"Bridging two worlds?": Towards cultural safety within schools of nursing in Australian universities

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“BRIDGING TWO WORLDS?”: TOWARDS CULTURAL SAFETY WITHIN SCHOOLS OF NURSING IN AUSTRALIAN UNIVERSITIES

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A thesis submitted in partial fulfilment of the requirements for the degree of Master of Philosophy

School of Nursing
The University of Notre Dame Australia

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Statement of authenticity

I declare that this thesis is an account of my research and contains as its main content work that has not been previously submitted for an award of degree, or diploma in any university or other institution. To the best of my knowledge, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signed

Samantha Petric
Abstract

Cultural safety has been a developing movement within the nursing profession in Australia over the past decade, led by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. This thesis explores this progress towards cultural safety; with a focus upon the Schools of Nursing in Australia. The philosophical and educational shifts from cultural awareness and competence, towards cultural safety are required within these very Schools that prepare nurses for their profession and its practice.

This thesis utilises a descriptive survey method, derived from the Aboriginal and Torres Strait Islander Health Framework, to gather information about the Schools of Nursing and their commitment and readiness towards cultural safety. This research is undertaken within a Decolonisation theoretical framework, turning the ‘gaze’ upon those who hold the dominant cultural position. The findings demonstrate significant progress towards cultural safety strategies and actions. Weaknesses in progress are identified in areas of organisational resources, in the recognition of the knowledge and needs of Aboriginal and Torres Strait Islander staff and students, and in the ongoing project of decolonising curriculum and faculty.

Recommendations are presented to support the continuing pathways towards cultural safety within the nursing profession. Cultural safety – in its philosophy and practice – requires continuing shifts in each nurse, in their relationships and practice, and in the nursing education that powerfully shapes the health care of Aboriginal and Torres Strait Islander peoples.
Acknowledgements

I acknowledge the Traditional Custodians of the land and sea where I live and work, and pay my respects to Elders past, present and future.

The beginning of this research project – another worldview

I thank my supervisor Bethne Hart who from our first meeting listened to my ideas and suggested my first (of many) attendances at the CATSINaM conferences. Thank you for your ongoing support and mentoring during this research project.

I thank my supervisor Janine Mohamed who with one sentence really set these past 3 years in motion. You were open and receptive to the project and I am grateful and humbled by the opportunity to work with you.

The continuous support over the thesis - grounding

I thank the communities that I have been lucky enough to work and live in over the duration of my thesis: Yarrabah QLD, Yalata SA and Oak Valley SA. The warmth that I received from community and from staff within these communities grounded me in the day to day of comprehensive primary health care and self-determination of Aboriginal health.

I thank CATSINaM for their ongoing support, especially Phoebe Dent for her help with survey mail outs.

I thank the University of Notre Dame and Miriam Cavanagh, the Schools of Nursing, the nurses who participated in the survey and the Council of Deans of Nursing for their support.

I thank Paulette Riley who listened and helped me understand the effects of colonisation in day to day life, especially when I found it hard to see and Deepa Harikrishnan who supported and encouraged me to complete this research study during our intensive study sessions.

The completion of the thesis- sprint home

I thank the people who helped me sprint home and complete this thesis. Laura Twyman for assistance with data collation and analysis, Jason Coombes for the passionate discussions about Aboriginal health and communities and Yane Kritski for helping with editing and reference checking.

I thank the National Tertiary Education Union (NTEU) and their Joan Hardy Scholarship award for financial assistance and ongoing support of the nursing profession.
Dedication

This thesis is dedicated to my mother, Veronika Petric, uz ljubav i šalicu čaja (with love and a cup of tea).

Culturally appropriate terminology: In this research study, different terminology is used to refer to Aboriginal and Torres Strait Islander peoples. It is recognised that the term 'Indigenous Australians' is not always agreed with, and that language/cultural names are often the preferred identification. Generic terminology has been used in this document, with no intention of disrespect, and with recognition of the sensitivities surrounding language use.
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Chapter 1- Introduction

1.1 Introduction

This is a study of cultural safety within Schools of Nursing in Australian universities. It is located within the theoretical framework of Decolonising Theory. Central to Decolonising Theory is the concept of cultural safety, and this study has been a part of my journey towards cultural safety. This chapter will introduce me as the student researcher and my pathways into Aboriginal and Torres Strait Islander health. I am a Registered Nurse, and a non-Aboriginal and Torres Strait Islander person from a Croatian background. This chapter will also introduce the focus and purpose of each following chapter.

1.2 Personal Journey to the Research Project

I have had an interest in working as a nurse in Aboriginal and Torres Strait Islander communities for many years. I was lucky enough to gain a mental health placement in Alice Springs, Northern Territory when I was a third-year nursing student. I had a positive experience in that my worldview was broadened, and I was able to spend time learning about Aboriginal and Torres Strait Islander culture and mental health. I had the feeling that I would one day return and kept this in the back of my mind. A few years later, I left a large hospital in Sydney to accept a 6-month contract back in Alice Springs Hospital, this time as a Registered Nurse. I remember Alice Springs had a significant impact on me. I felt that I was working with nurses who had an energy and passion for nursing. I enjoyed nursing Aboriginal and Torres Strait Islander patients and had no real understanding of the daily struggles for Aboriginal and Torres Strait Islander people. This understanding became deeper for me when I became a casual research data collector for the Menzies School of Health Research. It was the first time I was able to take my time, speaking one to one with an Aboriginal person and go through some of the questions that were part of the research study. These short interactions made Aboriginal health more meaningful for me. I was able to not just ‘do’ and have patients bend to the ‘nurse’; I was approaching patients on a more level playing field. If the patient chose not to take part in the research, there was no strong reaction as there might be in the clinical setting (for example, a patient refusing to take an anti-hypertensive medication). The research participant had rights that were recognised and respected. These were my early experiences into cultural safety.
1.3 Cultural Safety Journey

This journey began with my undergraduate nursing degree within the Aboriginal and Torres Strait Islander Health subject. This subject taught me to be culturally aware, sensitive and respectful towards Aboriginal and Torres Strait Islander people. I remember this subject did not examine the history of Australian nursing and its ongoing impacts upon Aboriginal and Torres Strait Islander health and cultures. As an undergraduate student I was not asked to critically evaluate my actions, my assumptions or the power that nurses brought into patient-nurse therapeutic relationships. The subject gave a very basic and brief understanding of Aboriginal and Torres Strait Islander cultures. I believe that if I had received a greater depth of understanding in my foundational years, I would have been better equipped to deal with challenging situations that I found myself in, and that other nurses have experienced after they have completed their undergraduate degree. For example, how to best approach a nurse who is expressing racist and discriminatory practice and how to have the tools to decolonise this nursing practice. I did not look at these power relationships until many years later after attending a Cultural Safety Training workshop.

I had attended Cultural Awareness Training through NSW Health that was mandatory for all staff. This gave me the impression that I understood culture and was aware of other cultures. However, I then attended a Cultural Safety Workshop run by CATSINaM and this illuminated personal accounts of racism within Australian healthcare, the history of Aboriginal and Torres Strait Islander people and colonisation and its ongoing effects. Understandings of equality, equity, respect and power relationships were explored in the Workshop in-group discussions. The Cultural Safety Workshop brought to my attention that I did not validate people’s experiences of racism. Whilst listening to personal accounts of racism I seemed to have an answer or possible explanations of why that may have occurred, with phrases such as ‘yes, but’ or ‘maybe you’re too sensitive’ circulating in my mind. This was shown to be the main consensus of the participants within the training as I listened to other group members express similar feelings. We were listening to these terrible stories, and simply could not accept that these were valid, real and continuing on today. It was a real challenge and wake up call.

Over the past three years, I have been working as an agency nurse with remote communities in South Australia and in Far North Queensland. I have been in these communities throughout much of the time that I have been completing this research project. One of the reasons I gained these contracts was that I wanted to remain authentic in my research. Initially, when looking over the cultural safety literature I thought, how can I complete this study truthfully by living in Sydney and working in a metropolitan hospital?
How can I write about cultural safety if I am not pushed to decolonise myself? These feelings of inauthenticity have subsided and recently I have come to some deeper understandings. I now realise that I will always be an outsider to Aboriginal and Torres Strait Islander cultures; that there is no ‘ending’ or finality to culturally safe practice; that there will be cross-cultural tensions and there will be moments where I want to retreat; and that there is inherent struggle between the biomedical model and the needs and wants of the Aboriginal communities.

As an Aboriginal nurse put it to me recently, “you’ve tried for 200 years and it’s not working- when are you mob going to work that out? Do something different”… (J. Coombes, personal communication, April 18, 2018).

1.4 Cultural Safety Study

The idea for this research study of cultural safety within Schools of Nursing of Australian universities started from another idea. I remember that one morning shift in Alice Springs Hospital, I looked around at my colleagues and realised that there was a distinct lack of Aboriginal nurses on shift. This was strange for me, as most of the patients I cared for identified as Aboriginal and/or Torres Strait Islander people. I remember the feelings of wanting some cultural help for myself in my daily tasks, that I felt isolated in my nursing practice and I wasn’t sure if I was culturally appropriate. After this experience I was lucky enough to attend a Congress of Aboriginal and Torres Strait Islander Nursing and Midwifery (CATSINaM) conference and had the opportunity to talk about my experiences in Alice Springs with the Chief Executive Officer of CATSINaM. She discussed with me the progress that CATSINaM was making with Aboriginal and Torres Strait Islander nurses and midwives. Then she mentioned that cultural safety within the nursing profession was the next step forward. I remember that she encouraged non-Indigenous nurses and midwives to look at ourselves first, to reflect upon and deconstruct our profession and our practice.

From this discussion, I began to have a closer look at the cultural safety nursing literature. It was obvious that CATSINaM was the leader in cultural safety within the Australian nursing profession and that this movement had been developing over the last 20 years. Cultural safety was gaining momentum within nursing curricula in Australian universities, with cultural safety becoming embedded within the now mandatory undergraduate nursing subject. However, I became aware of a gap emerging - where was the literature on the places where this teaching and learning was taking place? Were Schools of Nursing themselves being culturally safe? I knew that there were some Schools who had recognised champions of
cultural safety, who led cultural safety within their institutions and acknowledged the importance of power relationships within the institutions themselves. However, there was no published research on Schools of Nursing across Australia as to how culturally safe these institutions were. It seemed to me that this was fundamentally important; that nurses had to learn from people who practised cultural safety, within organisations that promoted cultural safety.

This Thesis is organised as follows:

Chapter Two will summarise and critically review the background literature to this study on cultural safety within the Australian nursing profession with discussion of key emerging areas of racism and antiracist nursing, white privilege within the nursing profession and its practices and the central concepts of cultural awareness and cultural competence.

Chapter Three will explore the theoretical framework of this study within the Australian nursing profession with Decolonisation Theory and its practice, disruption of power imbalances and the concept of the cultural interface discussed.

Chapter Four will present the methodology adopted for the study, a quantitative descriptive survey using the Occupational Commitment and Health Professional Program Readiness Assessment Compass survey (OCHPPRAC survey) (DOH, 2014) (Appendix A) to measure a School of Nursing’s commitment and readiness to implement cultural safety strategies and actions.

Chapter Five will present the research results collected from the OCHPPRAC (DOH, 2014) survey. Quantitative and qualitative data analysis is reported, and the strengths and limitations of this study are identified.

Chapter Six will highlight the implications for education and practice and makes recommendations for future research.

Critical Reflections
At the end of each chapter I have presented a critical reflection, in acknowledgment that the practise of cultural safety requires an ongoing reflection upon oneself and the impact of one’s culture upon nursing practice and knowledge. This also requires an understanding of the social, political and cultural environments in which we operate (J. Mohamed, personal communication, November 1, 2018). At the end of this Introduction chapter, I have reproduced the reflection of another profession, in its commitment towards culturally safe care.
“Listening more and talking less;

Following more and steering less;

Advocating more and complying less;

Including more and ignoring less; and,

Collaborating more and commanding less.”

(Carey et al., 2017, pp. 265)
Chapter 2- Literature Review

2.1 Introduction

This Chapter presents the central and contemporary literature that explores the factors that shape and challenge the Australian nursing profession in its progress towards cultural safety. The chapter discusses key emerging areas arising from the Literature Review: racist and antiracist nursing, white privilege within the profession and its practices, and central concepts of cultural awareness and cultural competence. Cultural Safety is explored as the contemporary concept and driving principle that is transforming nursing practice and nurse education. At the commencement of this Chapter, two national Frameworks directed towards the preparation of nurses to provide health care to Aboriginal and Torres Strait Islander people are presented. The final sections of this Chapter identify the policy work of four stakeholders – the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Nursing and Midwifery Board of Australia (NMBA), the Australian Nursing and Midwifery Accreditation Council (ANMAC) and the Nursing Council of New Zealand (NCNZ).

2.2 Background Frameworks

In 2014, The Australian Government released the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014) to support and guide higher education providers to develop cultural safety within their organisations, curricula and students. The Framework was developed from the Growing Our Future Report (HWA, 2011) recognising the immediate importance of non-Indigenous professionals working together with Aboriginal and Torres Strait Islander communities, to deliver culturally safe health care.

Within the Framework is a valuable measurement instrument, the Occupational Commitment and Health Professional Program Readiness Assessment Compass (DOH, 2014) that allows educational units within the universities to audit their progress, to identify enablers and barriers, and to set progressive goals. This tool works towards cultural safety by addressing commitment to cultural competency, leadership, support and partnerships and engagement with Aboriginal and Torres Strait Islander communities. Australian universities teaching health programs are now given resources, strategies, curricula design and collaborative networks through the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014).

In 2017, CATSINaM published The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (N & M Framework); an adaption of and complementary document to the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014). The development of the Nursing & Midwifery Framework (CATSINaM, 2017b) involved representatives from Australian Schools of Nursing and Midwifery providing recommendations on implementation of an interpretative guide for education within
universities, including professional development. The contents of the Nursing & Midwifery Framework (CATSINaM, 2017b) include implementation and accreditation guidelines for nursing and midwifery educators and three central concepts of learning in nursing and midwifery education i.e. cultural safety, the context and the operationalisation of Aboriginal and Torres Strait Islander health and wellbeing including principles and practices. Successful implementation of the Nursing & Midwifery Framework (CATSINaM, 2017b) includes leadership and strategy, embedding community partnerships in governance, staff capacity, Aboriginal and Torres Strait Islander student support needs, ensuring the allocation of sufficient resources, integrated and discrete curriculum content and continuous quality improvement. Its purpose is to bridge the gap from the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014) to a specific and dedicated nursing and midwifery curriculum.

2.3 The Literature Review

2.3.1 Search Question

What is known about the cultural awareness, cultural competence and cultural safety of the nursing profession towards Aboriginal and Torres Strait Islander peoples?

2.3.2 Search Strategy

The databases used to search for relevant articles were CINAHL, Informit and PubMed. The search terms used were ‘cultural awareness’, ‘cultural competence’ ‘cultural safety’, ‘education’, ‘Indigenous’ and/or ‘Aboriginal' and ‘nursing’. The search was conducted in 2016 and subsequently re-run in 2018 to capture newly published data. Publications matching the search terms were selected. Primary parameters for the search were: English language, full text articles, published between 1996 and 2018. The initial search retrieved 1672 publications. 1593 articles were excluded based on title and relevance; 14 duplicating articles removed; 65 abstracts were retrieved to review the aims, population and relevance. Based on the literature review search question 13 full text articles were selected, and 14 articles were obtained by manual search of databases and expert advice. Table 1 presents the literature search and processes of inclusion.
Table 1

<table>
<thead>
<tr>
<th>Process of article inclusion in the literature review</th>
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<tbody>
<tr>
<td>Total Articles</td>
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<td>Cinahl</td>
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<td>Informit</td>
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<td>PubMed</td>
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<tr>
<td>Manual</td>
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<td>Total</td>
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2.3.3 Quality Appraisal

Quantitative studies were appraised with The Quality Assessment Tool for Quantitative Studies (Thomas, Ciliska, Dobbins & Micucci, 2004). This tool gave a global rating for each quantitative publication of strong, moderate or weak with focus on selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop-outs, intervention integrity and analyses. Qualitative studies were appraised with The Critical Appraisal Skills Programme tool (Critical Appraisal Skills Programme, 2014). This tool requested a rating of ‘yes’, ‘can’t tell’ and ‘no’ and gave a global rating of ‘strong’, ‘moderate’ or ‘weak’ to duplicate the rating of the quantitative appraisal tool. The qualitative tool focused on aims, methodology, research design, recruitment strategy, data collection, relationship between researcher and participants, ethical issues, data analysis, and statement of findings. Quality appraisal was completed independently by two researchers, and where there was disagreement between researchers this was discussed and resolved.

