THE INTEGRATION OF CULTURAL SAFETY IN NURSING EDUCATION: AN

INDIGENOUS INQUIRY OF NURSE EDUCATOR EXPERIENCES

by

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Abstract

Since the release of the Truth and Reconciliation Commission of Canada's ([TRC's], 2015a, 2015b) report, cultural safety education has moved to the forefront of curriculum discussions for schools of nursing (SONs). To improve access, quality of care and the health outcomes for Indigenous people, the TRC called for all levels of government to "provide cultural competency training for all healthcare professionals" (p. 211, Call to Action #23, iii) and called upon SONs to integrate Indigenous-specific content on colonialism and Indigenous health, which will require that cultural safety be integrated into the curriculum and mandated for educators (p. 211, Call to Action #24). These Calls to Action specifically challenge nursing education and nurse educators to integrate cultural safety into SON, where nurse educators are vital in facilitating and disseminating cultural safety content. The objectives of this research were to (a) explore nurse educators' experiences of integrating cultural safety in nursing education, (b) describe the strategies that nurse educators use, and (c) identify the barriers and possible solutions to facilitate the integration of cultural safety into nursing education. The researcher used an Indigenous research methodology approach—that is, qualitative in nature—to meet these objectives and gain insight into nurse educators' experiences in nursing education. Findings from this study begin to fill a gap in the literature, where no other studies of nurse educator experiences integrating cultural safety were located. This study conducted in Ontario with participants from 11 of the 14 accredited nursing programs offers a better understanding of the current state of integrating cultural safety in nursing education. In total, 15 nurse educators participated in conversational interviewing. Conversing and listening to personal stories was central to the Indigenous methodology and the primary knowledge-seeking method. A harmonized narrative and thematic approach were used to analyze the conversations and stories from nurse educators. Results of this study highlight the

complexity of integrating cultural safety content into the colonial and academic environment in which nursing education exists. The researcher found that the current structure of nursing education is incompatible with and a barrier to the integration of cultural safety. As a consequence, the results of this study reveal more barriers than strategies for integration, which demonstrates the substantial need for leadership, resources, and institutional support to integrate cultural safety. Attempts to integrate cultural safety in such ways have amplified forms of structural violence experienced by Indigenous nurse educators. This form of violence has been labeled a silent or covert type of racism that manifests in ways such as *tokenism* and *othering* of Indigenous nurse educators. Information about barriers, challenges and successes experienced by study participants supports recommendations for the dismantling of colonial discourses that are pervasive in nursing education and a barrier to integration of cultural safety. This study of integrating cultural safety uncovered the problematic nature of decolonization and Indigenization approaches as solutions to ensure cultural safety. Micro-reconciliation was identified as a possible solution to promote successful integration of cultural safety in nursing education.

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CHAPTER ONE: INTRODUCTION

The intersections among colonialism, racism, and their legacies have a lasting impact on the Indigenous and non-Indigenous health inequity gap in Canada (Allan & Smylie, 2015; Browne, Smye, & Varcoe, 2005). The health disparities that stem from these inequities not only cut across a wide range of major health outcomes and health determinants but are also exacerbated by educational institutions such as those in which nurses are trained (Reading & Wein, 2013; Smylie et al., 2011). Recently, Indigenous health and well-being has moved to the forefront of discussions on health equity, following the release of the Truth and Reconciliation Commission of Canada's ([TRC] 2015a) report that contains 94 Calls to Action. Two Calls to Action specifically challenge nursing education and nurse educators: the call to provide cultural competency training for all healthcare professionals (p. 211, Call to Action #23, ii), and a call upon schools of nursing (SONs) to integrate Indigenous specific content relating to colonialism and Indigenous health that will require cultural competency and safety to be integrated within curriculum and mandated for educators (p. 211, Call to Action #24). Important ethical and moral obligations stem from the TRC report: the requirement that all health professional education, including nursing, address the widening health disparity gap through the incorporation of Indigenous knowledge and learning practices, that educators participate in collaborative and transformative change to advance Indigenous health and well-being through the education of future healthcare providers, and that non-Indigenous faculty acquire the necessary skills and knowledge to move the TRC Calls to Action forward competently in Canadian SONs.

