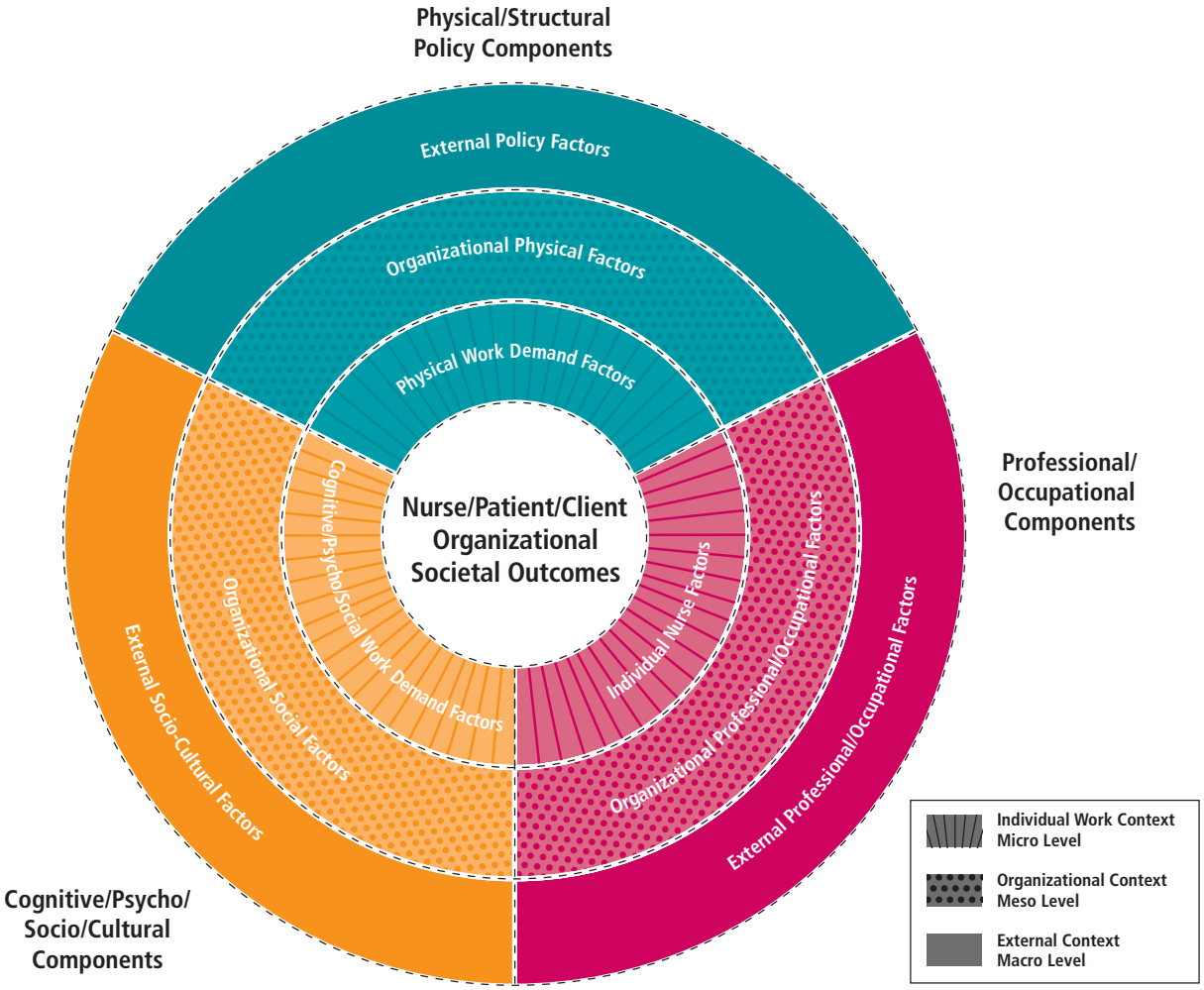

Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomes[i-iii]

A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes.

The Comprehensive Conceptual Model for Healthy Work Environments for Nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organizational (meso level) and external (macro level) system determinants as shown above in the three outer circles. At the core of the circles are the expected beneficiaries of healthy work environments for nurses – nurses, patients/clients, organizations and systems, and society as a whole, including healthier communities.[iv] The lines within the model are dotted to indicate the synergistic interactions among all levels and components of the model.

The model suggests that the individual's functioning is mediated and influenced by interactions between the individual and her/his environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors but also influence the system itself.[v,vi]

The assumptions underlying the model are as follows:

- healthy healthy work environments are essential for quality, safe patient/client care;
- the model is applicable to all practice settings and all domains of nursing;
- individual, organizational and external system level factors are the determinants of healthy work environments for nurses;
- factors at all three levels impact the health and well-being of nurses, quality patient/client outcomes, organizational and system performance, and societal outcomes either individually or through synergistic interactions;
- at each level, there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- the professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

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i Adapted from DeJoy, D.M. & Southern, D.J. (1993). An Integrative perspective on work-site health promotion. *Journal of Medicine,* 35(12): December, 1221-1230; modified by Laschinger, MacDonald & Shamian (2001); and further modified by Griffin, El-Jardali, Tucker, Grinspun, Bajnok, & Shamian (2003).

ii Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran D., et al. (2001, June). *Commitment and care: The benefits of a healthy workplace for nurses, their patients, and the system.* Ottawa, Canada: Canadian Health Services Research Foundation and The Change Foundation.

iii O'Brien-Pallas, L., & Baumann, A. (1992). Quality of nursing worklife issues: A unifying framework. *Canadian Journal of Nursing Administration,* 5(2):12-16.

iv Hancock, T. (2000). The evolution, The Healthy Communities vs. "Health". *Canadian Health Care Management,* 100(2):21-23.

v Green, L.W., Richard, L. and Potvin, L. (1996). Ecological foundation of health promotion. *American Journal of Health Promotion,* 10(4): March/April, 270-281.

vi Grinspun, D. (2000). *Taking care of the bottom line: shifting paradigms in hospital management.* In Diana L. Gustafson (ed.), *Care and Consequence: Health Care Reform and Its Impact on Canadian Women.* Halifax, Nova Scotia, Canada. Fernwood Publishing.

Physical/Structural Policy Components

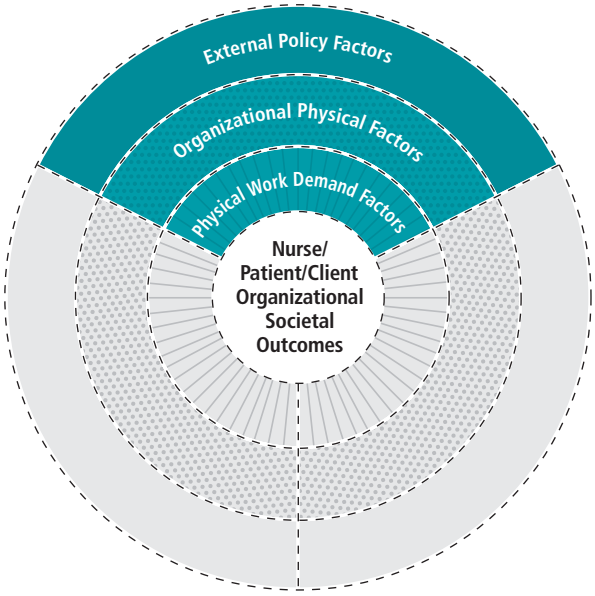


Figure 1A

Physical/Structural Policy Components

- At the individual level, the Physical Work Demand Factors include the requirements of the work which necessitate physical capabilities and effort on the part of the individual.[vii] Included among these factors are workload, changing schedules and shifts, heavy lifting, exposure to hazardous and infectious substances, and threats to personal safety.
- At the organizational level, the Organizational Physical Factors include the physical characteristics and the physical environment of the organization and also the organizational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible, and self-scheduling, access to functioning lifting equipment, occupational health and safety polices, and security personnel.
- At the system or external level, the External Policy Factors include health care delivery models, funding, and legislative, trade, economic and political frameworks (e.g., migration policies, health system reform) external to the organization.

vii Grinspun, D. (2002). *The Social Construction of Nursing Caring.* Unpublished Doctoral Dissertation Proposal. York University, North York, Ontario.

Cognitive/Psycho/Socio/Cultural Components

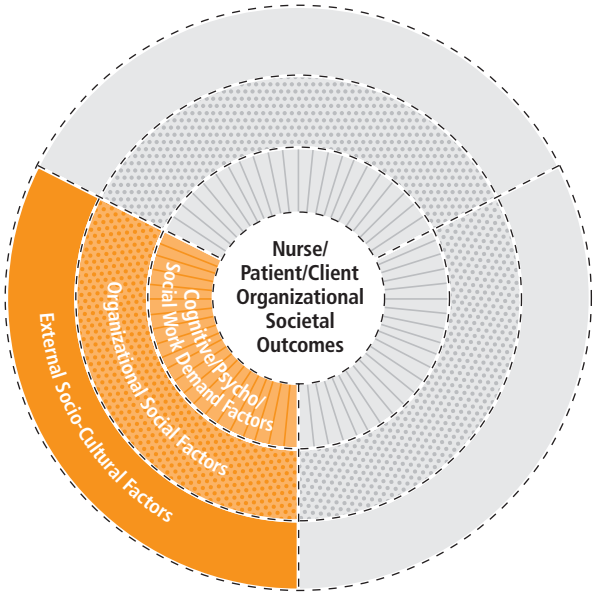


Figure 1B

Cognitive/Psycho/Socio/Cultural Components

- At the individual level, the Cognitive and Psycho-social Work Demand Factors include the requirements of the work which necessitate cognitive, psychological and social capabilities and effort (e.g., clinical knowledge, effective coping skills, communication skills) on the part of the individual.[vii] Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity, and role strain.
- At the organizational level, the Organizational Social Factors are related to organizational climate, culture, and values. Included among these factors are organizational stability, communication practices and structures, labour/management relations, and a culture of continuous learning and support.
- At the system level, the External Socio-cultural Factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics – all of which influence how organizations and individuals operate.

Professional/Occupational Components

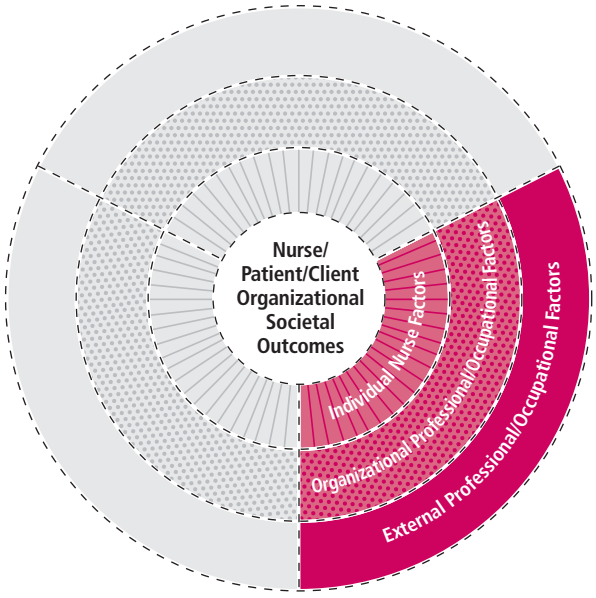


Figure 1C

Professional/Occupational Components

- At the individual level, the Individual Nurse Factors include the personal attributes and/or acquired skills and knowledge of the nurse which determine how she/he responds to the physical, cognitive and psycho-social demands of work.[vii] Included among these factors are commitment to patient/client care, the organization and the profession; personal values and ethics; reflective practice; resilience, adaptability and self confidence; and family work/life balance.
- At the organizational level, the Organizational Professional/Occupational Factors are characteristic of the nature and role of the profession/occupation. Included among these factors are the scope of practice, level of autonomy and control over practice, and intradisciplinary relationships.
- At the system or external level, the External Professional/Occupational Factors include policies and regulations at the provincial/territorial, national and international level which influence health and social policy and role socializations within and across disciplines and domains.

Background Context of the Guideline on Embracing Cultural Diversities in Healthcare: Developing Cultural Competence

The 21st century brings challenges to Canada that are similar in many ways to those faced by Canadians a hundred years ago. While the future promises a less robust rate of population growth than was the case in 1907, much like that era the bulk of our growth will come from immigration. We differ from our early 20th Century colleagues in that the vast majority of those new immigrants – some 80% – will arrive from non-European countries where most citizens are not white. They will be younger on average than most Canadians, and neither English nor French will be their first language.

Why this looming shift matters to the nursing profession is plain. These future Canadian citizens will access our health care system and receive a range of health care services from a variety of health care professionals, many of whom will be nurses. In addition, some of these future Canadians will become the nurses of the next and future generations. They bring with them different cultural norms and traditions, different values and beliefs about health and about illness and its treatment, all of which will influence their views about health care delivery in general, and nursing in particular.

While Canada has a long standing multicultural identity and a tradition of acceptance of diversity, reinforced for example by the Federal government's 1971 Multiculturalism Policy, government intentions have not been sufficient to achieve equity and integration. Racism and cultural oppression have been realities for many minority groups living in Canada, especially the First Nations' peoples,[G] with longstanding impacts of poverty, poor health, loss of identity and marginalization.[G] This realty, a part of all aspects of Canadian society, is clearly evident in our health care work environment. Nurses from visible and non-visible minority groups[G], working across Canada in different health care environments, speak of their experiences of discrimination[G] and racism[G] and the challenges of working effectively in such environments.

