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PERCEPTIONS OF PREPAREDNESS IN THE UNIVERSITY OF VERMONT'S BACHELOR OF SCIENCE IN NURSING PROGRAM

Taylor M. Perez
University of Vermont

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By

Taylor Pérez

Department of Nursing

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ABSTRACT

Background: In the US, the BIPOC community receives less than ideal healthcare as a result of the systemic racism deeply ingrained in the country. They are often under diagnosed, under screened, and experience higher mortality and healthcare complication rates than their white counterparts.

Purpose: The purpose of this cross-sectional quantitative study is to determine if there are differences in how undergraduate students and in the University of Vermont's undergraduate nursing program perceive how the program is doing in adequately teaching the AACN's social justice essentials.

Methods: The method of this study was a survey through UVM's RedCap platform. The survey had a demographics section, AACN essentials section, and a continuing education section that were estimated to take under 15 minutes to complete. The Likert scale of 1-5 was utilized and the survey was distributed to fourth year UVM BSN students and UVM BSN faculty.

Results: The survey had 58 respondents, 9 of which were faculty and 49 of which were fourth year students. Of significance, faculty had more confidence in student's ability to self report bias and advocate for social justice than the students themselves did upon entry to professional practice.

Conclusion: UVM BSN seniors need more education on just what advocating for social justice and communicating one's own bias entails. Additionally, they need more accessible DEI education beyond minimum licensure. The gaps in confidence between students and faculty should be further examined to streamline the program and the education it is facilitating.

TABLE OF CONTENTS

LIST OF TABLES & FIGURES

ACKNOWLEDGEMENTS

Thank you to my committee, friends, faculty, and mentors for helping me with this project. I owe a special thanks to Alan Maynard and Sue Kasser who were my mentors throughout this project.

I also owe a special thanks to Stephanie Kramer and the UVM Mosaic Center for teaching me that my roots are a point of pride and that I deserve to take up space in this world.

It’s been a ride, hope I didn’t shave too many years off anyone but myself!

CHAPTER 1: INTRODUCTION

Introduction

In the United States, many BIPOC (black, indigenous, and people of color) communities receive inadequate healthcare as a result of the systemic racism deeply ingrained in the country. BIPOC people are often under diagnosed, under screened, and experience higher mortality and healthcare complication rates than their white counterparts. Additionally, they are more likely to be under medicated for pain and to have other uncomfortable symptoms be dismissed (Bridges, 2017). In order to correct this, the roots to these disturbing facts must be examined.

Providing inclusive care is the responsibility of all members of the healthcare field. One of the most imperative parts of this inclusive practice is a dedication to continuing education. This study is informed by the Campinha-Bacote model which describes this concept best, detailing that cultural competence is “a journey rather than a destination” (Montenery et al., 2013). This framework involves cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Wall-Bassett et al., 2017). Continuing education in these specific areas becomes imperative in keeping medical practice up to par for the treatment of BIPOC people. Subsequently, it must be ensured that foundational education, such as an undergraduate nursing program, is up to par, so that the new generation of healthcare providers are equipped to treat the BIPOC community in the most equitable manner possible.

Changing the groundwork for undergraduate education ultimately falls into the hands of specific governing bodies. The governing body that oversees undergraduate nursing programs is the American Association of College of Nursing or the AACN. The AACN outlines essentials that a Bachelor’s in Science of Nursing program must adequately complete in order to be an accredited program. The essentials are deemed complete once a student in the program can

satisfactorily perform the skill that the essential is referring to. These essentials include competencies surrounding healthcare knowledge, assessments, and social justice (“The Essentials”, 2008).

The information from the essentials can be embedded throughout the program or brought up in specific classes to complete these requirements. Ideally, information and learning will be embedded throughout a program to provide maximum coverage of topics, but this is not the domain of the AACN. Rather curriculum boards for the specific college and program will design the program as they see best.

Knowledge of potential inclusive practice curricular gaps will be incredibly useful to the curricular board of UVM’s BSN program and nursing curriculum boards as a whole. There is a lack of concise literature looking specifically at cultural competence and inclusive practice in nursing baccalaureate programs and their subsequent curricula.

The Essentials

The nursing curriculum is dictated by a variety of essentials or competencies that must be assessed and evaluated in every BSN nursing program in order to receive accreditation. This is vital for nursing programs to keep running and producing effective and ethical nurses. The specific essentials that are listed under social justice education and have been chosen to be included in this study are as follows:

1. Assess predictive and genetic factors (environment, background, race, ethnicity, etc)
2. Conduct a health history that includes family background and genetic predispositions
3. Assess health/illness beliefs
4. Use behavioral change techniques to promote health
5. Use evidence based practice to follow these criteria

6. Use information and communicative technologies to promote health
7. Collaborate with other healthcare providers and patients to provide spiritual and culturally appropriate care
8. Use clinical judgment and decision-making skills in appropriate, timely nursing care during disaster situations
9. Collaborate with others to come up with intervention plans that take into account background, culture, etc
10. Participate in clinical prevention and population-focused interventions
11. Advocate for social justice
12. Use evaluation results to influence delivery of care, deployment of resources, and development of policies
13. Demonstrate tolerance for the ambiguity and unpredictability of the world and its effect on the healthcare system.
14. Promote achievement of safe and quality outcomes of care for diverse populations
15. Apply patient care technologies as appropriate to address the needs of a diverse patient population.
16. Explore the impact of socio-cultural, economic, legal, and political factors influencing healthcare delivery and practice.
17. Discuss the implications of healthcare policy on issues of access, equity, affordability, and social justice in healthcare delivery.
18. Use an ethical framework to evaluate the impact of social policies on health care, especially for vulnerable populations.

19. Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.
20. Communicate to the healthcare team one's personal bias on difficult healthcare decisions that impact one's ability to provide care. ("The Essentials", 2008)

It is important to assess whether graduating students are actually able to successfully fulfill these requirements. This can be assessed through surveys, standardized testing, and observation of students in the clinical setting.