In this study I explored nurse educators' perspectives on (a) their experiences and understanding of cultural safety and (b) the integration of cultural safety curricular content in SONs in Ontario.

A Note on Terminology

In this thesis the term *Indigenous* refers to Aboriginal populations in Canada. The federal government uses this term in recognition of Canada's original people who identify as First Nations, Métis, or Inuit (Royal Commission on Aboriginal Peoples, 1996). Researchers have used the term *Indigenous* in global and international literature, and because it is becoming more common in Canadian literature and society, I use it to refer to all First Nations, Métis, and Inuit peoples unless otherwise specified. Additionally, *Indigenous Peoples* of Canada include many different cultural groups who are Aboriginal but do or do not share a common language, experiences, customs, or traditions. I make a distinction by referring to *Indigenous Peoples* as encompassing all groups of Aboriginal people in Canada, rather than the term *Indigenous people*, which implies that they are all the same.

Furthermore, throughout this thesis I use *Nēhiyaw* (Cree) terms from time to time. Although I do not fluently speak our *Nēhiyawēwin* (Plains Cree) language, it is important that I use *Nēhiyaw* terms in this work to remain true to my *Nēhiyaw* identity. As *Nēhiyaw* people, we refer to ourselves in *Nēhiyawēwin* as people of the four directions, or four-bodied human beings. The French people who settled in the plains named us *Cree*, which comes from *la cris*, or the screamers, in the French language because they witnessed the Crees' cry of joy or greeting to one another, which uplifts and ignites the spirit. A conversation with an Elder from Saskatchewan, (A. J. Felex, personal communication, May 30, 2018), implanted the notion of Indigenous revitalization and resilience. He commented that it was not long ago that even our parents were sent to schools, where they were forbidden to speak *Nēhiyawēwin*. They were forced to lose their way and change their way of crying out to the Creator, Grandfather Spirits, and Grandmother Spirits. Today in this poor state, the new beings (young) do not speak

Nēhiyawēwin; they do not know their language. Residential schools and other federal

government policies that aimed to eliminate our Indigeneity and lifeways suppressed this spirit

for years. LaRocque (2010) reminds me that language is the epistemological basis of culture and

that, as Indigenous writers, we must begin with language to unpack the colonizing approaches

entrenched in our thinking. Thus, my use of *Nēhiyaw* indicates my cultural agency and political

orientation as a form of resistance to the colonization and hegemonic undercurrents in our

academic institutions and society.

Background

In Canada, over 1.6 million people are Indigenous and defined as First Nations, Inuit, or

Métis (Statistics Canada, 2018). Indigenous Peoples continue to be the most legislated, over

researched, and most marginalized population in Canada (Logan McCallum, 2017). No other

cultural group has seen this level of interference. Such interference continues today in Canada,

with the neglect of Indigenous knowledge and human rights through deeply entrenched

Eurocentric systems. Over the past 500 years Indigenous Peoples as the original inhabitants of

Canada have endured extensive racism through the process of colonization (Reading, 2018). The

TRC (2015b) report documented the myriad of ways the healthcare system, including healthcare-

education institutions, contributed to the oppression, marginalization, and discrimination of

Indigenous Peoples today. Furthermore, the TRC Calls to Action identify important

considerations in the training of healthcare providers and for nursing education. For instance,

Calls to Action #23 and #24 directly call for the training of all healthcare providers in cultural

competency and for SONs to integrate Indigenous-specific content on colonialism and

Indigenous health, which will require that cultural competency and safety be integrated into the

curriculum and mandated for educators. However, since the release of the TRC's report, racial

discrimination and structural violence continue to mark the experiences of Indigenous Peoples as they navigate systems of care (Berg et al., 2019; Goodman et al., 2017; Kitching et al., 2019). Therefore, Indigenous and non-Indigenous scholars and healthcare providers have identified an urgent need to reform health professional education, research, and health services for Indigenous Peoples to move toward addressing and decreasing the health disparities and inequities that Indigenous Peoples face in Canada. Given this extensive history and the negative effects of colonialism, concepts of cultural safety and cultural competency have been adopted as approaches to include Indigenous content in undergraduate nursing curricula (Aboriginal Nurses Association of Canada [ANAC], 2009a; 2009b; CNA, 2018).

