2023

Understanding Nursing Students' Cultural Competency Levels and Implicit Biases

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An Honors Thesis Proposal submitted in partial fulfillment of the requirements for Honors in *Nursing*

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ABSTRACT

In the United States, non-Hispanic Black women are approximately three times as likely to die from pregnancy-related complications as non-Hispanic White or Hispanic women. Racism has been identified as a significant barrier to health equality and the improvement of maternal health outcomes for Black patients. Cultural competence and implicit bias in health care has emerged in part to address factors that may contribute to racial/ethnic disparities in health care. Both can impact the way nurses consciously and subconsciously deliver healthcare to patients of a different gender, race, religion, culture, socioeconomic status, etc. Nurses who are more culturally competent and aware of their own implicit biases provide higher quality nursing care which leads to better health outcomes for diverse patient populations. Because nurses make up the largest group of healthcare professionals, they are in a prime position to improve health outcomes and decrease morbidity and mortality rates for African American women of childbearing age. Nursing students must be prepared to join the professional workforce and deliver high quality nursing care to diverse patient populations.

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November 2023
School of Nursing
Honors College
Georgia Southern University

Acknowledgements

Words cannot express my gratitude to my mentor for her invaluable patience and feedback throughout this process. Additionally, this endeavor would not have been possible without the generous support from Georgia Southern University's Honors Program and the Institutional Review Board (IRB), who approved my research. I am also grateful to my classmates, cohort members, and all Georgia Southern School of Nursing students for their willingness to participate in the study and moral support. Lastly, I would be remiss in not mentioning my family, especially my parents, because their belief in me has kept my spirits and motivation high during this process.

Understanding Nursing Students' Cultural Competency Levels and Implicit Biases

Introduction

Every year in the United States, approximately 700 women die because of pregnancy or delivery complications (CDC, 2022). Four out of five pregnancy-related deaths were preventable (CDC Newsroom, 2022). The CDC (2022) suggests that pregnancy-related mortality rates vary significantly by race. In the United States, non-Hispanic Black women are approximately three times as likely to die from pregnancy-related complications as non-Hispanic White or Hispanic women (Moore, 2022). The CDC (2019) reported that 41 black women died per 1,000 births as a result of pregnancy-related death. Despite efforts to improve maternal health outcomes, maternal mortality rates in the United States continue to soar above rates for comparable developed countries (Mcmillan-Bohler & Richard-Eaglin, 2021). Racism has been identified as a significant barrier to health equality and the improvement of maternal health outcomes for Black patients (Mcmillan-Bohler & Richard-Eaglin, 2021).

Cultural competence and implicit bias in health care has emerged in part to address factors that may contribute to racial/ethnic disparities in health care. Because nurses make up the largest group of healthcare professionals, they are in a prime position to improve health outcomes and decrease morbidity and mortality rates for African American women of childbearing age (Nurse Practitioners in Women's Health, 2022). Nursing students must be prepared to join the professional workforce and deliver high quality nursing care to diverse patient populations.

Literature Review

Cultural Competence & Implicit Bias in Healthcare

Cultural competence is a significant concern for healthcare professionals, including nurses (Lin, Guo, Chen, Liao, and Chang, 2021). Cultural competence in healthcare refers to the ability of healthcare professionals to demonstrate cultural competence toward patients with diverse values, beliefs, and feelings (Betancourt, Green, & Carrillo, 2002). This relates to being aware of one's own cultural beliefs, values, and how these may be different from other cultures— including being able to learn about and honor the different cultures of those that one works with and serves. Implicit bias refers to the unconscious prejudice individuals might feel about another thing, group, or person (Heath , 2020). It includes the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Cultural competence and implicit bias can impact the way nurses consciously and subconsciously deliver healthcare to patients of a different gender, race, religion, culture, socioeconomic status, etc (Strklja, Dembiwska, Vinokur, and Leinug, 2017). This means that the interactions that nurses have with patients are impacted by nurses' implicit bias and cultural competency levels.