The challenge of diversity, which has been with us for generations, must clearly be addressed for the future such that it is no longer acceptable to engage in practices or tolerate attitudes that limit the potential of many fellow Canadians. This becomes especially important in health care where we face serious recruitment and retention challenges in nursing and other health care professions. This best practice guideline for nurses on cultural diversity provides bold recommendations about actions that can be taken to embrace diversity in the health care work force as part of creating a healthy work environment and a healthy work team.

Cultural diversity in its broadest sense, must be addressed in order to create a truly integrated health care workforce that embraces all types of diversity. Minorities, whether they be Canadians of colour, First Nations' peoples, physically challenged, homosexual, etc., have made clear that there are ways and times they have felt unwelcome in nursing, in health care and in the workplace. They talk about treatment in the workplace that feels uncomfortable – either due to outward hostility or subtle discrimination. And although the health care workforce is becoming more diverse, this diversity may not always be reflected in senior leadership and middle management levels.

What can we do to prepare ourselves to integrate a new and changing workforce? How can we be innovative, welcoming, and responsive, protecting patient safety and integrating new ideas while at the same time maintaining and enhancing the best of what we have? How, indeed, can we create practice settings that embrace and advance the careers of the diverse groups of nurses who are already in the workforce?

This best practice guideline includes recommendations related to individuals, organizations and the external system. It is a critical tool that can be used by leaders to better understand and plan work environments that optimize the performance, productivity and satisfaction of every team member.

As employers and organizations strive to create meaningful and healthy work places that maximize worker potential, programs that focus on diversity, culture, team work and common values are no longer seen as superfluous offerings targeted to the minority. Such programs promote the full realization of each team member's potential as the most fundamental underpinning of a healthy and vibrant work environment.

Although there are numerous challenges in taking the agenda of embracing diversity forward, inaction is not an option. Attention to this aspect of the work environment is essential for quality health care based on retention of a productive and satisfied team of health care professionals, as well as successful ongoing recruitment. The guideline lays the foundation from which nursing leaders and others can develop a work environment that acknowledges and truly embraces diversity with positive outcomes for patients, nurses and the organization.

Development of the Guideline

While developing this guideline, the expert panel gave careful attention to its title. Diversity is a broad term and can refer to any number of distinct qualities, traits or characteristics – including, but not limited to skin colour, gender, age, race and ethnic identification, citizenship, sexual orientation, and physical and cognitive abilities. For the purposes of this guideline, the definition proposed by Friday was adopted.[34] The panel concluded that while embracing diversity is an ideology, cultural competence[G] is a skill and is reflected in behaviours. Embracing cultural diversity[G] in the workplace means a commitment to culturally competent practices that eliminate discrimination and disparity, affirm differences, and actively engage in strategies that draw on the strength of the differences.

Cultural competence (see model, Appendix B) ranges on a continuum from eliminating the negative end of destructiveness (racism and abuse) to a positive end, where cultural diversity is valued and has the potential to create innovative, transformative opportunities that maximize health, economic and social benefits. Cultural competence[35] in the workplace can be described as a congruent set of workforce behaviours, management practices and institutional policies within a practice setting resulting in an organizational environment that is respectful and inclusive of cultural and other forms of diversity.[35] The underlying values for cultural competence are inclusivity[G], respect, valuing differences, equity and commitment. These values have been embedded in all recommendations.

In reviewing the evidence related to this guideline, including expert opinion and stakeholder feedback, it became clear that there were divergent views and passionate opinions related to a number of issues. The guideline panel of experts concluded that it was important raise these issues and confront present inequities, disparities and gaps in order to challenge the systems and structures that created the current realities. These issues have been grouped under four themes: (1) terminology; (2) out-reach to under-represented groups (targeted recruitment); (3) collecting data in order to identify under-represented groups (measuring diversity); and (4) recruitment and retention of internationally educated nurses. Because these issues have no easy resolution, they have been identified as "thorny issues" and discussion of each has been incorporated into different sections of the guideline.

> *"Diversity refers to any attribute that happens to be salient to an individual that makes him/her perceive that he/she is different from another individual."*
>
> *Friday*[34]

Key Values for Cultural Competence

1. Inclusivity
2. Respect
3. Valuing differences
4. Equity
5. Commitment

This guideline provides recommendations that health care professionals in all roles can use to embed work environments with a culture that moves all team members to understand diversity and accept and embrace the differences it brings to work settings. Consistent with the conceptual framework for the Healthy Work Environment Best Practice Guideline programme, the recommendations in this guideline fall into three categories:

1. Individual Recommendations: target the professional behaviors of the individual practitioner and are grouped into those addressing self-awareness, communication and learning new behaviours.

2. Organizational Recommendations: target employers of nurses, unions, and groups of employees (such as in settings where staff are not unionized but may work together on workplace issues). These recommendations are grouped into two sections: recruitment and retention. The retention section is further categorized into recommendations targeting employee orientation and continuing education, workplace policies and practices, and the retention of internationally educated nurses. Note that these recommendations target all settings that employ nurses, including health care organizations and other clinical settings, education settings (e.g., colleges and universities employing nurses as professors), public health and community settings, and professional organizations.

3. External System Recommendations: target education and curriculum, governments, accrediting bodies, regulators, and professional associations that support nurses. Recommendations for academia are further sub-divided into those addressing students and faculty, and curriculum.

Each of the above sections is introduced with a background statement and includes recommendations and the related supporting evidence. Terms and phrases marked with the symbol "G" are defined in the Glossary Appendix A.

Thorny Issue: Terminology

Terminology in this guideline is a thorny issue since the choice of terminology used to distinguish groups of persons can be personal and contentious, especially when the groups represent differences in race, gender, sexual orientation, culture or other characteristics.

Throughout the development of this guideline the panel endeavoured to maintain neutral and non-judgmental terminology wherever possible. Terms such as "minority", "visible minority", "non-visible minority" and "language minority" are used in some areas; when doing so the panel refers solely to their proportionate numbers within the larger Canadian population, and infers no value on the term to imply less importance or less power.

In some of the recommendations the term "under-represented groups" is used, again, to refer solely to the disproportionate representation of some Canadians in those settings in comparison to the traditional majority.

Conceptual Framework for Embracing Cultural Diversity in Health Care: Developing Cultural Competence Guideline

The conceptual Model for Healthy Work Environments for Nurses was used in organizing the recommendations, based on the early literature review. However, the expert panel conceptualized a companion framework to guide the subsequent systematic literature review and analysis. The major precept of the framework is that outcomes, whether related to individuals, patients, groups or organizations, are influenced by four variables:

1. External characteristics such as globalization of society and the market place, the international workforce, multiculturalism policies, human rights legislation and the overarching nursing shortages.

2. Organizational characteristics such as the diversity climate in the workplace.

3. Group characteristics, such as diversity within the group, the culture of inclusion within the group, communication skills, and knowledge exchange between the members of the group.

4. Individual characteristics such as cultural background, beliefs, values, and ethnicity.

These variables are linked together and to outcomes by the "linking themes" noted in the Figure A and B.

Figure A

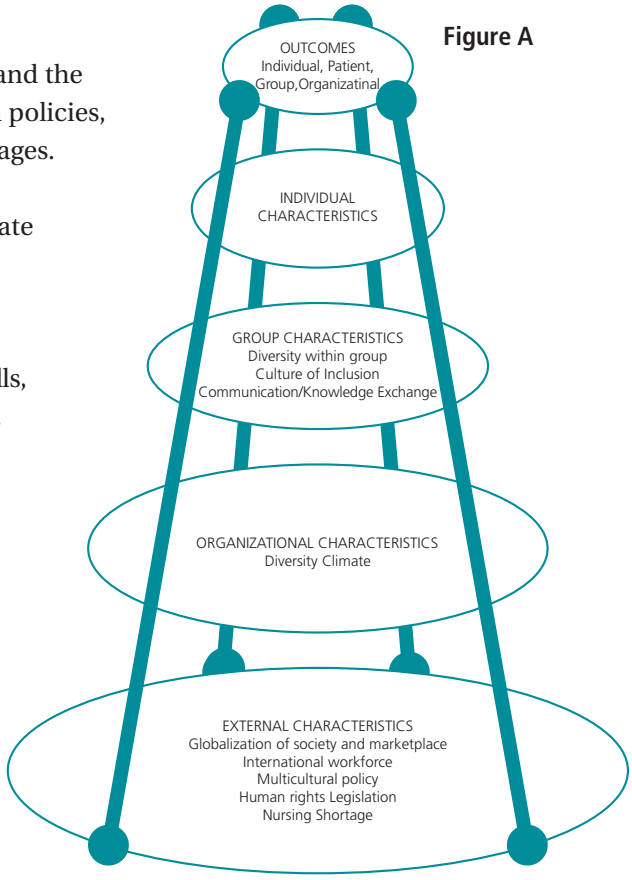
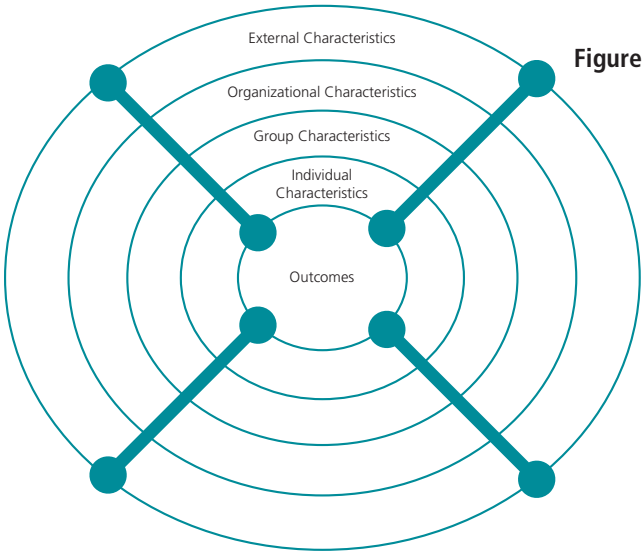


Figure B



Linking themes [ ]

1. Accountability mechanisms to embrace and sustain diversity
2. Culturally competent practices
3. Benchmarks and indicators
4. Guidelines and standards

Sources and Types of Evidence on Embracing Cultural Diversity in Health Care: Developing Cultural Competence

Evidence-based decision-making has become the generally accepted standard for health care practices and policies. However, it must be acknowledged that the term itself is open to multiple interpretations and perspectives. The World Health Organization defines evidence as "findings from research and other knowledge that may serve as a useful basis for decision making in public health and health care."[36]

> *"Evidence is inherently uncertain, dynamic, complex, contestable, and rarely complete."*
>
> *Canadian Health Services Research Foundation*[36]

While the desire to extend the guidance offered by evidence-based clinical practice to health services management is admirable, it has been argued that honouring or valuing research evidence over organizational and political evidence can be problematic. In a report on conceptualizing and combining evidence for health systems guidance, the Canadian Health Services Research Foundation (CHSRF) notes that evidence can be either colloquial or scientific. Colloquial evidence can be described as the "expertise, views, and realities of stakeholders"[36] and includes evidence about resources, expert and professional opinion, political judgment, values, as well as the particular pragmatics of the situation. Day-to-day health care decisions are predominantly guided by colloquial evidence.

Different types of evidence can be combined by the process of deliberation. A deliberative process is an integration of the technical (or research) analysis and stakeholder deliberation (expert panel consensus) and is desirable when the issues at stake are debatable. The process has clear objectives: is inclusive and transparent; challenges science; promotes dialogue between parties; and promotes a consensus about the potential decision. A deliberative process is different than a consultative process and reflects participation of the stakeholders. The intended outcome is balanced consensus, which "respects both scientific integrity, on the one hand and its implementability in a specific health system context on the other. Balanced consensus is obtained by careful consideration of all relevant evidence, and involving a good range of those best qualified to assess it and those most likely to be affected by it."[36]

> *"Colloquial evidence can complement or substitute for missing scientific evidence on context"*
>
> *Canadian Health Services Research Foundation*[36]

Perhaps for all these reasons, Davies[37] inserts a note of caution into talk of "best" practices, a term laden with subjectivity, and argues that a more realistic hope is to discover and share "promising" practices. With respect to governments, he warns that "evidence-based government is no substitute for thinking-based government." That same warning holds true for health care decision-making. Development of healthy work environments needs to reflect promising practices that are continuously evolving based on critical thinking and analysis of the specific environment.

Even during the time this guideline was being prepared, the accepted wisdom about evidence had begun to shift from "evidence-based" decision-making to "evidence-informed" decision-making.[36] This change recognizes some of the very real challenges of defining evidence and then deciding what is the "right" evidence in a given situation. It also acknowledges that the kind of evidence traditionally accorded the highest value – i.e. the results of rigorous, randomized controlled trials – does not represent the only, or best way of understanding a particular phenomena. Furthermore, many phenomena, including diversity and cultural competence, could not be studied using a randomized trial methodology.

Evidence-based practice can be described as a problem solving approach to clinical practice that integrates the conscientious use of best evidence with a clinician's expertise as well as patient preferences and values to make decisions about the type of care that is provided.[38] In other words the context and fit is critical to evaluating and utilizing evidence in practice. The context of diversity varies across the province (for example urban or rural) and across the nation. This must be considered in determining applicability of the evidence and recommendations to particular areas of practice.

These guidelines are a result of the systematic review conducted by the Joanna Briggs Institute (JBI), qualitative data review, extensive dialogue and debate within the expert panel, and feedback from a team of external reviewers. Due to a paucity of research on diversity, cultural competence and healthy work environments, logical inferences have been drawn from the literature from cultural competence in clinical practice where appropriate. The expert panel was composed of individuals within the nursing profession representing diversity in ideology related to the concepts of culture and diversity as well as diversity with respect to role and domain within the profession (education, policy, practice, administration and research, across clinical specialties), geography, and cultural identities including age, gender, education, race, ethnicity, sexual orientation and First Nations' people status. An outline of the process used in the development of this guideline is presented in Appendix C.