However, there is still considerable debate within nursing regarding the adoption of a cultural competency or cultural safety approach. *Cultural competence* is defined as the attitudes, knowledge, and skills essential for providing quality care to culturally diverse populations (ANAC, 2009a; 2009b); whereas *cultural safety* extends beyond cultural competence and is centered on understanding and addressing the power differentials inherent in healthcare through educational processes for health professionals (ANAC, 2009a; 2009b). The International Council of Nurses (2013), an international federation that represents more than 130 national nurses' associations, recommended that nurses be culturally and linguistically competent and demonstrate cultural competence, but it did not mention cultural safety. However, the CNA explained that cultural competence promotes cultural safety and that both are integral to equitable nursing care (CNA, 2018). Unlike cultural competence, cultural safety is created by and related to Indigenous Peoples' needs and is considered a "more radical, politicized understanding of cultural consideration, effectively rejecting the more limited cultural competent approach for one based not on knowledge but rather on power" (Brascoupe & Waters, 2009,

p. 10). Thus, cultural safety is considered a more appropriate approach to nursing education and is acknowledged by Indigenous nurse leaders (Canadian Indigenous Nurses Association [CINA], formally known as Aboriginal Nurses Association of Canada [ANAC],2009a) and nursing professional associations (CASN, 2013; CNA, 2018).

Through cultural safety, nurse educators are tasked with instilling a better understanding of who Indigenous populations are and incorporating the factors that influence their health into nursing education. The need for both the professional development of nursing faculty and the development of culturally relevant curricular content that embeds cultural safety is widely acknowledged as a key strategy to address racism, oppression, and discrimination across all levels of healthcare (ANAC, 2009b; Canadian Association of Schools of Nursing [CASN], 2013; TRC, 2015b). In addition, the reform of nursing education curricular content is required to ensure that future nurses, Indigenous and non-Indigenous, are prepared to become key agents of change to improve the health of Indigenous Peoples within mainstream settings and to reform the ingrained discriminatory healthcare practices and structures (Durey et al., 2011). Institutional, personal and professional commitment is required to ensure culturally safe healthcare environments, including educational institutions in which we train and educate healthcare providers.

Cultural safety is still a relatively new concept in the Canadian context, specifically with regard to incorporating concepts and frameworks into nursing education. Nurse educators in Canada have recognized the need for cultural safety in nursing curricula to prepare nurses (a) to meet the unique health needs of Indigenous populations, (b) to ensure care in delivered in a cultural safe environment, and (c) to create a culturally relevant learning environment so that nursing students, either Indigenous or non-Indigenous, feel safe (ANAC, 2009b; Martin &

Kipling, 2006). As Canadian nursing programs develop their curricula autonomously, what nurse educators teach nursing students varies considerably, and the inclusion of cultural safety content is inconsistent (Guerra & Kurtz, 2017; Rowan et al., 2013). Many educational frameworks are available to improve knowledge, skills, and the understanding of culturally based care. However, there is a lack of evidence of the effectiveness of integrating cultural safety curricula into the training of nurse educators in Canada (Durey, 2010; Guerra & Kurtz, 2017; Mazel & Anderson, 2011). In addition, not all nursing institutions are ready to adopt cultural safety frameworks/concepts or have appropriate supports in place for nurse educators to employ them effectively in the classroom (Rowan et al., 2013; Smye, Josewski, & Kendall, 2010).