Overall Research Questions

My overall research questions are as follows:

1) Do the faculty and students involved in the UVM BSN program think that the social justice essentials outlined in AACN's curriculum guidelines are being adequately met?
2) Do faculty and students involved in UVM's BSN program desire further opportunities for continuing education regarding inclusive practice?

Purpose Statement

The purpose of this cross-sectional quantitative study is to determine if there are differences in how undergraduate students and faculty in the University of Vermont's undergraduate nursing program perceive how the program is doing in adequately teaching the AACN's social justice essentials. With this information, further steps can be taken to fill in the knowledge gaps regarding inclusive practice and subsequently provide a safer, more welcoming environment to patients in the BIPOC community.

A Personal Account

The topic of inclusive practice for BIPOC patients is incredibly close to my heart, and I cannot complete this paper without also expressing my own truth and feelings about the matter. I

find that change is often enacted by the party that has faced discrimination and strife and it is partially through honest, first hand accounts that others begin to feel an understanding and subsequent kinship.

Through my education in the University of Vermont's baccalaureate nursing program, I have learned a lot about the medical and ethical practices of nursing. I have enjoyed my time up here immensely, but it has not been without its challenges regarding being a BIPOC person in a largely white state.

In 2019, the University of Vermont had an enrollment of 13,584 students. Of these students, 80.2% reported that they were white ("University of Vermont", 2020). 3.05% of students reported that they were mixed race, which is what I identify as.

I am white passing and have been oblivious to what others in the BIPOC community face until I came to this university. My first year of college, I dropped out of a program I thought would change my life. My supposed mentor and faculty called my family and I illegals in a time when we were all terrified of ICE and its influence.

In my nursing program itself, I saw repeated Latinx representations that seemed largely based on stereotypes. Beyond this, none of my peers spoke Spanish.

It was a bit of a lonely experience. This section is not intended to point fingers or demonize the university or program, it is rather to say that we all experienced it differently. The experience of some of my peers is just not what I experienced as someone in the BIPOC community. I hope this paper will raise a little awareness of the BIPOC experience in baccalaureate nursing programs.

CHAPTER 2: LITERATURE REVIEW

BIPOC Patients

Before asking how curriculum should be changed, it is important to look at why the need is there. Health outcomes tend to be worse for those of BIPOC and/or lower socioeconomic backgrounds as a result of deeply ingrained systemic racism and capitalist ideals. Given the growing population of US citizens that identify as a racial or ethnic "minority" this is something that must be examined within the healthcare profession.

In 2010, over a third of Americans identified with a racial or ethnic group that was not white and non Hispanic/Latino ("US Census..", 2022). The 2020 census reported that over 40% of people reported being of a BIPOC racial or ethnic group ("United States Census Bureau", 2020). These numbers are trending upwards and BIPOC people in America are quickly becoming a substantial percentage of the population.

Along with the upwards trending of BIPOC populations, there is a disturbing history of this community being mistreated or ignored by medical professionals. This is an area that has been studied with clear evidence to point to the fact that this population receives inferior medical treatment. In one systematic review cited, 45 different articles were all cited indicating that being in the BIPOC community put you at a greater risk from healthcare complications such as healthcare acquired infections and medical mistakes brought on by language barriers (Chauhan et al., 2020). There are many specific instances and statistics indicating the truth in these statements.

Black women are 4 times more likely than their white counterparts to die of preventable complications during childbirth (Flanders-Stepans, 2000). Black Americans are also 2 to 3 times more likely to die of preventable heart attack and stroke than their white counterparts. People of

color in America also have higher rates of obesity, diabetes, cancer, HIV/AIDS, asthma, and many other modifiable diseases (“African American Health”, 2020). These statistics come from systemic racism built into our healthcare systems, and a long standing ignorance of health disparities in black Americans.

The majority of many healthcare providers, including MDs, nurses, and LNAs are white and originate from America. In 2018, 17.1% of providers reported identifying as Asian, 5.8% identified as Hispanic/Latinx, and 5.0% identified as African American (“Figure 18”, 2018). This puts BIPOC patients at a disadvantage as studies have shown that BIPOC providers tend to treat this population of patients better. Having a provider of similar racial or ethnic background has been shown to improve trust, medication adherence, screening adherence, and overall understanding of healthcare teachings (Huerto, 2019).

While the trends of diversity, among physicians, has improved over the years, the same diversity is not seen in the nursing field. In 2017, only 6.2% of nurses identified as black, 7.2% identified as Asian, and 5.3% identified as Hispanic/Latinx (“AACN Fact Sheet”, 2019). As stated previously, in 10 years, 40% of the population identifies as a part of the BIPOC community which is a large contrast to the ~15% of nurses that identify as a non-white race or ethnicity (“AACN Fact Sheet”, 2019).

Latinx nurses in particular seem to be the missing link for a country whose Latinx population is quickly growing (Silva, 2021). On the patient end, 43 million people in America speak Spanish as their first language and may find it difficult to navigate the largely white healthcare field (“United States Census…”, 2020).

The literature regarding what to do about health disparities experienced by the BIPOC community is scarce. Upstream causes of these disparities include systemic racism, lack of educational opportunities, and a lack of diversity among medical professionals themselves.

When the healthcare field reflects the population that they are serving, that is when the best health care is provided. Ultimately this should be the goal for the healthcare system in order to provide the most inclusive care possible.

Education for Medical Professionals

Given the disparity experienced by BIPOC populations in health care, it is imperative to look at the education that healthcare professionals receive in regards to caring for BIPOC people. In the literature, both physicians and prevention have been highlighted as the biggest aspects in changing BIPOC outcomes.

As stated earlier, black Americans are 2 to 3 times more likely to die of heart disease than their white counterparts. Given these statistics, providers should be suggesting cholesterol and blood pressure screening as well as providing education on smoking cessation, diet, and exercise in these populations (“African American Health”, 2020).