2.3.4 Literature Search Outcomes

Twenty-seven publications were selected, which included fourteen literature reviews, five quantitative studies, two qualitative studies, three systematic reviews, two mixed methods studies and one PhD dissertation. Publications that were excluded focused on student experiences, teaching students (n=12), health care (n=11), clinical practice including mental health and primary health (n=10), Indigenous research methods (n=4) and refugee/migrants (n=1). The selected records were collated and reviewed. Table 2 provides a summary of the selected studies. It is noted that many selected papers were reviews of literature rather than empirical research.
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Focus</th>
<th>Research Design</th>
<th>Participants</th>
<th>Outcomes</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>McIntosh</td>
<td>USA</td>
<td>This study explores white privilege within society and subsequent disadvantage of Indigenous peoples.</td>
<td>Narrative Review.</td>
<td>Not applicable.</td>
<td>White privilege is identified as the dominant system within American society; disadvantaging Indigenous peoples</td>
<td>Weak.</td>
</tr>
<tr>
<td>Papps and Ramsden</td>
<td>NZ</td>
<td>This study explores implementation of cultural safety into nursing education in New Zealand.</td>
<td>Literature Review.</td>
<td>Not applicable.</td>
<td>Cultural safety within nursing practice is a tool that transfers power from nursing providers to Indigenous consumers. New guidelines from the Nursing Council of New Zealand implement cultural safety within nursing education.</td>
<td>Weak.</td>
</tr>
<tr>
<td>Ramsden</td>
<td>NZ</td>
<td>This study explores cultural safety and the impact of colonisation and racist historical practices within the NZ nursing profession.</td>
<td>Doctoral Dissertation.</td>
<td>Not applicable.</td>
<td>Four themes emerged as the steps towards Cultural safety: 1) it is a journey from Cultural Awareness through to Cultural Sensitivity and then on to Cultural Safety, 2) it means a disruption of power relationships within organisations, 3) it is measured by people receiving the care or service and 4) it is foresseen as a struggle to work towards and in its essence (changing power inequalities) it is designed to be.</td>
<td>Weak.</td>
</tr>
<tr>
<td>Puzan</td>
<td>USA</td>
<td>This study reviews the presence, reproduction and resistance of white privilege within the nursing profession.</td>
<td>Literature Review.</td>
<td>Not applicable.</td>
<td>‘Whiteness’ of nursing is identified within four domains of power: 1) structural, 2) scientific hegemony, 3) disciplinary and 4) the interpersonal. To dismantle this, the nursing profession must critically evaluate its white identity and privileged position.</td>
<td>Weak.</td>
</tr>
<tr>
<td>Bin- Sallik</td>
<td>AUS</td>
<td>This study reviews the development of cultural safety within Australian higher education.</td>
<td>Critical Reflection/ Literature Review.</td>
<td>Not applicable.</td>
<td>Cultural safety is the tool to reclaim Indigenous knowledge systems from non-Indigenous academics. Universities are responsible to create/provide education of professionals within culturally safe curricula and institutions.</td>
<td>Weak.</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Study Title</td>
<td>Research Design</td>
<td>Sample Size</td>
<td>Findings</td>
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<tr>
<td>Mooney et al. (2005)</td>
<td>AUS</td>
<td>This study evaluates the impact of cultural awareness training on health professionals’ understanding of Aboriginal Australians.</td>
<td>Quantitative study. Quasi-experimental research design. Questionnaire.</td>
<td>91 non-Indigenous health professionals (57% nurses) over a 7-month period in South Western Sydney Area Health Service. Participants were asked to complete a pre and post evaluation survey.</td>
<td>Cultural awareness training did not have significant effect overall on participants’ attitudes and beliefs post intervention (CAT). Findings were insignificant (p&gt;0.05) of participants perceptions in both the Intervention and Control groups, indicating CAT did not change perceptions.</td>
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<tr>
<td>Nash, Meiklejohn, and Sacre (2006)</td>
<td>AUS</td>
<td>This study measures cultural awareness of nursing staff following cultural awareness training.</td>
<td>Quantitative study. Descriptive statistics design. Questionnaire pre and post Cultural Awareness Training. IPTEAKS scale.</td>
<td>74 nursing faculty staff and clinical facilitators within the Queensland University of Technology.</td>
<td>Measurements of participants scores from pre to post cultural awareness training were significant (p=0.04) indicating an increase in cultural awareness of nursing faculty staff.</td>
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<tr>
<td>Sherwood and Edwards (2006)</td>
<td>AUS</td>
<td>This study reviews the contribution of decolonisation theory in changing the nursing profession and improving Aboriginal health care.</td>
<td>Critical Reflection/Literature Review.</td>
<td>Not applicable.</td>
<td>A change in the nursing profession is needed to decolonise Aboriginal health care. This is recommended as the way to improve Aboriginal health outcomes and to decolonise the current western dominant healthcare paradigm towards Aboriginal People.</td>
<td></td>
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<tr>
<td>Forsyth (2007)</td>
<td>AUS</td>
<td>This study explores the history of racism and discrimination within the Australian nursing profession and ongoing impacts of this.</td>
<td>Literature Review.</td>
<td>Not applicable.</td>
<td>Nurses enacted and upheld “White Australia” government policies upon Indigenous Australians from the 1890s- 1972 which embedded institutionalised racism within the practices of the profession.</td>
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</tr>
<tr>
<td>De Souza (2008)</td>
<td>NZ</td>
<td>This study explores cultural competence and cultural safety in the nursing profession in New Zealand.</td>
<td>Literature Review.</td>
<td>Not applicable.</td>
<td>Cultural competence guidelines can inform nurses and health care organisations on implementing cultural safety. Cultural competence as a goal is not effective; focus is now on the development of cultural safety within the nursing profession.</td>
<td></td>
</tr>
<tr>
<td>Edwards and Taylor (2008)</td>
<td>AUS</td>
<td>This study explores decolonisation as a method for the nursing profession to transcend the limitations of cultural</td>
<td>Critical Reflection/Literature Review.</td>
<td>Not applicable.</td>
<td>Cultural awareness, cultural security and cultural competence are inadequate to bring transformations of nursing practice. Cultural safety and decolonisation are identified as the processes required to transform nursing education.</td>
<td></td>
</tr>
<tr>
<td>Author(s) and Location</td>
<td>Study Design and Population</td>
<td>Methodology</td>
<td>Findings</td>
<td>Strength of Evidence</td>
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<tr>
<td>Paez, Allen, Carson, and Cooper (2008)</td>
<td>This study explores the relationship between the cultural competence of the primary health care provider and the health care clinic.</td>
<td>Quantitative study. Cross Sectional Study. Questionnaire based on Dogra’s Cultural Awareness Questionnaire, Godkin’s modified Cultural Competence Self-Assessment Questionnaire and the Cultural Competence Assessment Instrument.</td>
<td>69 primary care providers from 23 community based primary health clinics and 4 nurse practitioners. Participants were asked to complete an online survey assessing provider and clinic cultural competence. There was a higher incidence (n=37) of acknowledgement of one’s own power over others from non-dominant provider groups (Latino’s, women). This is indicative of providers practicing self-reflection and recognition of the imbalance within provider-patient relationships.</td>
<td>Moderate.</td>
<td></td>
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</tr>
<tr>
<td>Westwood and Westwood (2010)</td>
<td>This study discusses the effectiveness of cultural awareness training of health staff.</td>
<td>Literature review.</td>
<td>4 health care sectors (Bankstown, Fairfield, Liverpool and Wingecarribee) within South West Sydney Area Health Service. Cultural awareness training for health staff was found to lack clear policy direction, had uncoordinated training and a lack of accountability from the local and state levels of programs and policy.</td>
<td>Weak.</td>
<td></td>
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<tr>
<td>Williamson and Harrison (2010)</td>
<td>This study explores culturally appropriate nursing care to Indigenous peoples.</td>
<td>Systematic review.</td>
<td>A critical review of 58 research studies which measured culturally appropriate care within nursing. The evidence of successful implementation of cultural safety within nursing practice is lacking. Recommendations for a culturally safe structural framework to be incorporated into nursing practice.</td>
<td>Strong.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kowal (2011)</td>
<td>This study explores White Anti-racist identities of health care workers in Indigenous communities in the Northern Territory of Australia.</td>
<td>Critical Reflection/Literature Review.</td>
<td>Not applicable. Three themes within white- anti racist identities were presented: 1) Missionary, 2) Mother and 3) Child. White Anti-Racists struggle to transcend white stigma despite their goal of decolonisation and self-determination for Indigenous peoples. The negotiation of ‘white stigma’ requires critical reflection and further study.</td>
<td>Weak.</td>
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<tr>
<td>Downing and Kowal (2011)</td>
<td>This study reviews research findings of the effectiveness of cultural awareness training for health care workers in Australia.</td>
<td>Systematic Review.</td>
<td>A critical review of 9 research studies. Four studies demonstrated minimal positive change (knowledge/attitudes) experienced by participants post-cultural awareness training. The remaining five studies did not demonstrate an increase in cultural awareness for participants post training.</td>
<td>Strong.</td>
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<td>Author(s)</td>
<td>Country</td>
<td>Study Design</td>
<td>Methods</td>
<td>Sample Size</td>
<td>Response Rate</td>
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<td>Flavell, Thackrah, and Hoffman (2013)</td>
<td>AUS</td>
<td>This study measures the development and implementation of Indigenous content into nursing and midwifery health curricula.</td>
<td>Mixed methods. Online Student evaluation (eVALUate) survey post Indigenous Australian Culture and Health subject of study.</td>
<td>1742 undergraduate nursing and midwifery students over a 5-year period within Curtin University.</td>
<td>Response rate of 43% (n=748). Majority of students were satisfied with and motivated by the unit Indigenous Culture and History (&gt;80%) within the Indigenous Australian Culture and Health subject. Non-Indigenous nursing and midwifery academics require support, training and education in Indigenous Australian culture to become culturally competent. Organisational cultures can either encourage or obstruct the development of cultural competence in nursing students and academics.</td>
<td>Moderate.</td>
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<td>Sherwood (2013)</td>
<td>AUS</td>
<td>This study reviews the disadvantaged health of Indigenous Australians and the impacts of colonising nursing practices and views from health professionals.</td>
<td>Critical Reflection/Literature Review.</td>
<td>Not applicable.</td>
<td>Health professionals must review Indigenous history to decolonise their view and practice with an awareness of how this directly impacts on the lives of Indigenous Australians. A partnership approach between health professionals and Indigenous Australians is identified to improve health outcomes.</td>
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<tr>
<td>Chapman, Martin, and Smith (2013)</td>
<td>AUS</td>
<td>This study explores health professionals' knowledge and awareness of Aboriginal and Torres Strait Islander people post cultural awareness training in multiple Victorian Emergency departments.</td>
<td>Quantitative study. Pre-test- post-test intervention design. The &quot;Area human resources development/population health survey of participation in Aboriginal awareness training workshop&quot; tool.</td>
<td>72 non-Indigenous and 1 Indigenous health professionals (77% nurses).</td>
<td>Response rate 61% (n=44). Health professionals' knowledge and awareness of Aboriginal and Torres Strait Islander people had minimal changes in: 1) Attitude statements – I am apprehensive about interactions with Aboriginal clients. Confidence Interval- pre-CAT -0.16 to post CAT 0.39. 2) Perception statements- Aboriginal people use the ED more than non-Aboriginal people. Confidence Interval pre-CAT -0.03 to post CAT 0.62.</td>
<td>Moderate.</td>
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<tr>
<td>Herring, Spangaro, Lauw, and McNamara (2013)</td>
<td>AUS</td>
<td>This study explores cultural competence through the lens of racism and trauma within the experiences of Aboriginal people.</td>
<td>Critical Reflection/Literature review.</td>
<td>Not applicable.</td>
<td>Four themes emerged for health workers and health organisations to adapt a culturally competent framework: 1) recognition of Aboriginal and Torres Strait Islander trauma and racism, 2) organisations becoming informed of the barriers to health care, 3) working to health and employment parity targets, including Aboriginal and Torres Strait Islander employment within their organisations and 4) culturally competent collaboration with Aboriginal communities. Maori RNs experience racism throughout their nursing careers with these experiences occurring at the institutional level. Maori RNs perceived that the nursing curriculum was developed within ‘white’ frameworks with lack of content of Maori beliefs, values and experiences. Findings suggest reflection as a tool for institutions and individuals to develop understandings of racism.</td>
<td>Weak.</td>
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<tr>
<td>Author(s)</td>
<td>Country</td>
<td>Study Description</td>
<td>Design/Methodology</td>
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<td>Nielsen, Stuart, and Gorman (2014)</td>
<td>AUS</td>
<td>This study explores the 'whiteness of nursing' experienced by Aboriginal nurses.</td>
<td>Qualitative interview study. Qualitative review of 'whiteness in nursing' and the lived experience from Aboriginal nurses. Yarning method.</td>
<td>Participants describe the 'Whiteness of nursing' as oppressive to Aboriginal people and Aboriginal nurses within the white dominant healthcare construct. Cultural competence and culturally safe practices in health care must be the goal for the nursing profession.</td>
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<tr>
<td>Truong, Paradies, and Priest (2014)</td>
<td>AUS</td>
<td>This study reviews cultural competence training in health care worldwide.</td>
<td>Systematic Review. A critical review of 19 research studies.</td>
<td>Interventions to improve cultural competency can improve patient/client health outcomes. There was no reported uniform framework for cultural competency training across different health settings. This study recommended a culturally competent framework that will engage health care professionals, organisations and systems to influence change.</td>
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<td>Margolin (2015)</td>
<td>USA</td>
<td>This study explores white privilege and its ongoing links to discrimination and racism.</td>
<td>Critical Reflection/ Literature review. Not applicable.</td>
<td>White privilege theory requires critical appraisal; it may serve as a platform from which white people discuss their privilege without taking any action towards change.</td>
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<td>Best and Gorman (2016)</td>
<td>AUS</td>
<td>This study describes Aboriginal nurses and midwives' experiences in the Australian nursing profession from the 1950s onwards.</td>
<td>Critical Reflection/ review. Not applicable.</td>
<td>Four themes emerged throughout the historical overview of Aboriginal nurses and midwives within the nursing profession: 1) ongoing experiences of racism by Aboriginal nurses and midwives, 2) the desire of Aboriginal and Torres Strait Islander people to work within their communities, 3) the needed inclusion of Aboriginal health within the nursing curriculum and 4) the need for targeted strategies to recruit and retain Aboriginal nursing students.</td>
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<td>Milne, Creedy, and West (2016)</td>
<td>AUS</td>
<td>This study develops a self-report tool to measure Nursing and Midwifery academics' awareness of cultural safety.</td>
<td>Quantitative study. Cultural Safety and Awareness of Racism were measured with the online ACSS Questionnaire.</td>
<td>Response rate 57% (n= 42). The highest result within the study was Cultural Acknowledgement with a mean of 9.07 (SD 1.5) out of a possible 10. There was significant correlation between scores on the Awareness of Cultural Safety Scale and Awareness of Racism scores (p=0.002). The item mean for the ACSS was 3.90 (range 2.6-4.5) indicating that the participants were aware of cultural safety.</td>
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<td>Fleming, Creedy, and West (2017)</td>
<td>AUS</td>
<td>This study measures midwifery academics' awareness of cultural safety post education.</td>
<td>Mixed methods study. Cultural Safety and Awareness of Racism were measured with the ACSS Questionnaire. Yarning circles. 18 non-Indigenous Midwifery Academics. Participants engaged in a 12-week cultural safety education intervention program.</td>
<td>Response rate 72% (n=13). An increased awareness of cultural safety of midwifery academics post cultural safety training (p &lt; 0.04). Participants reported high levels of satisfaction and a willingness to participate in cultural safety training.</td>
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The central findings emerging from the Literature review are critically appraised in the following sections.

2.3.5 Racism and the Nursing Profession

The nursing profession has a racist history and nursing practices have impacted on Aboriginal and Torres Strait Islander peoples throughout Australian history. Nurses enforced and upheld White Australia government policies upon Indigenous Australians during the protection, integration and self-determination policy eras (Forsyth, 2007; Best & Gorman, 2016).

In the segregation/protection era of the 1890s-1950s, the power was firmly with non-Indigenous government professionals (Best & Gorman, 2016). Non-Indigenous nurses did not question the policies that dictated their practice however some were sympathisers to Aboriginal people (Best & Gorman, 2016). Non-Indigenous nurses removed Aboriginal children and participated in the segregation of Aboriginal patients in hospitals (Forsyth, 2007). The assimilation/integration era of the 1950s-1972 showed paternalism within nursing practice. Aboriginal people were excluded from decision making processes and treated differently to the non-Indigenous population with longer hospital stays (“for their good”) and forced female sterilisations (Forsyth, 2007). The Self-determination/self-management movement (1972 onwards) “was seen as the way forward” (Best & Gorman, 2016, pp. 152). This era did see both Indigenous and non-Indigenous nurses speaking out about racism and discrimination within health care, however, racist and discriminatory attitudes and behaviours were now firmly embedded within institutions and nursing practice (Forsyth, 2007). The remnants of paternalism still existed within the Self-determination era and into current day (Best & Gorman, 2016).

