2.6: Cultural Safety

Despite the remarkable growth in the literature in nursing on cultural competency, the delivery of culturally safe nursing care remains to be achieved (Racine, 2014). Cultural safety is a concept that originated from the pioneering work of Irihapeti Ramsden, a Maori nurse who described the persistent inequities affecting the Indigenous peoples of New Zealand (Nursing Council of New Zealand, 2011). Although cultural safety is a relatively new concept, it is critical to the understanding of the persistence of health inequities among Indigenous and minority populations in Canada. The continued existence of health inequities explains why cultural competency alone cannot address systemic and institutional barriers that affect health and health outcomes (Racine, 2014). Cultural competency helps us to understand other cultural norms and behaviours, but tends to overlook systemic barriers or those created by unequal access to the social determinants of health. The reason is that at the centre of race relations lies the concept of power, and race relations cannot be dissociated from issues of power that affect racial, gender, ethnic, and language discrimination (Racine, 2014). Cultural safety requires nurses to be aware of power relations in their interactions with clients or colleagues at work.

Cultural safety is defined as “nursing or midwifery action to protect from danger and/or reduce risk to patient/client/community from hazards to health and well-being” (Papps & Ramsden, 1996, p. 493). Contrary to cultural safety, transcultural nursing does not require nurses to examine their own cultural attitudes and behaviours and the impact these ethnocentric attitudes may have on patients (Ramsden, 1993). In cultural safety, the nurse becomes the centre of reflection whereas cultural competence focuses on knowing the ethnocultural backgrounds of clients, families, or communities. Cultural safety shifts the critical lens to the nurse, and the client judges the quality of culturally safe nursing care. As such, any nursing intervention that does not account for power relations may jeopardize individuals’ and groups’ health and integrity, and therefore can be seen as culturally unsafe. The presence of power relations within the nurse–client professional encounter requires nurses to reflect on their biases and racial or ethnic privileges when caring for culturally diverse individuals and groups. In other words, being culturally competent is not enough to provide nursing care that will be responsive to the health care beliefs and practices of diverse and vulnerable clienteles (Andrews &
Boyle, 2012). Cultural safety theorists urge nurses to become cognizant of the location of health problems within historical and social processes. Cultural safety is about building trust to make clients, families, and communities feel accepted and welcomed in the health care system. Browne and Fiske (2001) underline that culturally unsafe practices jeopardize clients’ access to health care because of nurses’ and other health care providers’ negative stereotypes about cultural differences. Cultural safety represents a powerful analytic lens to explore issues of power and how power affects nursing care and delivery (Smye & Browne, 2002).

Cultural safety is about power relations and more specifically about the impact of colonialism and post-colonialism in creating health inequities among marginalized groups (Racine, 2008). As well, Bourque Bearskin reminds nurses that their responsibilities “for cultural safety must include paying attention to the disparities in health care” (2011, p. 6). Within the twenty-first–century context of globalization, nurse migration and the massive displacements of refugees from developing to developed countries compels Western nurses to apply both cultural competency and cultural safety in professional encounters with non-Western clients and families. This ever-changing context of cultural diversity requires that nurse managers become aware of their central role in creating opportunities for training and advocating for the professional, cultural, and social integration of non-Western nurses in nursing workplaces. Although many efforts to achieve culturally competent and safe managing practices have been defined (see, for example, American Organization of Nurse Executives, 2015; Canadian Indigenous Nurses of Canada, 2009; Canadian Nurses Association, 2010; International Council of Nurses, 2012; Nursing Council of New Zealand, 2011), much action still needs to be taken as health inequities persist and internationally educated nurses still face challenges within Western health care systems (Mortell, 2013).

Research Note


Purpose

The purpose of this study was to describe the cultural competence of leaders and the health care staff, and to determine the association between leader cultural competence and staff cultural competence using a social network analysis. The first research question hypothesized that health care staff would likely be more culturally competent if their leaders were culturally competent. The second research question hypothesized that the leadership effect would depend on the characteristics of the leader, including the leader’s expertise in cultural competence.

Discussion

Three geographical zones reflecting non-resident populations were selected in Belgium. The final sample consisted of 24 health services: five outpatient primary care services and 19 inpatient services recruited from four hospitals. The 19 inpatient health services included four geriatric units, four intensive care units, four oncology units, three psychiatry units, two communicable disease units, one palliative care unit, and one endocrinology unit. Participants included leaders (n=71) and health care professionals (n=436). The Cultural Competence Scale was adapted to the Belgian context for all health care providers. The scale consisted of five different culturally competent domains: (1) paradigm (ability to adapt to a different type of care), (2) communication (ability to provide information to patients in clear language), (3) specificity (ability to provide specific care for specific groups), (4) organization (ability of the organization
to adapt to the needs of the patients), and (5) mediation (ability to negotiate with patients).

The cultural competence of the health care staff was associated with the leader’s cultural competence. This was especially significant in the cultural domains of mediation and paradigm, suggesting workplaces that encourage and role model different ways of providing care and that teach staff how to mediate cultural differences are better equipped to provide quality care to various migrant populations.

**Application to practice**

International migration is a global phenomenon challenging leaders and health care providers in the provision of culturally competent care. Leaders with formal positions have a greater positive impact on the diffusion of cultural competence among health care staff. Strategies such as role modelling may help to convey the value of empathy, respectful attitudes toward individuals of all cultures, and professionalism. Social relationships and leadership effects within health services should be considered when developing and implementing culturally competent strategies. Further research from a Canadian perspective is warranted.