Additionally, given that the majority of research is from the lens of a white, cisgendered male, the literature regarding inclusive practice in the field of medicine is often convoluted. A prime example of this lack of concise literature is the amount of contradicting or outdated information that can be found. One systematic review of inclusive practice related to patient outcomes reported that five different studies all reported that culturally competent care by primary care providers was correlated with much higher patient satisfaction (Betancourt & Green, 2010). However, another systematic review looking into a similar topic reported that it found low to medium quality studies that did not report a high correlation between inclusive

practice and patient satisfaction (Lie et al., 2011). This does not mean that there are no correlations, but rather the studies were a medium to poor quality and that correlation could not be drawn. This creates a gap in literature where more concise studies with more depth need to be performed.

Curriculum

The American Association of Colleges of Nursing accredits nursing programs every year. This accreditation is based on the successful completion of curricular essentials by the programs. The AACN has a multitude of essentials based on social justice which revolve around working with and understanding a diverse population of patients.

There have been many documented efforts to improve upon cultural competence in nursing curricula. In 2006, the state of California gave the AACN funding to expand the curricular teaching of cultural competence. This included an advisory board of nurse educators who specialized in inclusive practice to review the essentials that the AACN decided to require of nursing programs. Additionally, the AACN provides a “tool kit” for nursing programs in regards to their teaching of inclusive practice. This toolkit includes several different models including “Campinha-Bacote Model, Giger and Davidhizer's Model of Transcultural Nursing, Leininger's Cultural Care and Universality Theory Model, Purnell's Model of Transcultural Healthcare, and Specter's Health Transitions Model” (“AACN provides ‘toolkit’...”, 2009). All this combined has given the AACN a thorough knowledge base and subsequent expectation for knowledge imparted on students through curriculum building. Following through with curricular teachings then falls on individual programs and faculty to carry out.

Nursing Faculty

Nursing faculty are the backbone of nursing programs and an imperative part of the undergraduate learning experience. They are role models and guides to future nurses and greatly impact the next generation of nurses. It is the responsibility of nursing faculty to impart cultural competencies onto their students while additionally promoting diversity in the class itself. Unfortunately, nursing faculty have been faced with a multitude of problems in recent years including nursing shortages and lack of adequate support for the teachings of inclusive practice.

The idea that cultural competence in nursing students is the responsibility of the faculty is not a new one. This idea has stretched back to 1996 and beyond when Tanner, the original creator of the clinical judgment model, questioned the responsibility of nursing faculty to impart this wisdom. More specifically, he called upon nursing faculty to actively teach inclusive practice as part of their curriculum ("Cultural Competence…", 2007). However, faculty may only be as successful as their resources and curriculum allow them to be.

With a shortage of nursing faculty combined with the ever changing world of social justice, this may negatively impact student's ability to fulfill these competencies. The "aging out phenomenon" is the idea that the generation of nurses that make up the majority of nurses, are of the age of retirement ("A Continuing Challenge…", 2001). This means that a large percentage of the nursing workforce is currently retiring including nursing faculty.

Nursing faculty need further support and education to adequately impart cultural competence onto their students and to improve their practice as well.

Previous Studies

Studies similar to this have been conducted many times before to assess the cultural competence of nursing students, professional nurses, and the ability of nursing faculty to impart these competencies within a given curriculum. However, many of these studies focus on a

knowledge base of healthcare and how culture affects it. There is a literature gap in regards to nursing curriculum as approved by the AACN and whether or not curricular essentials are adequately being met on a curricular level rather than just a self knowledge level.

One such study, done by Lorinda J. Sealy, rated different aspects of cultural competency on a Likert scale of 1 to 5. This survey was knowledge based and asked participants to rate their level of agreement with different statements. Surveys were taken by nursing students and professional nurses who had recently graduated from the programs. While cultural awareness averaged out at 4.14, overall cultural competence averaged at 3.73 ("Cultural Competence…," 2007). This indicates that there is room to grow for these programs and their students.

Several survey studies like this have been performed before. In one such study, a similar survey was sent out to medical students, residents, and physicians alike to determine the extent of cultural competence each group had obtained through their studies. The average scores on general knowledge of BIPOC patients were low with each participant scoring, on average, 46% of the questions correctly (Seeleman et al., 2014). Another study looked at patient safety and cultural competence with BIPOC patients. The population involved in this study was senior baccalaureate nursing students. Out of 10 cultural competencies that were listed in this survey, 98% of participants reported only an average of 3 of said competencies to have been covered in their curriculums (Lee et al., 2020). This study will examine if there are similar gaps in UVM's Baccalaureate Science in Nursing program.

Interviews

In the beginning of research, Stuart Whitney (the head of the undergraduate nursing program in 2020), Jason Garbarino, and Tara Burnham, two individuals on the curriculum board and faculty themselves, were interviewed about UVM's BSN program.

Stuart Whitney, who retired this past year (2021), was interviewed in the beginning to get a general view of how he believed the program was doing in terms of DEI education and requirements. He was blunt in stating that he felt ignorant at times as things were changing and that he “grew up in a different world”. He also admitted that the university itself was not very diverse and the program wanted to attract more diverse faculty. Whitney identified these problems in the current program and was very open and honest about what could be done better.

Additionally, Jason Garbarino and Tara Burnham, members of the undergraduate nursing curriculum board and faculty in the program itself, were interviewed. The interview was focused on DEI education within the nursing program. They provided an informative interview, stating that D1 and D2 requirements within the university as a whole, are expected to satisfy some DEI requirements. Additionally, they are working on a competency based curriculum that focuses on how students fulfill competencies rather than relying on a content based curriculum alone. This and many of the other changes intended for the curriculum have been derailed due to the Covid-19 pandemic and they were unsure when these efforts would resume.

