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Cultural Communication For New Nurse Residents: K.I.N.D Communication Toolkit

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Abstract

Background*:* Micro aggressions can create a hostile work environment and decrease rapport and functioning in clinical and personal relationships. Exposure to micro aggression and implicit bias results in micro trauma and possible compassion fatigue by medical staff. Symptoms can include headaches poor sleep, depressions, and anxiety, similar to compassion fatigue.

Purpose*:* To develop a toolkit for healthcare staff to use as educational material to facilitate for cultural communication and cultural humility.

Methods*:* Nurses that were enrolled in a nurse residency program at a level 1 trauma center participated in the education of a communication toolkit related to K.I.N.D communication project. K.I.N.D stands for knowledgeable, inclusive, non-bias and delivery. It was developed in part of a capstone project that focuses on implicit bias awareness in communication to decrease microaggressions and increase health outcomes for disadvantaged populations. Education was provided using PowerPoint, interactive activities, videos and open-ended dialogue discussions.

Results: The Cultural Assessment Screening tool was administered both pre and post to 35 new nurse residents with resulting changes in cultural competence scores not statistically significantly. However, qualitative data yielded positive responses, reporting personal experiences with implicit bias and a desire to utilize resources in the tool kit as well as an appreciation for the in-service.

Conclusion: Utilization of toolkit increases awareness of cultural micro aggression, implicit bias by healthcare staff and decrease micro traumas in the clinical setting an. While survey tool may not have been sensitive enough for the specific intervention, qualitative data was able to yield positive results and feedback regarding the toolkit.

Keywords: *micro aggression, micro trauma, compassion fatigue, cultural humility, cultural competency*

Cultural Communication for New Nurse Residents

"Discrimination in healthcare has been linked to lower patient satisfaction and is significant since higher satisfaction is associated with improvements in symptoms, treatment plan adherence and better overall care" (Tajeu, Halanych, Juarez, Stone, Stepanikova, Green and Cherrington, 2018, p 464). There are people from many cultural backgrounds in medical settings, including both hospital staff and patients. This diversity may lead to conflicts which result in loss of rapport, trust and staff burnout. At times, in the medical setting, we can often make assumptions based on our own beliefs and misinterpret events, communication and body language. This can stem from implicit biases. Staying in the comfort zone of our long-held beliefs may be easier than accepting that we may have implicit bias. The result of implicit bias may lead to forms of aggressions that can have lifelong and devastatingly negative outcomes. Healthcare staff attempt to address the need for culturally responsive care by providing cultural competence trainings. However, these trainings do not tend to personalize the needs or beliefs of the user of competency trainings

The Substance Abuse and Mental Health Services Administration, SAMSHA, states that as providers, becoming aware of personal beliefs, attitudes and assumptions is necessary when providing culturally responsive treatment and care (SAMSHA, 2019). As healthcare providers, part of culturally responsive treatment should include the recognition of microaggressions and implicit biases in communication and assessments as providers. Examples of microaggressions include both intentional and nonintentional verbal. or non-verbal slights.

Microaggression targeted at ethnic and racial minorities is defined anything that includes various forms of insults or slights such as verbal, behavioral and even environmental insensitivities (Hollingsworth, Cole, O'Keefe, Tucker, Story & Wingate, 2017). These microaggressive acts towards members of various cultural backgrounds can cause a decrease in health outcomes for

disadvantaged populations as well as symptoms of micro traumas that can impact emotional health. Microtraumas are defined as arising from events such as “chronic exposure to minor insults, such as a chronic history of emotional neglect, whose damaging effects accumulate over time” (Sesides, 2010).

Implicit bias not only impacts patients in the medical setting, but bedside caregivers as well. In coming to understand this relationship between poor health outcomes and experiences of implicit, if these biases and microaggressive acts of discrimination can be prevented, this could lead to better patient outcomes and decreased experiences of microtraumas. Providing education and resources on implicit bias and communication to staff in the medical setting can be useful in improving health outcomes in disadvantaged populations, as well as increase health outcomes, decrease, microaggressions and implicit biases. Understanding culturally responsive care in order to counteract biases and assumptions by providers is an important part of culturally responsive treatment by healthcare (SAMSHA, 2019).

Some examples of microaggressions include both intentional and nonintentional verbal, non-verbal slights or snubs, hostile communication and hostile body language, insults and insensitivities. “Racial micro aggressions are verbal, behavioral, and environmental racial slights or insults directed to a person who is an ethnic minority group member” (Hollingsworth, Cole, O’Keefe, Tucker, Story & Wingate, 2017). These micro aggressive acts towards members of various cultural backgrounds can cause micro traumas that can impact emotional health. In addition, these racial micro aggressions have been found to be experienced more by the African American population compared to other ethnic minority populations. This link between microaggressions and minority groups has demonstrated a connection with mental health

conditions, especially in the African American population. Of particular concern, it was found to be indirectly linked to increased risk of suicidal ideation (Hollingsworth et al2017).

Assessing and quantifying implicit bias and perceived racism may be difficult. There are various scales of measurement for racial micro aggressions, including the Everyday Discrimination Scale and the Racial and Ethnic Micro aggression scale. The Everyday discrimination Scale is a tool used to measure "perceived discrimination. It was developed to capture aspects of interpersonal discrimination that are chronic and episodic, but generally minor" (Kim, Seldom, and Ford, 2014). Quantified items included in the scale include insults poor respect threats, name calling and perceived harassment. In addition, it has been found to be a "good utility and have advantages. Due to this, it has been applied to diverse racial and ethnic groups in the U.S., including African Americans" (Kim, Sellbom, and Ford, 2014). The Racial and Ethnic scale is similar in context but incorporates various assumptions such as criminality, inferiority, invalidation and length of time depending on the version (Nadal, 2011).

In the context of providing holistic and transcultural care and combat microaggressions and implicit bias, it is important to understand both cultural humility and cultural competence. This understanding may help prevent implicit bias and prevent acts of microaggression. Per Christensen (2019), cultural humility is a self-reflection inward, about our beliefs in order to establish healthy relationships. Additionally, Christen also states that cultural competency bestows expert status to one person on another person's belief. Understanding these key differences, will allow for the promotion of understanding of implicit bias within ourselves as well as the recognition of microaggressive acts.