Problem Statement

Despite the acknowledged importance of incorporating cultural safety in nursing curriculum, minimal research exists on how it is integrated in SONs and the experiences of educators who teach cultural safety concepts in their practice and curriculum content. Although SONs are taking steps to incorporate cultural safety into nursing education, it is unclear how or whether they are prioritizing cultural safety concepts as a focus or whether faculty support or guidance is available specifically for the effective integration of concepts into curriculum (Guerra & Kurtz, 2017). The purpose of this research study is to explore the experiences of nurse educators in SON who are positioned to integrate cultural safety concepts in nursing curriculum and education. In order to understand nurse educator experiences, and the challenges and hierarchies in nursing education systems an Indigenous research methodology approach was selected. The potential to prepare nurse educators and enrich nursing education requires careful consideration of how nurse educators currently integrate, understand, and experience cultural safety concepts. In addition, examining the current state of integration of cultural safety concepts

or approaches through the perspectives of nurse educators is essential to inform the development

of a standardized cultural safety framework with consistent concepts for Indigenous health and

knowledge in nursing curriculum. The findings from this study offer evidence in understanding

the experiences of nurse educators' teaching of cultural safety in nursing education and helps to

determine the effectiveness of the current approaches to cultural safety integration and identify

areas of improvement for SONs.

Research Purpose and Questions

My intentions in this Indigenous inquiry were to (a) explore nurse educators' experience

of integrating cultural safety into nursing education, (b) describe the strategies that nurse

educators use to integrate cultural safety, and (c) identify barriers and possible solutions to

facilitate the integration of cultural safety into nursing education. Pedagogy was consequently an

important dimension of this study; participants were asked about their most meaningful

educational experiences with cultural safety in their learning journey.

Primary question. What is nurse educators' experience of integrating and utilizing

cultural safety concepts in Ontario schools of nursing?

Secondary questions.

1. What behaviors and institutional factors are barriers to the integration of cultural

   safety?

2. What factors support the integration of cultural safety into nursing education?

3. What teaching strategies or approaches do nurse educators consider successful in the

   integration of cultural safety in the classroom and into the curriculum?

CHAPTER TWO: A REVIEW AND CRITIQUE OF LITERATURE

This chapter summarizes the current state of knowledge related to the research problem. The objective of this preliminary review was to summarize the scholarly discussion on cultural safety in nursing education, the approaches used to educate nursing faculty in SONs across Canada, and the emerging critical perspective on nurses' ability to deliver cultural safety concepts. Although a comprehensive and critical understanding of cultural safety requires a sociohistorical in-depth look at colonialism and its impact on the health of Indigenous Peoples, in this review I illuminate the scholarly discourse on cultural safety education in nursing. As a first step, I briefly review the social determinants of health and the health disparities, inequities, and racism that Indigenous Peoples face and that affect them, because this is an important body of evidence pertaining to the establishment and foundation of cultural safety. Next, I discuss in detail the emergence of the notion of cultural safety and the uptake of the ideology in the Canadian context. I then draw upon the experiences of New Zealand educators, who were the first to develop and integrate a cultural safety framework into nursing curricula. The findings from the literature reveal some confusion with regard to cultural safety frameworks that I explore in more depth. Finally, I will discuss how Canadian nurse educators are drawing on these frameworks to enhance both their practice and their teaching methods regarding cultural safety and the health and well-being of Indigenous populations.

Indigenous Health in Canada

Social determinants of health. In terms of health, colonization and assimilation have contributed to the emergence of the social determinants of health specific to Indigenous Peoples (Hackett, Feeny, & Tompa, 2016; National Collaborating Centre for Aboriginal Health, 2013; Riva et al., 2014). These determinants are grouped into three categories: proximal determinants

(health behaviors, employment and income, physical environment and education), intermediate determinants (health and education systems, community infrastructure, resources and capacity, environmental stewardship, and cultural continuity) and distal determinants (social exclusion, self-determination, colonialism, and racism; National Collaborating Center for Aboriginal Health, 2013). The determinants are at the root of health disparities among Indigenous Peoples and current disparities in the health of Indigenous Peoples in relation to their non-Indigenous counterparts are a serious cause for concern. Studies have shown that Indigenous people have a higher incidence of lung, cardiovascular, metabolic (especially diabetes), and infectious diseases (e.g., HIV, hepatitis C, and tuberculosis to name a few; Ospina et al., 2015; Statistics Canada, 2015a). For example, Inuit youth have a five to seven times higher suicide rate than the rest of Canadian youth (Government of Canada, 2017); and the suicide rate for Inuit youth is one of the highest in the world: 11 times higher than the global average (Orkin, Rajaram, & Schwandt, 2013). These disparities in health, both physically and psychologically, are directly related to the determinants mentioned above. The strongest predictors of health disparities in Canada are low socioeconomic status, Aboriginal identity, geographic location, and gender (King, Smith, & Gracey, 2009). In particular, Indigenous Peoples are especially vulnerable to the health-threatening effects of deteriorating conditions of poverty, employment, housing, and working conditions (Raphael, Curry-Stevens, & Bryant, 2008). In sum, these disparities increase the risk of morbidity and mortality for Indigenous Peoples in Canada simply because they are born Indigenous (Statistics Canada, 2015b).