The majority of DEI education is supposed to be in PRNU 240 Leadership & Ethics class and the attached senior seminar that fourth year students take in the spring semester. However, in student interviews, many students who are at the end of both this class and seminar, feel that it did not provide enough information regarding DEI whether that be in race, sexuality, gender, or other diversity topics.

CHAPTER 3: METHODS

Design

This study employs a cross-sectional quantitative survey design.

Subjects

To qualify for this study, subjects had to meet the following criteria: (1) fourth year in UVM's BSN program or (2) Faculty involved in UVM's BSN program. Demographics were determined from self reporting at the beginning of the survey. For faculty, the list was derived off of UVM's nursing faculty directory on their site. For fourth year nursing students, there were email lists of students as well as different social media pages many of them were a part of.

Subjects were recruited through email invitations as well as public postings on the UVM Nursing Class of 2022 Facebook page. An email was sent through the program's Office Support Generalist to all students in their fourth year of the BSN program. Individual emails were sent to the list of faculty on UVM's site.

Since we recruited from a large pool of individuals associated with the UVM BSN program, it was expected to largely involve women and people of Caucasian descent. This is because this is the demographic of the UVM BSN program. BIPOC people and men will be included, but the data will be UVM focused and subsequently have a higher Caucasian female population than many nursing programs.

Survey Instrument

The survey was created within UVM's RedCap server, and was distributed through a public link to the subjects. It consisted of a demographics section, AACN curricular essentials section, and other DEI statements section.

Demographic data included gender, ethnicity, race, and demographic group (ie: undergraduate or faculty). It was estimated to take 2 minutes to complete this section. Subjects were required to complete their academic status in order to sort them into the correct data group. Race, gender, and ethnicity came with the option to deny to answer.

Essentials listed in AACN's curricular guideline were listed with original language. Participants utilized Likert's 5 point scale of strongly disagree, 1, to strongly agree, 5, to determine the extent that they believe UVM BSN students were prepared to utilize these essentials in professional practice upon graduation. There are 20 essentials listed. It was estimated to take under 10 minutes to complete this section.

The final section of the survey had 4 statements regarding desire and opportunity for continuing DEI education. This was also measured by Likert's 5 point scale from strongly disagree, 1, to strongly agree, 5. It was estimated this section will take under 5 minutes to complete.

Once participants completed these three sections, they were thanked for their participation and could close the window. Their answers were uploaded into RedCap's database.

Procedures

As the study poses minimal risk, the data safety and monitoring plan included oversight by the PI. The survey was anonymous thus no identifying information was asked of the participants. All electronic data was held on a password protected computer within the PI's Department with the password only known to the PI. In addition, no adverse events were reported to the PI by participants.

Analysis

The data collected by the RedCap surveys was reviewed both by splitting up data between faculty and students and also by splitting up data between the BIPOC community and the white community within the nursing program's students and faculty. Percentages of each demographic will be reviewed as well as the percentages of responses in each essential/continuing education statement from strongly disagree, 1, to strongly agree, 5.

CHAPTER 4: ANALYSIS

Completed Responses

This study involved a 29 question survey that contained a demographics section, BSN essentials section, and continuing education section. It was estimated to take 10 to 15 minutes to complete.

There were 58 total responses. Of the 58 responses, 33, or 56.9%, of the responses were completed. Most participants who did not complete the survey stopped filling it out after the demographics section.

Demographics

Faculty received the link to the survey through an email that contained explanations regarding the purpose of this study and directions. Out of 26 faculty chosen to participate in this study, 9 responded to the survey which is approximately 35%.

The demographics of all individuals who completed this survey are displayed in *Table 1: Demographics.*

Table 1: Demographics

	Faculty	Students
Demographic	9	49
Gender		
Male	1	3
Female	8	38
Non-binary	0	4
Other	0	1
Prefer Not to Disclose	0	3
Race		
White	7	44

African-American	1	1
American Indian and Native Alaskan	0	0
Asian	0	2
Native Hawaiian or Pacific Islander	0	0
Other	0	1
Prefer not to disclose	0	1

The large majority of responses to this survey were from white women. Of the 58 responses, 79.3% were from women. There were 4 responses, or 4.69% each, for both male and non-binary respondants. There was 1.17% of the population that chose other and 5.2% of the population chose not to disclose.

The majority of respondents were also white individuals. Notably, there was no representation from any respondents of Native American/indigenous or native hawaiian/pacific islander populations. Out of all the respondents, 87.9% of respondents, 51,were white, 3.4%, 2, respondents were African American, 3.4%, 2, respondents reported other, and 1.17%, 1, respondent chose not to disclose.

Essentials

The analysis of these essentials is based on all of the recorded responses. The below 5 essentials displayed the greatest range in responses from both faculty and students.

1) Assess health/illness beliefs

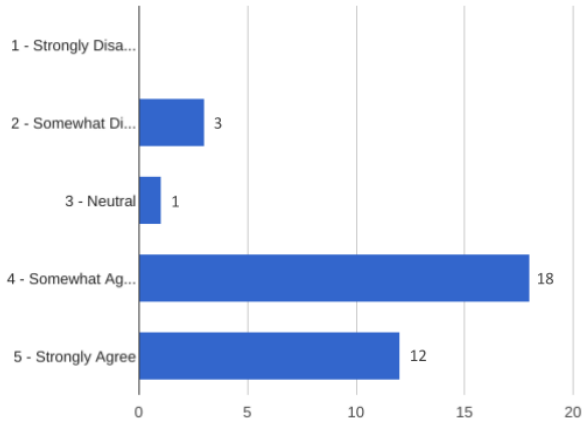

Figure 1: Essential #1

2) Collaborate with other healthcare providers and patients to provide spiritually and culturally appropriate care.