Background

Cultural humility emphasizes the other person as expert in their culture, utilizes best practices from a subjective point of view as well as encourages that the experience and utilization of cultural humility is an ongoing and lifelong process. Cultural competence assumes that someone else can be the expert in another culture. In addition, it uses an objective point of view and has an end point in its learning experience (Christensen, 2019).

Both cultural humility and competence have been utilized to combat biases and disparities. Healthcare disparities and lack of access to healthcare in the United States is rampant. People of color have poorer access to health care and resources than their white counterparts. In addition, they face more barriers to care (Hall et al., 2015). In addition, the quality of care received by people of color is not up to standard compared to white patients. African American patients generally report less satisfaction with their care. "The national Healthcare Disparities Report showed that White patients received better quality of care than Black American, Hispanic, American Indian and Asian someone patients (Hall et al., 2015).

As a result, people of color also have higher "mortality rates, morbidity rates and poorer health status" (Hall et al., 2015). Implicit biases by providers may contribute to these negative outcomes. In one study on provider implicit bias, it found that in the emergency room, "black patients received less EKG's and x-rays for Acute Coronary Syndrome (ACS)." (Dehon, Weiss, Jones, Faulconer, Hinton, Sterling & Choo, 2017) This same study found that black patients with pain were less likely to receive narcotic analgesic. Hall, et.al (2015), concludes that due to implicit biases, minority patients, particularly those of color, often find themselves having longer wait times for treatments and assessments.

Biases may be expressed in subtle ways including condescending and dominant attitude and tone, decreasing likelihood patients will feel heard and valued (Hall et al., 2015). In addition, these

attitudes can be described as both implicit and explicit. “Explicit is the thoughts and feelings people deliberately think about and can make conscious reports on. Implicit exists outside conscious awareness and are difficult to consciously acknowledge” (Hal et al., 2015). These biases can influence behaviors and actions without consciously being aware of the influence in decision making. In addition, it is reported that white Americans have tended to associate negative valence and certain feelings such as mistrust and fear with black Americans (Hal et al., 2015, p 61). Open communication is necessary to bridge the gap between compromised care and good care.

Clear discussions about disparities are important in the context of health outcomes and providing transcultural holistic care to combat disparities and biases. Without these discussions, there are missed opportunities to create an environment that provides transcultural care. Exposure to perceived racism, implicit bias and microaggressions leads to lifelong outcomes such as microtrauma. In considering poor patient outcomes, the relational trauma to bedside staff should also be considered as they too may be exposed to microaggression.

Similarly, compassion fatigue is defined by the American Bar Association as secondary trauma, with symptoms of becoming emotionally numb and detached, as well as being overwhelmed, and physical and emotionally exhausted (Americanbar.org). According to Adimando (2018), these lived traumatic experiences by staff create fear, emotional distress, grief, as well as symptoms that present similarly to depression and anxiety. Somatic complaints include headaches, sleep disturbance, poor concentration and muscle tension. This can lead to call outs and low staff to patient ration, increased workloads, errors, poor job performance, and motivation and endurance (Adimando, 2018).

These acts of microaggression and implicit bias can be considered a break in the alliance between provider and client and provider amongst provider. Without trust in a healthcare

partnership, health outcomes decrease. To improve outcomes related to these biases, there is a need to increase educational resources to healthcare providers to assist in acknowledging their implicit biases to avoid microaggressions and provide culturally responsive care.

Problem Statement

While cultural competence has been the current gold standard in providing an acknowledgement of the need for inclusivity, it lacks user accountability and does not provide for self -reflection. It may initially address and acknowledge the need for cultural education, however it does not allow for patient centered approaches or for life-long learning. It does little to educate on steps and guidance on communication education and bias self-reflection. The purpose of this DNP project was to create a tool kit as an educational resource to assist in increasing cultural humility and cultural communication in the healthcare setting. Having an evidenced based communication tool kit will decrease implicit bias and microaggression in the healthcare setting as well as reduce microtraumas.

Organizational "Gap" Analysis of Project Site

On review, members at the healthcare facility are all provided with an annual web-based training on cultural competence course through a web-based training. There was no formal education or training on cultural humility, micro aggression or implicit bias. Additionally, training did not provide resources or tools on how to recognize implicit biases or how to effectively communicate when implicit bias is recognized. There are no resources on cultural humility or tools to recognize microaggression. Organizational leadership, including Chief of Diversity, have noted a decrease in morale and patient satisfaction related to feelings of bias exposure and have reported a desire to improve to implicit bias and outcomes through training and resources.

.*Project Site:* A hospital level one trauma center in an urban setting that works with underserved populations served as the project site. New nurse residents were selected to participate in the in-service to receive both the KIND portion and the educational toolkit. The hospital that received the educational in-service, provides care to both pediatric and adult populations, as well as a wide variety of medical, emergency and mental health issues.

Review of the Literature

The following databases were included in the search for his project. The Cumulative Index of Nursing and Allied Literature (CINHAL), PubMed, Google Scholar, Substance Abuse and Mental Health Services Administration and Psych Info. Medical Subject headings (MeSH) terms included *cultural competence, cultural humility, cultural micro aggression, implicit bias, cultural training, micro trauma*, *micro aggression scale and tools* and *compassion fatigue*. Inclusion criteria included adults 18 years of age and older, minorities, medical setting, health care and health care professionals. Additional inclusion included published within the last five years with additional exception for items published within the last ten years to allow for research on history of cultural humility, cultural competence micro aggression and validated scales.

Approximately 20 articles were found in which approximately half of the articles were eliminated as they did not meet full criteria. Two reviews of literature were included for the purposes of an overview and history of micro aggression, cultural humility and cultural competence. Types of studies included in the review include three level five, two level one studies, two level three studies and two level two studies.

Humility vs Competency: There had been many opposing views as to whether cultural competency is the appropriate education and training needed to partner with a multitude of cultural backgrounds. In one level III study by Tormala, Patel, Soukep & Clarke, a two-step approach was

developed to assess graduate psychology students in a cultural competence course level of cultural competence and humility. In this study, cultural formulation assignments were used as a tool for measure and discussion. It was found that in the second portion of the training, over half the students demonstrated an increase in cultural awareness and used less undesirable language following the training. (Tormala, Patel, Soukup, & Clarke, 2018).