Sources of Evidence

Many sources of evidence are available. Klein[36] discusses three types of evidence: research, organizational, and political. The latter two are aimed at organizational capacity and implementation**.** Current practice in creating best practice guidelines involves identifying the strength of the supporting evidence.[39] Prevailing systems of evidence grading assess systematic reviews of randomized controlled trials (RCT) as the "gold standard" for evidence with other methods ranked lower.[40] However, not all questions of interest are amenable to the methods of RCT particularly where the subjects cannot be randomized or variables of interest are pre-existing or difficult to isolate. As well, not all questions are focused on cause and effect relationships. Therefore there is no single leveling system that fits all types of questions and evidence. While a systematic review or meta analysis of all relevant randomized controlled trials is the most desired type of

evidence for research questions concerned with a causal relationship, they are among the least desired when the research question requires understanding of experiences. The highest level of evidence in this situation is the evidence obtained from systematic reviews of descriptive and qualitative studies.[41] For this reason these guidelines do not include a rating system.

The literature on embracing diversity in health care consists largely of descriptive, qualitative studies, opinions, experience-based, and narrative reports based on program evaluations. The panel also relied on documents and reports from programs in the United States, Australia, UK, and Canada as well as first hand experiences of panel members in implementing cultural competence or diversity related initiatives in education, practice, and policy settings.

> *"Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research are the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins, for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience – while privileging the former over the latter."* [42]

Key Messages and Themes from the Systematic Literature Review

Key messages that emerged from themes identified from the systematic literature review conducted by the Joanna Briggs Institute[40] for this Best Practice Guideline are:

1. Practitioner Skill Set

Cultural competence is a mandatory skill set for all health care providers.

- Health care professionals need to attain appropriate skills in order to embrace diversity and practice competently with diverse groups.

2. Workforce Diversity

Recruiting and retaining staff to achieve diversity in the workforce can benefit not only the health care professional in the delivery of culturally competent care[G] but also minority groups in the care they access and receive.

- Organizations should implement processes to assist with ensuring workforce diversity exists in all roles, at all levels, and is maintained. Diversity in the workforce was suggested to positively impact on culturally diverse groups.[40]

3. Systems and Supports

Embedding cultural competence processes and practices within organizational structures and curricula will promote the development of cultural competence.

- Cultural competence was shown to be an ongoing process that was required to be embedded into organizational processes. A need was identified to establish a defined set of protocols and guidelines to support cultural competency and that these practices should be based on the best available evidence.

4. Decision Support Systems and Practice Improvement

Utilizing indicators related to an organization's diversity climate is critical to measuring success and determining accountability for embracing diversity.

- There was an identified need to measure success of specific strategies with ongoing monitoring of indicators that are reported and utilized to make decisions for subsequent actions and approaches.

5. Education and Training

Undergraduate and graduate education and lifelong learning within practice settings must embed the principles of cultural competence throughout the learning process.

- There was an identified need for health care professionals to receive education and training in cultural competency to prepare them to care for and address the needs of culturally diverse groups. It was identified that education and training should exist in initial curricula and continue through staff development processes offered by organizations.

6. Collaboration

Organizations that promote collaboration and work collaboratively with each other will improve services for culturally diverse populations[G] and contribute to a work environment that embraces diversity.

- Collaboration between health care providers and other agencies was indicated to improve care to culturally diverse patient groups. An increase in collaboration between health care providers and culturally diverse groups and their communities could also improve services and workforce productivity and satisfaction.

Overall Goals and Objectives

The focus of the Healthy Workplace Environment Best Practices Guidelines (HWE BPG) project is on creating healthy work environments for nurses which will impact on patients and organizations. Therefore, the *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* BPG does *not* focus directly on cultural competence as it relates to patients, but rather on cultural competence as it relates to the workplace and workforce.

Overall Goal and Objectives

To promote a healthy work environment for nurses by identifying best practices for embracing diversity within health care organizations. The goal is achieved through these objectives:

1. Identify culturally competent practices that enhance outcomes for nurses, organizations and systems.

2. Identify organizational values, relationships, structures and processes required for developing and sustaining culturally competent practices.

Purpose and Scope

This guideline addresses:

- Knowledge, competencies and behaviours that exist in culturally competent workplaces
- Indicators and features of culturally competent practice settings
- Organizational values, relationships, structures and processes that support development of culturally competent practices
- Learning and development required to develop, support, and sustain culturally competent practices
- Behaviours and practices that reflect cultural awareness and serve as facilitators to embracing diversity in the workplace

The recommendations in this guideline address:

- Culturally competent practices in the workplace
- Individual competencies, management practices and institutional policies that reflect culturally competent practices
- Transformational strategies for embracing diversity at the level of the individual, group, organization, and health care system
- Educational requirements and strategies to ensure a culturally competent workforce
- Policy changes to support and sustain culturally competent practices
- Future research opportunities

Target group:
The guideline is relevant to all domains and settings where nurses practice.

How to Use this Document

The guideline provides a comprehensive approach to embracing cultural diversity through developing cultural competence. It is not intended to be read and applied all at once, but rather, to be reviewed and with reflection over time, applied as appropriate for yourself, your situation or your organization. We suggest the following approach:

1. **Read the recommendations.**

2. **Decide on an area of focus:** Identify an area for yourself, your situation, or your organization that you believe needs attention to strengthen cultural competence.

3. **Critically reflect on your own assumptions regarding diversity and views of differences**

4. **Develop a tentative plan:** Having selected a small number of recommendations and behaviours for attention, turn to the table of strategies and consider the suggestions offered. Develop a plan to address your area of focus. (See Appendix F)

5. **Discuss the plan with others**: Take time to solicit imput from people whom it might affect, or whose engagement will be critical to success and from trusted advisors, who will provide feedback on the appropriateness of your ideas. Remember to seek out perspectives that will be different from yours.

6. **Identify resources for development:** Consider the resources within your organization. If you need more information, you may wish to refer to some of the references cited or to explore some of the models identified in Appendix B, tools suggested in Appendix F, and/or ideas for implementation in Appendix F.

7. **Get started**: It is important to get started and make adjustments as you go, if necessary. The development of cultural competence is a life-long quest that offers many opportunities for personal and professional growth and enrichment; **enjoy the journey!**

Individual Context: Best Cultural Competence Practices

Introduction

The concept of cultural competence is based upon a respect for others and a search to find greater meaning in how we can live and work together with ease and understanding.

> *"Whether or not an employer has embraced cultural competency, change must begin with each individual. Each of us must serve as culturally competent role models and share our skills and knowledge with others. We must engage others in discussions and challenge questionable behaviours or institutional practices."*
>
> *French*[43]

Broadly defined, culture is made up of learned and transmitted beliefs, as well as information and values that shape attitudes and generate meaning among members of a social group.[44] An individual's culture is influenced by many factors, such as race, gender, religion, place of birth, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person varies. Although the definition of culture is broad and includes values and beliefs, for the purposes of this guideline, the demographics of culture[G] that are important to monitor include, but are not limited to, age, gender, ethnocultural identification, first language and sexual orientation. Cultural competence is a continuous process of effectively developing the ability to work within the cultural context of community, family and individuals from a diverse cultural and ethnic background.[45]

Caring is often called the key attribute of being a nurse and is not limited to interactions with clients. Developing collegial and collaborative relationships with each other is an expression of caring. Developing cultural competence means that the health professional becomes aware of one's own cultural attributes and biases, and their impact on others. Understanding one's own worldview and that of the "other," avoids stereotyping[G] and the misapplication of scientific knowledge.

It is unrealistic to expect any one individual to have consummate knowledge of all cultures and it is unreasonable to expect that all members of any one group will behave the same way in any situation. However, it is possible to obtain a broad understanding of how cultures can affect beliefs and behaviours including beliefs and behaviours that relate to how care is provided. It is an incorporation of respect, acceptance and a willingness to be open and learn from new ways of being and interacting with one another, rather than following a menu of cultural competence activities as outlined in a policy manual.

As Canada becomes more diverse, so must its health care system. Men and women from all cultures need to be recruited and welcomed into a profession that is committed to the care of others. Through our actions and interactions we can support and learn from these diverse groups to create an environment that capitalizes on diversity and furthers the profession and the broader health care system. In striving towards developing quality professional practice environments, welcoming cultural diversity and enveloping cultural competence provides not only a rich environment in which to work and care for diverse populations, but also provides hospitals and other work places a competitive edge as they seek to recruit and retain staff.

> *"To care for someone, I must know who I am.*
> *To care for someone, I must know who the other is.*
> *To care for someone, I must be able to bridge the gap between myself and the other"*
>
> *Jean Watson, cited by J. Anderson*[46]

Individual Recommendations

For each individual, embracing diversity means development of the following competencies and behaviours. Tools to assist in developing these skills are suggested in Appendix E.

RECOMMENDATION
1. Self Awareness – To learn to embrace diversity in individuals:
1. Perform self-reflection of one's own values/beliefs, incorporating feedback from peers.
2. Express an awareness of one's own views of differences among people (e.g. different opinions, different world views, different races, different values, different views of society).
3. State and continually explore, through reflection and feedback, how one's own biases, personal values, and beliefs, affect others.
4. Identify cultural differences among clients and colleagues in the practice setting.
5. Acknowledge one's own feelings and behaviours toward working with clients, families and colleagues who have different cultural backgrounds, health behaviours, belief systems, and work practices.
6. Explore one's strategies for resolving conflicts that arise between self and colleagues and/or clients from diverse groups.
7. Identify and seek guidance, support, knowledge and skills from role models who demonstrate cultural proficiency.[G]
8. Recognize and address inequitable, discriminatory, and/or racist behaviours or institutional practices when they occur.
9. Acknowledge the presence or absence of individuals from diverse cultural backgrounds at all levels in the workplace, reflecting the cultural makeup of the clients or community being served.
10. Reflect and act on ways to be inclusive in all aspects of one's practice.
2. Communication – To develop communication skills that promote culturally diverse settings:
1. Are aware of different communication styles and the influence of culture on communication.
2. Are aware of one's preferred communication style, its strengths and limitations, and how it affects colleagues and recipients of care.
3. Seek feedback from clients and colleagues, and participate in communication validation exercises (e.g. role-playing exercises, case studies).
4. Use a range of communication skills to effectively communicate with clients and colleagues (e.g. empathetic listening, reflecting, non-judgmental open-ended questioning).
5. Seek and participate in learning opportunities that include a focus on communication and diversity.

RECOMMENDATION
3. New Learning – To attain cultural competence in individuals:
1. Acquire knowledge of the range of cultural norms, beliefs and values relevant to clients and colleagues as a starting point to foster understanding – and further inquiry.
2. Are aware of the disparities (e.g. health outcomes, access to care, economics, job opportunities) that exist for diverse populations,[6] and understand the factors and processes that contribute to them.
3. Recognize how culture and diversity influence behaviours and interactions.
4. Develop and apply cultural competence knowledge and skills in the areas of communication, care planning, conflict resolution and change management.
5. Access, utilize, and partner with cultural resources.

Anticipated Outcomes:

A workforce composed of nurses who are open-minded, inclusive, and respectful of all colleagues and recipients of nursing services. Individual members of the workforce identify and are co-operative with one another to address barriers to equity and diversity, and build practice environments in which every person's contribution is valued thus allowing the full potential of all to be maximized. These individuals refuse to participate in discrimination, harassment or bullying and address the issue in a way that will effect change

Evidence[a]

Self Awareness

These recommendations are supported by the Joanna Briggs Institute (JBI)[40] data synthesis from the systematic review of qualitative and discursive evidence.[G] Self-awareness is the first step in achieving cultural competence. Evidence has shown that our attitudes, whether we are conscious of them or not, have a direct and significant impact on the people around us. This is of concern especially when we are trying to build a health care team.[47] Through self reflection, health care providers are able to acknowledge their own cultural beliefs and values, which will aid them in achieving cultural competence in practice. Awareness of one's self, both personally and professionally through the use of reflective practices can help strengthen the nursing professional role.[40]

The literature discusses structured ways to assist nurses achieve cultural self-awareness and cultural sensitivity[G] to others[43,48] and provides examples of the use of small-group exercises to consider differences such as race, ethnicity, ability and experiences, and how they have shaped our behaviour. The studies share a common theme that self-awareness followed by information gathering and analysis of work practices are the first steps towards cultivating cultural competence and valuing workplace diversity.

The review of Canadian, American and international literature on cultural competence reveals that self awareness is a fundamental attribute of cultural competence.[49-53] Self awareness extends to clarifying motivation and vision related to becoming culturally competent.[54] Numerous tools are available for self-examination, ranging from those that focus on general self-examination[55] to those with a specific emphasis on cultural competence. A selection of these tools, based on recommendations of the expert panel and stakeholders is available in Appendix E.