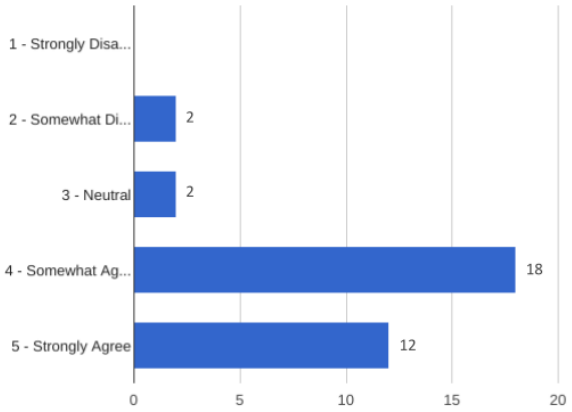

Figure 2: Essential #2

3) Apply patient care technologies as appropriate to address the needs of a diverse patient population.

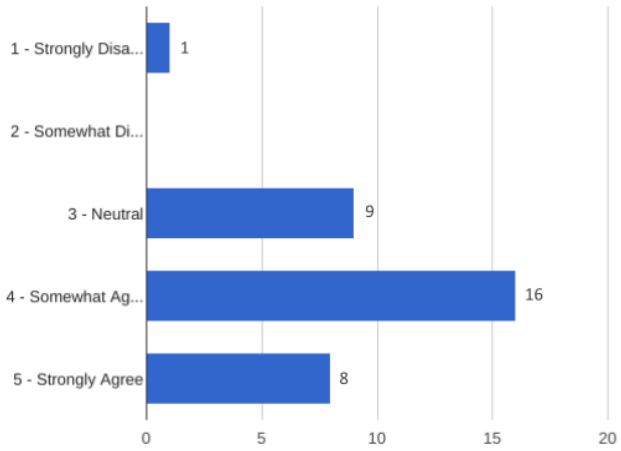

Figure 3: Essential #3

4) Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.

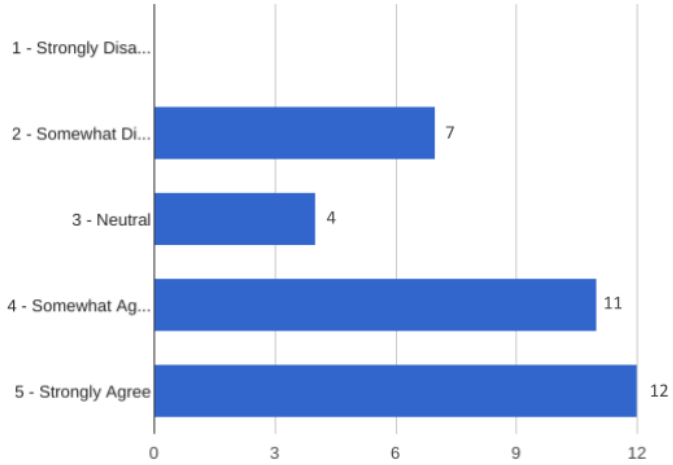

Figure 4: Essential #4

5) Communicate to the healthcare team one's personal bias on difficult healthcare decisions that impact one's ability to provide care.

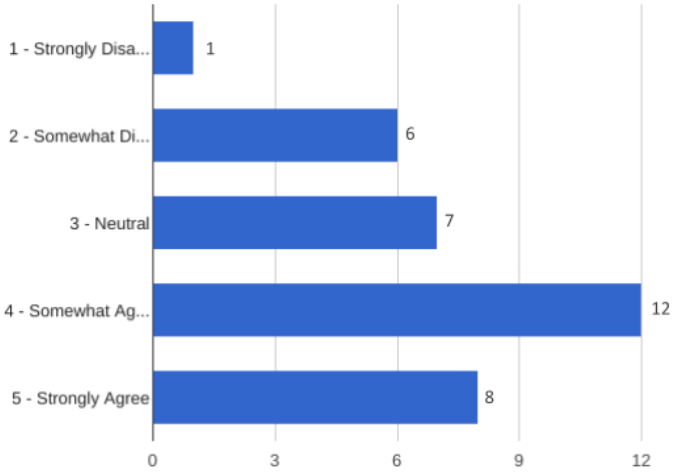

Figure 5: Essential #5

Comparison of Faculty and Student Responses

- Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.

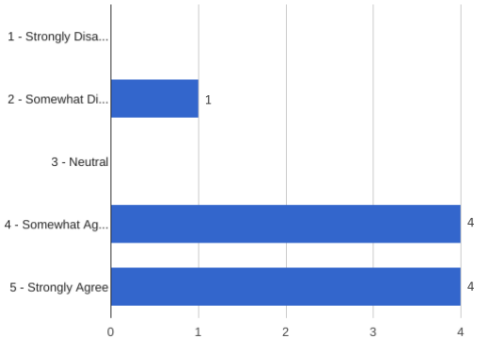

Figure 6: Faculty Responses

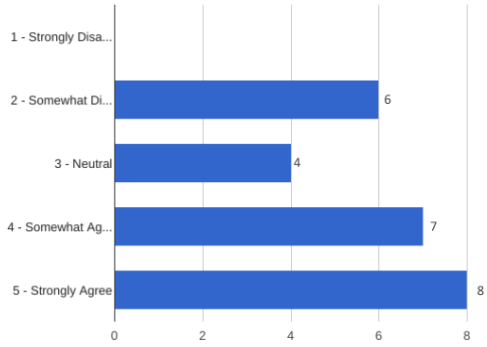

Figure 7: Student Responses

- Communicate to the healthcare team one's personal bias on difficult healthcare decisions that impact one's ability to provide care