A second study on cultural humility education by Knettle, included 119 volunteer community health care providers, found that while there was a willingness to be open and make improvements in cultural understanding, a lack of familiarity with their "circumstances" led to the lack of completion of course. This was similar to a Level 1 study by Danso. The study concluded that to be humble and have respect for a culture, one must develop "awareness or sufficient knowledge of that culture (Danso, 2018, p. 422). Common themes among the studies were a willingness for education, and acknowledgement of cultural biases.

Microtrauma and Compassion Fatigue: It review, it was found that some exposures to implicit was prolonged. Symptoms that appeared similar were that of microtrauma and compassion fatigue. Due to this possibility and the similarity in symptoms and outcomes, a review of literature of compassion fatigue was performed. One level V independent study on compassion fatigue, provided education on symptoms of compassion fatigue, offering learning opportunities in the form of various scenarios. Compassion fatigue was defined as "the physical, emotional, and spiritual result of chronic self-sacrifice or prolonged exposure to difficult situations that renders a person unable to love, nurture, care for or empathize for another's suffering" (Lanier, 2017).

A second level V study, by Mattiolo, Walters and Canon in 2018, also reported a comparison of compassion fatigue. It described burnout as having induced bitterness, self-doubt, exhaustion, and negativity as well as having had a rapid onset and departure once stressors were

alleviated. Compassion fatigue was. Found to have led to physical ailments such as: cardiovascular disease, diabetes, gastrointestinal conditions, hypertension and inflammation (Mattioli et al. 2018). Mattioli, Walters and Canon utilized the validated Professional Quality of Life assessment tool to assess for compassion fatigue. This was similar to a study by Lanier in 2017. In the Lanier study, in additional to previously described symptoms, additional symptoms included poor sleep, muscle tension, headaches, mood swings, avoidance or dread of work, oversensitivity, anxiety, depression, resentment, inability to feel joy, substance use and mood swings (Lanier, 2017).

Microaggression: A level III study by Forest and Cuellar, (2018), regarding micro aggressions found that micro aggressions were linked to poor emotional health. These symptoms were similar to those of microtrauma and burnout. Whether directly or indirectly, it was found to have long lasting scarring and effects on individuals that led to burnout, contributed to hostile work environments and compassion fatigue.

Two level II studies were examined regarding tools to assess microaggression. The first was by Williams, DeLapp and Prinz and was called the TSDS (Trauma Symptoms of Discrimination Scale). This scale was a self-measure tool containing 21 questions focused on anxiety related trauma symptoms and discrimination (Williams, DeLapp, Prinz, 2018). Symptoms assessed included avoidance, social fears, negative thoughts and cognitions, future worries. It also assessed anxiety related symptoms such as nervousness, anticipation of possible harm. The study concluded the TSDS tool to be a validated tool.

A second scale by Mekaei and Todd, 2018, utilized a tool to attempt to be able to recognize micro aggression. The study aimed at the recognition and acceptability of micro insults and micro invalidations related to micro aggressions. The sample population consisted of 596 students. The study found a correlation between acceptability of micro aggressions and the increased likelihood

of committing micro aggressions. In addition, there was a link between victim blaming and racism (Mekaei & Todd, 2018).

Scales: A level two study was assessed regarding the EDS (Everyday Discrimination Scale). The tool sought to validate its usefulness with everyday perceived racism. It defined everyday discrimination acts such as receiving poor service or disrespect. It reported it as happening over the course of a lifetime. This study by Harnoise, Campbell, Keith and Bastos (2019), reported that while the scale had been validated and useful when measuring everyday discrimination, it urged caution when attempting to draw inferences without taking into context the situations or events that led to misinterpretation.

A second study by Gonzalez, Goins, Noonan, Acton, Roubideaux, Henderson, Beal and Madison (2016) utilized the EDS. The aim was to study the everyday discrimination of Alaskan and Native Americans. It tried to determine health outcomes within these populations in relation to experiences of perceived racism. The study concluded that the tool itself was a valid tool in measuring their perceived racism.

Trauma: A number of studies correlate micro aggressions to both emotional and physical symptoms of trauma. In experiencing trauma, studies have found that chronic experience of trauma leads to a multitude of physical and emotional outcomes for the receiver of micro aggressions. Experiences of micro aggression have led to micro trauma experiences. In turn, it can be considered that symptoms of micro trauma experiences similar to symptoms of compassion fatigue and burnout out.

Competence and humility: In reviewing cultural competence and humility, there were various definitions for both competence and humility. Cultural competence was defined as “developing an awareness of one’s own existence, sensations, thoughts, and environment, without having an

undue influence on those from other backgrounds" (Casselius, 2018). Additionally, Casselius also reported that with cultural competence, there was no allowance for self-checking or reflection of assumptions, accountability or acknowledgement. A second definition by SAMSHA, discussed cultural competency as a respectful response or approach to others to other cultures or backgrounds (SAMSHA, 2019).

According to Danso (2018), cultural competence was viewed as assuming that the provider, system or user of competence is dominant in the situation or interaction" (411). In addition, Danso (2018), also discussed cultural competency as having encouraged power struggles between ethnic groups. Danso also reported that it created an assumption of a power dynamic in communication, potentially having had placed the title of expert on one individual of another person's culture.

Cultural humility, in comparison, was found to be defined as "an acknowledgement of the limitations of one's own culture and understanding. It addressed the power balance in the patient-clinician dynamic and provided cooperation instead of an authoritarian relationship" (Casselius., 2018, p. 9). Cultural humility allowed for self-reflection or acknowledgement of assumptions and biases and an understanding that what one believed isn't true. (Yeager & Wu, 2013). Cultural humility enabled a person to look at themselves as a whole and become aware of their own biases and assumptions.