Implicit and explicit biases are among many factors that contribute to disparities in health and health care. Implicit biases are unconscious attitudes and beliefs that surreptitiously influence judgment and can, without intent, contribute to discriminatory behavior (Edwards-Maddox, Reid, and Quintana, 2022). It can be difficult to be aware of one's implicit biases due to them being outside of the conscious realm (Yanick & Davis, 2021). One can possess definite equitable beliefs while having implicit attitudes and stereotypes that contradict their conscious beliefs (Sabin, 2022). In healthcare, practices and policies that are influenced by unfair implicit biases not only negatively affect patient care and healing environment, but also restrict the diversity of staff, which can lead to an unbalanced distribution of funding, professional development (Sabin, 2022). In a study conducted by Yanick and Davis (2021), 80% of students

involved did not feel as if they were exposed to implicit bias awareness and were shocked by the lack of knowledge received about implicit bias and its effects on culture and race. Implicit bias is hidden and difficult to recognize in oneself and awareness of bias is one step toward behavior change. Without an awareness of implicit bias, the availability of quality care is expected to continue to decrease for patients due to the unconscious discrimination towards patients of different cultures (Yanick & Davis, 2021).

Racial and Health Disparities in African American Women of Childbearing Age

African American women had the highest acceleration of maternal deaths between the years 2007 to 2014 and, in some cities, died at a rate 12 times higher than Caucasian women (Howell, 2018). According to the United States Government Accountability Office (2022), health disparities are defined as "preventable differences in the burden of disease, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other populations." A number of factors lead to health care disparities among racial and ethnic groups, including low socioeconomic status, transportation issues, poor education and lack of health insurance (Daymude, Daymude, & Rochat, 2022). Sociocultural differences among patients, health care providers, and health care systems in particular, are seen by health care experts as potential disparities (Betancourt, Green, & Carrillo, 2002). A lack of culturally competent care can lead to poor communication between providers and patients of different racial, ethnic, and cultural backgrounds (Strklja et al., 2017). It can also lead to poorly designed systems of care to meet the needs of diverse patient populations and lack of diversity in health care's leadership and workforce (Strklja et al., 2017). A patients' ability to recognize symptoms of diseases and illnesses, thresholds for seeking care, expectations of care, and understanding the prescribed treatment are some common issues seen in healthcare.

Failure-to-rescue (FTR) is defined as the failure or delay to recognize and intervene in a patient experiencing complications from a healthcare condition or medical intervention (Hall, Lim, & Gale 2020). FTR often results in serious injury or complication or death. In a retrospective cohort study by Guglielminotti, Wong, Friedman, and Li (2021), data from delivery hospitalizations for women with severe maternal morbidity were categorized by race and ethnicity. The study analyzed the maternal morbidity and temporal trends in the failure to rescue rate for patients and hospitarations. The study showed that the failure-to-rescue rate ratio for African American women was 1.79 in comparison to 1.39 for women of other races and ethnicity, 1.43 for women without race and ethnicity data, and 1.08 for Hispanic women (Guglielminotti, et al., 2021).

Implicit bias could impact how well a patient understands her own health or is invited to engage in her care (Heath, 2020). For example, some nurses may provide fewer opportunities for shared decision-making or limited explanations of medical care because their implicit bias tells them a patient may not fully understand the information being presented or wish to engage in their own care. All of this, coupled with implicit biases that tell a nurse that a patient may not be able to afford specialty care, may decrease the likelihood of a patient receiving appropriate medical care. Nurses must recognize risk factors for high-risk pregnancy, symptoms of pregnancy complications, and know when it is most appropriate to seek higher levels of care. They should not let their own issues related to unconscious bias or cultural competency interfere with the care patients are afforded.

Access to healthcare for African American women is not always determined by socioeconomic status. It can also be due to availability of healthcare providers and facilities in the area in which they reside. From 2012 to 2016, nine Labor and Delivery units in rural Georgia

closed. This led to a further reduction in the number of practicing obstetric-gynecology (OBGYN) providers in areas with higher proportions of Black female residents of reproductive age, Black birthing patients, and patients with government medical insurance or self-pay (Daymude, Daymude, & Rochat, 2022).

Nurses' Role Promoting Health Equity

"Being a registered nurse or midwife in 2020 must mean being aware of social injustices and the systemic racism that exist in much of nursing, health, and social care and having a personal and professional responsibility to challenge and help end them" (Moorley, Darbyshire, Serrant, et al., 2020). Health equity is achieved when everyone has a fair and just opportunity to be as healthy as possible. Promoting health equity for all is done when nurses use holistic and impartial humanitarian principles while facing racism with humanitarian ethos (McMillian-Bohler & Richard-Eaglin, 2021). The American Association of Colleges of Nursing's (AACN) Essentials describes the importance of promoting health equity and social justice and calls of action regarding bias, health inequities, and structural racism (AACN, 2021)."Nurses are uniquely positioned to promote birth equity and ensure that Black mothers in their care are listened to and respected" (Moore, 2022). Due to their position, they can play a major role in addressing the underlying causes of poor health by understanding and recognizing the wide range of factors that influence how well and long people live (Moore, 2022). They can also contribute to helping create individual and community-targeted solutions, and facilitating and working with interdisciplinary and multisector teams and partners to implement solutions (Moore, 2022). Addressing social needs across the health system can improve health equity from the individual to the systems-level. The American Nurses Association's Code of Ethics obligates

nurses to be allies and to advocate and speak up against racism, discrimination, and injustice" (McClendon, 2020).