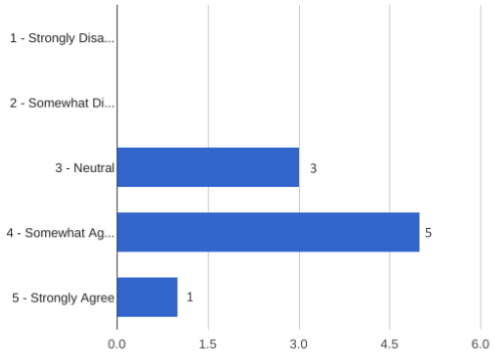

Figure 8: Faculty Responses 2

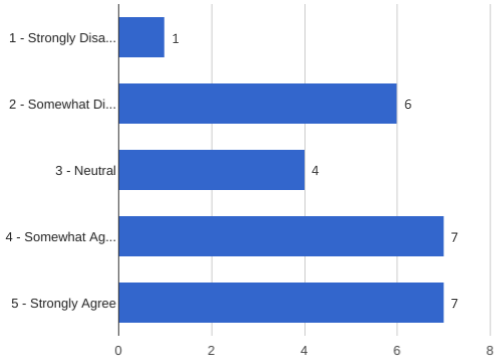

Figure 9: Student Responses 2

As you can see from the figures above, more students chose to somewhat disagree or strongly disagree with how much they believed they would be able to carry out each of these essentials. Faculty had a higher degree of confidence in students fulfilling these competencies upon graduation.

Continuing Education

In my continuing education section, four statements were utilized to determine participant's personal opinions about their desire and opportunities for continuing education. These are split for comparison between faculty responses and student responses.

These statements were as follows:

1) I feel like I am able to address the needs of diverse populations.

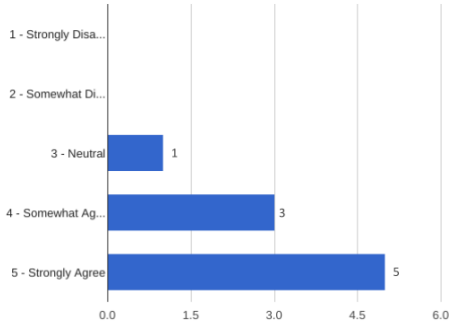

Figure 10: Faculty Responses CE #1

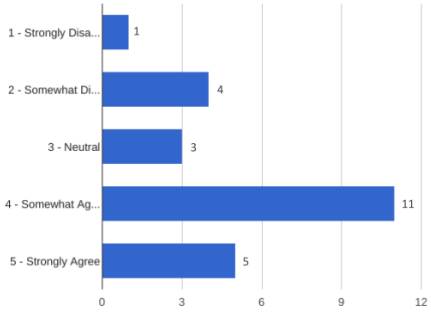

Figure 11: Student Responses CE #2

2) I feel that I am able to empathize with patients that have different experiences than my own.

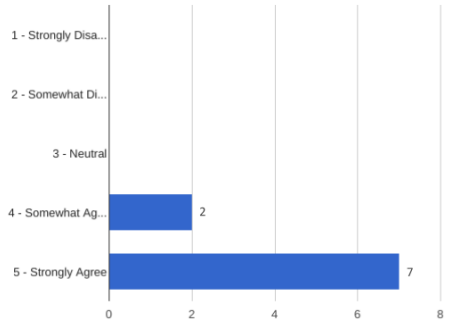

Figure 12: Faculty Responses CE #2

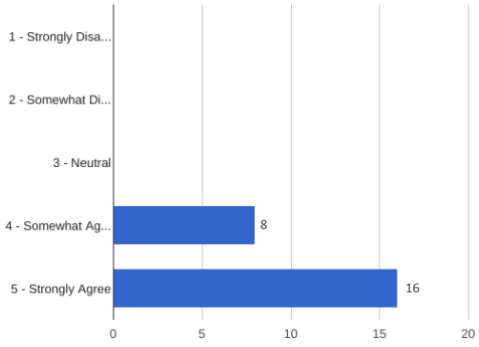

Figure 13: Student Responses CE #2

3) I desire more information and development in these areas than the minimum for licensure.

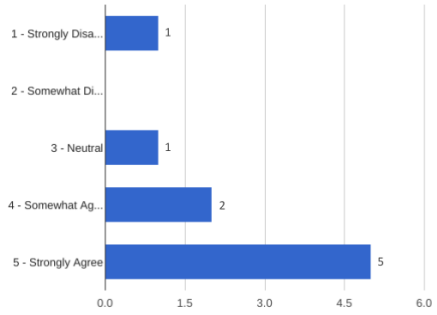

Figure 14: Faculty Responses CE #3

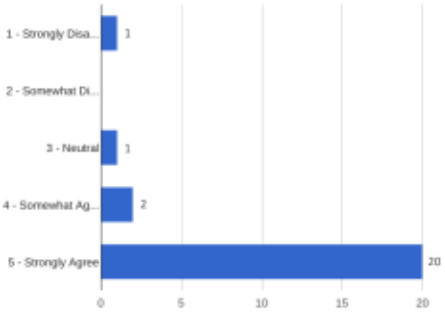

Figure 15: Student Responses CE#3

4) I feel that I am given opportunities to expand upon my knowledge of inclusive practice.

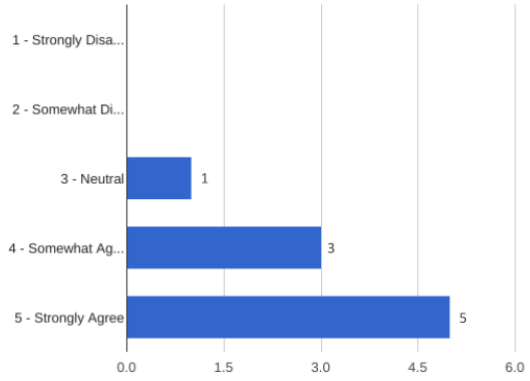

Figure 16: Faculty Responses CE #4

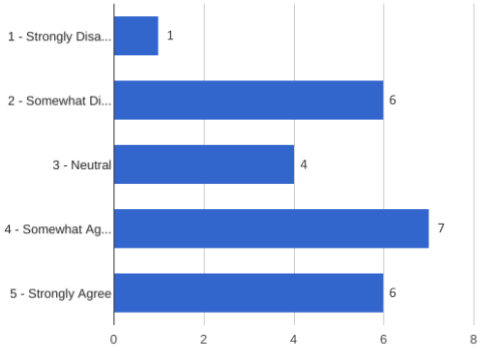

Figure 17: Student Responses CE#4

BIPOC Responses

Only 6 responses out of the 58, were from respondents of color. Only 1 out of 6 of these responses was from a faculty member, and only 4 of these respondents completed this entire survey. It is unfortunate as it would have been compelling to look at BIPOC responses versus their white counterparts side by side but the response rate and population of BIPOC faculty and students as a whole was too low to make an accurate comparison.