The research review included evidence of micro aggression, micro trauma and emotional results of micro aggression as well as evidence of compassion fatigue that can stem from burnout. The last decade of studies had found additional correlations of data for links to both physical health and mental health as a result of micro aggression. In addition, several studies had related micro aggressions to mental illness or symptoms of depression and suicidality in racial minorities. One

study by Wang Leu and Shoda, (2011) revealed a link between emotion suppression and microaggression. Emotions experienced were similar to those of anxiety and depression. In addition, the study revealed a link to emotional suppression and cardiovascular disease. All of this was also linked to emotional outbursts similar to emotions of anger which is associated with frequent experiences of microaggression.

The review of literature suggested a gap in tools or education in the healthcare setting to educate team members on biases as well as what to do in the event that a bias is recognized. This suggested a need for transcultural care quality improvement. Therefore, this author proposed a project to create a tool kit as a cultural communication resource to assist healthcare providers to recognize implicit biases and micro aggressive behaviors in order to improve health care quality and reduce exposure to implicit bias in the healthcare setting.

Theoretical Framework or Evidence Based Practice Model

The theory used to guide this project was Leininger's Culture Care Theory: The theory of Culture Care Diversity and Universality. This framework described a guide for providing culturally supportive care. The theory placed the patient and their cultural needs at the center of care and allows for a cultural alliance between healthcare provider and patient. This theory described nursing as transcultural, serving people from all over the world. (www.nursingtheory.org). At the core of the theory was caring, which was described as central to healing. Culture was defined as "the learned shared and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions and actions in a patterned way" (Zajac, 2015, p.89).

A main component of this theory was to understand and find what was diverse or different with a culture and what was universal, or the same (Zajac, 2015). Leininger also stated that the reason

for importance of this was that it allowed for understanding similarities and appreciation of the differences in expressions of culture for complete and holistic care (Zajac, 2015). Leininger described caring as an action word at nursing's core and also describes it as culturally rooted meaningful and beneficial allowing for a possible connection between theory and practice (Zajac, 2015). This particular theory had several important factors, including: "technological factors; religious and philosophical factors; kinship; political and legal; economic and educational components (Zou, 2017). The dynamic Leininger's sunrise model was that it allowed for the focus of the multiple influences and phenomena on healthcare, including historical, cultural and environmental factors (Zou, 2017)..

This DNP project was a quality improvement design that focused on the incorporation of Leininger's Culture Care Theory and education on the K.I.D communication technique, cultural, cultural assessment tools, education on implicit bias and microaggressions were a part of the toolkit. Additionally, research was available in the toolkit regarding micro traumas and cultural humility, as well as examples and role play scenarios on various types of implicit bias, videos and interactive activities as well as current research were also included.

The KIND communication approach included in the toolkit was developed by a DNP student in part of this joint capstone project to assist on recognition of implicit bias. K.I.N.D stands for **K**inesics, **I**nclusive Language, **N**on-Biased and **D**eliverable. KIND assisted in recognizing biases exhibited in communication style such as body language, facial expressions, using gender neutral terminology, avoiding assumptions and acknowledging cultural deficits, and avoiding stereotypes. KIND was created as a method of building a rapport and engaging clients with various cultures and assists in self-checking implicit biases and assumptions.

Methods

The DNP students met with the healthcare institutions Chief of Diversity to discuss the project as well as the magnet nurse residency program director. IRB approved the project in the fall of 2019 and a date was set for the communication in-service for February 2020. Copies of the cultural assessment tool as well as the toolkit were given to the nurse residency director and nurse resident participants.. The educational training incorporated two parts: education on cultural communication using K.I.N.D communication, described above (APPENDIX A).

The educational in-service was approximately 60 minutes in duration. There were 32 participants in total. The first thirty minute included education on microaggressions and KIND communication and the next 30 minutes focused on items from toolkit and education on resources. It provided a combination of group activities including education on neologisms that were culturally biased in which the history of the word was discussed. Other activities included a provider patient scenario in which no words were spoken with the provider using body language to convey communication and time was allotted post education for questions and feedback.

The toolkit's educational component consisted of an initial introduction video on implicit bias and microaggressions. This was followed by an interactive activity and discussion on biases. The second was a video regarding everyday vocabulary, phrases and body language, followed by role playing and discussion. Comment cards were utilized post presentation to assess qualitative feedback in relation to the presentation to allow for real time commentary, thoughts or feelings and utilized as part of qualitative data collection to augment the quantitative results of the survey data.

Project Site and Population

The DNP project involved two DNP students who were in the psychiatric mental health nurse practitioner program at UMASS. One student, K.T., had ten plus years of experience as a

psychiatric nurse, the second student, J.C., had five plus years as a psychiatric nurse. Both students were psychiatric certified registered nurses as well as CARN (certified addiction registered nurses).

The in-service participants were attendants at the new nurse residency program at a level one trauma facility in Springfield, MA, newly employed at the Healthcare facility. The healthcare facility provides multidisciplinary medical care, in an underserved community in Springfield, MA.

Measurement Instruments

The Cultural Assessment Tool was utilized to measure cultural awareness levels of the nurse residents. The Cultural Assessment Tool was a validated tool for self-exploration and self - awareness of individual bias and cultural awareness (Shen, 2015). The tool measured categories of experience, cognitive awareness, research issues, interactions including behaviors and comfort levels, as well as clinical issues. This tool was designed to scale cultural awareness among nursing staff and was originally developed to measure knowledge of nursing students in 2003 by Rew, Becker, Cookston, and Khosropour. (Appendix B). The Cultural Awareness Tool was a 17- item questionnaire that assessed various levels of experience and comfortability with culturally diverse populations (Anitori, 2014). Personal information was withheld, however demographics such as age, race, gender, religious affiliation as well as personal quotes from comment cards were utilized in data collection.

Goals and expected Outcomes

The Goals for this project included the following: 1. Raising awareness for the need of cultural communication and educational resources to decrease microaggressive behaviors through training at a Nursing Nurse Resident In-service and 2. Gain support for use of cultural communication

tool kit use for healthcare staff by the healthcare organization The expected outcome for this research project was to implement the cultural communication toolkit as an effort to increase awareness of the effects of implicit biases on healthcare outcomes and patient satisfaction. In addition, participants should be able to identify how these micro aggressive behaviors lead to micro traumas and were able to display a willingness to seek continued education on cultural communication techniques.