Implicit Bias Awareness and Development of Cultural Competence in Nursing Students

In a study by Strklja, Dembiwska, Vinokur, and Leinug (2017), students evaluated their own implicit bias and levels of cultural competency. Students expressed the need for nursing courses that offered cultural competency training and simulations to prepare them to care for different minority groups based on race, values, customs, religion, diagnosis, etc. (Strklja et al., 2017). In a study by Kirby, Earle, Calahan, and Karagory (2021), the Intercultural Development Inventory was administered to nursing students to assess the mindset of undergraduate nursing students in order to create a custom Intercultural Development Plan that will prepare the student for care of diverse populations. When scoring the Intercultural Development Inventory test, a score of 55 to 69 is denial, 70 to 84 is polarization: defense or reversal, 85 to 114 is minimization, 115 to 129 is acceptance, and 130 and greater is adaptation (Minimization, 2022). Results indicated that the pretest scores of first-year students were about five to seven points lower, on average, than the fourth-year students. Both cohorts scored in the range of minimization for developmental orientation. The fourth-year cohort showed improvement of almost 10 points in a 14-week span when cultural competency, implicit bias, diversity, and inclusion was taught in the curriculum (Kirby, Earle, Calahan, et. al, 2021).

According to the AACN's Position Statement (2017), "nursing education must develop a workforce who fully value the importance of diversity, inclusion, and equity to promote the health of the nation and the world." Implicit bias can have adverse effects on the patient experience, negatively impact patient-provider interactions, and lead to poor health outcomes (Heath, 2020). Nursing students must be aware of a patient's feelings, opinions and observations

about their health and health care. In many situations, patients can sense a nursing student's implicit bias, and report a poor healthcare experience as a result. Patients can be dissuaded from seeking care with a provider if they feel the provider is treating them in a stereotypical manner (Heath, 2020). This type of implicit discrimination developed as a result of the mistrust many Black and Brown patients have towards healthcare and medical institutions (Heath, 2020).

Delivering the highest quality of care to every patient, regardless of race, ethnicity, cultural background is the goal of every health care system (Russell, 2021). Nurses who are more culturally competent and aware of their own implicit biases provide higher quality nursing care which leads to better health outcomes for diverse patient populations (Lin, et al., 2021).

Methodology

The following research questions were used to guide this thesis project: (1) What are nursing students' perceived levels of cultural competence in the provision of care to diverse patient populations, and (2) What are nursing student's attitudes and behaviors for bias in the care of diverse patient populations?

Outcomes

The purpose of this thesis project was to evaluate nursing students' cultural competency and attitudes and bias behaviors in the care of diverse patient populations . The intended outcome is to raise awareness about nursing students' cultural competency levels and attitudes and behaviors for bias in the care of diverse patient populations.

Setting and Participants

The setting for this study was a nursing program at a Southeastern United States university. A convenience sample of nursing students enrolled in the undergraduate and graduate

nursing programs at the university were invited to participate in the study. Forty-three nursing students completed and returned surveys.

Ethical Considerations

The Georgia Southern University Institutional Review Board (IRB) granted ethical approval for this study. Implied consent was obtained from nursing students who completed and submitted the surveys. In order to protect participant confidentiality, no potential identifiers were included on the surveys received from participants.

Design

A descriptive, cross-sectional design was used to evaluate nursing students' perceived levels of cultural competence and attitudes and behaviors for bias.

Procedures

Nursing students were invited to participate in the study through a recruitment flyer that was posted in the announcement section of the Undergraduate and Graduate Nursing Student learning management system group and in the nursing student break room on campus. The recruitment flyer was also sent to nursing students via campus email. Participants were informed about the purpose and procedures of the study through web-based access to the survey via a Qualtrics^{XM} link posted in the recruitment flyer. The consent was included as the first question in the anonymous, web-based survey and included a statement that certified that by proceeding with the survey, participants acknowledged agreement to the consent. Participants were given up to two weeks to complete the study.