Within this historically racist profession, Aboriginal and Torres Strait Islander nurses experience racism and discrimination within their professional nursing careers (Best & Gorman, 2016). This racism is seen in their struggle to conform to a ‘white’ workplace and their suppression of their culture to fulfil their work duties (Puzan, 2003; Nielsen et al., 2014). This is not just specific to Australia. New Zealand Maori registered nurses experience racism throughout their nursing careers at the institutional level within education, health care organisations and clinical practices (Huria et al., 2014).

To further explore racism within nursing, it is worth reflecting on whether our behaviours and normalised practices and policies are discriminatory (De Souza, 2008). Within a health care
system dominated by western reasoning and western knowledge (Sherwood, 2013) it is not a shock that 22% of Aboriginal people report racism from their health providers (Herring et al., 2013). In the education system, a ‘white’ dominated framework or curriculum without Indigenous representation, participation and partnership and with a lack of content of Indigenous beliefs, values and experiences (Huria et al., 2014) can hide racism, discrimination and ongoing trauma. This leads to an increase in harm within health care practices (Sherwood, 2013). Without health care providers’ recognition of this, in a further harmful turn, shaming happens to Aboriginal people; when health professionals are blind to intergenerational trauma and racism experienced by Aboriginal people and communities they only see dysfunction and illness (Herring et al., 2013).

Nursing practices that supported segregation and assimilation are often unrecognised by non- Indigenous nurses; however, for those who seek to explore the impacts of these nursing actions, a very real discomfort can ensue. Racism within institutions of education and healthcare are also often unrecognised; and the revelation of this is sometimes challenged (Puzan, 2003). This discomfort and unease are imperative as processes of professional change; the recognition and acknowledgment of the presence of racism within nursing and the effects of this nursing history must be the starting point in the decolonisation process of nursing and health care (CATSINaM, 2017a).

2.3.6 The Nursing Profession and Antiracism

Anti- racist nursing is an ongoing professional movement within the Australian nursing profession. It upholds the need for education and understanding of the history of racism in nursing, and the impact on Aboriginal people. It specifically speaks of the need for nursing recognition and responses to the ongoing trauma of racism and colonisation (Forsyth, 2007). Forsyth (2007) argues that discrimination and racism can only be challenged when nurses understand and speak out about the institutional racism that they have been a part of. She acknowledges that throughout the history of the Australian nursing profession there have been antiracist nurses who worked against the dominant colonising practices of government, healthcare and nursing education.

This racist and colonising history is the catalyst for change (Edwards & Taylor, 2008) where denial and guilt can be transformed to inquiry and reflection. Decolonising the nursing profession involves cross-cultural reconciliation (Herring, et al., 2013), heightening the voices of Aboriginal and Torres Strait Islander nurses and increasing numbers of white anti-racists (Kowal, 2011) to bring reconnection and healing (Herring et al., 2013). This
decolonising “gaze” requires the profession to look inwardly and reflect on historical and contemporary practices. In particular, the “gaze” is now also strongly upon those who prepare nurses for their profession and practice, as it is in the contexts of education that the profession and its practices can be perpetuated or changed

Health professionals who recognise white privilege and racism are aptly coined white anti-racists (Kowal, 2011). However, a white anti-racist role takes different forms and struggles and also reacts to the stigma of whiteness. Kowal (2011) identified three reoccurring roles within white- anti racist identities of health professionals working with Aboriginal and Torres Strait Islander people in northern Australia. The ‘Missionary’ is the evangelist, campaigner or advocate whose motivations range from duty and obligation to guilt and politics. This identity role is seen as enforcing one’s own beliefs upon Aboriginal people. The ‘Mother’ role is the mother figure approaching Aboriginal people with unconditional love. This identity role is seen through the mother-child relationship where non-Indigenous staff - as the mother - enact power and paternalism, through a loving orientation. The ‘Child’ identity role is the innocent non-expert, with no hidden meanings or agenda brought to healthcare. This identity role is seen by Kowal (2011) as the remedy to white anti-racist stigma, with power handed back to Aboriginal and Torres Strait Islander people. This portrayal of anti-racist identities gives the nursing profession valuable standpoints to critically appraise their perspectives and practices towards Aboriginal people.

2.3.7 White Privilege and the Nursing Profession

The nursing profession is a challenging place for Aboriginal and Torres Strait Islander nurses within the dominant white constructs, and the racist and colonising history of the profession (Edwards & Taylor, 2008). This can be seen within nursing ideology through the conjured dominant image of the benevolent white nurse tending to the patient. An example of this upheld white ideology is framed in the often-lauded Florence Nightingale, but can be reframed as a British woman from a wealthy family with profound white privilege (Kowal, 2011). In this regard, nursing very readily in our minds is represented by this white ideal rather than in recognition of the struggle that minorities have faced within the historical practices of the profession (Nielsen et al., 2014).

In her seminal work, McIntosh (1988) describes white privilege as being given daily because of skin colour, rather than class, merit or location. McIntosh (1988) states the goal of white
privilege is to fight racism and she powerfully provides examples of the daily life of white privilege:

“I can be pretty sure of having my voice heard in a group in which I am the only member of my race

I do not have to educate my children to be aware of systematic racism for their own daily physical protection

I can do well in a challenging situation without being called a credit to my race

If I declare there is a racial issue at hand, or there isn’t a racial issue at hand, my race will lend me more credibility for either position than a person of colour”.

(McIntosh, 1988, pp.1-2).

McIntosh (1988) confronts her white privilege in a non-threatening tone in order to coax the reader to reflect on white privilege. However, to explore white privilege, there must be an acknowledgement of its hidden, invisible and silent nature and its harmful effects. This silence in part refers to the unspoken realities of colonisation, ongoing racism and the lack of acknowledgement of the legacy of ongoing trauma (Herring et al., 2013; Sherwood, 2013). Also, silence is linked to white privilege with advantage given to people who are white, act white or appear white within the white culture (Nielsen et al., 2014). The invisible or hidden nature of white privilege hides discriminatory and racist behaviours and, in its essence, has no consideration of the non-dominant community on which it stands.

In contrast to McIntosh (1988), Margolin (2015) found several other meanings hidden within white privilege theory and raised core concerns regarding its uncritical acceptance. Firstly, white privilege places the focus on white people’s personal identity and experiences rather than on Indigenous identity and experiences. Secondly, by allowing white people to ‘confess’ their unearned privileges, did not lead to positive benefits for Indigenous people, but rather gave white people a platform to be right (Margolin, 2015).

“… In other words, that white privilege pedagogy operates in large part as an antiracist cover, a sham that allows whites to have their cake and eat it too by
providing them the appearance of selflessness and antiracism without requiring them to do anything selfless or antiracist.” (Margolin, 2015, pp. 4).

In recognition of Margolin’s concerns, there is a need for the deconstruction and diminishing of the ongoing colonising processes of nurse education and nursing practices, as well as recognition of the continuing impacts of colonisation, racism and trauma within the everyday lives of Aboriginal people, and Aboriginal nurses and students.

2.3.8 Cultural Awareness in Nursing

Cultural awareness is the first step towards cultural safety. The goal of cultural awareness is to increase health professionals’ knowledge, skills, processes and practices to function effectively and appropriately in culturally diverse situations (Chapman et al., 2013; Mooney et al., 2005). Cultural awareness is the first essential step (Mooney et al., 2005) for improving health outcomes and health delivery (Westwood & Westwood, 2010). The method of increasing understanding of Indigenous culture for non-Indigenous health professionals, became known as Cultural Awareness Training (CAT) (Mooney et al., 2005). The objectives of CAT are to influence non-Indigenous health professionals’ attitudes and perceptions of Aboriginal people with topics including Aboriginal history, disempowerment of Aboriginal culture, current health status and health concerns (Mooney et al., 2005; Westwood & Westwood, 2010).

Cultural Awareness Training (CAT) can have positive effects on the knowledge and awareness of Aboriginal and Torres Strait Islander peoples’ cultures and health (Chapman et al., 2013; Downing & Kowal, 2011; Mooney et al., 2005; Nash et al., 2006;). These positive effects include increases in cultural awareness overall of nursing faculty staff (Nash et al., 2006), increases in responsive perceptions of Aboriginal patients in emergency department staff (Mooney et al., 2005) and increases in friendship, familiarity and understanding of the complexity of Aboriginal patients in a major health service (Chapman et al., 2013).

However, Downing and Kowal (2011) completed a systematic review of 60 Australian research reports and found just 7% of articles reported some degree of positive change in knowledge and attitudes after CAT. More specifically, Downing and Kowal (2011) evaluated 10 Indigenous cultural training programs and found only 4 of these demonstrated a positive change, 2 programs anticipated a change and 4 programs found no change. The small amount of positive change experienced by participants post-training shows that training on its own is not enough, it requires action within organisations (Mooney et al., 2005). Shifting
training goals from teaching about “culture”, towards examining individual and organisational processes of power, colonisation and identity is required. This requires personal exploration (Downing & Kowal, 2011) and meaningful action within places of learning and education.

Westwood and Westwood (2010) argue CAT is a failure with a lack of clear policy direction, and uncoordinated, unaccountable training programs. They recommend organisational change with streamlined and focused delivery of training programs and related policy. There needs to be a long-term view to sustained change, and not just the quick fix of an isolated and single training program (Westwood & Westwood, 2010). The cultural awareness movement is now clearly the subject of well-developed critique; and it has been found wanting in both its processes and outcomes (Westwood & Westwood, 2010; Chapman et al., 2013; Mooney et al., 2005). The current position upholds that cultural awareness is part of the journey towards cultural safety (Ramsden, 2002; Milne et al., 2016).

2.3.9 Cultural Competence in Nursing

Cultural competence in nursing began with the New Zealand movement led by Maori woman Irihapeti Ramsden when a bi-cultural model was used in response to cultural diversity and cultural inequalities in New Zealand (Ramsden, 2002). Cultural competence is a set of behaviours, attitudes and interactions that acknowledge and incorporate the importance of culture within health care interactions (Flavell et al., 2013; Paez et al., 2008; Truong et al, 2014). Cultural competence is an important strategy to increase health outcomes for Aboriginal and Torres Strait Islander people (Flavell et al., 2013), to decrease health disparity (Truong et al., 2014) and for non- Indigenous health professionals to overcome their own biases and racial prejudice (Paez et al., 2008). Cultural competence has been defined as a broad conceptual term for the many interventions (CAT, cultural competence training and cross-cultural training) with the goal of improving health services for ethnic groups (Truong et al., 2014).

Limitations to the concept of cultural competence and its related training interventions have been identified within the literature review. Cultural competence may be too finite a concept i.e. reduced to checklists or competencies on a form, and as something that is achieved and no longer an ongoing process (De Souza, 2008). The questions of cultural competence remain in part unanswered- does a certificate, training, or embedding units of study make the workforce and workplace culturally competent? and by whose definition and measurement? Large differences exist within the spectrum of language, teaching and outcomes within cultural competence training, with Indigenous students, staff and their
supporters perceiving the cultural competence literature and teaching as rhetorical rather than a sustained strategy (Bin-Sallik, 2003). Lack of empirical knowledge poses the question as to whether cultural competence interventions are effective, or only theoretically established (Truong et al., 2014).

The focus of cultural competence has moved forward from the interpersonal to the organisational arena (Truong et al., 2014). An organisation’s culture could either encourage or obstruct the development of cultural competence in students and academics (Flavell et al., 2013) and there is the need for health care organisations and universities to be held accountable for their own cultural competence. Paez et al. (2008) found cultural competence training is unlikely to change behaviour and attitudes without organisational supports such as the implementation of culturally sensitive practices and integration of cultural competence into an organisation’s daily practices. Similarly, Truong et al. (2014) recommended that successful cultural competence training must include consideration of the culture of the organisation, with real change in competence to come through leadership commitment and policy changes. An organisation’s unsuccessful implementation of culturally competent actions and strategies increases the potential for colonising and discriminatory practices to remain embedded within teaching and curricula. It is also suggestive of the inability of cultural competence to transform or recognize and disrupt power relationships within organisations (De Souza, 2008). Clearly, the institutions in which people learn and explore personal worldviews and their professional practices influences their emerging practices within the health work force.

The need for health care organisations and universities to be held accountable for their own cultural awareness and cultural competence is highlighted. Overall, the assertion is that cultural competence in curriculum development is achievable (Paez et al., 2008; Truong et al., 2014) however, it must be within a culturally safe framework and context (Nash et al., 2006; Milne et al., 2016; Williamson & Harrison, 2010).

2.3.10 Cultural Safety in the Nursing Profession

The concept of cultural safety can be clearly defined as

A journeying process, beginning with:

- Cultural awareness
  (I am aware of my own culture)
To cultural sensitivity
(I respect others and their differences, I am understanding others)

And on to cultural safety
(I see my own cultural identity, I am reflecting on other cultures, I am listening and prepared to share and engage with others, I recognize the impact of my culture on others)
(Ramsden, 2002; Milne et al., 2016)

Ramsden (2002) defines cultural safety with the term ‘culture' used broadly and the word ‘safety' chosen as it is nursing profession specific. This concept requires the researcher/educator/practitioner to firstly reflect upon their own culture, and its impact upon the other culture (Sherwood, 2013); the marginalised and colonised culture. Cultural safety is foreseen as a struggle (in its essence it is designed to be) (Ramsden, 2002). Emphasis is placed on the health worker understanding their own culture and identity, and how this is manifest in their professional practice (Papps & Ramsden, 1996). Cultural safety is not special treatment, it’s an outcome (Bin- Sallik, 2003) where everybody involved is responsible and has a vital role. It is unique both philosophically and in practice, in that unlike cultural competence, where a person could be measured as to where they fit on the competence spectrum (although this too is debated) cultural safety cannot be claimed by people and is measured only by an Aboriginal and/or Torres Strait Islander person who says that you are culturally safe (and they can only speak for themselves). A recent Australian study from Milne et al. (2016) measured the awareness of cultural safety in nursing and midwifery academics – within one university - with a 57% participation rate. There was a significant correlation between scores on their newly developed Awareness of Cultural Safety Scale (ACS) and Awareness of Racism scores; with researchers’ recommendations for the development of a nursing and midwifery cultural safety framework and further research on the ACS within a larger and diverse sample. A study by Fleming et al. (2017) found that 13 midwifery academics’ perceptions of racism did not change pre and post cultural safety education on the ACS. The authors found that the reflection on one’s own worldview is the first step towards awareness of cultural safety (Fleming et al., 2017). This study highlighted that the development of cultural safety is directly correlated with awareness of racism. The researchers gave recommendations for a culturally safe framework to improve pedagogical outcomes. Overall, they argued that when institutions engage with Indigenous perspectives and embed Indigenous pedagogy, cultural respect and cultural humility are promoted.
Cultural safety and culturally safe institutions are reached through the disrupting of established and historical power relationships (De Souza, 2008). Understanding of these power inequalities can then identify the barriers to cultural safety. Individual and institutional change can focus upon diminishing inequalities and disadvantage (Sherwood & Edwards, 2006). The promotion of cultural safety within Schools of Nursing must include a decolonisation process; a decolonising gaze is needed to reflect on the political and historical events that have directly impacted on the lives of Aboriginal and Torres Strait Islander Australians and nurses/students (Sherwood, 2013). Decolonisation practices will include the developed understanding of the colonising beliefs, attitudes, policies and practices within nursing education.

2.3.5 Literature Review and forward action

This review of the literature indicates the following:

- that the nursing profession has a racist history;
- that the nursing profession must engage in truth telling in its history;
- that nursing education must recognise its colonising practices;
- that cultural safety is the current and continuing goal for the nursing profession and its education contexts;
- that the Aboriginal and Torres Strait Islander Nursing and Midwifery Health Curriculum Framework (CATSINaM 2017b) is the national policy towards cultural safety for university programs in Australia;
- that formal measurement of cultural safety within Schools of Nursing in Australia will be an important step towards the profession reflecting upon and monitoring progress;
- that the nursing profession must uphold accountability of the Schools of Nursing in Australia in providing culturally safe education for academics, students and Aboriginal and Torres Strait Islander people.