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was prior to initiating the DNP Project. All information collected as part of this project had no demographic identifiers and survey responses and information collected in interviews or role playing were kept confidential. Screening and surveys were locked in lock box in which DNP students were the only members to have a key. The DNP student completed CITI training and was knowledgeable about Health information and Privacy procedures due to current institutional and current work practices.

Results

The DNP project took place at a 716-bed teaching hospital, located in a culturally diverse area in Massachusetts. The participants of the in-service included 32 nurse residents. The project took approximately 6 months to complete, including research and data gathering. The in-service took place over the course of a day, and both pre and post survey collection took approximately two weeks before and after the in-service. Ethnicity varied amongst participants and ages of participants were between the ages of 21-48. Qualitative data gathered from post in-service was also included in the results in order to include real time feedback on the course as well as immediate

feelings following the presentation. Expected outcomes for the project included 100% participation for both pre and post Cultural Assessment survey. However, of these 32, only 19 participants completed both pre and post survey assessments.

Table one demonstrates the distribution of the participants age. The initial data collection assessed the mean age of the sample was 27.9. (Table 1). N=32 for the number of participants. Minimum age in the distribution was found to be 21.00 with a maximum age of 48.00. Age was collected in order to identify if age could be identified as a correlation with cultural awareness in healthcare providers. However, age could not be determined either way to play a role in cultural awareness.

Table 1

Initial sample participants' age distribution

	N	Minimum	Maximum	Mean
Age	32	21.00	48.00	27.9688

Race was collected in order to assess if a healthcare provider's race was linked to increased or decreased cultural awareness. However, no link could be determined. Table 2 includes the reported race that participants identified with. Data was collected anonymously. The distribution of participants' race found the majority of the responses indicated that the participants were White/Caucasian (23, 71.9%). The remaining were Hispanic (4, 12.5%), Black (2, 6.3%), and Other (3, 9.4%).

Table 2

Initial sample participants' race distribution

	Frequency	Percent	Valid Percent	Cumulative Percent
White	23	71.9	71.9	71.9

Hispanic	4	12.5	12.5	84.4
Other	3	9.4	9.4	93.8
Black	2	6.3	6.3	100.0
Total	32	100.0	100.0	

In terms of religious belief, the initial sample consisted of mostly non-religious participants 15 (46.9%). There were 9 (28.1%) Christians, 5 (15.6%) Catholics, and 3 (9.4%) identifying as other religions (Table 3). The collection of data related to religious affiliation was obtained in order to determine if religious or spiritual beliefs could be linked to an increase or decrease in cultural awareness, however, no affiliation could be determined.

Table 3

Initial sample participants' religion

	Frequency	Percent	Valid Percent	Cumulative Percent
None	15	46.9	46.9	46.9
Christian	9	28.1	28.1	75.0
Catholic	5	15.6	15.6	90.6
Other	3	9.4	9.4	100.0
Total	32	100.0	100.0	

The following results were determined using n=19 secondary to only 19 participants completing both pre and post The pre-test and post-test data were compared after the study was completed. Due to attrition, only 19 participants were able to complete both the pre- and the post-test for cultural awareness. Of the 19 paired participants, the youngest was 22 and the oldest was 48. Although the range of age did not change, the attrition primarily happened in the younger age groups (Table 4).

Table 4

Paired Pre and Post Cultural Assessment data sample

	N	Minimum	Maximum	Mean	Std. Deviation
Age	19	22.00	48.00	29.4737	7.62575

Compared to the initial sample, the paired race distribution remains similar in structure. Most participants were White (13. 68.4%), and the remaining 6 were Hispanic, Black, and Other (Table 5).

Table 5

Racial Identification of the New Nurse Residents that Completed both Pre and Post Assessment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	13	68.4	68.4	68.4
	Hispanic	3	15.8	15.8	84.2
	Other	2	10.5	10.5	94.7
	Black	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

In the paired sample, there were 9 (47.4%) non-religious participants. The remaining reported to being Christian (4, 21.1%), Catholic (3, 15.8%), and other (3 (15.8%). This distribution structure also remained similar to the initial sample (Table 6).

Table 6

Religious Affiliation of New Nurse Residents that completed both Pre and Post Cultural Assessment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	9	47.4	47.4	47.4
	Christian	4	21.1	21.1	68.4
	Catholic	3	15.8	15.8	84.2
	Other	3	15.8	15.8	100.0
	Total	19	100.0	100.0	

Participants were asked to answer questions regarding cultural awareness in both sessions, and the results are shown in Table 7. The scores range between 17 and 31 in the pre-test; the ranges became 18 to 35 in the post-test. For reference, the highest possible score for the cultural awareness test is 51, and the lowest possible score is 17. To be considered a high degree of cultural awareness, one needs to score 40 points and up. Between 30 and 39 points, a participant is considered to have average cultural awareness. Between 17 and 29 points, a participant is considered to have low degree of cultural awareness. The mean awareness score in both tests fell under the average awareness range.

Table 7
Pre and Post *Cultural Assessment Scores*

	N	Minimum	Maximum	Mean
CA Total Pre	19	17.00	31.00	24.4211
CA Total Post	19	18.00	35.00	25.1053
Valid N (listwise)	19			

Although the overall scoring did not significantly improve, there was slight increase in cultural awareness for some participants. To statistically test for the difference and whether the scores significantly increased, a paired samples t-test was utilized. Using a paired samples t-test instead of other forms of mean-comparison gives the researcher a chance to evaluate the within subject factors. Results in Table 8 showed that although the range of scores increased between pre- and post-tests. The table demonstrates paired differences using a t test.

Table 8

Cultural Assessment Paired Differences using t-test

	Paired Differences							
			S.D.	95% CI Difference				Sig. (2-
	Mean	S. D.	Mean	Lower	Upper	t	df	tailed)
Pre-Post	-.68421	4.91090	1.12664	-3.05119	1.68277	-.607	18	.551

Results in Table 8 showed that although the range of scores increased between pre and posttests, the difference was not significant enough to reject the null hypothesis, which indicated that there would be no difference between the two time periods. The mean difference between the two times was -.684, and the t score was -.607 (p=.551). Possible reasons for results not being significantly different could be that nursing residents may not have had time to incorporate the tools they used into practice. Additionally, the cultural assessment scale that was given post-test does not have the ability to assess improvement, rather the post-test used was the same scale for preassessment. Other possible reasons include that some participants may have not been accurate inn their rating of their cultural awareness pre-test. This may be true if comparing post qualitative data.