Communication

The JBI systematic review[40] focused on work between staff and patient that examined the relationship between sensitive communication with diverse groups and the care provided. By having an understanding of other cultures, staff effectively communicated health information and care for improved health outcomes. While self examination and reflection are required to communicate effectively, flexibility and openness are also necessary attributes for effective intercultural communication. Health care professionals need to learn appropriate communication skills across cultures to practice competently and to discuss health related issues effectively.[40]

> *"Although culturally diverse groups have the potential to generate a greater variety of ideas and other resources than culturally homogenous groups, they need to overcome some of the group interaction problems that make group functioning more difficult."*
>
> *Dreaschslin[59]*

a The source of the evidence for all recommendations is the JBI systematic review, background literature in the JBI narrative summary, literature suggested by the expert panel, and consensus opinion from the panel experts

In a meta-synthesis of qualitative studies on nurses caring for patients from cultures that are different than their own, communication was identified as an overarching factor in "connecting with the client."[56] Language and cultural differences have been identified consistently in the literature as factors that act as barriers to the development of genuine (vs. superficial) relationships between clients and nurses. In our experience, cultural differences in communication styles can also negatively affect relationships between health care team members leading to misunderstandings and racial tensions. Knowledge of the range of communication styles and awareness of one's own style, sensitivity to contextual issues, and understanding of the differences in communication styles from peoples of different cultures are all key factors in communication. Recognizing these differences within a specific context is critical. Intercultural communication is influenced by a number of factors including how power and authority are shared in the culture, values of individualism and collectivism and the role of context in communication.[53,57] Anthropologist, Edward Hall,[58] proposed a continuum of low to high context with respect to contextualizing the messages sent and received. Low context cultures (such as Canadian and American) emphasize the words used in the communication with less emphasis on the context such as who says it, how it is said and what is not said. In high context cultures such as Asian cultures, for example, the context of the message is just as important as the words used and influences how the message is understood.[45]

Communications, in particular among diverse groups, becomes a key issue in developing colleagial relations in the work team. Dreachslin[59] builds on the general management literature that demonstrates a strong association between racial diversity and difficulties with communication and conflict resolution in teams. Research highlights a significant association between diversity, group conflict and communication difficulties with more diverse groups experiencing more conflict and miscommunication.[59]

There is a strong business case for initiating communication about culture as a platform for change.[60] Dreachslin[59] identifies leadership as the mitigating factor; leaders who validate the different perspectives and realities represented in the nursing care team and demonstrate a willingness to talk about differences achieve a positive outcome.

New learning

The JBI systematic review[40] identifies the need for health care practitioners to have a comprehensive understanding of different cultures in order to effectively demonstrate a range of communication skills. It is important to create a balance between the cognitive, affective and behavioural processes as well as the learning strategies for culturally competent programs.[40] Health care providers require a particular skill set

> *"In order to attain cultural competence, health care providers must be made aware of the impact of social and cultural factors on health beliefs and behaviours and be equipped with tools and skills to manage these factors through training and education."*
>
> *Betancourt*[61]

to deliver culturally competent care. Developing this skill set includes knowledge, an awareness of disparities, culturally sensitive communication skills and a greater understanding of the attitudes, beliefs and culture of diverse groups.[40]

In acquiring this skill set an attitude change, and indeed, unlearning is required. There is a need to unlearn the notion that culture and difference is negative or problematic. This involves asking the question: "How do we learn that our view is a perspective and *the* perspective"? Staff also need to learn how to conduct assessments of cultural needs, and to be aware of available cultural resources.[G]

A systematic review and analysis of the literature on studies from 1980-2003 evaluating interventions to improve the cultural competence of health professionals[62] concluded:

- There is excellent evidence that cultural competence training improves the knowledge of health professionals.
- There is good evidence that cultural competence training improves the attitudes and skills of health professionals.
- There is good evidence that cultural competence training positively affects patient satisfaction.

Organizational Context: Best Cultural Competence Practices for Employees and Unions

Health care organizations serve a range of diverse people, but they are not adequately meeting the needs of specific populations.[63, 64] When it comes to creating healthy and productive practice settings employers and unions (where they exist) are inextricably linked. An important role for health service employers is to hire and retain knowledgeable, competent staff to provide care for the clients and families that access health services. Employees must be able to maximize their contribution within their workplace to assist the organization to achieve its overall goals and objectives and obtain personal and professional satisfaction. One of the union's goals is negotiating collective economic and other working conditions for their members.

In working towards the goals of quality care and professional satisfaction, employers and unions must co-create work environments that provide support for cultural competence in care delivery and staff relationships. Employers and unions alike must value diversity in order to establish the policies and procedures needed for the people in the organization to develop and "live" cultural competence. At the most basic level they must choose to engage deeply in the diversity agenda if real change is to happen for the next generation of nurses and other health care workers.

Engaging in the diversity agenda in the workplace involves creating an inclusive environment in which our diverse skills, cultural perspectives and backgrounds are recognized and valued. Cultural misunderstanding can lead to miscommunication, tensions between people, and wrongful assumptions. These can lead to the kinds of cultural conflicts that impede the agenda of inclusivity, acceptance and respect for other points of view. It is a lost opportunity for all. Healthy work environments recognize cultural conflicts and when they are addressed openly, in a respectful and thoughtful manner, many of these conflicts and resulting tensions can be mitigated.

There are many benefits for patients and staff when employers and unions work together towards cultural competence. When professionals are culturally competent, they establish positive, helping relationships that engage the client/patient and improve the quality of services that are provided.[40] As a recruitment and retention factor, improved job satisfaction and commitment through greater opportunity for participation in decision making together with the flexibility to better balance work and personal commitments are key. Improved performance and greater innovation are possible through harnessing the creativity that comes from cooperation within diverse groups. For patients/clients and residents, this means better and more responsive services that builds on our diversity.

In order to recruit and retain a diverse nursing workforce, it is essential that leaders embrace the challenge of understanding their current environment and develop programs that affirm and reflect the values of the differences those nurses will bring.[65] Embracing diversity and providing culturally competent services has the potential to create a healthier work environment that improves patient, staff and organizational outcomes.

Recommendations

RECOMMENDATION
1. Workplace policies and procedures – To move forward on environment of cultural safety organizations:
1. Articulate, implement, and evaluate the effectiveness of a mission statement, values and corporate strategic plans that emphasize the value of cultural diversity and competence.
2. Dedicate funding in the budget, including funding for human resources and expertise to plan, implement and evaluate strategies to strengthen diversity in the workplace.
3. Integrate cultural competence into the organization's Code of Conduct and enforce the code. (Codes of conduct implemented in work settings must reflect the principles of the existing Canadian Charter of Rights and Freedoms, and be consistent with provincial/territorial human rights codes.)
4. Develop policies, guidelines and processes to address change and conflict.
5. Implement, evaluate and adapt policies and guidelines that are respectful of cultural diversity, integrate cultural competence and eliminate discriminatory practices.
6. Implement and evaluate strategies to develop leadership skills for succession planning that target under-represented populations to address the organization's identified gaps and inequities.
2. Recruitment – To recruit a diverse nursing workforce, employers and unions:
1. Identify and monitor the cultural, ethnoracial, linguistic and demographic profile of the workforce in the organization and in the communities it serves on a systematic basis.
2. Identify gaps by asking, "Who is not here who should be here?" (e.g. men, First Nations people, other ethnic groups) and develop a plan to address the gaps.
3. Establish outreach processes in collaboration with cultural communities and other organizations to recruit a culturally diverse population[G] for the workforce.
4. Purposefully seek applications from qualified professionals of diverse cultural backgrounds to recruit to all levels of the organization, including leadership roles so that the organization is reflective of the communities served.
5. Review and amend all steps in recruitment processes (e.g. wording of job advertisements, role profiles, credentials required) to assess cultural competence and remove systemic biases[G] in the selection process.

RECOMMENDATION
3. Retention – To retain a diverse nursing workforce, employers and unions:
1. Plan employee orientation and continuing education programs, based on culturally sensitive preferred learning styles, assumptions and behaviours within culturally diverse groups.
2. Develop educational strategies to address the diversity of preferred learning styles and behaviours within employee groups.
3. Follow a cultural diversity model in implementing education and training for cultural competence (see examples in Appendix B).
4. Provide employees with ongoing continuing education on concepts and skills related to diversity and culture including: • Communication • Cultural conflict • Competence models • Culturally-appropriate assessments
5. Allocate fiscal and human resources, as part of the operating budget for educational strategies to promote cultural competence.
6. Evaluate the results of cultural competence education and adapt strategies as appropriate.
7. Work with national and jurisdictional organizations to collectively monitor the diversity of the workforce and the extent that diverse cultural and linguistic communities, ethnoracial groups, and demographic characteristics are represented.
8. Work with national and jurisdictional organizations to collectively establish mechanisms to address barriers to the recruitment and retention of underrepresented groups within the workforce.
4. Internationally educated nurses – To better support internationally educated nurses:
1. Assess the unique learning needs of internationally educated nurses and the staff who will work with them.
2. Establish support and mentoring programs for internationally educated nurses and the existing members of the workforce who will work with them.
3. Implement and promote programs to help internationally educated nurses transition successfully into Canadian practice settings.
4. Establish competency-based orientation and continuing education for internationally educated nurses, with a focus on: • Introduction to Canadian multicultural society[G], the health care system, and nursing as a profession in Canada • Language nuances and social norms • Psychosocial skills • Human rights • Employer and employee expectations, rights, and responsibilities • Mentoring

Anticipated Outcomes

A workplace in which all employees experience cultural safety, diversity is celebrated, the atmosphere encourages curiosity, creativity, innovation, and engagement, and there are no systemic barriers affecting hiring and retention of employees

Thorny issues: Targeted Recruitment

It is acknowledged that "affirmative action[G]" and purposefully seeking out members from underrepresented groups are controversial and are perceived by some as 'reverse discrimination' or as lowering of standards. The recommendations are based on the recognition that there are longstanding, historic and ongoing imbalances in the power and cultural makeup of the nursing workforce, particularly at the formal leadership and decision-making levels. Existing structures may be embedded with systemic biases that lead to subtle discrimination. Both research and consensus evidence indicate that targeted recruitment is an effective strategy to enhance workforce diversity.[40] Purposeful outreach to underrepresented groups could help diversify, enrich, and therefore strengthen nursing.

Thorny Issues: Measuring Diversity

Talk of measuring diversity in populations as a way to reach out to under-represented groups arouse passionate responses. Concerns are often grounded in the belief that information collected will be used against these same diverse populations.

Concern that information will be misused has become a default excuse for not measuring these important variables about cultural diversity. Inadvertently, these concerns have weakened the very programs intended to reach out to under-represented groups, and in turn, to develop programs that would help such groups succeed and advance in the health care system. The reality is that much of what we "know" about the Canadian nursing workforce (beyond age, gender, education and employment status) is purely anecdotal in nature and based on shared experiences. Equity census within sectors such as health care is important, because unless this kind of information is collected, measures to develop and support a culturally diverse workforce could be inadequate based upon poor evidence. Examples of organizations who are collecting such information include the University of Toronto and, more recently, the Toronto District School Board.[66]

The most common misconception – so powerful that it has taken on an aura of "fact" in the minds of many people – is the notion that it is "illegal" to ask Canadians questions about their cultural demographics, such as race, religion, physical abilities or sexual orientation. So pervasive is this belief that to even raise the topic arouses significant negative opinion.

What are the facts? It is illegal for employers or universities, for example, to require that Canadians declare characteristics such as race or sexual orientation in a job application, or in an application to a school of nursing. However, it is completely within the rights of governments, employers, regulators and schools to ask if nurses or nursing students wish to voluntarily declare the way they identify themselves (or not) on a range of demographic measures. Furthermore researchers are completely free to survey samples of citizens, including nurses, and ask them if they wish to declare any identifying cultural characteristics. It must be clear to both those asking the questions and those being asked, that refusing to answer cannot carry with it an implication that doing so will in any way bias the process for a job candidate, an applicant to a school of nursing or a nurse renewing her or his registration.

This guideline therefore recommends that health care employers ask staff and schools of nursing ask students to provide demographic data on a voluntary basis. It similarly asks regulators to do the same for the larger nursing workforce and for employers to pay attention to the cultural make-up of its workforce. The purpose of soliciting, monitoring and evaluating these data is to determine more correctly the actual (not presumed) cultural make-up of the nursing profession. Knowing that information will allow the identification of gaps and weaknesses (including under-represented cultural groups), and facilitate the development of appropriate recruitment and retention strategies.