This stands against the background of the two national Curriculum Frameworks (DOH, 2014; CATSINaM, 2017b) providing the foundations towards the preparation of health professionals, and specifically nurses, who would learn within curricula and institutions that upheld principles and practices of cultural safety, anti-racism and decolonisation.
2.4 Cultural Safety and Stakeholders in the Nursing Profession

2.4.1 The Australian Nursing and Midwifery Accreditation Council

In Australia, The Australian Nursing and Midwifery Accreditation Council (ANMAC) does include cultural safety in the Registered Nurse Accreditation Standards (ANMAC, 2012). Four out of the nine Standards from ANMAC (2012) include the keywords of cultural safety and Indigenous health within nursing curricula. Standard 2.4 (i) of the Curriculum conceptual framework states Schools of Nursing must “Promote emotional intelligence, communication, collaboration, cultural safety, ethical practice and leadership skills expected of registered nurses”. (ANMAC, 2012, pp. 18). Although cultural safety is highlighted, the abovementioned standard does not ask nurses to decolonise their practices, beliefs and value systems or to recognise nursing as a profession that participated in colonisation policies and practices (Forsyth, 2007). ANMAC is a powerful stakeholder, shaping the curricula and teaching practices and contexts of Schools of Nursing in Australia. It is envisaged that it will continue to drive forward changes towards cultural safety in these arenas. It may be that culturally safe educators, assessments, and learning environments can become accreditation criteria.

2.4.2 The Nursing and Midwifery Board of Australia

The Nursing and Midwifery Board of Australia (NMBA) have released updated Registered nurse standards for practice (NMBA, 2016). The NMBA (2016) states:

“RNs recognise the importance of history and culture to health and wellbeing. This practice reflects understanding of the impact of colonisation on the cultural, social and spiritual lives of Aboriginal and Torres Strait Islander peoples, which has contributed to significant health inequity in Australia.” (NMBA, 2016, pp. 1)

This paragraph acknowledges the impacts of colonisation on the wellbeing of Aboriginal and Torres Strait Islander peoples and requires the profession to have an understanding of history and culture. This standard brings forward cultural awareness and cultural sensitivity but does not explicitly uphold cultural safety. However, cultural safety has been clearly stated within the NMBA (2018) Code of Conduct for Nurses where nurses are to:
“Understand that only the person and/or their family can determine whether or not care is culturally safe and respectful.

Create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues.”

(NMBA, 2018, pp. 9).

The presentation of cultural safety within the Australian nursing profession’s Code of Conduct represents a powerful statement of cultural awareness and cultural humility. It allows the profession to uphold and require cultural safety in all health care contexts. It requires curricula and teaching practices and contexts to prepare nurses to practice within the Code, and for this level of conduct to be assessed as a criteria of membership of the profession.

To commit to cultural safety in further depth, it is worth considering the Nursing Council of New Zealand (NCNZ) guidelines. In its enactment of cultural safety strategies, the NCNZ has four principles embedded in their professional accreditation document, specifically in the interests of Maori culture. As stated in Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice (NCNZ, 2011):
“Principle 1.2: Cultural safety aims to improve the health status of New Zealanders and applies to all relationships through nurses acknowledging the beliefs and practices of those who differ from them

Principle 2.1: Cultural safety aims to enhance the delivery of health and disability services through a culturally safe workforce by identifying the power relationship between the service provider and the people who use the service

Principle 3.1: Cultural safety is broad in its application recognising inequalities within healthcare interactions that represent the microcosm of inequalities in health that have prevailed throughout history and within our nation more generally

Principle 4.2: Cultural safety has a focus on challenging nurses to examine their practice carefully, recognising the power relationship in nursing is biased toward the provider of the health and disability service”. (NCNZ, 2011, pp. 9-10)

Unlike ANMAC and NMBA, the NCNZ guidelines (2011) specifically ask for nurses to consider their power relationships when working with people who use the service. Consideration of power relationships are essential to successfully implement cultural safety into practice and to decolonise nursing practice and nursing education (Edwards & Taylor, 2008). This is further discussed within Chapter 3.

2.4.3 The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) has since its beginnings in 1997 aimed to increase the number of Aboriginal and Torres Strait Islander nurses and midwives. Today, the national profile and exposure of the organisation challenges the nursing profession’s history, ideology and practices of white dominance. It promotes a nursing profession that is more reflective of diverse and cross-cultural Australia, and its First Peoples. This is significant
not just to increase population parity of Aboriginal and Torres Strait Islander nurses, but also to firmly plant solid ground for current and future nurses to work in cross cultural collaboration towards professional and social change. CATSINaM (2017b) upholds cultural safety as the professional goal, and as the journey against racism and colonisation.

Aboriginal and Torres Strait Islander health and cultural safety is clearly stated:

“…cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in health care encounters.” (CATSINaM, 2017b, pp. 11).

The above professional standards and conduct requirements towards cultural safety show a clear trajectory in the governing bodies of the profession in support of a decolonising nursing practice. This then leads to a challenge to nursing education providers to respond to this professional governance, and prepare and support nurses to shape their knowledge, reflections and practices towards cultural safety. This also strengthens the relationships between the nursing profession and Aboriginal and Torres Strait Islander people.

2.5 Towards Cultural Safety: Measuring Progress

The exploration of the cultural awareness and cultural competence literature found that these concepts and related training programs were found to be lacking: the concepts were limiting, and the training programs had limited outcomes. Cultural safety has become the professional goal. Against the social history of colonisation in Australia, and the central role that the profession of nursing has played in this historical process, recognition is now given to the significant steps that have been recently taken to build cultural safety within the nursing profession. Many of these commence within the
education programs of nurses, in strong partnerships with Aboriginal and Torres Strait Islander stakeholders and communities. The “gaze” is particularly now on those who prepare nurses for practice.

There has been no national measurement of the progress towards cultural safety that is being made in Schools of Nursing in Australia. The Occupational Commitment and Health Professional Program Readiness Assessment Compass (DOH, 2014) enshrined within the two national Frameworks, has been used within some organisations as an assessment of progress, and as a guide towards elements that make up ongoing successful progress. This leads to a clear pathway in the measurement of progress towards cultural safety within Schools of Nursing in Australia.

2.6 Critical Reflection

I have found the exploration of the historical impacts of the nursing profession and the (in) action of the profession against racism and trauma, very important and shocking. The exploration of white privilege, white anti-racist theory, cultural awareness, cultural competence and cultural safety has given me many questions to reflect upon within my own nursing education and nursing practice. As I work in rural remote communities and Aboriginal health services, my ideal is to allow myself to be the ‘child’, the non-expert.

I believe that a decolonisation process for nursing education providers will be one step towards acceptance of some responsibility for our contribution to the social determinants of Aboriginal and Torres Strait Islanders people’s health. Progress towards cultural safety and the will to seek to try and correct these historical legacies must give power and support to self-determination processes and reconciliation. There is to be truth telling when coming from the racist history that the nursing profession is based upon. The next chapter presents the theoretical framework of decolonisation theory and discusses the disruption of power imbalances between the colonising worldview dominating the worldview of Aboriginal and Torres Strait Islander people.
Chapter 3- Decolonisation as a Theoretical Framework

3.1 Introduction

Successful implementation of cultural safety within the nursing profession must be located within a Decolonisation Framework (Sherwood & Edwards, 2006; Edwards & Taylor, 2008). This informs transformations within nursing education and nursing practice. Decolonisation theory and practice must be understood to deconstruct the nursing profession’s ongoing practices of colonisation within health care services and nursing education. This chapter explores Decolonisation theory and its disruption of power imbalances between the colonising worldview dominating the worldview of Indigenous peoples. The concept of a cultural interface is examined; describing the space in which these two worldviews come together. The nursing profession, and its higher education organisations are now given responsibility for the decolonisation of their curricula and practices (Sherwood & Edwards, 2006). This chapter also locates the study of the cultural safety of these higher education organisations within a Decolonisation theoretical framework.

3.2 Decolonisation Theory

Linda Smith (1999), a prominent scholar within Decolonisation theory, explores this theory as the framework in which Indigenous stories, knowledge and research is shared. She highlights that this theory reclaims Indigenous perspectives within academia and research methods.
“Colonialism was, in part, an image of imperialism, a particular realisation of the imperial imagination. It was also, in part, an image of the future nation it would become. In this image lies images of the Other, stark contrasts and subtle nuances, of the ways in which the Indigenous communities were perceived and dealt with, which make the stories of colonialism part of a grander narrative and yet part also of a very local, very specific experience.” (Smith, 1999, pp. 24)

Decolonisation theory is focused on confronting and diminishing the power imbalances between Indigeneity and a colonising worldview (Parkes- Sandri, 2013) and the disruption of the dominant, Eurocentric Western ideology (Sherwood, 2013). Decolonisation theory is an active process and it is complex, with its critical gaze upon the historical roots of colonialism and imperialism (McLaughlin & Whatman, 2007). It addresses the “inequities brought about by colonisation by recognising First Nations people’s rights, autonomy, diversity, language, culture and our (Indigenous/non-Indigenous) shared histories” (Sjoberg & McDermott, 2016, pp.29).

This disruption of the dominant colonising worldview and acknowledgement of colonisation can create tensions and have a jarring effect between Western and Indigenous communities. These tensions are reported internationally within the literature exploring decolonisation and Canadian Aboriginal, New Zealand Maori and Native Alaskan American communities. Canadian Aboriginal worldviews have often been oppressed within a Western gaze, with tensions leading to radical Indigenism (Getty, 2010) that highlights the imperative to transform worldviews (Hart, 2010). New Zealand Maori worldviews are influenced by the commitment of the Treaty of Waitangi (1840) with cross-cultural tensions emerging despite partnerships between Maori and the New Zealand Government (DeSouza, 2008). Tensions exist for Native Alaskan Americans when re-asserting their positions of living between ‘two-worlds’ and struggling against the external colonial world in which they live (Barnhardt & Kawagley, 2005). The destabilizing and challenging of established and dominant worldviews clearly meets resistance and creates instability (Getty, 2010), and this leads to strengthened actions by Indigenous peoples to struggle against and expose continuing colonisation practices and policies. Scholars in this theoretical arena emphasise that it is not the intention to demonise Western worldviews (Nakata, Nakata, Keech, & Bolt, 2012) nor should there be a tactic to target the privileged who may resist the relinquishment of power. Rather, the emphasis for scrutiny and change is placed upon the dominant worldview within which Indigenous people live. This challenge of Indigenous ideology within the dominant white
worldview complements the struggle towards developing colonial awareness of colonisation and its ongoing impacts (DeSouza, 2008).

The Indigenous Research Agenda figure (Smith, 1999) (presented below) is included to highlight the process of decolonisation and Decolonisation theory. Its intended use is for Indigenous researchers within western academia; it is also a valuable image to conceptualise and position Decolonisation theory for the nursing profession. Nursing education organisations need to develop understanding of the four directions of decolonisation, transformation, mobilisation and healing in order to fully disengage the “imperialism and colonialism at multiple levels” (Smith, 1999, pp. 20). Transformation in nursing education requires the (un)learning of whiteness and privilege for educators and the academy within the decolonising space (Phillips & Stacey, 2017). From this, nursing education organisations can make informed decisions about Aboriginal health, Aboriginal education and become change agents within the nursing profession (DOH, 2014). Mobilisation begins with the personal and individual request for non-Indigenous academics to accept and move beyond their ‘whiteness’ and privileges (McLaughlin & Whatman, 2007). From this change at the personal/individual level, nursing education organisations ultimately have the people power (both Indigenous and non-Indigenous peoples) to decolonise education practices and embed Indigenous perspectives (McLaughlin & Whatman, 2007). Nursing education organisations must have collaborative and meaningful partnerships with Aboriginal and Torres Strait Islander peoples, and through these partnerships, healing of the injuries of colonisation can occur (Wilson, Kelly, Margarey, Jones, & Mackean, 2016). These four directions of decolonisation and are to be understood within Decolonisation theory and the greater concept and practices of self-determination.
3.4 Decolonising Nursing

Historically, the nursing profession has impacted the lives and cultures of Aboriginal and Torres Strait Islander people, as shown by historians and commentators (Forsyth, 2007; Best & Gorman, 2016; Sherwood, 2013). Nurses have upheld and enforced White Australia policies of assimilation, segregation and integration, and actively engaged in colonising practices and policies. Awareness and acknowledgment of this nursing history can be a catalyst for change (Edwards & Taylor, 2008); feelings and actions of denial and guilt within the profession can be transformed to actions of inquiry, reflection and change. Decolonising the nursing profession involves cross-cultural reconciliation (Herring et al., 2013), heightening the voices and presence of Aboriginal and Torres Strait Islander nurses and increasing the numbers of white anti-racists (Kowal, 2011). These decolonising practices require the profession to look inwardly and reflect on historical and contemporary practices. The decolonizing “gaze” is now also strongly upon those who prepare nurses for practice; nurse educators and the tertiary education institutions in which nursing programs take place.
In the context of nursing education, cultural safety and Decolonisation theory guides education organisations to reflect upon their own culture, and its impact on Aboriginal and Torres Strait Islander peoples (CATSINaM, 2017a). A decolonisation approach requires the commitment needed to challenge colonising practices in teaching, curricula, and teaching institutions; it is political and deeply personal (McLaughlin & Whatman, 2007). This requires nursing education providers to amend their practices and environments, upholding the cultures of Aboriginal and Torres Strait Islander people (Downing & Kowal, 2011; Sherwood & Edwards, 2006), and implementing a cultural safety framework for continuing change.

Nursing education institutions have not recognised the knowledge systems of Aboriginal and Torres Strait Islander people (Hart, Cavanagh & Douglas, 2015); this contributes to the continuing racism, prejudice and lack of awareness of nursing students and academic nursing staff. Western interpretations and oppressions of Indigenous knowledge systems and histories contribute to Indigenous knowledge production remaining mostly invisible within curricula (McLaughlin & Whatman, 2007). Decolonising practices within universities are reported in education studies (McLaughlin & Whatman, 2011), however there is little reported regarding the application of decolonising theory and cultural safety frameworks within nursing faculties and nursing curricula in Australia.

3.5 Decolonisation and the Cultural Interface

In a Decolonisation Framework, responsibility falls to universities to address disadvantage, racism and discrimination within nursing education. Acceptance of this responsibility requires white dominant education frameworks to give place for Aboriginal and Torres Strait Islander worldviews within curricula. This inclusion can be described as taking place at a cultural interface, a shared intersection of Western and Indigenous domains (Nakata, 2002). It is an intercultural space, the meeting place between non-Indigenous and Indigenous peoples, where negotiations of meaning, knowledge, power and privilege can take place (Hart, Cavanagh, & Douglas, 2015). This cultural interface (Nakata, 2002) or intercultural space (Hart et al., 2015) is the place where people and organisations meet; each bringing their culture, narratives and meanings and can either:

“…inform, constrain or enable what can be seen or not seen, what can be brought to the surface or sutured over, what can be said or not said, heard or not heard, understood or misunderstood, what knowledge can be accepted, rejected, legitimised or marginalised, or what actions can be taken or not taken on both individual and collective levels.” (Nakata, 2007, pp. 324).
The cultural interface in nursing education organisation contexts, is the interface between Indigenous and non-Indigenous knowledges, curricula, and ways of being and doing (CATSINaM, 2017a). It requires a recognition of the colonisation of Indigeneity in all its forms (Nakata, 2002), and the privileging of Indigeneity throughout the profession’s history and within the profession’s contemporary practices (Kowal, 2011).

It is important to note that within Decolonisation theory, Post-Colonial theory has been debated extensively (McLaughlin & Whatman, 2007; Smith, 1999). A central critique of Post-Colonial theory is that it upholds that the colonial period is over, in that it is “finished business” (Smith, 1999), however this is contested by many academics (Prior, 2007; McLaughlin & Watson, 2007; Parkes- Sandri, 2013; Smith, 1999). In addition, Post-Colonial discourse is seen as not including Indigenous peoples concerns, ways of knowing and being, and this can further privilege non-Indigenous people (Smith, 1999). Decolonising theory is seen as the central framework within which Indigenous voices, knowledges and ways of being are privileged, and within which non-Indigenous people must reflect upon their position and their ways of thinking, doing and being (CATSINaM, 2017a). Within this, cultural safety is both a philosophy and a practice; and any exploration of cultural safety must be framed by Decolonisation theory.

3.6 Critical Reflection

Working, thinking and researching within a Decolonisation framework has been an ongoing process for me. Most of my colonising thoughts are deeply embedded and are not in my uppermost consciousness. In the practice of my profession I am quick to act without realising the ripple effect of my actions on others. This is a learning process in my pathway towards cultural safety. I see that the cultural interface or intercultural space is present in every nurse-patient interaction. To this space I bring my own worldview and the patient brings their worldview. At times there is a jarring effect, both worldviews crash into each other and the intercultural space becomes uncertain and conflictual. In other times both worldviews can intersect, and both parties can collaborate and share an equal respectful and safe place.