Qualitative Data

Qualitative data collected post presentation via anonymous comment cards demonstrated positive results and feedback. Most qualitative data reflected positively on the in-service. Participants found the use of videos helpful as well as education on microaggressions. This post reflection demonstrated several common themes as demonstrated in the table below:

Table 9

Common Themes or Narratives

What are some common thoughts comments or reflections regarding this presentation
Microaggression: Microinsults, Microinvalidations, Micro assaults

"I wish we heard more about the microaggressions and examples because I feel like they're very common but also an unknown topic to a lot of people including myself."

"Thank you so much for teaching us today! Important to think About how before you even see or meet a patient you're already formulating a picture of them in your mind just by hearing or seeing their name. Videos are really good and so engaging. Acknowledge, acknowledge, acknowledge. I thought I knew what microaggressions were, but I learned even more. KIND is really good and easy to remember."

"It was interesting to me to see how many people experience prejudice and microaggression that shape their lives and lump them into general category, and how hurtful that is."

Implicit Bias:

"This presentation gave a good demonstration about how bias sometimes is natural, but we must be aware of it. Asking is key and communication is key. Please keep doing this presentation thank you"

"Implicit bias- understanding that everyone has it instead of denying it, recognize it exists, learn from it, ask questions, & be mindful. I love the personal stories and appreciate the stories. Thank you for sharing with us"

"Assumption is the common factor that people become a fool quickly. Thank you for this lecture, it's a nice fresh nursing alarm call. Hopefully we get this session more frequently in the next months.

"I found myself recognizing my own biases inn the videos"

"I enjoyed the video where several young Black men were talking about their experiences that involved race. One person said that the way people perceive you isn't determined by you. I feel like this is a good summation of how ***implicit bias works."***

Videos:

"I really enjoyed and appreciated the NY times video because it showed these young men's perspectives in their own words and with their emotions apparent which I found more impactful than when a teacher lectures about the perspectives of people of color."

"Excellent presentation!!! Growing up Black video brought tears to my eyes, it's sad that we've come so far, yet we are still so far from where we need to be. I think your presentation should be seen by everyone hospital wide."

"Racism is a "lifetime of learning." The *Friends* video was nice to watch because even though it was cheesy, it gave good insight into our nonverbal communication."

"NY Times video was really eye opening. Offered insight into a perspective I'd never really thought about too much before. Powerful video. Learned a lot from the inclusive language activity. Really liked hearing your personal stories because it made me realize microaggressions happen everywhere everyday"

"

Interactive activities/Dialogue

" I would love to hear more personal experiences. I appreciate you talking about the negativity with saying "I'm colorblind" and how you need to see it to validate that person as an individual, which impacts patient care."

"I liked how you guys discussed specific examples of language people use every day that are offensive. A lot of the phrases I have used before and I didn't even think about how it could be offensive. It really showed me I do have implicit bias. I feel like every teacher tell us but has not given real life examples. Great presentation."

KIND

"Usage of KIND is important and a great teachable approach. I feel this needs to be implemented everywhere"

"KIND was easy to remember and effective."

Self-Reflections

"My husband does not believe in white privilege and it bothers me because I see it every day-I'm White. My parents were very racist growing up (Hiltowns), I became best friends with a Black girl in high school. I felt like I was doing something wrong by my parents. I have experienced racism at work toward my Black coworker and I backed her up. White woman asked my coworker If her hair was real. I don't know why White people ask this; it bothers me. My White manager asked my White assistant manager if she felt "safe" talking to my black coworker alone we talked about it and she cried but I supported her."

"I liked the point about how improving conditions for those who are struggling the most can result in benefits across the board." "I like when you mentioned it's okay to admit you don't know and that people would rather you be honest that you are trying"

"Honing in on the Black population will benefit all races. All races have prejudices and biases against Black people, so it is a good place to focus in on. The disability act is a really great example to explain and prove the idea"

"I learned that even if you are unaware of your biases, you can still have racist behavior implicitly."

In reviewing the themes and examples of participant's statements, it is clear that many participants reported being thankful for the presentation. "This presentation gave a good demonstration about how bias sometimes is natural, but we must be aware of it. Asking is key and communication is key. Please keep doing this presentation thank you". More specific examples relating to the toolkit include appreciation of the topic of microaggressions as well as requests for additional information on that topic.

One participant stated, "I wish we had learned more about the microaggressions and examples because I feel like they are very common, but also an unknown topic to a lot of people including myself". Several participants made comments reporting an increase awareness and recognition in their bias from watching. Such comments included, "I found myself recognizing my biases in the videos. Additional comments regarding the toolkit and activities included the language activity regarding biased neologisms. One participant stated "I liked how you guys discussed specific examples of language people use every day that are offensive. A lot of the phrases I have used before and I didn't even think about how it could be offensive. It really showed me I do have implicit bias. I feel like every teacher tells us, but, has not given real life examples. Great presentation."

The participants were in agreement about the language activity stating ""Appreciations-1st video emphasized how implicit bias is normal. Inclusive language activity-really eye opening because you don't even realize it. I like how you both draw on your own experiences/backgrounds. The summary chart at the end was helpful."

Others agreed about the activity as well as the educational video regarding implicit bias as well as personal stories from presenters regarding microaggressions and biases, reporting “NY Times video was really eye opening. Offered insight into a perspective I’d never really thought about too much before. Powerful video. Learned a lot from the inclusive language activity. Really liked hearing your personal stories because it made me realize microaggressions happen everywhere everyday”

Discussion

Leadership within the organization and nurse residency program were eager to provide culturally motive training on implicit bias as well as receive resources and a toolkit to provide further education to future residents. This can be linked to their mission statement that includes making lasting connections with their client .The presentation was well received by the participants with immediate positive feedback via comment cards.