Evidence

Workplace policies and procedures

The word "diversity" is increasingly becoming integrated into management and human resource circles and organizations of all sizes and types are discussing the benefits of embracing diversity within their policies and procedures. There is a growing recognition that it makes business sense to take diversity seriously.[84] An organization needs to develop a clear mission statement that highlights the importance of cultural competence.[63, 85] The workforce needs to improve its knowledge concerning differing diversity perspectives in order to create an atmosphere of cultural safety.[G] Appropriate funding and resources need to be allocated to strengthen diversity.[40]

Friday[34] outlines eight sequential steps that together contribute to a successful process for managing diversity within organizations. These are:

1. Exposure
2. Experience
3. Knowledge
4. Understanding
5. Appreciation
6. Respect
7. Modifying attitudes and behaviour, and
8. Healthy interaction

> *"It has been purported that if diversity can be effectively managed in an organization, some potential benefits to the organization include greater creativity and innovation, and improved decision making."*
>
> *Cox, cited by Friday[34]*

Organizational leaders need to emphasize the importance of cultural competence and make it more evident in workplace policies and practices. Organizations must develop a Code of Conduct and implement policies and procedures to eliminate discriminatory practices. Strategies including mentoring need to be incorporated for succession planning.[86] Research on the perceptions of managers, frontline staff and patients/clients about diversity highlights that culturally competent care is a critical aspect of quality care.[87] The meaning of cultural competence, however, differs depending on ones role within the health care setting. Those in senior management roles often equate cultural competence with structural components (i.e. degree of diversity among the staff complement, policies and procedures related to diversity, and presence of programs such as translation services). Front line managers have a greater awareness of the ability of culturally diverse groups to work together and view cultural competence through this lens. Front line staff

a The source of the evidence for all recommendations is the JBI systematic review, background literature in the JBI narrative summary, literature suggested by the expert panel, and consensus opinion from the panel experts

> *Diversity is identified as one of the areas where executive leadership is often ineffectual and espoused beliefs are often inconsistent with behaviour.*
>
> *Thomas*[54]

and patients/clients have views that relate more to the challenges associated with actually being able to give and receive appropriate care in the setting respecting the cultural diversity of both staff and patients.[86]

Organizations face unique challenges in implementing workplace policies in ways that acknowledge cultural diversity. For example, performance appraisals with attendant goal setting procedures and feedback processes can be a cultural disconnect with some individuals. Differences in values and behaviours influenced by culture, can make performances appraisals difficult[33] and in some cases, power structures and expectations make such appraisals risky in cultural diverse groups.[88]

Leadership is clearly a critical variable to the success of any diversity initiative.[89] Attention to the knowledge domains and associated core competencies for achieving diversity in management is key to preparing future health care industry leaders and to enhancing the skills, knowledge, and abilities of today's health services management professionals.[90]

> *Sensitivity to diversity issues at the senior executive level had an effect on diversity management practices used by hospitals.*
>
> *Dreaschslin*[33]

A few research studies link diversity and organizational behaviour.[33] It is difficult to build a clear business case for diversity as the linkages between diversity management practices and outcomes – such as financial performance, customer satisfaction, productivity, absenteeism, turnover, organizational citizenship, and job satisfaction – are in the early stages of study in both the business and health care literature. The relationship is complex with contextual variables such as management style and leader involvement exhibiting a strong influence on impact and outcome. Only a small number of studies have examined the link between specific management practices and organizational outcomes. However, there is some evidence that diversity management initiatives may improve overall commitment and satisfaction of all employees, irrespective of race and ethnicity. Much of this evidence is presented in case studies, which, when cumulative, can be useful to health care settings.[91, 92] There is also some evidence linking diversity to company effectiveness and performance, and a positive association with public image.[33]

Recruitment

Although the available evidence concerning the inter-relationship between cultural competence and recruitment is limited, it is important to be able to describe the cultural make-up of organizations to clearly identify gaps and inequities. An important role for national level professional and accrediting organizations is the collaborative development, testing and dissemination of standardized measurement tools to enable employers and unions to collect data describing the cultural make-up of organizations and the workforce.

> *"Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professional students."*
>
> *Institute of Medicine*[67]

After an organization has identified the cultural make-up of the workforce, the next step is to develop a plan that addresses any inequities identified.[67] Evidence presented by the High Court of Australia[48] stresses the need to develop an outreach program to purposefully recruit professionals of diverse backgrounds. There are gains for both professionals and patients when the cultural makeup of the workforce mirrors the communities they serve.[40]

The expert panel on the development of U.S. national standards for culturally and linguistically appropriate services (CLAS) has also concluded that language and culture are important factors in the provision of health care services. The CLAS standards were developed with input from a broad range of stakeholders to support a consistent and comprehensive approach to cultural and linguistic competence in health care (see Appendix G) and are seen as a means to correct inequitites. The CLAS standards (standard 2)[68] indicate that health care organizations should implement strategies at all levels of the organization to recruit, retain, and promote a diverse staff and leadership that are representative of the demographic characteristics of the service area.

> *A long tradition of research has demonstrated that individuals are generally more comfortable when they are surrounded by people they perceive as more like them. Social similarity acts as a mechanism of exclusion or inclusion… groups include those who feel familiar or safe and exclude those who don't.*
>
> *Foldy*[71]

In Canada the population in general, and thus the service area for health care, is becoming more diverse. Villeneuve and MacDonald[69,70] note that "one in eight Canadians was a member of a visible minority in 2001," a proportion that grew by 25 per cent between 1996 and 2001 while overall population growth was just four per cent. Furthermore they note that between 1996 and 2001, "the proportion of the population reporting First Nations' peoples identity increased 22.2 per cent" and there are now one million First Nations' people in Canada. Thus, the diversity of the country has grown rapidly, and will continue to do so in the coming 50 years. This means that the patient population will continue to become more and more diverse. Moreover, a growing body of evidence suggests that the nursing workforce needs to reflect that diversity (CLAS Standards, see Appendix G).

Furthermore, workforce diversity is likely to translate into more positive health care services and outcomes. Parallel service models in which minority health care providers serve their own ethnocultural community have been linked to improved communication, patient satisfaction with care and use of preventive services.[72,73] Similarly, bridging delivery models where service providers establish partnerships with members of the ethnocultural communities being served have been found to enhance culturally congruent care.[74]

Organizations must be deliberate in reviewing and revising all steps in the recruitment process to affirm diversity, remove biases, and to set recruitment goals.[54] Evidence of systemic bias has emerged in application processes for jobs as well as loans and housing using the paired tester methodology.[75-79] A growing body of literature on culture and ethnic diversity in health services reveals cultural and ethnic disparities in career outcomes, including satisfaction, salary and hierarchical position, "even when human capital variables such as educational background and years of experience are taken into account."[33] While this is U.S. data, it may be a cause to examine similar trends in Canada.

Workforce diversity can assist in professional attainment of culturally competent practices.[40] It creates exposure opportunities and promotes interaction among colleagues that may result in a greater understanding of cultural competence. Maintaining workforce diversity is an essential component to providing culturally competent care which can benefit both the health professional and the patient/client as recipent of that care.

Retention: Employee orientation and continuing education

Orientation and ongoing continuing education need to address cultural competence ranging from awareness to skill building. A competency-based diversity model provides (see Appendix B) the conceptual framework for an organization to organize structured cultural competence education while attending to diverse learning styles and teaching approaches for culturally diverse groups. Employees need to develop the relevant skills, including communication, conflict resolution and how to conduct a culturally appropriate assessment.[68, 80]

It is important that appropriate funding is allocated for cultural competence employee orientation, continuing education, and ongoing access to cultural diversity training. The results need to be regularly monitored and acted upon as appropriate.[40] Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery (see Appendix F).[68]

According to Friday,[34] the outcomes of participating in diversity training include: the ability to clearly articulate ideas and feelings; conflict management skills; effective giving and receiving of feedback; effective listening; group observation skills and group decision skills, all of which will facilitate modified attitudes and behaviours to support healthy interactions with diverse individuals. A commitment to diversity competence is a long-term commitment and the focus on skill building is continuous.[65]

Communication is a critical topic for ongoing education. In a metasynthesis of qualitative research on providing care in a diverse environment, Coffman[56] notes that communication (not only language but all other methods of sharing information) is the primary barrier to providing culturally sensitive care. The influence of cultural factors, power dynamics, verbal and non-verbal behaviours in the communication process have been cited by Lowenstein & Glanville[80]; Dreachslin et al[32] and Srivastava.[53]

> *"Recruiting and retaining an adequate nursing workforce is a priority as well as a challenge. Creating an environment that respects every individual's unique differences is key."*
>
> *Frusti*[65]

Conflict is an inevitable aspect of human relations in health care settings, and team members from diverse cultural backgrounds have different conflict behaviours in the workplace.[81] Team members and managers need to be cognizant of different conflict behaviours as well as different approaches to conflict management. The nurse manager is in a pivotal position to identify, label and deal with cultural conflict and conflict resolution.

Managers set the tone for their employees, while both staff and managers have the responsibility to set the tone for a positive working climate.[80] Srivastava[53] proposes a team level of cultural competence that involves creating an environment and processes that promote dialogue on differences in a positive way in order to

understand diverse viewpoints and develop unique, innovative and transformative interventions. Team level cultural competence makes the group values explicit and establishes and clarifies the group norms.[32, 53]

A number of cultural competence models that provide systematic and comprehensive understanding are available in the literature. Appendix B lists models for exploration and consideration. Although the majority of the models for cultural competence have been developed for patient care, they are applicable to cultural competence within the workplace in general. Lowenstein and Glanville[81] suggest the use of a model for assessing and intervening in conflict in health care settings. Dreachslin[82] presents a five-part change process model for diversity management with performance indicators for each stage. The stages range from 'discovery: emerging awareness of racial and ethnic diversity as a significant strategic issue' to 'revitalization' (see Appendix B). The performance indicators are based on best practices in health services organizations and in the business sector.[33]

> *"Cultural diversity issues affect the health care workplace and nursing practice. Cultural diversity will continue to grow in the health care workplace… Nurses must increase sensitivity, become aware of cultural nuances and issues, and make cultural assessment a routine part of their assessment and planning not only for patient care, but also with their co-workers and subordinates." Validating and clarifying perceptions are essential.*
>
> *Lowenstein & Glanville[80]*

Gilbert[83] differentiates between work-force diversity training and cultural competence training for health care professionals. Workforce diversity training is focused on improving relationships and interactions among members of a diverse workforce. Cultural competence training is focused on improving the quality of care for and enhancing service delivery to diverse patient populations. Although managers may want to provide training for both cultural competence and workforce diversity, the two types of training should not be confused. There are different goals and objectives for each and it is important to recognize the differences between the two.[83] In addition, the training should be provided by educators who are aware of, and are competent in the different skill sets for each type of training.

Internationally educated nurses

Diversity in the workforce needs to extend to the integration of care providers educated outside Canada.

Thorny Issues: Recruitment and Retention of Internationally Educated Nurses

Recruitment, integration and retention of nurses educated outside Canada is a contentious issue for some. The topic nearly always leads to a fear that more economically developed, or more politically powerful nations such as Canada will "poach" nurses through targeted, mass recruitment drives from less economically developed, less politically powerful nations that cannot afford to lose nurses. It is important to note that the purpose of these recommendations is to target the recruitment of those internationally educated nurses who have already immigrated to Canada and who require support to navigate the Canadian system in order to practice nursing in Canada.[93] The panel acknowledges that international education and diverse cultures do affect the integration of such nurses into the workplace and, consequently, their retention within the health care profession in Canada.

O'Brien-Pallas[94] surveyed internationally born nurses (IBNs) experience of their work environment. The data indicated that changes are needed to improve the work environment, and nurses' perception of the quality of care provided. IBNs experience more physical, verbal and emotional abuse than Canadian nurses and there appeared to be some inequity between the opportunities to attend educational activities.

Barriers for integrating overseas skilled workers into the mainstream workforce[95] include:

1. Lack of information
2. Lack of employer contacts
3. Lack of Canadian work experience
4. Lack of knowledge of local labour market information and employment
5. Other barriers related to licensing/registration and accreditation[G]

The authors of the Canadian report on internationally trained workers[95] suggest involvement from all stakeholders, governments, education and licensing bodies, employers, labour and volunteer organizations to build strategies that could facilitate integration of internationally educated workers into the local labour market.

Given the limited literature and documented experience of internationally educated nurses, a number of questions/issues need to be addressed. Some of the questions concern the need for more data regarding the reported issues, the number of internationally educated nurses in Canada, the number of those taking exams and the success rate, the number of nurses immigrating each year, the number of those who were refused entry, and the countries of origin. It would be helpful to know where the internationally educated nurses work, their stories, the perspectives of organizations employing them, and other available evidence. Employers and unions are encouraged to engage in this work.

External Context: Best Cultural Competence Practices for Academia, Governments and Regulators, and Professional Associations

Professions such as nursing are shaped and formed by professional knowledge as well as laws, regulations, rules of government and regulatory bodies.[G] Regulatory bodies set the Standards for Professional Nursing Practice, influence the curricula for schools of nursing and intervene when a nurse's practice does not meet the standards. Schools of Nursing are responsible for developing curricula that not only prepare nurses for entry into the profession but also open their minds to ways of thinking that help them realize and correct social injustices and inequities that can hinder individuals, groups and society. Professional Associations advocate for the profession as a whole and identify those broader system factors that need to be addressed for the advancement of the profession.

The push and pull of these often-competing agendas and the influence of governments, regulatory bodies, academia and professional associations on them all profoundly affect nurses. Crucial to this best practice guideline is how all stakeholders influence cultural competence in the workplace. Alignment in the stakeholder agendas is critical to the development of a system that holds all accountable and a work environment that embraces cultural diversity.

Given the numbers and comprehensiveness of nursing roles, multiple paradigms have been used to guide initiatives with varying levels of commitment and success. In order to advance diversity in a meaningful way, consistency and commitment across health care sectors and domains of nursing are essential. For example, experience from the U.S. shows that development of national standards for cultural competence (see CLAS, Appendix G) has provided a strong foundation for development in other areas – i.e. academia, accreditation.

The Healthy Work Environment model for this project along with the Cultural Competence model, clearly outline the inter-relationships between the external and the organizational levels. Recommendations in this section are focused on nursing students, curriculum, research and researchers, governments including accrediting bodies, regulators, and professional associations. Specific recommendations have not been developed for nursing faculty in this section as the individual level recommendations apply to the individual faculty members and the organizational/employer recommendations apply to Schools of Nursing.