CHAPTER 5: DISCUSSION

The current literature displays compelling evidence that those in BIPOC communities will experience better outcomes when treated by BIPOC providers. It also states, that regardless of the provider's BIPOC status, providers with more cultural competence and knowledge into inclusive practice, will provide better care and better health outcomes to their BIPOC patients (Huerto, 2019).

While cultural competence is imperative, it is still difficult to be measured. There are tools out there to determine how much cultural exposure someone has received or how much knowledge on different races and ethnicities they possess, but whether or not they are able to provide culturally competent care while recognizing one's own biases remains to be seen.

One of the best ways to gauge how well people are able to provide culturally competent care, is to have them look at specific social justice curricular essentials and determine if they have confidence in completing these skills. This is the direction that this study took and it was able to display more specific fields in which people feel that they themselves and others need improvement.

Data & Implications

In regards to the AACN essentials, there were polarizing responses in regards to whether or not people felt that UVM BSN students in their final year were prepared to enter practice.

As displayed in *Figure 9*, 56% of the students who responded, somewhat agreed or strongly agreed that they were able to communicate one's own bias to the healthcare team. However the other half felt that this was a skill they might not possess or might not have full confidence in. There was a similar trend displayed in *Figure 7* in how students felt regarding their ability to advocate for social justice particularly for vulnerable populations. About half the respondents, 10, chose somewhat disagree or neutral for how well they thought they were able to fulfill this competency.

Comparably, faculty had much more confidence in the fact that they thought graduating BSN students were able to fulfill competencies surrounding social justice advocacy and knowing one's own biases. As shown in *Figure 6*, 89% of the faculty who responded somewhat agree or strongly agreed that students could advocate for social justice. Regarding communicating one's own bias, all of the faculty respondents chose neutral, somewhat agree, or strongly agree (*Figure 8: Faculty Responses 2*, p. 25).

The faculty was relatively confident that their students could communicate bias and advocate for social justice. This divide is an important thing to be brought to the faculty's

attention as it calls to attention the need for additional education and subsequent confidence building for students.

Students need more education on just what advocating for social justice and communicating one's own bias looks like. Students need to be taught communication and education techniques that they can use when speaking to other members of the healthcare team that may be engaging in bias. Additionally, the importance of recognizing one's own bias must be emphasized in this program. Students need the adequate encouragement and the words themselves in order to express biases they may hold without being persecuted.

The results in the continuing education program were also broken up between faculty and students. In *Figure 10*, 89% of faculty selected somewhat agree or strongly agree for the statement, "I feel that I am able to address the needs of a diverse population." They also as a whole agreed that they desired further education than the minimum for licensure in the arena of DEI and additionally agreed that they knew where to find it (*Figure 14.*.., p. 26*; Figure 16.*.., p. 26*).*

Senior students in the UVM BSN program stated that they desired more education than the minimum for licensure in DEI but failed to know where they could obtain this information (*Figure 15.*.., p. 26*; Figure 17.*.., p. 26*).* This could bring in the potential that senior BSN students need more knowledge about where DEI information can be reached. At the University of Vermont, BSN students could be connected with the Mosaic Center or Prism Center in order to obtain further information regarding DEI in the larger community. The college of nursing as a whole could put in an intentional effort to connect students to these learning opportunities and seminars the same way faculty are.

The racial complexities in today's world can be challenging for healthcare professionals to navigate. However, given that UVM's BSN program is producing healthcare professionals, it must rise to the challenge and give its all to produce the most knowledgeable and compassionate healthcare professionals for the BIPOC community.

Future Research

Further research for UVM's BSN program would include a similar study that would include the recent graduate population. This population, through the initiation of real life practice, would be better able to articulate what the program prepared them to do well and what might've been lacking from the curriculum.

Further down the line, country wide surveys should be implemented by the AACN itself to ensure that every nursing program is equipping its students with the necessary skills for providing inclusive practice. The ambiguity on AACN essentials and the lack of streamlining between nursing programs requires further research in order to ensure that our healthcare professionals are able to take care of all populations equitably.

Limitations

This study lacks a full data set to fully gauge the thoughts of individuals regarding cultural competence in the UVM BSN program. There were 49 senior student responses and 9 faculty responses. Ultimately the survey did not reach the intended number of responses and thus the data is not a full set and will have many confounding variables. Additionally, it only takes into account the University of Vermont's baccalaureate nursing program. The sample was made up of strictly UVM students and thus the data and results can only be applied to this program.

The loss of new graduate data is a big one as it is thought that senior nursing students may not fully grasp what they know and what knowledge must be improved upon until they are

actively in the nursing field. This could be skewing the data either way if senior nursing students are overly confident in their knowledge and abilities or alternatively, are more knowledgeable and prepared for practice than they originally anticipated.

Conclusion

It is the responsibility of all healthcare providers to ensure that they are providing inclusive care to all individuals. If they are not providing inclusive care, it is then the responsibility of these healthcare providers to pursue the necessary education and verbalize their potential biases to the healthcare team in the meantime.

Education is ultimately the best way to ensure that inclusive practice and cultural competence/humility is being reached. Communicating one's own biases and subsequently advocating for social justice are both skills that seniors in UVM's BSN program feel that they are lacking. More education and communication strategies surrounding these essentials in particular need to be integrated throughout the curriculum and the 4 years of the program in order to fill these gaps in knowledge and confidence. Additionally, more surveys like this need to be deployed to continually gauge the opinion of students and faculty into how well this specific program is doing in regards to inclusive practice and cultural competence/humility.