Measurements

For this project, a survey about cultural competence awareness and bias attitudes and behaviors were administered. The Personal Self-Assessment of Anti-Bias Behavior Survey was

developed by Tatum and Ayvasian in 1978 (Anti-Defamation League, 2021). Permission to use the instrument was obtained. Content validity was established by the original author. This instrument consists of a 17-item questionnaire measuring attitudes, beliefs, current practices, knowledge, and barriers to implicit bias using a five-point Likert scale ranging from 1=never to 2=always.

The Cultural Competence Self-Assessment Checklist was developed by Central Vancouver Island Multicultural Society (2012). Permission to use the instrument was obtained. Content validity was established by the original author. This instrument consists of a 14-item questionnaire that measures an individual's cultural competence. Nursing students' perceptions of their personal attitudes in regards to race, religion, and creed were measured using a five-point Likert scale ranging from 1=agree to 5=disagree. Intrapersonal responses for current practices, knowledge, and barriers to cultural competence were measured using a four-point Likert scale ranging from to 1=never to 4=always.

Data Analysis

Composite mean scores and frequencies were calculated for quantitative variables. All statistical analyses were conducted in SPSS Statistics (SPSS) software (version 23).

Results

This study examined nursing students' knowledge, skills, attitudes, and comfort level in the delivery of culturally competent nursing care and their attitudes and behaviors for bias in the care of diverse patient populations. The intended outcome was to evaluate nursing students' perceived levels of cultural competence and attitudes and behaviors for bias.

A total of 43 nursing students participated in the survey (Table 1). Students ranged in age from 19 to 47 years, with a mean age of 26. Nursing students from four programs participated in

the study: 35 nursing students from the Traditional BSN program (81.40%), 6 students from the Accelerated BSN program (13.95%), 1 student from the Master of Science in Nursing Education program (2.3%), and 1 student from the BSN-DNP program (2.3%). A total of 5 students identified as male (11.63%) and 38 identified as female (88.37%). The ethnic makeup of the sample was 53.49% White or Caucasian, 32.56% Black or African American, 4.65% Hispanic or Latino, and 9.3% Multicultural. Of the students participating in the study, 90.7% were born in the United States. When asked to describe their current level of cultural competence, most students reported being somewhat competent (62.49%).

Attitudes and Bias Behaviors

Composite mean scores (Table 2) and frequencies were calculated to determine students' knowledge and attitudes for biases towards diverse patient populations. Overall, the majority of nursing students (46.2%) report sometimes educating themselves about the culture and experiences of other racial, religious, ethnic and socioeconomic groups. Students often (59%) spend time reflecting on their own upbringing and childhood to better understand their own biases and the ways they may have internalized the prejudicial messages that they received. They often (56.4%) look at their own attitudes and behaviors as an adult to determine the ways they may be contributing to or combating prejudice in society. The value of diversity was always (51.3%) reflected in their work even when not personally represented in their community. Forty-three percent of students always avoid stereotyping and generalizing other people based on their group identity. Forty-eight percent of students are always comfortable discussing issues of racism, antisemitism, and forms of prejudice with others, but report a stronger agreement to always being open to other people's feedback about ways in which their behavior may be culturally insensitive or offensive to others. Students always (74.4%) give equal attention to

other people regardless of race, religion, gender, socioeconomic class, or other difference. Students always (33.3%) and often (38.5%) work intentionally to develop exclusive practices and to increase their awareness of biased content in television programs, newspapers, and advertising. When other people use biased language and behavior, only 28.2% of students always feel comfortable speaking up, asking them to refrain, and stating their reasons. The majority of students sometimes (33.3%) or often (33.3%) demonstrated their commitment to social justice in their personal lives by engaging in activities to achieve equity.