Recommendations

RECOMMENDATION
1. **Nursing curriculum and nursing students – To support the development of a culturally competent workforce, leaders in academia:**
1. Set an initial and over-arching tone of inclusivity, and set expectations regarding understanding and embracing diversity.
2. Provide special consideration in the curriculum to teaching about: • respect, acceptance, empathy, inclusivity, collegiality, and valuing differences • Canadian society, the health care system, and nursing as a profession in Canada • Language nuances and social norms • Psychosocial skills • Human rights • Mentoring
3. Incorporate and evaluate theoretical cultural competence models as part of the nursing curriculum.
4. Develop and implement core competencies in humanities that include concepts and skills related to cultural competence and addressing racism and discrimination.
5. Incorporate diverse learning styles and strategies into the development and delivery of the curriculum.
6. Monitor and evaluate the impact of cultural competence education.
7. Identify and address the professional, theoretical and cultural biases in curriculum content.
8. Identify and monitor the cultural demographics[G] of students in all programs (undergraduate, graduate). Questions about issues such as ethnic background, place of origin, or sexual orientation must be asked with sensitivity, kept confidential, and not used against the subjects being questioned. Answering these kinds of questions is always optional, with no penalty attached to choosing not to answer.
9. Undertake purposeful outreach initiatives to encourage applications from First Nations' peoples students and students from other culturally diverse backgrounds.
10. Include cultural competence as part of student orientation, development and expectations of professional behaviour.
11. Identify and meet the specific learning needs of the growing population of culturally diverse students coming into nursing programs.
12. Monitor the academic success and attrition rates of students in relation to in relation to cultural, ethnoracial, linguistic, and demographic characteristics to determine the presence of correlations and identify areas for support.
13. Adopt formal policies and transparent processes that are consistent with the Canadian Charter of Rights and Freedoms to address discrimination, harassment, and intolerance occurring within the school or during academic activities.

RECOMMENDATION
2. Research and Researchers – To support the development of a culturally competent workforce, researchers:
1. Make every effort to include diverse populations as subjects of research.
2. Direct funding to explore diversity issues as topics of research in order to reduce disparities across populations (e.g. the impact of diversity variables on job satisfaction and retention).
3. Conduct research to: • Determine the contributions, strengths, and benefits of the inclusion of health professionals from diverse cultures • Identify key challenges and barriers regarding cultural diversity in the workplace • Evaluate the impact of strategies (e.g. cultural competence education) implemented to address diversity challenges in work and education settings
4. Conduct research to identify strategies to embrace diversity challenges in workplace and educational settings, with special attention to attracting, graduating and retaining nurses from diverse cultural backgrounds, including First Nations' peoples nurses.
3. Governments – To support the development of a culturally competent workforce, governments:
1. Develop, disseminate and operationalize accountability expectations of employers around mission statements, hiring policies, promotion opportunities, and career advancement that maximize the potential of all health system employees and seek out under-represented groups.
2. Require that employers, schools and regulators measure and describe the cultural demographics of the Canadian nursing workforce and Canadian nursing students.
3. Fund programs and research in which diversity, discrimination, vulnerable populations and disparities will be a focus, or are a foundational theme.
4. Include and monitor cultural diversity of workforces and populations being served in the criteria for budgets/funding applications submitted by hospitals, community agencies and other publicly-funded service providers.
5. Package and disseminate accessible data on the cultural demographics of communities to employers and educational institutions to assist them shape their strategic plans regarding diversity initiatives.
4. Accrediting Bodies – To support the development of a culturally competent workforce, accrediting bodies:
1. Embed diversity proactively and systematically throughout all mission statements, values, corporate strategic plans and outcome measures.
2. Develop, test and modify (as appropriate) clear cultural competence indicators in standards for accreditation.
3. Collaborate with employers or educational institutions they accredit to collectively monitor the diversity of the workforce or the student body and the extent that diverse cultural and linguistic communities, ethnoracial groups, and demographic characteristics are represented.
4. Work with employers or educational institutions they accredit to collectively establish mechanisms to address barriers to the recruitment and retention of under represented groups within the workforce and educational institutions.

RECOMMENDATION
5. **Regulators – To support the development of a culturally competent workforce, regulators:**
1. Embed cultural competence in the behavioural indicators of Professional Practice Standards and guidelines and Codes of Ethics and Conduct.
2. Treat professional misconduct infractions related to discrimination against peers in the workplace in the same manner as those involving clients.
3. Reflect requirements for cultural competence in entry examinations and continuing competence programs.
4. Collect data, identify trends and make recommendations to assist policy makers, employers, unions and educators to strengthen cultural competence.
5. Streamline the process for registration for all nurses, both Canadian and internationally educated, to maximize nurses' contribution to the profession. The registration process must be sensitive to the needs of a diverse applicant pool.
6. Continually assess licensing/registration examinations and related processes for nurses for cultural bias and revise when necessary.
6. **Professional Associations – To support the development of a culturally competent workforce, national and jurisdictional professional associations (such as the Canadian Nurses Association, Academy of Canadian Executive Nurses, Registered Nurses' Association of Ontario, Canadian Association of Schools of Nursing, and their member organizations):**
1. Serve as role models by including diverse representation within their workforce, memberships, leadership, board and committees, and staff.
2. Establish outreach programs, and purposefully encourage the participation of members and leaders from diverse groups.
3. Consistently embrace diversity in policies and procedures, values, mission statements, and codes of conduct.
4. Reflect the importance of diversity and cultural competence in guidelines and educational materials developed by the association.
5. Establish mechanisms and structures that foster transparency and encourage feedback from members.
6. Develop and communicate common lobbying messages for diversity in collaboration with other associations to achieve more effective political lobbying.
7. Educate members and the public regarding positions on diversity, inclusively and cultural competence.

Anticipated Outcomes

Educational institutions, Governments, Regulatory Bodies, and Professional Associations provide an external contextual framework that fosters and supports cultural competence among the individual members of the workforce, and in the workplace.

Evidence[a]

Curriculum

The evidence for the recommendations regarding curriculum comes from multiple sources.[50, 96] Literature from the High Court of Australia[48] recommends supporting workplace learning and development activities that assist staff to contribute to their maximum potential.

The JBI Systematic review[40] highlights two syntheses recommendations concerning education and training, and practitioner skill set, from numerous articles in the literature related to curriculum. These are:

- Health care professionals need to attain appropriate skills in order to practice competently with cultural diverse groups
- Embedding ongoing education and training related to cultural competence in organizational processes will increase the cultural competence of staff

There is no single correct way to include cultural competence in the nursing curriculum and there are ongoing discussions of potential frameworks and successful initiatives. The editorial "How do we effectively teach cultural competence in nursing education?" addresses the issues of: what should be taught and how, how to evaluate the process; and what should be the qualifications of the faculty? It is a journey and transformational process that is faced with issues such as barriers for ethnically diverse students, challenges faced by culturally diverse faculty in predominately white institutions, gender and disabilities issues among nursing students, as well as linguistic issues in caring for culturally and ethically diverse patients.[97]

However, progress is being made and many efforts are underway to develop frameworks and core competencies for cultural competence. Examples from the U.S. include the work done by the California Endowment, who after exhaustive review of the literature and consultations developed *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*.[98] The U.S. Department of Health and Human Services is also developing a cultural competency curriculum for nurses to enhance the quality of care for diverse patient populations as well as other related documents that discuss both content to be taught as well as suggested methods for teaching and implementing the proposed curriculum.[97]

Villeneuve[99] highlighted the need to develop and implement a Canadian-specific set of core competencies in the curriculum that address concepts and skills related to cultural competence. The U.S. frameworks can serve as a basis on which to further develop these Canadian competencies. While the panel acknowledges the paucity of research in the area, collective experience suggests that to establish cultural competence, students need to learn from role models who are culturally competent. To achieve that goal demands an honest examination of existing curricula, and revision where appropriate, to include cultural competence theories and practices in all nursing programs.

French[43] refers to the *Cross Cultural health care* staff development program in Seattle that is designed to prepare faculty to return to their organization and assist others in cultural competency. This program aims to create a culturally safe environment for patients, a respectful work environment for staff and lay the foundations for future learning of cultural care.

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a The source of the evidence for all recommendations is the JBI systematic review, background literature in the JBI narrative summary, literature suggested by the expert panel, and consensus opinion from the panel experts

Eisenbruch[49] identifies short-, mid- and long-term outcomes regarding building capacity in cultural competence and in clinical governance. Multicultural health programs are seen as long-term initiatives demanding continuity and unified purpose.

Students

In the U.S., the Institute of Medicine[63] reports that admission criteria should balance quantitative data such as prior grades and standardized test scores with qualitative data. Qualitative data may include a comprehensive review of each applicant, including an assessment of applicants' attributes such as race, ethnic background, experience and multilingual abilities.[63]

There is a need to collect data concerning the cultural composition of the student body to analyze whether, and to what extent, Canada's nursing students reflect the communities they will serve. Consequently, as these data become available the panel recommends ongoing initiatives to purposefully recruit students from diverse backgrounds to redress gaps.

There is a and effectively discuss health related issues with minority patient groups, the JBI systematic review[40] emphasizes that health professionals need to attain appropriate skills, including appropriate communication skills and a greater understanding and knowledge of the attitudes, values/beliefs and culture of minority groups.

The Diversity Resource Paper of the Honor Society of Nursing, Sigma Theta Tau International[100] presents numerous successful initiatives that promote success for culturally diverse students. Seven key areas are:

- presenting an inclusive image
- reaching out to diverse student populations
- making connections at the middle/high school level
- supporting students through the application process
- mentoring as the key to retention
- facilitating student success
- launching a coordinated out reach program

Diversity needs to be acknowledged within the student population and incorporated in the curriculum. Although nurse educators value diversity within the classroom, there is little evidence with respect to how the diversity is experienced by students. In a study of Canadian nursing students, Paterson, Osborne and Gregory[101] describe the student experience as being "bounded by unwritten and largely invisible expectations of homogeneity" (p.1) The authors note that the "stated intention of the teachers and curriculum to foster an appreciation of cultural diversity is often compromised and often contradicted" and nursing students quickly learn that being different can be problematic and lead to marginalization.[G] Similar findings have been reported by Hagey[102] from the first phase of a research initiative to integrate antiracism into the undergraduate curriculum. She found denial of racism in the nursing profession reflected in a curriculum that does not support theory about racist phenomena or the open discussion of issues. In a study of Canadian medical students, Beagan[103] notes that despite exposure to a course addressing social and cultural issues in medicine, most students "failed to recognize, or even denied, the effects of race, class, gender, culture, and sexual orientation." Even when the students did acknowledge the effect of social

differences, they recognized disadvantages experienced by others but not their own social issues related to culture, power, and privilege.

Clearly, purposeful strategies are needed to acknowledge and embrace diversity within nursing schools to ensure all students experience a positive learning environment and are socialized into a profession that values diversity and cultural competence. Many of the images, symbols and language of nursing are strongly female and white. Combining with faculty that also are overwhelmingly female and white, the textbooks, journals, pictures in hallways and so on can all combine to feel unwelcoming to anyone who is not part of that demographic. To give a concrete example nurses, even with men present, often are referred to as "she" and "her" which is highly uncomfortable for many men, and is a culture shock for the younger newer recruits into schools of nursing. Another frequently cited example is the practice of assigning students of minority ethnic groups to patients who appear to share the ethnicity with the assumption that the student will better understand and care for this patient. Student needs and views in such situations are rarely explored and the opportunities to develop cultural understanding in the group as a whole are frequently lost. International students and students from non-Western ethnic backgrounds also report feeling misunderstood and labeled as being 'stupid' 'slow' or 'lacking initiative' because of differences in values and language proficiency.[101]

Interventions designed to enhance the integration of minority nursing students into a supportive learning environment include assistance in using the available resources to help students feel connected and supported by peers and faculty.[104] Diversity within the student body has been noted to enhance the educational experiences of medical students in two U.S. medical schools.[105] Creation of safe spaces to foster dialogue on difference is a critical factor in the experience and development of cultural competence. Foldy[71] argues that heterogeneous groups function better when they believe that cultural identities can be tapped as sources of new ideas and experiences about work.

Research: Organizational Diversity

Dreachslin's[33] review of the literature notes that research about the impact of diversity management practices on public policy, clinical practice and organizational behaviour at the individual, group and organization levels in health care organizations is limited. Based on the dearth of research Dreaschslin[33] offers an agenda for future study identifying the need for five general research areas:

1. Document the current state of diversity leadership practices.
2. Examine the relationship between diversity practices and employee satisfaction and productivity.
3. Study association of diversity management practices with patient outcomes and patient satisfaction.
4. Study characteristics of leaders and their impact on the patient, organization and community.
5. Study characteristics of diversity training models and their short and long-term outcomes.

Research in these areas will provide a greater understanding of the dynamics of cultural diversity associated with public policy, clinical practice and organizational behaviour.

> *"Nurses need to develop a sophisticated understanding of issues and concerns relevant to race and health care, including the history of race, current literature on race and health care as well as stereotypes[G] and biases regarding race."*
>
> *Tashiro[106]*

At the individual level, there is a generalized belief in the U.S. that career outcomes are generally poorer for people of colour and perceptions of the workplace are more negative for managers of colour.[33] In Canada, research on diversity in the workplace and career experience is needed to determine if the findings are similar. Anecdotal evidence and expert opinion suggest that the overall picture is comparable. Under-employment in the new immigrant population has been well documented.[107] However, the extent to which cultural characteristics impact on career progression and experiences is not known.

There is a need for research that addresses key challenges and barriers that arise related to cultural diversity in the workplace which could be modeled on effective cultural diversity research in business. One such example is a business case study[54] that notes the following key factors for success of diversity task forces:

- Strong support from company leaders
- An employee base that is fully engaged with the initiative
- Management practices that are integrated and aligned with the effort
- A strong and well articulated business case for action

It is clear that more research is needed to identify and demonstrate the need and strategies for embracing diversity and developing cultural competence within the health care environment and as important, document their effects.