Personal Perspective

This study looked at the AACN's social justice curricular essentials and to what degree fourth year UVM BSN students and their faculty thought they were equipped to satisfy these skill requirements upon entry to the professional field. I was pleasantly surprised to see a decent amount of confidence in many of the social justice essentials but two stood out: advocating for social justice for vulnerable populations and communicating one's own bias to the healthcare

team. Additionally, there was a knowledge gap for senior BSN students in understanding where they may find additional DEI teachings.

At the end of this study, there is still further research to be done and further conclusions to be drawn. For the PI of this study, I have gained insight to my own biases and the areas in which I need to pursue further education. I hope UVM's BSN program is able to utilize this research to better their program and continue turning out competent and caring healthcare professionals.

REFERENCES

AACN Fact Sheet - Enhancing Diversity in the Nursing Workforce. (2019). American Association of Colleges of Nursing. Retrieved April 6, 2022, from https://www.aacnnursing.org/news-information/fact-sheets/enhancing-diversity#:~:text=Considering%20racial%2Fethnic%20backgrounds%2C%20the,%3B%20and%202.9%25%20other%20nurses.

AACN provides "Toolkit for cultural competent education". (2009). Nurse Educator, *34*(1), 33. https://doi.org/10.1097/01.nne.0000343395.80953.48

A Continuing Challenge: The Shortage of Educationally Prepared Nursing Faculty. (2001). The Online Journal of Issues in Nursing. Retrieved March 8, 2022, from http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume62001/No1Jan01/ShortageofEducationalFaculty.html

African American Health. (2020). Centers for Disease Control and Prevention. https://www.cdc.gov/vitalsigns/aahealth/index.html

Betancourt, J. R., & Green, A. R. (2010). Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. *Academic Medicine: Journal of the Association of American Medical Colleges*, *85*(4), 583–585.

Bridges, K. (2017). *Implicit Bias and Racial Disparities in Healthcare*. Americanbar.org. Retrieved May 7, 2022, from https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., Leone, D., Mears, S., & Harrison, R. (2020). The safety of health care for ethnic minority patients: a

systematic review. *International Journal for Equity in Health*, *19*(1), 1–25.

Cultural Competence of Baccalaureate Nursing Faculty. (2007). In Journal of Nursing Education (Vol. 46, Issue 8, pp. 360–366). https://doi.org/10.3928/01484834-20070801-05

Figure 18. Percentage of all active physicians by race/ethnicity, 2018. (2018). AAMC. Retrieved April 6, 2022, from https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

Flanders-Stepans, M. B. (2000). Alarming racial differences in maternal mortality. *The Journal of Perinatal Education*, *9*(2), 50–51.

Griffey, T. (2017). The Decline of Faculty Tenure. *LAWCHA*. Retrieved March 8, 2022, from https://www.lawcha.org/2017/01/09/decline-faculty-tenure-less-oversupply-phds-systematic-de-valuation-phd-credential-college-teaching/#:~:text=As%20the%20chart%20above%20indicates,the%20same%20types%20of%20institutions.

Huerto, R. (2020) Minority Patients Benefit From Having Minority Doctors, But That's a Hard Match to Make. *University of Michigan*. Retrieved March 8, 2022, from https://labblog.uofmhealth.org/rounds/minority-patients-benefit-from-having-minority-doctors-but-thats-a-hard-match-to-make-0

Lee, S. E., Lee, M. H., Peters, A. B., & Gwon, S. H. (2020). Assessment of Patient Safety and Cultural Competencies among Senior Baccalaureate Nursing Students. *International Journal of Environmental Research and Public Health*, *17*(12). https://doi.org/10.3390/ijerph17124225

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H., 3rd. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review

and proposed algorithm for future research. *Journal of General Internal Medicine*, *26*(3), 317–325.

Montenery, S. M., Jones, A. D., Perry, N., Ross, D., & Zoucha, R. (2013). Cultural competence in nursing faculty: a journey, not a destination. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing*, *29*(6), e51–e57.

Seeleman, C., Hermans, J., Lamkaddem, M., Suurmond, J., Stronks, K., & Essink-Bot, M.-L. (2014). A students' survey of cultural competence as a basis for identifying gaps in the medical curriculum. *BMC Medical Education*, *14*(1), 1–10.

Silva, C. (2021). *There are too few Latino nurses. Covid showed how important they are*. NBC News. https://www.nbcnews.com/news/latino/are-latino-nurses-covid-showed-important-are-rcna1110

The Essentials of Baccalaureate Education for Professional Nursing Practice. (2008). Retrieved March 8, 2022, from https://nursing.lsuhsc.edu/Docs/Quality/AACN Essentials of Baccalaureate Education for Professional Nsg Practice (2008).pdf

United States Census Bureau. (2020). *QuickFacts: United States* [Data set]. Retrieved March 8, 2022, from https://www.census.gov/quickfacts/fact/table/US/PST045221

University of Vermont. (2020). *Data USA*. Retrieved April 6, 2022, from https://datausa.io/profile/university/university-of-vermont#:~:text=The%20enrolled%20student%20population%20at%20University%20of%20Vermont%20is%2080.2,Hawaiian%20or%20Other%20Pacific%20Islanders.

US Census Bureau. (2022, January 12). *Decennial census P.L. 94-171 redistricting data*. Census.gov. Retrieved May 7, 2022, from https://www.census.gov/programs-surveys/decennial-census/about/rdo/summary-files.2010.html#par_textimage

Wall-Bassett, E. D., Hegde, A. V., Craft, K., & Oberlin, A. L. (2017). *Using Campinha-Bacote'S framework to examine cultural competence from an interdisciplinary international service learning program*. https://doi.org/10.5281/zenodo.1134303