Cultural Competence

Composite mean scores (Table 3) and frequencies were calculated to evaluate students' cultural competence in the provision of care to a diverse population. Students agree that spiritual and religious beliefs are important aspects of many cultural groups (81.3%), individuals can identify with more than one cultural group (87.5%), and that everyone regardless of their cultural heritage should be treated with respect (93.8%). They also agree that people from different cultures can define the concept of "health care" in different ways (87.5%) and that their knowledge about different cultural groups can help them in their work with individuals, families, and groups (78.1%). Fifty-six percent of students always seek information about cultural needs when they meet new people at work or in an educational institution. They report always (43.8%) having access to textbooks and other materials that help them learn more about people from different cultures. They equally indicate that they ask people to tell them about their expectations regarding nursing care and services always (34.4%) or most of the time (34.4%). Half of the students avoid using generalizations to apply stereotypes to groups of people most of the time and 43.8% avoid doing so all the time. Fifty percent of students recognize potential barriers to healthcare services that different people might encounter most of the time and 40% recognize

barriers all the time. Fifty percent of students remove those barriers when identified most of the time while 37.5% remove the barriers all the time. The majority of students (81.3%) indicate they always gladly accept feedback from clients on how they relate to people from different cultures. However, only 56.3% of students report always finding possibilities to adapt their nursing services to fit the cultural preferences of individuals and groups.

Discussion

Overall the results of this study have the potential to improve health outcomes for not only African American women of childbearing age, but all diverse patient populations by informing nursing educators of nursing students' attitudes and bias behaviors and cultural competency levels. Only 23% of nursing students in this study reported prior cultural competency training. Sixty-two percent described their current level of cultural competence as somewhat competent. Less than half of the students reported always having access to textbooks and other materials that help them learn more about people from different cultures. The care of all diverse patient populations must be addressed in nursing curricula in order to prepare students to provide culturally competent care to all patients they may encounter in the healthcare setting. Nursing students must be exposed to content and resources needed to learn how to provide culturally competent care to all patients.

Nursing students must be able to recognize potential barriers to healthcare services that different people might encounter and actively work to remove those barriers to ensure quality healthcare is provided. The results of this study indicated that students did not always recognize potential barriers and that when barriers were recognized, they were not always removed. When students are confident in their ability to recognize potential barriers to healthcare services, they will be better equipped to remove these barriers for patients and provide the highest quality of

care to diverse patient populations during their nursing education and in their future nursing practice.

Half of the students in this study reported often looking at their own attitudes and behaviors as an adult to determine the ways they may be contributing to or combating prejudice in society. Only forty-three percent of students reported that they always avoid stereotyping and generalizing other people based on their group identity. Implicit bias and racism in the health care system significantly contribute to poor health outcomes, notably in maternity care for African-American women of childbearing age (Saluja & Bryant, 2021). Healthcare provider bias impacts how well a patient understands their own health and how they are invited to engage in their care (Heath, 2020). It is imperative for educators to be able to conceptualize where students are lacking awareness of their attitudes and bias behaviors and knowledge of culturally competent care. Addressing bias in the academic setting gives nursing educators the opportunity to educate students about the impact of bias on patient care and health outcomes. Current research suggests that the practice of self-cultivation and reflection through journal writing following a clinical rotation are strategies that can make students more aware of their implicit biases (Edwards-Maddox, et al., 2022). It also suggests that evaluating students' strengths and weaknesses in the provision of culturally competent care can inform nurse educators of potential knowledge deficits for students (Chen, et al., 2018).

Conclusion

Cultural competence and implicit bias impacts the way nurses consciously and subconsciously deliver healthcare to diverse patient populations. Because nurses make up the largest group of healthcare professionals, they are in a prime position to improve health outcomes. Nursing students must be prepared to join the professional workforce and deliver

high quality nursing care to all patients. Opportunities still exist for addressing bias and culturally competent healthcare in nursing education. With adequate awareness of their own biases and knowledge of culturally competent care, students will be prepared to contribute to the reduction of racial and ethnic disparities and provide quality care to all patients.

Table 1. Full Sample of Demographics

	Total Sample (N = 43) N (%)
Age, mean (SD)	26 (7.37)
Age Range	
Under 20	2 (4.7%)
20 to 24	23 (53.5%)
25 to 29	5 (11.6 %)
30 to 34	8 (18.4%)
35 to 39	2 (4.7%)
40 to 44	1 (2.3%)
45 to 49	2 (4.7%)
Gender	
Male	5 (11.6%)
Female	38 (88.4%)
Race	
Black or African American	14 (32.6%)
Hispanic or Latino	2 (4.7%)
White	23 (53.5%)
Multiracial	4 (9.3%)
Program	
Traditional BSN	35 (81.4%)
Accelerated BSN	6 (14%)
Master of Science in Nursing Education	1 (2.3%)
BSN-DNP	1 (2.3%)
Years of Professional Nursing Experience	
Less than 10 years	42 (97.7%)
More than 10 years	1 (2.3%)
Nursing Education	
Nursing student in an educational program	34 (79.1%)
Nurse	4 (9.3%)
Nurse with a bachelor's degree	4 (9.3)
Nurse with a master's degree	1 (2.3%)
Speak More Than One Language	
Yes	9 (20.9%)
No	34 (79.1%)
Born in the United States	
Yes	39 (90.7%)
No	4 (9.3%)
Prior Cultural Diversity Training	
Yes	10 (23.3%)
No	33 (76.7%)
Describe Your Level of Cultural Competence	
Very incompetent	1 (2.3%)
Somewhat incompetent	3 (7.0%)
Neither competent nor incompetent	5 (11.6%)
Somewhat competent	27 (62.8%)
Very competent	7 (16.3%)