> *Additional data collection and research are needed to more thoroughly characterize under-represented minority groups' participation in health professions and in health professions education and to further access the benefits of diversity among health professionals, particularly with regard to the potential economic benefits of diversity.*
>
> *Institute of Medicine*[63]

Research: Health Disparities

A body of literature has documented racial and ethnic disparities in both health care service and health outcomes.[63, 64, 99] Racial and ethnic health disparities are strongly associated with social factors that impact the understanding of health care needs. There is a need to understand race and its impact on assumptions and biases in health care.[106] To that end, research initiatives are necessary to investigate and examine the health care needs of diverse groups.[40] Beiser[108] outlines why researchers should care about culture and calls for further research on health disparities.

> *Canada must support and expand its efforts to create a knowledge base that informs relevant policies and practices. Research is required to document inequities, to elucidate the mechanisms that produce health inequities, to design and test interventions that reduce inequities and to evaluate programs already in effect.*
>
> *Beagan* [103]

Although there is a paucity of literature related to the needs of culturally diverse groups and the link with clinical outcomes, this evidence is growing. According to early findings of a study funded by the Canadian Institute of Health Research on the impact of racism on the health of indigenous black Canadians, immigrant African and Caribbean Canadians, there is a significant correlation between racism-related stress and emotional ill health. The notion of 'everyday racism'[G] has been posited by Essed to highlight how racism is reproduced largely through routine and taken-for-granted practices and procedures in everyday life, thereby impacting negatively on health and well being as well as work environments.[109]

Logical inferences may be drawn from the literature on health disparities as they apply to cultural competence in the workplace. Health disparities related to social-economic disadvantage can, to some extent, be alleviated in part by creating and maintaining culturally competent health systems. The link between discrimination in the workplace and health disparities needs further study and research to determine the impact on employees and the workplace.[33]

Governments, Accreditors, Regulatory Bodies and Professional Associations

Recommendations for governments, accrediting bodies, regulators and professional organizations are based on the reality that policy making, standard setting and politically active bodies have an integral role to play in supporting the development of a culturally competent healthy work environment.

Cultural competence[G] through all aspects of health care is key to reducing disparities of access and enhancing quality of care.[50] According to Betancourt, in order to achieve systemic cultural competence in the health care system it is imperative to develop initiatives, processes and practices such as the following:

- conducting community assessments to determine cultural makeup;
- developing opportunities and mechanisms for broad community and patient input;
- accommodating patient's racial/ethnic and language preferences in all data collection systems;
- acknowledging diverse populations in development of quality indicators and measures; and
- ensuring cultural appropriateness in all aspects of health care, including health education, health promotion and disease interventions.

Information from other jurisdictions can serve as a solid foundation that can be refined to address questions with in the Canadian context.[48,49,63,67,68,96]

In Ontario, research is being carried out by the College of Nurses of Ontario[110] to identify what, if any, interventions are needed to support internationally educated nurses as they transition into the Ontario workplace. It is anticipated that this descriptive study will provide evidence about needs and interventions that could influence policies and programs at organizational and system levels.

> *"Local and national efforts must be undertaken to increase broad stakeholders' understanding of and consensus regarding steps that should be taken to enhance diversity among health professionals."*
>
> *The Johns Hopkins University Evidence-based Practice Center*[111]

Professional associations, accrediting bodies and regulatory bodies are in a pivotal position to both offer support as well as hold organizations accountable for change on particular issues. For example, when issues such as ethics, patient safety and satisfaction and quality improvement are identified for attention by such agencies, organizational commitment and support often follows. Such coordinated efforts also lead to development of indicators, national standards and benchmarks for internal and external comparison as well as guidelines and support. The end result is development of knowledge, practice and ultimately patient outcomes.

Professional associations and regulatory bodies can have a tremendous influence on individual nurses as well as the profession as a whole through standards, best practice guidelines, continuing education workshops and other formal and informal dialogue. These bodies create the expectations and the culture of the profession and contribute to the health and well-being of society and the profession. By embracing diversity as a core value, professional and regulatory bodies are in a pivotal position to promote the development of cultural competence in all aspects of the nursing profession Through outreach, role modeling and lobbying, these bodies can leverage their power, position and influence to foster healthy work environments for all.

Conclusion

Embracing cultural diversity and developing cultural competence are key components of healthy work environments and influence all aspects of the environment including leadership, teamwork, and professional practice. The decision to have a guideline on cultural competence reflects recognition of the significant need for focused attention on this topic. The result is this set of evidence-based practices that can be used by nurses, organizations and those in the broader health system to strengthen cultural competence as they strive to build healthy work environments.

Given the nature of the topic, the challenges in uncovering hard evidence were significant. Little about the topic lends itself to randomized controlled trials or experiments, and much of the expertise in the field lies in individual experiences, observations of human behaviour, and trial-and-error. That said, there are common practices, success stories and practical wisdom known to improve cultural competence and reduce conflict, and these findings are reflected in this guideline.

The resulting recommendations on both the published research on the topic and the combined wisdom of various expert panels as well as the panel of experts assembled to give life to this fundamental component of a healthy workplace. This expert panel believes the guideline reflects “promising” practices more than definitive “best” practices, consistent with the policy thinking of Davies.[37]

The nature of the work is iterative, therefore this guideline should be viewed as a much-needed first step. Much as the country and nursing will evolve, so too must guidelines such as these, as they are rooted in human relationships and their associated challenges. The original intention was to help nurses, employers and those in the broader system understand the urgency of the need to act, and to suggest directions based on evidence. In this regard, we are confident we are on the right course in giving words and structures to “embracing cultural diversity” for *all* the nurses, and future nurses, of Canada, in all roles, wherever they work.

Process for Reviewing and Updating the Healthy Work Environments Best Practice Guidelines

The Registered Nurses' Association of Ontario proposes to update the Healthy Work Environments Best Practice Guidelines as follows:

1. Each healthy work environment best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area to be completed every five years following the last set of revisions.
2. During the period between development and revision, RNAO Healthy Work Environment project staff will regularly monitor for new systematic reviews and studies in the field.
3. Based on the results of the monitor, project staff may recommend an earlier revision period. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the five-year milestone.
4. Six months prior to the five-year review milestone, the project staff will commence the planning of the review process by:
   a) Inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b) Compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c) Compiling relevant literature.
   d) Developing detailed work plan with target dates and deliverables.
5. The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Glossary of Terms

Accreditation: The act of accrediting or the state of being accredited, including the granting of approval to an institution of learning by an official review board after the school has met specific requirements

Affirmative Action: Specific actions in recruitment, hiring, upgrading and other areas designed and taken for the purpose of eliminating the present effects of past discrimination, or to prevent discrimination.

Cultural Competence: Cultural competence is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations.[112,113]

Cultural Demographics: Those characteristics that define a particular group of people such as cultural and ethnoracial background, language, age, gender, sexual orientation, disability, religion, education and socio-economic statistics.

Cultural Diversity: This term is used to describe variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class, or life experiences.

Cultural Proficiency: Involves holding cultural differences and diversity in the highest esteem, pro-activity regarding cultural differences, and promotion of improved cultural relations among diverse groups.

Cultural Resources: Sources of cultural knowledge. Cultural resources may be take the form of expressed information (printed, electronic, art, or other forms of media); policies or guidelines that provide direction; or individuals and groups that assist with information and understanding about cultures.

Cultural Safety: Includes cultural awareness, cultural sensitivity and cultural competence and involves the recognition of unequal power relations to address inequities in health care.

Culturally Competent Care: The ability to provide care with a client-centered orientation, recognizing the significant impact of cultural values and beliefs as well as power and hierarchy often inherent in clinical interactions, particularly between clients from marginalized groups and health care organizations.

Culturally Diverse Populations: (also see Cultural Diversity): Marked difference or inequality between two or more population groups defined on the basis of race or ethnicity, gender, educational level or other criteria.[114]

Culture Sensitivity: Refers to awareness, understanding, and attitude towards culture and places the focus on the self-awareness and insight.

Discrimination: An act of differential treatment toward a group, or an individual as a member of a group. Discrimination is based on negative attitudes, values, or beliefs that lead to action or behaviour that limits the opportunities of others. Systemic discrimination results from seemingly neutral policies, practices, and procedures that have different, frequently unintended, effects on different groups.

Everyday Racism: Daily experiences which are characterized by routine encounters with another's and discriminatory behaviour that pervade people's daily social interactions. Everyday racism can include mundane hassles as well as overt, severe racist experiences.

First Nations' people: The descendant of the original inhabitants of North America. The Canadian Constitution recognizes three groups of Aboriginal people – Indians, Métis people and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs.[115]

Healthy Work Environment Best Practice Guidelines: Systematically developed statements based on best available evidence to assist in making decisions.

Healthy Work Environment: A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organization performance.

Inclusivity: Refers to an organizational system where decision – making includes perspectives from diverse points of view. It includes the rights of individuals and groups for equal opportunity and participation.

Marginalization: To relegate or confine to a lower or outer limit or edge, as in social standing. The social process of marginalization refers to a lack of equitable access to social, political and economic benefits, including health on the basis of one's membership in an identifiable group.

Minority Groups: Existing in proportionally smaller numbers. Within social contexts it is a misleading term to describe non-dominant ethnic identities.[51]

Multicultural Society: Multiculturalism – An official policy of the Canadian government recognizing the diversity of Canadians in ethnicity, national or ethnic origin, colour, and religion, as a fundamental characteristic of Canadian society.

Nurses: Refers to Registered Nurses, Licensed Practical Nurses (referred to as Registered Practical Nurses in Ontario), Registered Psychiatric Nurses, nurses in advanced practice roles such as Nurse Practitioners and Clinical Nurse Specialists.

Patient/Client/Resident: Refers to individuals, (family member, guardian, substitute caregiver) families, groups, populations or entire communities. In education, the client may be a student; in administration, the client may be staff; and in research, the client is a study participant.

Prejudice: A set of attitudes held by one person or group about another person or group, which casts the other in an inferior light despite the absence of legitimate or sufficient evidence.

Productive Diversity: Effective utilization of the diversity of the workforce to accomplish organizational goals.

Racism: An attitude as well as specific actions through which one group exercise power over others on the basis of skin colour and racial heritage. The effect is to marginalize and oppress some people and to sustain advantages for people of certain social groups.

Regulatory Body: A regulatory body, in the context of professions, is an external organization that has been empowered by legislation to oversee and control professional practice and outputs germane to it. Its primary activity is to protect the public.

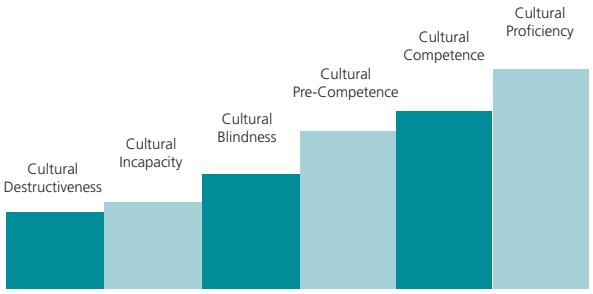
Stereotype: A generalized conception of a group of people, which results in the unconscious or conscious categorization of each member of that group, without regard for individual differences.[116]

Systemic Bias (Systemic Racism, Systemic Discrimination): Policies, practices and procedures that are considered normal that can discriminate against individuals or groups.

Appendix B: Summary of Key Models Related to Cultural Competence

Cultural Competence Continuum[i, ii]

Cultural competence at the organizational and individual level is an ongoing developmental process. The following chart is designed to highlight selected characteristics that organizations may demonstrate along two stages of the cultural competence continuum.



Moving Towards Cultural Competence

- Cultural destructiveness acknowledges only one way of being and purposefully denies or outlaws any other cultural approaches.
- Cultural incapacity supports the concept of separate but equal; marked by an inability to deal personally with multiple approaches but a willingness to accept their existence elsewhere.
- Cultural blindness fosters an assumption that people are all basically alike, so what works with members of one culture should work within all other cultures.
- Cultural pre-competence encourages learning and understanding of new ideas and solutions to improve performance or services.
- Cultural competence involves actively seeking advice and consultation and a commitment to incorporating new knowledge and experiences into a wider range of practice.
- Cultural proficiency involves holding cultural differences and diversity in the highest esteem, pro-activity regarding cultural differences, and promotion of improved cultural relations among diverse groups.

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i **Definitions source:** Adapted by T. Goode (2004) from: Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume 1*. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Available at: http://gucchd.georgetown.edu/nccc/sidsdvd/continuum.pdf (accessed 11/05). Available at: http://www.nccccurricula.info/documents/TheContinuumRevised.doc Accessed 7/28/06).

ii **Graph** Source: Goode, T.D. and Harrison S. (2004). *Cultural Competence Continuum.* Policy Brief 3, 5. Washington, DC:National Center for Cultural Competence-Bureau of Primary Health Care Component, Georgetown University Child Development Center.http://www.nccccurricula.info/assessment/B3.html (accessed 11/05)

These characteristics have been adapted and expanded from original work of Cross, et al., in several ways: (1) to ensure their relevance for health care organizations; (2) to incorporate salient items from the NCCCOs Policy Brief 1 checklist (Cohen & Goode, 1999), http://www.med.umich.edu/multicultural/ccp/tools.htm and (3) to emphasize the role of health care organizations in research.

Theoretical frameworks for cultural competence training

Crandall, George, Marian and Davis[117] describe theoretical frameworks for the design of cultural competency training. They stress that educators must initially determine the level of competence desired appropriate to the developmental stages of the learners. The frameworks can be used to design course content and educational experiences and to help determine changes in students' knowledge, skills and attitudes.