The following chapter presents the research study measuring progress and readiness towards cultural safety within Schools of Nursing in Australia. A Decolonisation framework governs this study; in its methodology and in consideration of its limitations.
Chapter 4- The Research Study

4.1 Introduction

This research study sought to measure cultural safety within Schools of Nursing in Australian universities. The Occupational Commitment and Health Professional Program Readiness Assessment Compass (OCHPPRAC) (DOH, 2014) was used as the instrument to measure cultural safety. The OCHPPRAC tool was recommended to the research team by the Congress of Aboriginal Nurses and Midwives (CATSINaM) as the most appropriate method to measure progress towards cultural safety within the Schools of Nursing in Australia. In the OCHPPRAC tool (DOH, 2014), four critical success factors are used to measure this progress; organisational commitment to cultural competency, health professional program leadership and commitment, structures and support for implementation, and partnerships and engagement. This chapter presents the research question, methodology and methods, and closely considers ethical issues and methodological limitations. It returns to a critical reflection to consider the research study within a Decolonisation framework; asking the questions: is this study giving new information about cultural safety, and is this study itself culturally safe?

4.2 The Research Question

What are the levels of commitment and readiness towards cultural safety within Schools of Nursing in Australian universities?

4.3 The Research Methodology

Quantitative Descriptive Survey Research Design

The purpose of descriptive quantitative research is to find “what is”, with survey methods used to collect data (Gall, Gall, & Borg, 2007). Quantitative research seeks to test theories and relationships of variables within numerical data (Creswell, 2014). Quantitative research is highly accurate and provides frequencies, averages and other statistical calculations (Chi-Square, t-test, ANOVA) to show the characteristics of the data (Mujis, 2004). Quantitative methodology was selected for this study; as the research question was to measure the levels of progress towards cultural safety within Schools of Nursing. This measurement would provide a ‘snapshot in time’ of the current levels of commitment and readiness to
cultural safety of each School of Nursing and across Schools of Nursing as a whole. The Schools of Nursing in Australia are not homogenous; they are diverse in history, place, programs and resources. This study selected a standardised tool in order to gain responses to consistent statements (Sapsford, 2007). Due to the locations of Schools of Nursing across Australia a survey provided confidentiality and geographical reach, with comparatively low costs and anticipated high response rates (Jirojwong, Johnson & Welch, 2014).

There are no reported studies of levels of cultural safety within Schools of Nursing in Australia. Other surveys identified in the literature review measured cultural awareness (Nash et al., 2006;) and cultural competence (Flavell et al., 2013; Paez et al., 2008) but did not measure cultural safety at an education organisational level. As shown in Chapter 2, levels of cultural awareness and cultural competence and cultural safety are not synonymous. It was fundamental to this research methodology to identify and utilise a measuring tool that was specific to the concept and processes of cultural safety.

In the literature review, the only measuring instrument approximating this research aim was the OCHPPRAC survey (DOH, 2014). This was reported to measure cultural safety by addressing the four factors of: commitment to cultural competency, leadership, support and partnerships, and engagement with Indigenous communities. This OCHPPRAC survey had at its central purpose the intention to guide educational units within the universities to assess and record their progress, to identify enablers and barriers, and to set progressive goals towards cultural safety.

4.4 The Research Instrument

Organisational Commitment and Health Professional Program Readiness Assessment Compass survey (OCHPPRAC)

Developed by Universities Australia (2011), the OCHPPRAC tool (DOH, 2014) is presented in the Appendix of the National Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014) which supports the preparation of graduates across the health professions to provide culturally safe health care to Aboriginal and Torres Strait Islander peoples. Its current use is for the guidance and future accreditation of academic departments within Universities. A summary of the history of the OCHPPRAC tool (DOH, 2014) is presented below.

In 2007, Australian Medical Schools were assisted to implement the Indigenous Health Curriculum Framework with the Indigenous Health Project Critical Reflection Tool (CRT)
The goal of the Indigenous Health Curriculum Framework (Phillips, 2004) was for Indigenous health to be shared across the entire Medical School with a ‘partnership approach’ to Indigenous pedagogy and curriculum development. The CRT (Phillips, 2004) was a guide for individuals, working groups and committees to review their current policies, procedures, curricula and teaching strategies. The CRT (Phillips, 2004) had seven themes: (1) context of the medical school (2) the outcomes of the medical course (3) the medical curriculum (4) assessment of student learning (5) the curriculum, monitoring and evaluation (6) Indigenous students and (7) implementing the curriculum (Phillips, 2004). The CRT (Phillips, 2004) was the first step in the development of the OCHPPRAC tool with the above seven themes echoed throughout the OCHPPRAC tool (DOH, 2014).

In 2012, The Inter-professional Collaborative Organisation Map and Preparedness Assessment tool [IP-COMPASS] (Parker & Oandasan, 2012) was developed as a quality improvement framework tool for healthcare organisations to develop and deliver inter-professional education. Its intended use was between two or more healthcare professionals who host healthcare students within in the clinical setting (with patients) (Parker & Oandasan, 2012). The IP-COMPASS has four constructs that support inter-professional education providers: (1) commitment to inter-professional collaboration (2) structures and support for inter-professional collaboration (3) commitment to inter-professional education and (4) structures and support for inter-professional education (Parker & Oandasan, 2012). The IP-COMPASS most closely resembles the structure of the current OCHPPRAC tool (DOH, 2014) with the design, layout and rating system of ‘Absent, Weak, Adequate and Strong’. However, the IP-COMPASS (Parker & Oandasan, 2012) does delve deeper into reflective practices with sections such as ‘celebrating strengths’ and ‘ideas for strengthening your organisational culture’, which the OCHPPRAC tool (DOH, 2014) does not.

In 2012, the Health Workforce Australia Organisational Readiness for Undertaking Scope of Practice: An Evidence Based Evaluation Framework was developed to support healthcare organisations (Thompson et al., 2012). This framework encompasses whole-of-organisations to evaluate their practice interventions to improve Aboriginal and Torres Strait Islander health outcomes. Evaluations were based on four themes: (1) implementation evaluation, (2) economic evaluation, (3) training evaluation and (4) national implementation requirements (Thompson et al., 2012). This framework is vastly different from the two above tools as its focus is on evaluating outcomes, rather than requiring self-reflection and evaluation of processes within organisations.
The OCHPRACC survey (DOH, 2014) was chosen for this research study as it asked Schools of Nursing to reflect upon their organisational, leadership, engagement and educational processes. Their reflection was structured within the four critical success factors:

(1) Organisational commitment to cultural competency
A whole-of-organisation commitment must be present for the successful implementation of cultural competency within the higher education setting (DOH, 2014). For example, “the mandatory completion of Aboriginal and Torres Strait Islander awareness training for all staff” (DOH, 2014, p. 85). This demonstrates the commitment the organisation has to not only support and educate all staff in cultural competency, but also the shared vision of a culturally safe and reflective organisation.

(2) Higher program provider leadership and commitment
In order for the HPP (Higher Program Provider) to lead and commit towards cultural safety, necessary reforms must be taken, and resources allocated in curricula, governance and education. For example, “there is meaningful participation of Aboriginal and/or Torres Strait Islander representation in the governance structures of the HPP” (DOH, 2014, p 86). Meaningful participation promotes Aboriginal and Torres Strait Islander student and academic engagement and links the School of Nursing with the Aboriginal and Torres Strait Islander communities.

(3) Structures and support for implementation
Implementing the Aboriginal and Torres Strait Islander Health Curriculum Framework requires support from the HPP. For example, “the HPP acknowledges the emotional impact of teaching, provides support for educators (mentoring, training) and allocates resources in this area” (DOH, 2014, p. 87). This shows whole-of-organisation recognition of the structures and support needed to implement the Curriculum Framework.

(4) Partnerships and engagement
Whole-of-organisation partnerships and engagement with Aboriginal and Torres Strait Islander stakeholders and communities are essential elements of progress towards cultural safety. For example, “There is meaningful participation of Aboriginal and/or Torres Strait Islander peoples on curriculum development, review and implementation committees” (DOH, 2014, p. 88). Meaningful engagement, partnerships and participation with Aboriginal and Torres Strait Islander stakeholders and communities are identified as essential elements of
curriculum, staff development, student and staff support and organisational cultural safety. The OCHPRACC tool (DOH, 2014) in this research design was modified to facilitate measurement and completion. The original tool had one column titled ‘need more info’ (if there was not enough information in the statement to make a rating) and another column titled ‘action’ (if this was an area that the HPP would like to action). These were removed due to the research focus on what was being currently achieved. At the end of the completed survey participants were invited to give general commentary regarding the survey and their responses. The modified OCHPPRAC survey used in this research study is presented in Appendix A.

The OCHPPRAC tool (DOH, 2014) used a 4-point Likert Scale with answers recorded as ‘Absent’, ‘Weak’, ‘Adequate’ or ‘Strong’ with 36 statements in total. Likert scales are commonly used to measure an opinion, providing responses to a question or statement on a scale (Jamieson, 2004). Benefits of a Likert scale can be seen by the way it is constructed with clear and straightforward statements and with each statement reflecting a desired behaviour or attribute, rather than fact (Maranell, 2017). The use of a Likert Scale ensured ease, clarity and focus for participants completing the survey.

Survey limitations

The OCHPPRAC tool (DOH, 2014) has not been utilised as a research tool; its current use is for the guidance and future accreditation of academic departments within Universities. This raises questions of reliability and validity. There are very few validated surveys in the areas of organisational change and cultural safety within healthcare (DOH, 2014). The OCHPPRAC tool (DOH, 2014) has been piloted, however, minimal information is offered within The Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014) to confirm the process of rigour and validity. The development of the Framework was undertaken with an environmental scan of professional accreditation standards, key informant interviews, National Consultation workshops, online forums and case studies (DOH, 2014).

The OCHPPRAC’s (DOH, 2014) intended use was for Australian health care organisations, which provides a greater reach to health care providers, but it is not focused on the nursing profession and its Schools in universities. This is in contrast to the Australian Medical School’s Critical Reflection Tool (Phillips, 2004), which was specifically developed for use within Australian Medical Schools. This is recognised as a limitation of the survey as each academic professional department is particular to the profession, with its own set of
curriculum requirements, history, and challenges, when implementing Indigenous health curricula.

Overall, the OCHPPRAC tool (DOH, 2014) has had a lengthy process of construction with themes such as ‘whole-of-organisation’ and ‘partnerships’ emerging throughout the development of the survey. The OCHPPRAC tool (DOH, 2014) requires the self-assessment of academic units (i.e. Schools of Nursing); structuring their reflection upon specific elements that measure their readiness and preparedness in implementation of the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014). Thereby, academic units and key stakeholders within are constituted as responsible for the preparation of culturally safe health professionals.

4.5 Ethical Considerations

Ethical considerations surrounding this research study about cultural safety informed the researchers’ decisions regarding participant recruitment, data collection, and data analysis. Ethics approval to undertake this study was granted by the University of Notre Dame Australia (UNDA) Human Research Ethics Committee (017173S) (Appendix B). The principal ethical issues arising from this research study were informed consent (protecting autonomy) and non-maleficence (minimising risks of harm). These issues are explored below.

Informed consent
Alby, Zucchermaglio & Fatigante, (2014) state that informed consent is achieved by receiving voluntary consent from the research participants with a full and understandable explanation of the aims and procedures. The Participant Information Sheet (Appendix C) provided information about the study detailing how data was collected and participants’ rights, including the right not to participate. Participation was voluntary. Consent was indicated by the completion and return of the survey, with the distribution and return processes of the survey clearly stated. The role of CATSINaM’s administration staff in the distribution and collection of returned surveys was clearly outlined. This role and process of distribution and collection further protected the anonymity of the participants.

Risks of harm
The foreseen risk of harm in this research study was the risk of reputational damage to the participating School of Nursing. A School of Nursing could be concerned about reported data
that identified them, that could weaken their reputation. This ethical concern was addressed by conducting a confidential and anonymous survey. Reputational damage was further minimised by the utilisation of the CATSINaM administration office as the sender and receiver of surveys; thereby ensuring that the research team could not identify the participants in the survey return process. Overall, no specific University School of Nursing could be identified in data collection, through data analysis or in the reporting of results.

Protection of privacy

Access to completed surveys and collated data was limited to the primary researcher and supervisors. The hard copy surveys were collated into computer-based records, and the original documents were securely stored in the Principal Supervisor’s office. In responding, the Dean of the School of Nursing, or their selected spokesperson, completed the survey – without identifying themselves.

4.6 Recruitment of Research Participants

The Australian Council of Deans of Nursing were informed of this proposed research study and had indicated their support in principle. A letter was sent to the Head of this Council prior to the research commencing, indicating its commencement, identifying the survey distribution process, including the survey and Participant Information Letter, and welcoming their continuing support. Recruitment reached out to the entire cohort of the Heads of Schools of Nursing. Their participation was elicited by invitation to complete and return the survey. An online program for survey delivery was considered; however, the research team accepted the recommendations of stakeholders (Deans of Nursing Council and CATSINaM) that mailed hard copy distribution and return was the most appropriate method for data collection. This method strongly protected anonymity and confidentiality and strengthened the reach of the survey into Deans’ correspondence already characterised by voluminous electronic communication.

Thirty-six surveys, Participant Information Letters and pre-paid return envelopes were mailed in unaddressed envelopes to the CATSINaM administration office. The CATSINaM office placed the addresses of the Head, School of Nursing (via their established mailing list) onto each envelope and posted them from their office in Canberra, ACT. The participants returned their completed surveys to the CATSINaM office with each return envelope clearly marked as UNDA Cultural Safety Research Study. Three mail outs were distributed over four-weekly intervals. The latter two mail
outs included a brief reminder letter encouraging participation if it had not already been undertaken.

Response rate
The response rate was considered to be a critical factor within study recruitment processes, and networking with stakeholders (Deans of Nursing Council and CATSINaM) facilitated this. The 2016 data collection from a similar cohort of academics, in an earlier study (Milne et. al, 2016) generated a 57% response rate. This response rate was considered as the desired minimum response rate for this study. In order to match the desired response rate of 57%, with 36 participants invited to complete the survey, 20 completed surveys would be required.

4.7 Data Collection

The OCHPPRAC tool (DOH, 2014) gathered self-reported data from each School of Nursing. Demographic data inclusive of state/territory and their School of Nursing location (capital city, major urban centre, regional city and smaller town) was collected within the survey. The 4-point Likert Scale of the OCHPPRAC tool (DOH, 2014) asked participants to give a response to statements regarding their organisation’s readiness and commitment to cultural safety. Further general comments were invited from survey participants, at the end of the survey.

4.8 Research Data Analysis

Data from the OCHPPRAC tool (DOH, 2014) was analysed through the Statistical Package for Social Science (SPSS) program (25.0 edition). This program is highly accurate and provides frequencies, averages and other statistical calculations (Chi-Square, *t*-test, ANOVA) to show the characteristics of the data collected. The quantitative data was analysed with descriptive statistics gained from participant responses on the OCHPPRAC tool (DOH, 2014).

The responses to each statement were numerically measured. An ‘Absent’ response was scored ‘1’, ‘Weak’: ‘2’, ‘Adequate’: ‘3’, ‘Strong’: 4 with higher scores indicative of higher commitment and action. All data was recorded separately, within the four success factors (1) Organisational commitment to cultural safety, (2) HPP commitment and organisational leadership, (3) Structures and support for implementation and (4) Partnerships and engagement. The survey results were collated separately, and as a whole for each
participating School of Nursing. For example: A mean of (4.0) = Strong (High commitment to implement the factor and/or Framework).

Descriptive statistics were used to analyse the data, these included measures of central tendency (Mean, Median, and Mode) and measures of dispersion (SD and Range) (Mujis, 2004). The four critical success factors and ‘Geographical Area' (Metropolitan vs. Regional) were the comparisons of interest and were analysed by the Mean and Standard Deviation. To determine reliability of the OCHPRAC tool (DOH, 2014) Cronbachs Alpha was applied to ascertain internal consistency of the scale and test items (Mujis, 2004).

Quantitative data arising from participants’ concluding comments was analysed with content analysis to give collated reporting of the elicited responses. Commentary was coded to identify themes; independently by two researchers and then collaboratively finalised through consensus across all researchers of the team (Vaismoradi, Turunen & Bondas, 2013). These analyses of participants’ responses to statements within the four success factors provided a measure of commitment and readiness towards cultural safety within Schools of Nursing in Australia. The additional commentary from participants gave indications of their thoughts/reflections arising from their completion of the survey.