In reviewing the qualitative data, participants described an ability to achieve cultural humility as well as continued learning. This is similar to the cultural education study by Knettle, (2017). According to the study by Knettle where cultural education was provided, it was found that there was a willingness to be open to cultural education and to make appropriate changes. The nurse residents that participated in this project displayed a similar willingness to continue education about K.I.N.D communication as well as implicit bias and microaggressions and requested additional trainings by the DNP students.

The language portion of the training found similar findings in participants willingness to be mindful of biased language following the biased language exercise. This was evident in participants reporting that they appreciated the activity and had initially no idea the history of the

words and phrases they were using. This is similar to a study by Tormala et al.., (2018). In this study, participants displayed a less use of undesirable language following cultural training and education.

The assessment tool was found to have limited change in score both pre and post assessment. In comparing to a study on an assessment of microaggression knowledge and acceptability of microaggressive behaviors, they utilized an assessment tool to assess participants susceptibility to accept microaggressive acts as well as likelihood to commit microaggressions. This study found a link between victim blaming and racism. Compared to the DNP project participants answers on both a pre and post-test did not change, therefore, no link could be determined. This could have been due to the fact that not enough time had passed between the session and post assessment test. However, per the qualitative data, participants did report a desire to continue learning about microagression and microaggressive acts and behaviors.

The results of the Cultural Assessment Tool utilized by the students did not demonstrate clinical significance so inferences may be difficult to make based on this data alone. However, when looking at qualitative data, and comments by participants, it is obvious that the in-service was successful. In one study that utilized the Everyday Discrimination scale by Hanroise et al. (2019), it urged caution when utilizing this tool and attempting to draw inferences. This is a similar finding for this DNP project using the Cultural Assessment Tool.

Results from Antiori in 2014 had varied results using the Cultural Assessment tool. Antiori utilized the scale to assess cultural awareness inn sonographers This study found no correlation between years of experience and cultural awareness. Although this project did not assess similarities between years of experience and knowledge of cultural awareness, there was no supporting data to correlate years of experience in healthcare with cultural awareness.

In considering the theoretical framework used for this project by Madeline Leininger, the theory emphasized the patient and cultural needs at the center of care. When thinking about this theory in terms of understanding implicit bias, it provides support for a need to become aware of unconscious barriers placed mentally by the provider when providing care for patients from other cultures. This is validated in the qualitative data provided by the participants. They self-reported personal experiences with barriers they have faced as people and providers with implicit bias and microaggression. Additionally, they acknowledge a desire to continue to make Cultural Care a priority in patient outcomes.

Leninger's theory describes caring at the center of healing. Understanding implicit bias, microaggressive acts in healthcare is by definition providing care, and placing the patient at the center of care. The K.I.N.D toolkit provided a guidance for understanding implicit bias and microaggressions in order to promote cultural humility and cultural care.

Limitations of the project include the lack of consistent responses to the pre and post survey via survey monkey and small sample size. Due to this, it was difficult to ascertain data needed to demonstrate enough evidence that the in service was clinically significant. There was not enough time to do a third post assessment thirty and 9-0 days out secondary to time constraints provided by the facility.

The use of survey monkey allowed for participants to remain anonymous, which may have helped them answer questions more honestly.. The use of the cultural screening tool also allowed for a measure of cultural awareness to participants both pre and post educational in-service. While there may not have been enough statistical evidence to quantify the knowledge change from the intervention, the qualitative data gathered from the comment cards showed a deep appreciation for the in-service.

Participants also reported enjoying the videos and interactive activities that demonstrated experiences of admitting bias, gratitude and requests for more information. In terms of microaggression, this could speak to an increased need for continuing training in healthcare. Secondly, it could also mean that there is not enough education regarding what microaggression is and how to decrease it. Additionally, some of the nurse's residents did not participate in either a pre or post survey.

For future projects, it may be beneficial to break down the in service to several sessions, allowing for each topic of the toolkit to be a highlight of the in-service. For the sustainability of the project at the institution perhaps each essence of KIND communication could be assessed and promoted on different days and times to allow for the further discussion of topics of microaggression as well as role-playing situations.

Conclusion

The consequences resulting from implicit bias have an emotional and physical impact, leading to microaggression in the workplace and poor patient outcomes and satisfaction. As evidence demonstrates, disadvantaged populations, disproportionately, have lower health outcomes. They are at a direct disadvantage and often the victim of implicit bias in healthcare. Knowledge on implicit biases and microaggressions can lessen the experience of microaggressive acts and behaviors and improve outcomes, in not just disadvantaged populations, but amongst healthcare providers in the healthcare setting. Improvement in these skills can improve morale, trust and rapport amongst staff and between client and provider.

The successful implementation of an educational resource toolkit allows for continued education on the effects of implicit bias. The tool kit availability allowed for the accountability of an individual to understand their own biases as well as take ownership and humility in their cultural

awareness and allows for the facilitation of cultural responsiveness. Participants who participated in the DNP project reported benefitting from the experience as well as a desire for continued learning in the future.

This project provided is in practice with the framework of this project: Leninger's Culture Care Theory. Per Leininger, a lack of cultural care knowledge in nursing leads to detriments in healing wellness and support. In order to improve health outcomes in disadvantaged populations, cultural humility and cultural knowledge should be at the forefront. Without cultural humility and understanding of our implicit biases, these outcomes may not improve and culturally diverse populations may continue to suffer at the hands of microaggression and bias in healthcare. However, with education and training and resources on implicit biases in healthcare facilities, these outcomes may be able to improve and the rapport between client and provider will continue to grow into a partnership and can be truly seen as culturally responsive care.