The Crondell, et al.[117] models communication theories were used to inform the design, implementation and evaluation of diversity training. Howell's[115] communication theory describes levels of communication competence. Howell describes five levels as:

Level 1 unconscious competence
Level 2 conscious incompetence
Level 3 conscious competence
Level 4 unconscious competence
Level 5 unconscious supercompetence

Although the case study is focused on medical students, it can be adapted for use in nursing. Culhane-Pera[117] adapted Bennett's[117] developmental model and Howell's[115] level of competence to develop curriculum to assess cultural competence in medical students.

Developmental phases of models of cultural competency*

Level of Competence (Howell)[117]	Behaviours Relate to Level of Cultural Competence (Culhane-Pera et al)[117]
Unconscious incompetence (Level 1)	**Level 1:** No insight about the influence of culture on medical care
Conscious incompetence (Level 2)	**Level 2:** Minimal emphasis on culture in medical setting
Conscious competence (Level 3)	**Level 3:** Acceptance of the roles of cultural beliefs , values and behaviours on health disease and treatments
Unconscious competence (Level 4)	**Level 4:** Incorporation of cultural awareness into daily medical practice
Unconscious supercompetence (Level 5)	**Level 5:** Integration of attention to culture into all areas of professional life

*Adapted from developmental phases of models of cultural competency:

[iii] Crandall, SJ., George, G., Marian, GS., & Davis, S. (2003). Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study. *Academic Medicine,* 78(6).

Models that reflect and/or describe cultural competence on a continuum

- Frusti.[65] The Diversity Competency model is used to conduct an assessment of an organization's diversity initiatives in nursing. Drivers, linkages, cultures and measurement are four main elements of the model.
- Campinha-Bacote.[99] Process model of cultural competence has constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.
- Dreachslin.[82] A five-part change process model for diversity management with performance indicators for each stage. The stages range from 'discovery: emerging awareness of racial and ethnic diversity as a significant strategic issue' to 'revitalization'. The performance indicators are based on best practices in health services organizations and in the business sector.[33]
- Lowenstein and Glanville.[80] A model for assessing and intervening in conflict in health care settings.

Other models of cultural competence are summarized in the literature. These models have largely been assessed for implications with respect for practice, education, and research. The models are helpful in understanding the conceptualization of cultural competence and cultural care. (See CLAS standard, Appendix G)[50, 53, 81]

Appendix C: Guideline Development Process

The Registered Nurses' Association of Ontario convened an expert panel of nurses chosen for their expertise in practice, research and academic sectors representing a wide range of nursing specialties, roles and practice settings.

The panel undertook the following steps in developing the Best Practice Guideline: The scope of the guideline was identified and defined through a process of discussion and consensus in a Scope and Purpose statement.

Focused research questions were developed to guide the literature review process:

- Search terms relevant to cultural competence were sent to the Joanna Briggs Institute[40] (JBI) to conduct a broad review of the literature
- The panel developed a framework to organize the concepts and content of the guideline
- The panel reviewed the JBI interim report
- Supplemental literature was sourced by the panel
- The findings from the systematic review of literature from JBI were reviewed
- Through a process of discussion and consensus preliminary recommendations were developed based on the evidence in the literature
- Drafts of the BPG were reviewed and revised by the expert panel
- The BPG was sent out for stakeholder review February 2006
- A sub-group of the expert panel reviewed and discussed all stakeholder feedback
- Recommendations with supporting evidence were finalized
- The expert panel reviewed and signed off the final document

Appendix D: Process for Systematic Review of the Literature Completed by the Joanna Briggs Institute

1. **Broad review of the literature using keywords associated with the broad topic of Cultural Competence entered into:**

   - CINAHL
   - Embase
   - Medline
   - PsychInfo

2. **Development of a protocol to direct a review to identify:**

   - The organizational structures and processes that support development of effective culturally competent practices
   - The impact of culturally competent practices on the quality of outcomes for clients, nurses, organizations and systems

3. **The search terms identified included:**

   - Affirmative action and intercultural communication and workforce diversity
   - Affirmative action
   - Attitude of health personnel
   - Cultural brokering
   - Cultural diversity
   - Cultural justice
   - Delivery of heath care
   - Democratic racism
   - Everyday racism
   - Health service
   - Intercultural communication
   - Minority groups
   - Organizational cultural competence
   - Prejudice
   - Productive diversity
   - Social cohesion and diversity
   - Subtle discrimination
   - White privilege
   - Workforce diversity
   - Workplace diversity

4. **Search terms identified included:**
   The search strategy aimed to find both published and unpublished studies and papers written in the English language. A three-step search strategy approach was utilized. An initial limited search of MEDLINE and CINAHL databases was undertaken to identify optimal search terms followed by an analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second extensive search using all identified keywords and index terms was then undertaken. The third step is a search of the reference list for additional studies of all identified reports and articles. The databases searched include:

   - ABI/Inform
   - CINAHL (1982-2003)
   - Cochrane Library (Current Contents to September 2003)
   - Database of Abstracts of Reviews of Effectiveness (DARE)
   - Econ lit
   - Embase (1980-2003)
   - ERIC
   - Google
   - OVID Medline (In-Process and Other Non-Indexed Citations and Ovid Medline 1966-2003)
   - PsycINFO (1966-2003)
   - PubMed
   - Sociological Abstracts
   - The search for unpublished studies included:
   - Dissertation Abstracts International

5. Studies identified during the database search were assessed for relevance to the review based on the information in the title and abstract. All papers that appeared to meet the inclusion criteria were retrieved and again assessed for relevance to the review objective.

6. Identified studies that met inclusion criteria were grouped into type of study (e.g., experimental, descriptive, etc.).

7. Papers were assessed by two independent reviewers for methodological quality prior to inclusion in the review using an appropriate critical appraisal instrument from the SUMARI package (System for the Unified Management, Assessment and Review of Information) which is software specifically designed to manage, appraise, analyze and synthesize data.

   Disagreements between the reviewers were resolved through discussion and if necessary with the involvement of a third reviewer.

Results of Review

A total of 653 studies resulted from the search strategy undertaken. From this amount a total of 64 papers were deemed relevant to the review criteria and selected for retrieval and further assessment.

The review resulted in the following recommendations for practice:

- health provider agencies establish and maintain collaborative processes with other organizations to address the needs of culturally diverse patients and their communities;
- health provider agencies include cultural competence in decision support systems such as practice and policy manuals;
- cultural competence should be a component of education and training programs in all specialties and areas;
- health care information developed for patients should be designed to meet the needs of those culturally diverse groups with the health agencies population;
- staff development plans should accommodate the skills needed to deliver culturally competence care to the specific population served;
- decision support systems should include cultural competence components for all policies and practices; and
- staff recruitment plans should accommodate the skills needed to deliver culturally competent care to the specific population served. The review provided the following recommendations related to future research initiatives.

It is therefore recommended that research investigating the impact of culturally competent practices to patient, nurses and organizational outcomes be conducted and published.

Appendix E: Tools

The following list of selected references and websites are presented in alphabetical order. All websites were accessed in December 2006 and January 2007.

Betancourt, J.R., Green, A.R., Carrillo, J.E. et al. (2005). Cultural Competence and Health Care Disparities: Key Perspectives and Trends. *Health Affairs.* 24(3): 499-505.

Boyle D., Dwinnell, B. & Platt, F. (2005) Invite Listen and Summarize: a patient-centered communication technique. *Academic Medicine* 1:80(1): 29-32.

Campinha-Bacota. J. (1999) A model and instrument for addressing cultural competence in health case. *Journal of Nursing Education*, 38: 203-207.

Campinha-Bacote, J.(2002). The Process of Cultural Competence in the Delivery of Health Care Services: a Model of Care. *Journal of Transcultural Nursing*, 13(3): 181-184.

Centre for Addiction and Mental Health (CAMH). (2004). *A Review of Cultural Competence: Definitions, Key Components, Standards and Selected Trainings*. Toronto, ON: Author.

The Change Management Tool Book. Three principal sections: Self, Team and Larger System.
http://www.change-management-toolbook.com/index.html

College of Nurses of Ontario. (2004). *Practice Guideline Culturally Sensitive Care.* Toronto, ON: Author.

A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia. (2005).
http://www.gov.ns.ca/.../primaryhealthcare/pubs/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf
Numerous references for self-awareness, links to websites, assessment tools, etc.

Davis, C. (2003). How to help International Nurses Adjust. *Nursing 2003 Career Directory* http://www.nursingcenter.com
Institure for Diversity in Health Management. (2004) Strategies for Leadership: *Does Your Hospital Reflect the Community it Serves?* http://www.diversityconnection.org/diversityconnection/cultural-competency-and-leadership/Insitute-files/GPNMN.pdf

Goode T. (2000). *Self-Assessment Checklist for Personnel Providing Primary Healthcare services*. National Center for Cultural Competence. http://www.vdh.virginia.gov/ohpp/clasact/documents/clasact/research/SelfAssessmentChecklist.pdf

Lynch E. & Hanson, M. (1998). *The Cultural Competence Continuum.*
http://www.cde.state.co.us/earlychildhoodconnections/SCCT/Cultural_Competence_Continum.pdf

A Manager's Guide to Cultural Competence Education for Health Care Professionals.
www.calendow.org/reference/publications/pdf/cultural/TCE0217-2003_A_Managers_Gui.pdf

www.ons.org/clinical/Treatment/Toolkit.shtml – Oncology Nurses Association Multicultural toolkit

University of Toronto, Anti-racism and cultural diversity office http://www.library.utoronto.ca/equity/race.html
Provides training and education, a mechanism for dialogue and information about an inclusive environment
Zoucha, R. (2000). The keys to culturally sensitive care. *American Journal of Nursing*. 100(2): 24GG-HH, 24KK.

Other selected websites of interest. All websites accessed in December 2006 and January 2007.

http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm
Cultural competency assessment tool from Vancouver, B.C.

http://ctb.ku.edu/tools/en/section_1168.htm
Understanding culture and diversity in building communities.

http://www.aucd.org/councils/multicultural/Cultural_Competence_Survey.htm
Assessment of organizational cultural competence.

http://www.hrsa.gov/culturalcompetence/indicators/
US Department of Health and Human Services – assessing cultural competence.

http://www.diversityrx.org/HTML/ESSEN.htm
U.S. diversity essentials.

http://www.medqic.org/dcs/ContentServer?cid=1122904863620&pagename=Medqic%2FMQTools%2FtoolTemplate&c=MQTools
CLAS Standards Assessment Tool.

http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf
(See Appendix G)

http://www.healthycommunities.on.ca/publications/ICO/index.html
Ontario Healthy Communities Coalition, Inclusive Community Organizations: A toolkit.

http://www.diversityrx.org/
How language and culture affect the delivery of quality services to ethnically diverse people.

http://www.tcns.org/
Transcultural nursing.

http://www.transculturalcare.net/
Transcultural nursing, cultural competence clinical research administrative and education.

http://cecp.air.org/cultural/default.htm
Cultural competence in education.

http://www.culturalcompetence2.com/
Cultural competence online resources.

http://www.amsa.org/programs/gpit/cultural.cfm
Cultural competency in medicine.

http://www.culturalcompetence.org
Cultural Competence Training: New Skills for a Diverse World. Multicultural Association of Nova Scotia.

http://ublib.buffalo.edu/libraries/units/hsl/resources/guides/culturalcompetence.html
Cultural competence resources.

http://www.hrsa.gov/culturalcompetence/
U.S. Department of Health and Human Resources. Cultural Competence Resources for Health Care Providers.

Appendix F: Implementation – Tips and Strategies

During the development of this guideline the expert panel repeatedly noted that the success of the recommendations will be dependent not just by what is done but how they are implemented. Key issues that emerged during the panel deliberations as well as during the stakeholder review process are highlighted below.

Key Issues and Needs

Safe Environment: The topic often generates strong feelings and emotions, therefore there is a compelling need to create safe environments in which to reflect, talk, and explore these feelings.

Skilled Facilitation: Skilled facilitation is needed to manage the emotions, the divergent perspectives and potential conflicts that may arise. Facilitators need an understanding of the complexities and paradoxes related to diversity in order to go beyond the surface level expressions of understanding or distress.

Link to the Broader Organizational Agenda: The goal of embracing diversity should be viewed as something that will help individuals and organizations achieve their mission and objectives in a multicultural society – not an additional initiative to meet someone else's needs or agendas. Therefore, it is important to pay attention to the organizational culture that currently exists as the starting point. Making explicit the current values, assumptions, biases, fears, and desires is not only a critical first step, but also an essential step to sustain the work.

Flexibility will be Key: Organizations will have varying needs and priorities which are likely to evolve as the organization changes. Milestones will be important, but the underlying values of respect, inclusivity, valuing differences, equity and commitment require that the specific approaches be continually reviewed to ensure that all staff feel included and respected.

Success Stories: It is easy to get overwhelmed with all that needs to be done in order to truly embrace diversity at an organizational level in order to create a healthy work environment. The complexity that comes with diversity adds to this challenge. Therefore, it is important to focus on small steps that are successful versus one big change. Examples of small successes achieved are not only inspirational, but informative with respect to how to address the complexity in any given situation.

Not a One Person Job: Many organizations have chosen to address diversity by assigning the task to a particular individual or portfolio. While this may clarify accountability, it creates a challenge and responsibility for a single individual. One person, no matter how well informed, will be limited by her or his own perspective. The strength of diversity is in the richness that comes from multiple perspectives. It is therefore recommended that implementation be undertaken by a group or committee that can model the value of diversity and effectively identify and address the multiple realities that may exist throughout an organization, and hold each other accountable in a respectful manner.

Appendix G: CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services in Health Care[68]

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

For more information, visit: http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

Adapted from: Office of Minority Health, US Department of Health and Human Services.[68]

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L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

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