4.9 Methodological Rigour

Methodological rigour is demonstrated by evidence of reliability and validity. In descriptive survey research design, reliability is the strength by which the survey obtains the same measurement when repeated (Watson, 2015). The OCHPRAC tool (DOH, 2014) has not formally been used as a research instrument, however, the OCHPRACC tool (DOH, 2014) was pilot tested prior to its study distribution. Five senior teaching academics (in another health discipline) self-administered the survey and confirmed its readability, clarity and meaningfulness to the research team. As a further test of reliability of the OCHPRAC tool (DOH, 2014) Cronbachs Alpha was applied after data collation to ascertain internal consistency of the scale and test items (Mujis, 2004).

Validity is the extent by which the research instrument measures what the researchers are seeking to measure (Watson, 2015). Face and content validity were demonstrated through the processes of the development of the OCHPRAC tool (DOH, 2014), in that it was constructed by experts through a comprehensive process of consultation and validated with pilot testing with five senior academics as abovementioned. The OCHPRAC tool (DOH,
2014) is an amalgamation of the IP-COMPASS tool (Parker & Oandasan, 2012) in layout and content. For this reason, the IP-COMPASS tool (Parker & Oandasan, 2012) is referenced for its reliability and validity. The IP-COMPASS was pilot tested at four different sites and at 12 clinical sites across Ontario, Canada. Pilot testing found that the IP-COMPASS tool demonstrated reliability in its measuring of change at one site over time (i.e. in a longitudinal study) (Parker & Oandasan, 2012). The IP-COMPASS demonstrated face and construct validity with a user feedback system from interviews and assessments from experts (Parker & Oandasan, 2012) with data collected and analysed using qualitative data analysis software (NVivo).

4.10 Methodological Limitations

Methodological limitations of quantitative research design include gaining numerical data and analysis without an in-depth understanding of ‘why’ the trends and correlations exist (Creswell, 2014). The limitations of descriptive survey research also include that self-report data can be limited by social desirability bias, low response rate and response bias (Robson & McCartan, 2016).

Social desirability bias

In this research study, the participant, as a respondent for their academic department/School, may have wanted their organisation to appear in a ‘good light’ (Robson & McCartan, 2016). Social desirability bias can lead to biased results in each self-reported ‘rating’ with a rating that is not representative of the actual environment of the School. Anonymity and confidentiality of the data collection and reporting processes minimised the tendency for participants to be influenced by a positive reporting bias.

Response bias

There was a possibility that only the Schools of Nursing that perceived they are doing well in their progress towards cultural safety would be participants in the study. In this study, response bias looks at the respondents who perceived a negative view of their progress towards cultural safety and that this may have potential negative effects overall in the study (Robson & McCartan, 2016). Response bias cannot be eliminated completely, however, it can be minimised with the below strategies.

Within the OCHPPRAC tool (DOH, 2014) the response scale was Absent, Weak, Adequate and Strong. The response bias was minimised by the rating of ‘Absent’, which gave participants a rating similar to ‘not-applicable’ or ‘does not apply’ (Robson & McCartan,
2016). By the inclusion of this rating, this gave a response for participants that may have perceived negative outcomes. Also, a self-reported weaker overall rating was not seen as a ‘bad’ or ‘wrong’ result. A weaker overall rating was seen as a ‘starting point’ in which Schools of Nursing could reflect upon where they lie on the cultural safety continuum.

Minimising these negative effects of self-report data included inviting participants to provide concluding commentary at the end of the OCHPPRAC tool (DOH, 2014). These comments provided an opportunity for participants to comment on cultural safety and the survey itself.

Response Rate

The desired response rate was n=20 based upon a recent study of a similar cohort by Milne et. al (2016) which had a minimum response rate of 57%. A low response rate within this research study would indicate a nonresponse bias. A nonresponse bias would mean it would be difficult to prove reliability and validity of the OCHPRAC tool (DOH, 2014). This limitation was minimised through the repeated recruitment processes to potential participants via postal mail with welcoming reminders, and by eliciting the support of the Australian Council of Deans of Nursing.

4.11 Critical Reflection

The survey used in this research study measures readiness and commitment towards the organisational structures, processes, partnerships and practices that are required within institutional change toward cultural safety. This research began with a ‘decolonising gaze’; recognising that these powerful organisations that prepare nurses to enter the profession must reflect upon their own ways of being and doing. Does this research study bring new knowledge about ways of doing and being? It asks ‘old’ questions of the Schools of Nursing respondents in a progressive way and provides for their view of their actions towards cultural safety. Clearly this is not the only view, but it asks for powerful leaders to look upon their places of influence. Is this research study culturally safe? It is supporting progress towards cultural safety and is promoting a decolonising nursing. This shifts the gaze away from Aboriginal and Torres Strait Islander nurses, students, stakeholders and communities being asked to carry the burdens of change towards cultural safety. It is acknowledged that the collaborative evaluators of a School of Nursing’s progress towards cultural safety would also be these very Aboriginal and Torres Strait Islander nurses, students, stakeholders and communities. This is a future goal. The next chapter presents the results of the survey, with discussion of the findings, for the future.
Chapter 5- Results and Discussion

5.1 Introduction

This chapter presents the results of the Organisational Commitment and Health Professional Program Readiness and Assessment Compass (DOH, 2014) survey. This survey was distributed to the Deans of Schools of Nursing in Australia. Chapter 4 has explained the research methodology and the four critical success factors of The OCHPPRAC tool (DOH, 2014) i.e. Organisational Commitment to Cultural Competency, Health Professional Program Leadership and Commitment, Structures and Support for Implementation, and Partnerships and Engagement. The responses to the four critical success factors were analysed to ascertain the levels of readiness and commitment of Schools of Nursing towards cultural safety. This chapter presents a summary of the data findings, and statistical analysis of the Schools of Nursing responses to the OCHPPRAC survey. A discussion of results is presented following the reported data analysis. Limitations of the data collection and data analysis are discussed at the end of the chapter. In the next chapter, recommendations arising from these research findings, and for future research are presented.

5.2 Overview of Data Findings

The OCHPPRAC survey (DOH, 2014) contained thirty-six statements within four success factors and the responses to these indicated the commitment and readiness towards cultural safety, within each School of Nursing. The statements were presented as scale items with the following possible responses: ‘Absent’, ‘Weak’, ‘Adequate’ and ‘Strong’. Thirty-six questionnaires were distributed (from CATSINaM) via paper mail to each School of Nursing Dean in Australia. Twenty-two completed surveys were returned to CATSINaM representing a response rate of 61.1%. The first two questions focused on demographic information about the participants. Demographic data received showed a third of participants from NSW (33%) and the majority from a capital city (55%).

Schools of Nursing located in regional areas ($M= 119$) presented higher success factor scores than Schools of Nursing in metropolitan Areas ($M= 108.4$) with a median of 0.058. Success Factor 3- Structures and Support for Implementation was the lowest scoring factor ($M = 21.18$) and the highest scoring factor was Success Factor 2- Health Professional Program Leadership and Commitment ($M= 34.81$). Success Factor 2 contained both the highest rated statement “the Head of the Health Professional Program (HPP) is supportive
and committed to the framework” \((M = 3.89, \ SD = 0.38)\) and the lowest rated statement “A dedicated HPP Framework budget has been established” \((M = 2.50, \ SD = 0.99)\).

The OCHPPRAC survey (DOH, 2014) was found to be highly reliable (36 items: \(\alpha = 0.96\)). Qualitative data from participants’ additional comments was manually coded independently by two researchers. Five themes emerged: cultural safety, collaboration, recruitment and retention, curriculum changes, and staff recruitment.

### 5.2.1 Participant Demographics

Table 3

<table>
<thead>
<tr>
<th>Geographical Location</th>
<th>(n^a) (%)</th>
<th>Schools of Nursing in Australia(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State or Territory(^c)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>7 (33.3)</td>
<td>11</td>
</tr>
<tr>
<td>ACT</td>
<td>1 (4.8)</td>
<td>1</td>
</tr>
<tr>
<td>VIC</td>
<td>3 (14.3)</td>
<td>8</td>
</tr>
<tr>
<td>SA(^d)</td>
<td>4 (19.0)</td>
<td>3</td>
</tr>
<tr>
<td>WA</td>
<td>1 (4.8)</td>
<td>5</td>
</tr>
<tr>
<td>QLD</td>
<td>5 (23.8)</td>
<td>7</td>
</tr>
<tr>
<td>TAS</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>NT</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Area(^e)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital City</td>
<td>11 (55.0)</td>
<td>21</td>
</tr>
<tr>
<td>Major urban centre</td>
<td>4 (18.2)</td>
<td>10</td>
</tr>
<tr>
<td>Regional city</td>
<td>5 (25.0)</td>
<td>4</td>
</tr>
<tr>
<td>Smaller town</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

\(^a\)\(n = 22.\) \(^b\)\(n = 36.\) \(^c\)Missing data from one participant. \(^d\)Participant’s responses from SA indicate more surveys received than the amount of School of Nursing within that state. \(^e\)Missing data from two participants.

Table 3 reports demographic data of School of Nursing location inclusive of state/territory. The total Schools of Nursing in Australia data is included to give context to response rates within each State/Territory and Area. A third of participants were from NSW (33.3%) with the majority from a Capital City (55%). One participant did not state their State/Territory and two
participants did not state their Area. Four responses were received from South Australia (SA) despite three SON within SA as indicated by Table 3. There were no participants from Tasmania and the Northern Territory, and no participant indicated their School of Nursing was in a smaller town (< 25 000 pop.). This is comparable with data from Universities Australia (2017) with the majority of Universities (main campus) located in or close to Capital Cities and a higher proportion within NSW.

Figure 2. Total OCCHPRAC Survey score by location

Figure 2 reports overall scores on the OCHPRAC survey (DOH, 2014) shown in a boxplot graph. A School of Nursing’s location of either metropolitan (Capital City) or regional (Major Urban Centre, Regional City) was analysed. There is a higher commitment and readiness towards cultural safety in regional areas (Mean= 119; Median= 120; IQR= 116-132) when compared to metropolitan areas (Mean= 114; Median= 108.4; IQR= 96-117). The long lower whisker in regional areas indicates participants’ views are varied amongst the lowest quartile group, and very similar for the highest positive quartile group. The minimum scores are similar for regional (85) and metropolitan (80) areas, although the maximum scores show a large difference between regional (144) and metropolitan (133) areas. The maximum
possible score for the OCHPPRAC survey (DOH, 2014) was 144 (indicating all statements were ‘Strong’) which may indicate an outlier within the regional data set.

5.2.2 Summary of Descriptive Data Analysis

Table 4

<table>
<thead>
<tr>
<th>Analysis of OCHPPRAC survey results by Success Factor variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Success Factor</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Mode</td>
</tr>
<tr>
<td>Range</td>
</tr>
<tr>
<td>Min, Max</td>
</tr>
<tr>
<td>Minimum score possible</td>
</tr>
<tr>
<td>Max score possible</td>
</tr>
</tbody>
</table>


Table 4 presents participant results from the OCHPPRAC survey. Success Factor 2- Health Professional Program Leadership and Commitment was the highest rated success factor ($M = 34.81$). This indicates that there is leadership and commitment towards cultural safety within Schools of Nursing. Success Factor 4- Partnerships and Engagement, had the largest spread ($SD = 6.89$), indicating that there is a larger spread from the average across this success factor. This is suggestive of a weaker commitment within this factor, indicating that Schools of Nursing may not display readiness and/or commitment to partner and engage with Aboriginal and Torres Strait Islander stakeholders. This may also indicate a lack of staff capacity and the absence of cultural safety champions. There is a similar pattern between Success Factor 2- Health Professional Program Leadership and Commitment and Success Factor 4- Partnerships and Engagement with same range (22), minimum score (22) and maximum score (44). This indicates that Schools of Nursing are working towards cultural safety, however, the higher standard deviation displayed from Success Factor 4 suggests
that participants' views are varied. Success Factor 3- Structures and Support for Implementation was the lowest rated success factor ($M=21.18$) and contained the lowest score overall (12). This data demonstrates that there is School of Nursing leadership, commitment and readiness towards cultural safety, however, there is a weaker implementation of the structures and support needed for cultural safety. The lowest score of 12 is indicative of a weakness in the implementation of this success factor. Elements of this success factor attend to the capacity and ongoing cultural safety development of staff, recognising and supporting staff teaching/championing, promoting Aboriginal and Torres Strait Islander pedagogies, and embedding curriculum review and change processes.

Figure 3. Success Factor Variable Data

![Radar chart of each participant result by Success Factor.](image)

**Note.** Success Factor 1= Organisational Commitment to Cultural Competency. Success Factor 2= Health Professional Program Leadership and Commitment. Success Factor 3= Structures and Support for Implementation. Success Factor 4= Partnerships and Engagement. Each participant is represented as a number around the outside edge of the radar chart. Participants who did not respond are shown with the spoke hitting the centre of the Graph, seen with Participant 12.
Figure 4. Total Mean for each Success Factor.

The Figure 3. radar chart demonstrates the mean of each participant’s responses to each Success Factor. Higher performance is indicated by higher number of spokes as seen with Participant 2. This participant achieved the highest results for each success factor. This data demonstrates a similar pattern between Success Factor 2 and Success Factor 4 with these success factors achieving higher scores across most of the participants. A weaker commitment is presented in Success Factor 1 and Success Factor 3, with scores closer to the centre of the radar chart. This relationship indicates a weakness within Schools of Nursing in their implementation of cultural safety actions and strategies. Figure 4. radar chart demonstrates the mean of each Success Factor. Similarly, to Figure 3. the characteristics of this graph show a skewed rhombus image with higher scores in Success Factor 2 and Success Factor 4 and lower scores in Success Factor 1 and Success Factor 3 overall.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Success Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Head of the Health Professional Program (HPP) is supportive and committed to the framework</td>
<td>3.89</td>
<td>4.0</td>
<td>0.38</td>
<td>2</td>
</tr>
<tr>
<td>All students must undertake a core unit in Aboriginal and Torres Strait Islander cultural studies or similar</td>
<td>3.83</td>
<td>4.0</td>
<td>0.39</td>
<td>1</td>
</tr>
<tr>
<td>The organisation has relevant policy or strategic documents related to Aboriginal and/or Torres Strait Islander education and system change (e.g. Reconciliation Action Plan or Reconciliation Statement, employment strategies and student recruitment and retention initiatives, community engagement initiatives).</td>
<td>3.55</td>
<td>4.0</td>
<td>0.60</td>
<td>1</td>
</tr>
<tr>
<td>There is a strong organisation-wide senior executive commitment to developing the cultural capabilities of the organisation</td>
<td>3.50</td>
<td>4.0</td>
<td>0.60</td>
<td>1</td>
</tr>
<tr>
<td>The Framework is part of the HPP strategic direction and is being promoted</td>
<td>3.50</td>
<td>4.0</td>
<td>0.62</td>
<td>2</td>
</tr>
<tr>
<td>The HPP has previously undertaken similar major curriculum change with success</td>
<td>3.44</td>
<td>3.0</td>
<td>0.51</td>
<td>2</td>
</tr>
</tbody>
</table>

*Note.* Mean taken from all participants of the OCHPPRAC survey.  
Success Factor 1 = Organisational Commitment to Cultural Competency.  
Success Factor 2 = Health Professional Program Leadership and Commitment.  
Success Factor 3 = Structures and Support for Implementation.  
Success Factor 4 = Partnerships and Engagement.

Table 5 presents the highest mean statements from the OCHPPRAC survey (DOH, 2014). Participants identified the survey items of ‘Adequate’ (3.0) or ‘Strong’ (4.0) responses. The highest rated statements from Table 5 indicate that the participants had implemented these actions demonstrating the Schools of Nursing commitment towards cultural safety. This commitment is seen across all participants with Schools of Nursing Head Professional Program commitment ($M=3.89$, $SD=0.38$), senior executive commitment ($M=3.50$, $SD=0.60$), core units in Aboriginal and Torres Strait Islander studies ($M=3.83$, $SD=0.39$) including curriculum change success ($M=3.44$, $SD=0.51$), Aboriginal and Torres Strait Islander policy and documents related to education and/or system change ($M=3.55$, $SD=0.60$) with The Framework part of the organisations strategic direction ($M=3.50$, $SD=0.62$).
Table 6
OCHPPRAC survey statements by Lowest Means

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Success Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>A dedicated HPP Framework budget has been established</td>
<td>2.50a</td>
<td>2.5</td>
<td>0.99</td>
<td>2</td>
</tr>
<tr>
<td>There is strong commitment to the sustainability of the Framework through dedicated human resourcing (e.g. Project Officer, Coordinator)</td>
<td>2.56</td>
<td>2.5</td>
<td>1.042</td>
<td>2</td>
</tr>
<tr>
<td>Monitoring and cyclical quality improvement processes have been established</td>
<td>2.72</td>
<td>3.0</td>
<td>0.90</td>
<td>2</td>
</tr>
<tr>
<td>Completion of Aboriginal and Torres Strait Islander awareness training or similar is mandatory for all staff.</td>
<td>2.80b</td>
<td>3.0</td>
<td>1.24</td>
<td>1</td>
</tr>
<tr>
<td>There is a commitment to the time and resources required within the HPP for building and maintaining relationships with Aboriginal and/or Torres Strait Islander stakeholders.</td>
<td>2.89c</td>
<td>3.0</td>
<td>0.71</td>
<td>4</td>
</tr>
<tr>
<td>The HPP acknowledges the emotional impact of teaching in this area and the need for additional support or mentoring and has identified a support strategy for educators and allocated resources to that strategy.</td>
<td>2.89</td>
<td>3.0</td>
<td>1.079</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. Mean taken from all respondents of the OCHPPRAC survey. Success Factor 1= Organisational Commitment to Cultural Competency. Success Factor 2= Health Professional Program Leadership and Commitment. Success Factor 3=Structures and Support for Implementation. Success Factor 4= Partnerships and Engagement. a= Missing data from one participant. b = Missing data from two participants. c= Missing data from one participant.