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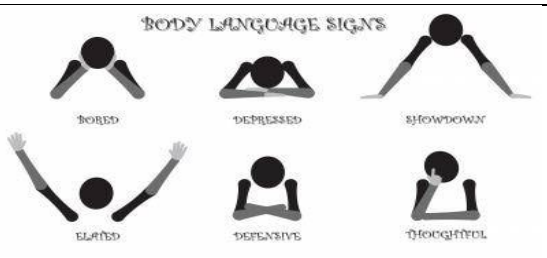
Appendix A

KIND Communication

K	Kinesics	Are you knowledgeable about your kinesics (communicating through body language including facial expressions, gestures, personal space, and postures)? ✓ Cool, Calm, and Collected

		
I	Inclusive Language 	Words in Ways that Work ✓ Gender neutral (Fireman vs Firefighter) ✓ Plural Pronouns (Their, They, Them) ✓ Avoid idioms, jargons, and acronyms ✓ Ask about preferences and acknowledge limited awareness
N	Non-biased 	Individuation vs stereotypes and generalizations, and categorization ✓ One box does not fit all
D	Deliverable	Was communication effective? ✓ Did you make a compassionate connection? ✓ Was the patient satisfied with their care

	 Elements of Baystate Health Compassionate Connections Be Aware and Prepare Connect with Care Be Purposeful Link to the next Moment	

Appendix B

CULTURAL AWARENESS SCREENING TOOL

Statement	Always	Sometimes	Never
I feel comfortable when discussing alternative lifestyles with clients.	3	2	1
I support the use of traditional cultural healing practices for hospitalized clients.	3	2	1
I know the limits of my communications skills with clients from different cultures.	3	2	1
Outside the work setting, I make an effort to be involved with people from different cultures.	3	2	1
When assessing clients, I recognize the biologic variations of different ethnic groups.	3	2	1
I accept that there is a strong relationship between culture and health.	3	2	1
I consider the race, sex, and age of my clients when administering medications.	3	2	1
When caring for clients from different cultures, I consider the specific diseases common among their group.	3	2	1
I openly acknowledge my own prejudices and biases when working with clients from different cultures.	3	2	1
I seek out and attend in-service classes that deal with cultural and ethnic diversity.	3	2	1
I remain calm when my healthcare values or beliefs clash with those of a client.	3	2	1
I practice culturally competent nursing when dealing with all clients, not only those from different ethnic groups.	3	2	1
When assessing clients initially, I consider their geographic origins, religious affiliation, and occupation as important elements of the care plan.	3	2	1
I have a high level of knowledge about the beliefs and customs of at least two different cultures.	3	2	1
I use a standardized cultural assessment tool when performing admission assessments on clients from different cultures.	3	2	1
I take into consideration the policies of my institution that serve as barriers for the effective provision of culturally competent care.	3	2	1
I recognize the cultural differences between the members of the same culture.	3	2	1

Cultural Awareness Scale

40 to 51 points = High degree of cultural awareness

30 to 39 points = Average degree of cultural awareness

17 to 29 points = Low degree of cultural awareness

APPENDIX C
TIMELINE

TABLE 1

SIMPLIFIED PROJECT TIMELINE

TASK	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANNUARY	FEBRUARY	MARCH
RECRUITMENT	X	X	X	X	X		
PRE-SURVEY						X	
INTERVENTION/IN-SERVICE						X	
POST SURVEY						X	X
ANALYSIS						X	X
RESULTS							X

Appendix D
Cost Analysis

Supplies	Paper, room	$150.00
Food prizes	Food, prizes…	$100.00
Miscellaneous items	Time spent cost	$25.00
Total		$275.00

Appendix E
Toolkit

Toolkit Proposal

Type	Tool	Format	Availability
KIND Communication	PowerPoint, Leaflet Interactive Exercise	Verbal, Video, PowerPoint	Available at in-service, workplace website
Videos	Ted Talk, Implicit Bias commercial, Perception Friends video Interactive Exercise Exercises (Mirror exercise, post it gallery, inclusivity language exercise)	Verbal Presentation	In-service and link to workplace website
Research Resource Links	Literature reviews, Scholarly links to implicit bias research, Microaggression and Scales	Links to videos in folders to take home, posted on institution website	Available at in-service and workplace website

Appendix F IRB Approval

Eric Griffin MSN, RN, CEN
Director
Baystate Health Nurse Residency Program
Baystate Medical Center Magnet Program Director
Baystate Medical Center
759 Chestnut St
Springfield, MA 01199
(413) 794-1479

August 16, 2019

UMASS School of Nursing

Reference: Jennifer Caraballo Capstone Project

To Whom It May Concern,

As the Director of the Baystate Health (BH) Nurse Residency Program, Jennifer Caraballo has my permission to conduct her quality improvement project in October 2019, with the BH nurse residents contingent upon IRB determination.

Sincerely,

Eric Griffin MSN, RN, CEN

Appendix G

<table>
<tr><th colspan="2">Educational Presentation: KIND Communication Toolkit</th></tr>
<tr><td colspan="2">Learning Goals:
After completion of this workshop, new nurse residents will gain an understanding of implicit bias, cultural humility, microaggression and microtrauma and its impact on healthcare patents and employees.
Nurses will gain an understanding of toolkit and implicit bias that will be used as a resource as well as KIND communication when engaging with cultures different from themselves as a way to build rapport, decrease potential microaggressive acts and improve healthcare outcomes.
Teaching Methods:
This workshop utilizes video clips and personal experiences of implicit biases of educators as well as participants. In addition, there are several interactions and exercises throughout the workshop along with a PowerPoint presentation</td></tr>
<tr><th>Objectives</th><th>Outcomes:
Outcomes will show an increase in participant on implicit bias as evidence by a pre and post workshop survey</th></tr>
<tr><td>1. Participants will gain an understanding of implicit bias and microaggressive
a. participants will hear real life experiences as well as participate in videos and exercises</td><td>1. I can define implicit bias
2. I can provide define microaggression and its consequences on emotional health
3. I can identify acts of implicit bias and microaggression</td></tr>
<tr><td>2. Participants will gain an understanding of microaggression and its consequences on emotional health
a. Challenges to include are: understanding difference between racism and implicit bias</td><td>4. I know specific examples of microaggression and implicit bias
5. I am able to identify consequences of microtrauma and cite examples of symptoms
6. I am able to define the difference between racism and implicit bias</td></tr>
<tr><td>3. Participants will gain an understanding KIND Communication
a. Participants will learn about resources and toolkit.</td><td>5. I can identify the steps in KIND communication
6. I can utilize the steps in KIND communication to self-check
7. I can identify location of resources needed to assist in understanding implicit as well as toolkit</td></tr>
</table>