Table 2. Personal Self-Assessment of Anti-Bias Behavior

	Mean (SD)
I educate myself about the culture and experiences of other racial, religious, ethnic, and socioeconomic groups by reading and attending classes, workshops, cultural events, etc.	3.31 (0.832)
I spend time reflecting on my own upbringing and childhood to better understand my own biases and the ways I may have internalized the prejudicial messages I received.	3.97 (0.707)
I look at my own attitudes and behaviors as an adult to determine the ways they may be contributing to or combating prejudice in society.	4.00 (0.725)
I avoid stereotyping and generalizing other people based on their group identity.	4.28 (0.826)
I value cultural differences and avoid statements such as "I never think of you as_____," which discredits differences.	4.21 (0.978)
I am comfortable discussing issues of racism, antisemitism, and other forms of prejudice with others.	4.21 (0.864)
I am open to other people's feedback about ways in which my behavior may be culturally insensitive or offensive to others.	4.51 (0.644)
I give equal attention to other people regardless of race, religion, gender, socioeconomic class, or other difference.	4.72 (0.510)
I am comfortable giving constructive feedback to someone of another race, gender, age, or physical ability.	4.10 (0.968)
The value of diversity is reflected in my work, which includes a wide range of racial, religious, ethnic, and socioeconomic groups, even when these groups are not personally represented in my community.	4.31 (0.832)
I work intentionally to develop inclusive practices, such as considering how the time, location and cost of scheduled meetings and programs might inadvertently exclude certain groups.	3.97 (0.932)
I work to increase my awareness of biased content in television programs, newspapers, and advertising.	3.90 (0.882)
I take time to notice the environment of my home, office, house of worship and children's school, to ensure that visual media represent diverse groups, and I advocate for the addition of such materials if they are lacking.	3.59 (1.117)
When other people use biased language and behavior, I feel comfortable speaking up, asking them to refrain and stating my reasons.	3.74 (1.044)
I contribute to my organization's achievement of its diversity goals through programming and by advocating for hiring practices that contribute to a diverse workforce.	3.44 (1.188)
I demonstrate my commitment to social justice in my personal life by engaging in activities to achieve equity.	3.59 (1.019)

Response Scale: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always

Table 3. Cultural Competence Assessment Scale

	Mean
Spiritual and religious beliefs are important aspects of many cultural groups.	1.31 (0.738)
Individuals can identify with more than one cultural group.	1.13 (0.336)
I believe that everyone, regardless of their cultural heritage, should be treated with respect.	1.06 (0.246)
I understand that people from different cultures can define the concept of "health care" in different ways.	1.13 (0.336)
I think that my knowledge about different cultural groups can help me in my work with individuals, families, and groups.	1.31 (0.693)
*I seek information about cultural needs when I meet new people at my work or educational institution.	1.53 (0.718)
*I have access to textbooks and other materials that help me learn more about people from different cultures.	2.06 (1.216)
*I ask people to tell me about their expectations regarding nursing care services.	2.25 (1.244)
*I avoid using generalizations to apply stereotypes to groups of people.	1.66 (0.701)
*I recognize potential barriers to healthcare services that different people might encounter.	1.69 (0.644)
*I remove barriers regarding nursing services affecting people from different cultural backgrounds when I identify them.	1.84 (0.920)
*I gladly accept feedback from clients on how I relate to people from different cultures.	1.19 (0.397)
*I find possibilities to adapt my nursing services to fit the cultural preferences of individuals and groups.	1.50 (0.672)

Response Scale: 1=Agree, 2=Somewhat Agree, 3=Neither Agree nor Disagree, 4=Somewhat Disagree, 5=Disagree

***Response Scale: 1 = Always, 2 = Most of the time, 3 = About half the time, 4 = Sometimes, 5 = Never**

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