Table 6 presents the lowest mean statements from the OCHPPRAC survey (DOH, 2014). Participants identified in the survey items a ‘Weak’ (2.0) or ‘Adequate’ (3.0) response. These statements represent a weaker commitment and readiness towards cultural safety. This
weaker commitment is seen across all participants regarding dedicated budget ($M=2.50, SD = 0.99$), improvement processes ($M = 2.72, SD = 0.90$) and human resourcing ($M = 2.56, SD = 1.042$) receiving lower scores. This is compounded by a lack of cultural awareness training ($M= 2.80, SD = 1.24$), weaker partnerships with Aboriginal and/ or Torres Strait stakeholders ($M=2.89, SD = 0.71$) and weaker supports for educators teaching in this area ($M=2.89, SD = 1.079$). As seen in Table 6., the lowest reported statements were in Success Factor 2- Health Professional Program Leadership and Commitment. Although this success factor had the strongest Mean overall ($M= 35.33$), it is clear that analysing individual statements can highlight the weaknesses in specific cultural safety actions and strategies such as budgeting ($M= 2.50$). The largest spread ($SD = 1.24$) is presented with the statement *Completion of Aboriginal and Torres Strait Islander awareness training or similar is mandatory for all staff.* This is an indication that there is a larger spread from the average across this statement and is suggestive of a weakness within Schools of Nursing to support and educate culturally safe academic and support staff.

### 5.2.3 Participants’ Comments

The following section reports on the qualitative data collected in the survey which invited additional comments from participants. The comments were coded independently by two researchers, and where there was disagreement between researchers this was discussed and resolved. Coding of the comments found five themes.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Safety</td>
<td>5</td>
</tr>
<tr>
<td>Collaboration</td>
<td>3</td>
</tr>
<tr>
<td>Recruitment and Retention of students</td>
<td>2</td>
</tr>
<tr>
<td>Curriculum changes</td>
<td>2</td>
</tr>
<tr>
<td>Staff Recruitment</td>
<td>1</td>
</tr>
</tbody>
</table>
Cultural safety was seen in a positive light:

“‘Generally - we do cultural safety well.’”
Participant 4

“I have provided training in cultural safety and cultural awareness to all academic staff in 2017.”
Participant 14

However;

“Additional funding resources are not yet currently available, nor is cultural training available for academic staff generally.”
Participant 1

The conceptualisation of cultural safety was challenged:

“This research is really - Indigenous cultural safety - title or focus on "cultural safety" is misplaced.”
Participant 2

There was a focus on collaboration. Participants identified partnerships across the whole-of-organisation:

“These involve the faculty Indigenous Unit and designated Aboriginal Health Care Course Coordinators”…. “We are in the process of increasingly working with Aboriginal nurses and community members and focussing on improved recruitment and retention of Indigenous students.”
Participant 1

“Most of the improvements to our programs have been driven by faculty.”
Participant 14

However, barriers to implement collaboration and partnerships were identified:

“‘Meaningful participation" is hampered by ability to engage (access) the appropriate representation. Staff are consistently moved across areas leading to lack of consistent "meaningful participation.””
Participant 3
Recruitment and retention of Aboriginal and Torres Strait Islander students was identified as an indicator of cultural safety within a School of Nursing:

“There is strong support for ATSI students and great links to scholarship and study support.”
Participant 4

“…and focussing on improved recruitment and retention of Indigenous students.”
Participant 2

Curriculum changes were identified:

“Our nursing school and faculty are in the process of implementing new cultural safety curriculum changes.”
Participant 1

“In late 2017 a number of curriculum changes have been initiated to enhance quality of programs in Indigenous health.”
Participant 14

Staff recruitment was identified:

“We have now recruited an Indigenous nurse and have academic leadership from Associate Dean (Indigenous).”
Participant 14
5.3 Discussion

The following section discusses the results of the OCHPPRAC survey (DOH, 2014). This discussion reviews progress towards cultural safety and geographical differences, Schools of Nursing and Success factors and participant comments. Conclusions are made regarding the research findings, through knowledge arising from the Literature Review.

5.3.1 Progress towards Cultural Safety – geographical differences

The data demonstrates higher commitment towards cultural safety within regional universities. The literature review hasn’t indicated any metropolitan and regional differences amongst universities to explain this higher commitment. This finding could be explained as indicating stronger networks, connections and partnerships between regional Schools of Nursing and the local Aboriginal and Torres Strait Islander communities. The lower commitment and readiness from metropolitan universities may be explained by both historical and contemporary differences, with factors including patterns of colonisation, university-community relations, university imperatives, health sector cross-cultural networks, presence of cultural safety champions, employment and establishment of Aboriginal and Torres Strait Islander staff and Education Units, completion of cultural safety awareness and staff development. Given complex and diverse historical and contemporary differences, the clear way forward would be to identify those Schools of Nursing who can provide leadership to other Schools in their journeys towards cultural safety.

5.3.2 Schools of Nursing and Success Factors

The data demonstrates similarities and connections between Health Professional Program Leadership and Commitment and Partnerships and Engagement. This is suggestive of Schools continuing to progress, with some Schools indicating a very high commitment and engagement towards cultural safety actions. There are clearly Schools who champion cultural safety strategies and should be recognised for their commitment and dedication. There is a valuable opportunity for leadership and knowledge sharing between higher progressing and lower progressing Schools.

The data demonstrates a connection between Organisational Commitment to Cultural Competency and Structures and Support for Implementation. These results are reflective of
a weaker commitment towards implementation of whole-of-organisation cultural awareness and cultural safety. These success factors highlight the importance for Schools of Nursing to review, reflect, and implement the Nursing and Midwifery Framework (CATSINaM, 2017b) and to audit internal processes.

5.3.3 Participant Comments

These valuable additional comments presented from participants demonstrate the themes of cultural safety, collaboration, recruitment and retention of students, curriculum changes and staff recruitment. These comments reflect champions, with strong partnerships, collaboration, training and leadership either driven from high level (Dean) or from the faculty collectively. There are weaknesses in the implementation of cultural safety actions i.e. funding, engagement and meaningful participation with Aboriginal and Torres Strait Islander academics and communities. Curriculum changes, and recruitment and retention of students and staff are identified as positive outcomes and indicators, however, there is still the need for targeted strategies to continue increasing Aboriginal and Torres Strait Islander completion rates (Best & Gorman, 2016) and to provide culturally safe environments for Aboriginal and Torres Strait Islander academics (CATSINaM, 2017b). Cultural Safety ‘training’ is evidenced as a central part of progress; however, the promotion of the wider philosophy of cultural safety and the necessity for continuing professional development and support (CATSINaM, 2017b), may need stronger messaging and monitoring.

5.3.4 Towards Cultural Safety

Overall the data demonstrates elements of a decolonising approach towards curriculum and policy and a very positive commitment towards cultural safety. High level leadership is essential for successful implementation of cultural safety (CATSINaM, 2017b) and it is clear the mandatory ANMAC standards (2012) and the Nursing and Midwifery Framework (CATSINaM, 2017b) have been implemented. Examples of this implementation include the inclusion of an Aboriginal and Torres Strait Islander health subject (ANMAC, 2012; Best & Gorman, 2016), cultural awareness policies for staff and a visible strategic direction. Notably, both the above Standards and Framework require Schools of Nursing to implement these
cultural safety actions as the required minimum, therefore these strong statements reflect the achievement of starting points towards cultural safety.

In contrast, this data demonstrates weaknesses in the implementation of other cultural safety actions. The lowest reported statement (a dedicated HPP Framework budget has been established) is a very specific strategy that can be implemented by a School of Nursing. Specifically, a financial strategy (including resources and time) would build staff capacity and prepare and support academic teaching within Aboriginal and Torres Strait Islander subjects including cultural supervision and mentoring for both Indigenous and non-Indigenous academics (CATSINaM, 2017b). An organisation’s culture can either encourage or obstruct the development of cultural competence in nursing students and academics (Flavell et al., 2013) and if financial and human resourcing strategies are not implemented, the shift towards cultural safety and decolonising practices cannot take place; consequently, the whiteness of nursing will continue to dominate curriculum and pedagogy (Puzan, 2003).

There must be mindful consideration and support of the Aboriginal and Torres Strait Islander people working with the university, including a dedicated Indigenous employment strategy (CATSINaM, 2017b) within human resource development. A worthy goal may be to attempt to meet parity of the Aboriginal population within their School of Nursing and their university (Herring et al., 2013) therefore promoting a culturally safe place. This cannot be achieved without quality improvement processes, auditing of internal policies and review of frameworks (Westwood & Westwood, 2010). It is clear a structural framework is needed (Williamson & Harrison, 2010) to support the implementation of cultural safety actions (De Souza, 2008).

The contemporary literature clearly demonstrates that Cultural Awareness Training (CAT) is not enough (Mooney et al., 2005; Downing & Kowal, 2011; Chapman et al., 2013) to decolonise Schools of Nursing, and it has been found to lack accountability and clear policy direction (Westwood & Westwood, 2010). However, when Cultural Safety Training (CST) was applied, it was found to increase academic understanding of cultural safety (Fleming et al., 2017). Cultural Safety education must be a mandatory requirement for academics and support staff within Schools of Nursing (CATSINaM, 2017b). This will promote partnerships and networks as a high priority (CATSINaM, 2017b) and this approach between the profession and Aboriginal and Torres Strait Islander peoples improves health care and outcomes (Sherwood, 2013), and embeds culturally safe collaboration (Herring et al., 2013). The fundamental differences between cultural awareness and cultural safety – as
philosophical paradigms and education practices – must be recognised (CATSINaM, 2017b; NCNZ, 2011; NMBA, 2018). Cultural awareness may be conceived as the first step along a journey/process towards cultural safety; the notion that Cultural Awareness Training, or indeed Cultural Safety Training, is all that is required, must be strongly rejected (Westwood & Westwood, 2010; Chapman et al., 2013; Mooney et al., 2005).

There must be a recognition of the emotional labour of those academics teaching and championing cultural safety (CATSINaM, 2017b). Aboriginal and Torres Strait Islander academics must have access to professional development and support without the assumption that they are experts simply on the basis of their cultural identity (CATSINaM, 2017b). Similarly, non-Indigenous nursing academics require support, training, mentoring, supervision and education (Flavell et al., 2013) towards their cultural safety.

Schools of Nursing – through Health Professional Program Leadership – are aligning their actions to the Nursing and Midwifery Framework (CATSINaM, 2017b). This alignment is reflective of a decolonising gaze (Sherwood, 2013) and shared learning within the Schools of Nursing. However, weaknesses are revealed through this study; leadership cannot be sustained without the ongoing cultural safety development of all staff, and strong networks with stakeholders and communities cannot be nourished when staff do not have cultural safety awareness and capacity. Additionally, whilst Schools of Nursing characteristically have established systems and processes of curriculum review and change, it is now imperative that these processes engage with Aboriginal and Torres Strait Islander pedagogies, through a cultural safety framework.

5.4 Reliability of OCHPPRAC Survey

Cronbach’s (1951) alpha coefficient was applied to assess the reliability of the OCHPPRAC survey in its entirety and was applied to each individual statement as shown in Table 8 and Appendix D. In the social sciences, a result over 0.70 indicates very high reliability (Burns & Grove, 2001).
Table 8  
Reliability of the OCHPPRAC survey

<table>
<thead>
<tr>
<th>Reliability Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach’s Alpha</td>
</tr>
<tr>
<td>Cronbach’s Alpha based on Standardised Items</td>
</tr>
</tbody>
</table>

Note. \( n = 36. \)

The coefficient alpha for the total scale was 0.96, demonstrating internal reliability (Burns & Grove, 2001) and Cronbach’s Alpha for each individual statement ranged from 0.1 to 0.87. Cronbach’s Alpha of each statement of the OCHPPRAC survey and non-parametric testing of each success factor and total overall score of the OCHPPRAC survey (DOH, 2014) is shown in Appendix D. The OCHPPRAC survey (DOH, 2014) has not previously been utilised as a research tool. To assess reliability a second sub sample would need to complete the OCHPPRAC survey (DOH, 2014), with comparisons made from both results from the first survey and the second survey.

5.5 Research Data Limitations

5.5.1 Participant Responses

This research study had a small sample size of thirty-six as it was limited to the Schools of Nursing in Australia. The response rate was 61%. This survey does not reflect all Schools of Nursing and their cultural safety actions and progress. It could be that participants who perceived they were working well towards cultural safety were more likely to respond. However, this remains valuable data, as the survey sought an indication of progress towards cultural safety, and strong outcomes are strong indicators of this. There is no data from a Northern Territory or Tasmanian School of Nursing.
5.5.2 Data Measurement

The research data indicates levels of commitment and readiness towards cultural safety within the Schools of Nursing, as measured by the OCCHPRAC survey. It measures this against four ‘Success Factors’ as determined within the Aboriginal and Torres Strait Islander Health Curriculum Framework (DOH, 2014). across the Schools of Nursing, at one particular point in time (end of year 2017).

The survey did not measure perceptions or experiences of cultural safety within the Schools of Nursing. Readiness to implement cultural safety actions and strategies, and the commitment to cultural safety was measured. As such, this study does not measure the levels of cultural safety, and this must be carefully noted in the reporting of the research outcomes.

5.5.3 Self- Report Data

This study gathered self-reported data. It is uncertain whether the data collected was an accurate representation of each School of Nursing. The participants may have wanted to be perceived favourably or may have liberally represented the actions and strategies undertaken within the organisation. However, it remains the perception and the projected representation. It is important to note, the OCHPPRAC survey (DOH, 2014) contained a broad mix of statements over four success factors that when combined provided a comprehensive measurement of where the weaknesses and strengths lie within a School of Nursing and was able to specifically identify areas that needed further development such as budgeting, or cultural safety education.

5.6 Critical Reflection

The OCHPPRAC survey has highlighted which areas are receiving strong commitment and other areas that are characterised by weakness, requiring further development. The OCHPPRAC survey provides cultural safety actions and strategies that can be used as a guide and as a measure of progress. This is just the starting point. The research findings do give evidence of progress towards cultural safety and the strong influence of CATSINaM and other stakeholders and champions. I am hopeful that this research kindles interest and commitment within the nursing profession as it makes further progress towards cultural safety and that a bridge is formed to connect two worldviews; between the worlds of
Indigenous and non-Indigenous peoples, nurses, their students and educators/leaders. The next and final chapter looks at the building of this bridge and makes recommendations from the findings of this research study.
Chapter 6- Recommendations towards Cultural Safety

6.1 Introduction

This is the final chapter of the thesis; the last stage of this cultural safety journey. This thesis has acted as the bridge connecting two worlds i.e. white dominant nursing education systems and Indigenous worldviews. This chapter arises from the research findings regarding Schools’ of Nursing readiness and commitment towards cultural safety, as measured by the OCHPPRAC survey (DOH, 2014). Recommendations for nursing education and practice are made based on the study findings. These recommendations respond to the findings on each of the Success Factors of the OCHPPRAC survey and are also drawn from the overall outcomes of the survey. This chapter ends with a reflection of the study overall and for future research that can continue the dialogue and inform the changes required along the profession’s cultural safety journey.

6.2.1 Recommendations from Success Factor 1: Organisational Commitment to Cultural Competency

- That Schools of Nursing provide mandatory cultural safety workshops for all academics and support staff to increase academic capacity to both understand and teach cultural safety to students;
- That Schools of Nursing promote organisation-wide Reconciliation Action Plans;
- That organisation-wide senior executive give leadership to Schools of Nursing to further develop cultural capabilities throughout the organisation;
- That CATSINaM lead the development of a shared vision for culturally safe Schools of Nursing in Australia.

6.2.2 Recommendations from Success Factor 2: Health Professional Program Leadership and Commitment

- That Schools of Nursing implement the Nursing & Midwifery Framework (CATSINaM, 2017b);
- That Schools of Nursing commit a dedicated budget and resources to support the implementation of cultural safety strategies;
- That cultural safety targets be identified and reported within Schools of Nursing, with quality improvement processes established;
• That Schools of Nursing uphold national and organisational Indigenous employment policies and strategies.

6.2.3 Recommendations from Success Factor 3: Structures and Support for Implementation

• That Schools of Nursing conduct a yearly cultural safety audit;
• That Schools of Nursing recognise and support the emotional labour of Indigenous and non-Indigenous academics in teaching Aboriginal and Torres Strait Islander health subjects;
• That Schools of Nursing ensure Aboriginal and Torres Strait Islander academic staff have access to professional development and support;
• That Schools of Nursing provide cultural mentoring for academic staff;
• That whole-of-organisation recognition and action be given to the structures and support needed to implement the Nursing & Midwifery Framework (CATSINaM, 2017b).

6.2.4 Recommendations from Success Factor 4: Partnerships and Engagement

• That Schools of Nursing have meaningful engagement – as defined by CATSINaM - with Aboriginal and Torres Strait Islander stakeholders;
• That Schools of Nursing form strong partnerships with Aboriginal and Torres Strait Islander Education Units/Centres; supporting the recruitment, retention and graduation of Aboriginal and Torres Strait Islander nursing students

6.3 Overall Recommendations towards Cultural Safety

• That Schools of Nursing formally recognise CATSINaM as the leader towards cultural safety;
• That Schools of Nursing with significant progress towards cultural safety provide leadership towards other members of the nursing higher education sectors;
• That stakeholders within the nursing profession recognise the leadership and dedication of cultural safety champions within the nursing higher education sector;
• That Schools of Nursing continue to reflect upon racism and colonisation within the profession and their organisations, upholding cultural safety within the places of education of the profession, as well as in the practice of the profession;
• That national stakeholders within the nursing profession collaboratively articulate an Apology to Aboriginal and Torres Strait Islander peoples, recognising past and present racism and colonisation;

6.4 Towards Cultural Safety in Schools of Nursing - Future Research

• That further research measures the implementation of Nursing & Midwifery Framework (CATSINaM, 2017b); identifying barriers to implementation;
• That further research enacts the principles of cultural safety, in gathering data from Aboriginal and Torres Strait Islander nursing students, academics and stakeholders within Schools of Nursing, regarding their evaluations of cultural safety within their nursing education environments.

6.5 Critical Reflection

I hope that in 5 years from now, the Schools of Nursing are continuing to decolonise their practice, and their cultural safety outcomes are now audited yearly. I hope that Schools of Nursing will have contributed to the nursing profession by fostering a shared meaning of both Indigenous and non-Indigenous worldviews. I envisage new nurses will be better equipped to recognise and disrupt racist attitudes and beliefs and nursing academics will have mandatory cultural safety workshops. I am optimistic that in the future there will be more knowledge sharing and learning between Schools of Nursing and that the whiteness in nursing becomes more visible and is named for what it is. It is important that shared understanding develops regarding the philosophy of cultural safety; we must resist this being reduced to just a cultural safety training event. For the future, I think it would be worth exploring the kinds of barriers that are experienced in implementing cultural safety actions: is it whiteness in the nursing profession, is it the staff within the Schools of Nursing, is it whole-of-organisation systems and processes that halt cultural safety progress? These questions can best be answered by the ‘participants’; staff and students, the wider profession, and Aboriginal and Torres Strait Islander students and communities. Cultural safety actions are a bridge to connect the Indigenous worldview and the non-Indigenous worldview within Schools of Nursing and within the profession and its practice. Cultural safety gives us this
intercultural space. I want Schools of Nursing to feel different, to be different; becoming safe places for those who have been marginalised and colonised, and for those who have privilege.
“The first stage involves finding out what you have, the second stage is to dismantle it, the third stage is to put something else in its place and lastly, the fourth stage is translating the changes into action.” (Ramsden, 1997, pp.113-114).
Appendix A- Occupational Commitment and Health Professional Program Readiness Assessment Compass

Organisational Commitment and Health Professional Program Readiness Assessment Compass

The Organisational Commitment and Health Professional Program Readiness Assessment Compass (OCHPPRAC) has been developed to assist the HPP to identify the readiness of their environment for implementing The Aboriginal and Torres Strait Islander Health Curriculum Framework. The tool aims to support HPP:

i. Assess the nature and degree of leadership and commitment across the whole organisation and how this may in turn, affect the implementation of the Framework

ii. Identify HPP readiness, key enablers and possible barriers to effectively implementing the Framework.

The OCHPPRAC recognises there is a variety of elements that will influence and support successful implementation of the Framework, and that these will interact in unique ways in every setting. To create a better chance of successful implementation of the Framework, it is important that the HPP identifies the nature of these elements and the local developments and improvements that may be required. These elements include:

- Commitment and leadership within the HPP and across the broader organisation
- Professional development for all staff and support for educators
- Work plans
- Financial and human resources earmarked to support implementation of the Framework
- Aboriginal and Torres Strait Islander engagement and other stakeholder partnerships.

The OCHPPRAC is not intended for use in place of an implementation plan; nor does it assess whether a HPP can or can’t implement the Framework. Instead, the OCHPPRAC aims to support HPP by highlighting critical success factors by providing a tool that can be used to assist planning and dialogue across the organisation.

The OCHPPRAC recognises four critical success factors, each with a suite of influential elements that are important for successful and sustainable implementation of the Framework.

i. Organisational commitment to cultural competencies
ii. HPP Leadership and Commitment
iii. Structures and Support for Implementation
iv. Partnerships and Engagement.

Effective implementation of the Framework throughout a HPP is most likely to occur if there is a whole of organisation commitment and leadership. The degree of this commitment will be variable across different settings and will consequently impact some aspects of the implementation of the Framework in a HPP. It is important that the HPP identifies and has strategies to work with the possible challenges that may exist due to the broader organisation in which they operate.

The Universities Australia (2011) Best Practice Framework is a powerful resource to support HEPs to develop their system and practice with respect to Aboriginal and Torres Strait Islander cultural ‘competency’. While there is some contention around the use of the word ‘competency’, this Universities Australia document is widely respected across the sector and denotes competency as an institutional whole-of-organisation aim. As this is a Critical Success Factor, the notion of cultural competency has also been applied here to synergise with this important sector document.
### Demographic Questions

Please circle the appropriate answer.

**Your School of Nursing location:**

<table>
<thead>
<tr>
<th>NSW</th>
<th>ACT</th>
<th>VIC</th>
<th>TAS</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
<th>QLD</th>
</tr>
</thead>
</table>

**Your School of Nursing area:**

| Capital City | Major Urban Centre >100,000 pop. | Regional City 25,000-100,000 pop. | Smaller Town <25,000 Pop. |
SUCCESS FACTOR 1
Organisational Commitment to Cultural Competency

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is strong organisation-wide senior executive commitment to developing the cultural capabilities of the organisation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is demonstrated organisation-wide action around addressing the system and cultural barriers associated with Aboriginal and Torres Strait Islander health curricula, employment, engagement and education.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organisation has relevant policy or strategic documents related to Aboriginal and/or Torres Strait Islander education and system change (e.g. Reconciliation Action Plan or Reconciliation Statement, employment strategies and student recruitment and retention initiatives, community engagement initiatives).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completion of Aboriginal and Torres Strait Islander awareness training or similar is mandatory for all staff.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All students must undertake a core unit in Aboriginal and Torres Strait Islander cultural studies or similar.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continual learning and development is part of the organisation’s culture.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander cultural capabilities are a consideration when hiring and orienting new staff.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Success Factor 2: Health Professional Program Leadership &amp; Commitment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The head of the Health Professional Program (HPP) is supportive and committed to the Framework.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>The Framework is part of the HPP strategic direction and is being promoted.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Senior leaders across the HPP are supportive and committed.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Senior champions who are committed to the implementation and sustainability of the Framework have been identified.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There is meaningful participation of Aboriginal and/or Torres Strait Islander representation in the governance structures of the HPP.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Monitoring and cyclical quality improvement processes have been established.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>The HPP has previously undertaken similar major curriculum change with success.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>A dedicated HPP Framework budget has been established.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There is strong commitment to the sustainability of the Framework through dedicated human resourcing (e.g. Project Officer, Coordinator).</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>The HPP is committed to providing ongoing employment and career development of Aboriginal and Torres Strait Islander educators.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Continual learning and development is part of the HPP culture.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
</tbody>
</table>
A curriculum review and change management plan has been developed clearly outlining elements required to implement the change.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

A process for integrating Aboriginal and Torres Strait Islander pedagogies into teaching practice has been established.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

The Health Professional Program (HPP) has a governance/curriculum change committee in place with appropriate representation to oversee and review the implementation of the Framework. The HPP has capacity to ensure formal project management skills are employed to support implementation of the project.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

The HPP has a documented record of providing ongoing training of staff within its organisation and appraising and supporting the development of staff.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

HPP supports all educators to develop skills and knowledge to strengthen cultural capabilities.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

The HPP has a professional development strategy to support educators to develop skills and knowledge to teach specific Aboriginal and/or Torres Strait Islander content.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
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</thead>
</table>

The HPP acknowledges the emotional impact of teaching in this area and the need for additional support or mentoring and has identified a support strategy for educators and allocated resources to that strategy.  

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
</table>

Commitment to the change and management of the process is recognised as a shared responsibility between Aboriginal and Torres Strait Islander and non-Indigenous staff across the Health Professional Program (HPP).

<table>
<thead>
<tr>
<th>Management structures and course coordination use a partnership approach.</th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>The HPP has experience of successfully working in partnership with Aboriginal and/or Torres Strait Islander stakeholders.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Collegial relationships with Aboriginal and Torres Strait Islander learning centres on campus are productive and partnerships in the context of implementing the Framework have been formalised.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There is a clearly defined strategy for engaging and maintaining Aboriginal and/or Torres Strait Islander involvement in the development and implementation of the proposed curriculum change (e.g. steering committee).</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>Governance of the Framework includes meaningful Aboriginal and/or Torres Strait Islander representation.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There is meaningful participation of Aboriginal and/or Torres Strait Islander peoples on curriculum development, review and implementation committees.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There is a commitment to the time and resources required within the HPP for building and maintaining relationships with Aboriginal and/or Torres Strait Islander stakeholders.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
<tr>
<td>There are formal linkages with Aboriginal and/or Torres Strait Islander health services.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
</tbody>
</table>
The HPP has established a strategy for ongoing engagement with regulation bodies and the health system.

<table>
<thead>
<tr>
<th></th>
<th>Absent</th>
<th>Weak</th>
<th>Adequate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>The HPP governance requirements include all key stakeholders.</td>
<td>Absent</td>
<td>Weak</td>
<td>Adequate</td>
<td>Strong</td>
</tr>
</tbody>
</table>

Please circle the appropriate answer.
6 November 2017

Associate Professor Bethne Hart & Ms Petric  
School of Nursing  
The University of Notre Dame  
Australia PO Box 944  
Broadway NSW 2007

Dear Bethne and Samantha,

Reference Number: 017173S  

Project Title: "Bridging two worlds? Towards cultural safety within School of Nursing in Australian universities."

Thank you for submitting the above project for Low Risk ethical review. Your application has been reviewed by a sub-committee of the university's Human Research Ethics Committee in accordance with the National Statement on Ethical Conduct in Human Research (2007, updated May 2015). I am pleased to advise that ethical clearance has been granted for this proposed study.

Other researchers identified as working on this project are:

<table>
<thead>
<tr>
<th>Name</th>
<th>School/Centre</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjunct Prof Janine Mohamed</td>
<td>School of Nursing, Sydney</td>
<td>Co-Supervisor</td>
</tr>
</tbody>
</table>

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

- Dr Natalie Giles  
  Research Ethics Officer  
  Research Office

cc: A/Prof Joanna Patching, SRC Chair, School of Nursing Sydney
PARTICIPANT INFORMATION SHEET

PROJECT TITLE: “Bridging two worlds?”: towards cultural safety within Schools of Nursing in Australian universities

CHIEF INVESTIGATOR: Associate Professor Bethne Hart (School of Nursing, The University of Notre Dame, Australia-Sydney Campus)

CO-INVESTIGATOR: Ms. Janine Mohamed (CEO- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives)

STUDENT RESEARCHER: Ms. Samantha Petric (RN/RAN)

STUDENT’S DEGREE: Master of Philosophy (Nursing) Candidate

Dear Participant

You are invited to participate in the research project described below.

What is the project about?
The purpose of this study is to measure the levels of commitment and readiness towards cultural safety within Schools of Nursing in Australian universities.

Who is undertaking the project?
This project is being conducted by Ms. Samantha Petric and will form the basis for the degree of Master of Philosophy (Nursing) at The University of Notre Dame Australia, under the supervision of Associate Professor Bethne Hart and Ms. Janine Mohamed. Samantha Petric is a Registered Nurse and a Remote Area Nurse working in both metropolitan and remote contracts in Australia.

What will I be asked to do?
This survey asks questions about your workplace (demographics: location and area) and your opinion of your School of Nursing’s position in completion of the Occupational Commitment and Health Professional Program Readiness Assessment Compass Survey. Participation is
voluntary, and the respondent (on behalf of the academic department) will be anonymous and will not be known to the researchers.

If you agree, kindly complete the attached short survey. It should only take you 30 minutes. You will also find a self-addressed pre-paid envelope that can be used to return your completed questionnaire.

This survey has been distributed from the Canberra office of CATSINaM (The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) using their mailing list to all Deans of Schools of Nursing in Australia.

The return envelope is addressed to their offices, and the de-identified returned surveys will be collected by the Student Researcher.

Are there any risks associated with participating in this project?
There are no foreseeable risks associated with your participation in the study.

What are the benefits of the research project?
There are no direct benefits to you if you participate in this study. Results of this study can inform continuing developments, policies and actions within Schools of Nursing in Australian universities as they move towards organisational and professional cultural safety. These transformations can contribute to the culturally safe practices of nurses, and can impact upon the enduring health and social inequalities experienced by Aboriginal and Torres Strait Islander peoples.

What if I change my mind?
Participation in this study is completely voluntary. You cannot withdraw after you submit your survey, as surveys are non-identifiable.

Will anyone else know the results of the project?
Information gathered about you will be held in strict confidence. This confidence will only be broken if required by law. Anonymity and confidentiality is ensured, as individual Schools of Nursing will not be identified in the reported results.

Hard copy surveys will be collated into computer-based records, and the original documents will be securely stored in the Principal Supervisor’s office.

Once the study is completed, the data collected will be stored securely in the School of Nursing at The University of Notre Dame Australia for at least a period of five years. The results of the study will be published as a thesis, journal articles, and presented as conference papers.

Will I be able to find out the results of the project?
After the Thesis has been examined, a summary of the results will be provided to all Schools of Nursing in Australia.
Who do I contact if I have questions about the project?

Associate Professor Bethne Hart  
School of Nursing  
The University of Notre Dame, Australia  
160 Oxford St  
Darlinghurst NSW 2010.  
Bethne.Hart@nd.edu.au  
Telephone: (02) 8204 4294

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 017173S). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame’s Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Thank you for your time. This Participant Information letter is for you to keep.

Yours sincerely,

Associate Professor Bethne Hart  
Bethne.Hart@nd.edu.au  
(02) 8204 4294

Ms. Janine Mohamed  
ceo@catsinam.org.au  
(02) 6262 5761

Ms. Samantha Petric  
Samantha.petric1@my.nd.edu.au
### Appendix D- Reliability testing of the OCHPPRAC Survey

**Cronbach’s Alpha of each statement of the OCHPPRAC survey**

<table>
<thead>
<tr>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach’s Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Commitment</td>
<td>110.89</td>
<td>340.575</td>
<td>.689</td>
</tr>
<tr>
<td>OrgWide Action</td>
<td>110.94</td>
<td>335.820</td>
<td>.783</td>
</tr>
<tr>
<td>Policy</td>
<td>110.89</td>
<td>337.869</td>
<td>.811</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>111.61</td>
<td>337.663</td>
<td>.397</td>
</tr>
<tr>
<td>CoreUnit</td>
<td>110.61</td>
<td>351.310</td>
<td>.359</td>
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<tr>
<td>ContLearning</td>
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<td>345.765</td>
<td>.457</td>
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<tr>
<td>Hiring</td>
<td>111.39</td>
<td>333.899</td>
<td>.637</td>
</tr>
<tr>
<td>HeadHPP</td>
<td>110.56</td>
<td>349.203</td>
<td>.605</td>
</tr>
<tr>
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*Note.*  \( n = 36. \)
### Non-parametric testing of each Success factor and Total Overall Score

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<td>0.058</td>
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*Note.* Metro= Capital City. Regional= Major Urban Centre and Regional City.
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