  Health disparity and inequity. Although health disparities and health inequity are intertwined, Adelson (2005) distinguished between them and defined health disparities as indicators that show a disproportionate burden of disease on a particular population and health

inequities that point to the underlying causes of the disparities. Contrary to the belief of some

health professionals, the health disparities that Indigenous Peoples face are not inherent in their

lifestyle, culture, or genetic make-up (Adelson 2005; Browne & Fiske 2001). They result from

the complex interplay between the social determinants of health (proximal, intermediate, and

distal) and many political, economic, historical, and structural factors that are linked to the

colonization of Indigenous people in Canada (Adelson 2005). This means that the health

disparities and inequities that Indigenous Peoples face are intrinsically linked to and an outcome

of colonization. To improve the health of Indigenous people, health equity is vital. Pursuing

health equity means "striving for the highest possible standard of health for all people and giving

special attention to the needs of those at greatest risk of poor health, based on social conditions"

(Braveman, 2014, p. 6). It is therefore important to recognize these differences that result from a

vulnerability that is produced and not inherent to Indigenous Peoples and is an outcome of

colonization. Finally, the promotion of health and healing in Indigenous communities requires

competencies related not only to disease, but also to culture (ANAC, 2009b).

Epistemological racism in healthcare. Despite this acknowledgement from researchers,

healthcare providers, and the public regarding the disproportionate burden of disease, poor health

outcomes, and the widening health disparity and inequities, Indigenous Peoples continue to face

racism as they navigate the systems of care. Racism is driven by the overarching belief that one's

own race is superior to another's; and ultimately encourages discrimination that manifests as

intolerance, stereotyping, and ostracism and is particularly effective in the hands of those with

power (Reading, 2013). Racism functions at systemic, epistemic, and individual levels (Allan &

Smylie, 2015). Systemic racism in healthcare concerns the unjust distribution of power that is

present in law, policy, and economic practice, such as the Indian Act and the residential school

system, which continue to heap an unfair burden of poor health on Indigenous Peoples (Allan & Smylie, 2015; Matthews, 2017). Epistemic racism is the imposition of one dominant worldview over another (Matthews, 2017) such as the positioning of mainstream biomedical knowledge over Indigenous healing practices and traditions. Systemic and epistemic racism work in tandem as they further erode the culture of Indigenous people and determine which knowledge is privileged. Furthermore, racism at both epistemic and systemic levels is manifested in interpersonal relationships and at this level can be overt or covert (Allan & Smylie, 2015). Such forms of racism affect which patients have access to which healthcare resources, as well as the quantity and quality of care. Studies on the experiences of Indigenous Peoples' access to services have shown that delaying or avoiding access to healthcare is related to anticipated racism and the reporting of past negative experiences that involved healthcare providers' discrimination, stigmatization, and stereotyping (Horrill, McMillan, Schultz, & Thompson, 2018). The case of Brian Sinclair, an Indigenous man who died in a Winnipeg emergency room after waiting 34 hours for care, illustrates how entrenched societal stereotypes of Indigenous Peoples influence the type of care that they receive (Brian Sinclair Working Group, 2017). In Brian Sinclair's case, a treatable urinary tract infection resulted in his death because the physical signs and symptoms of his infection were perceived as intoxication, and healthcare providers ignored him until he died. Unfortunately, medical education, including nursing, is not immune to racism: rather it is hidden in curriculum that reinforces traditional power structures (Tomascik, Dignan, & Lavallee, 2018). Educational practices influence the attitudes of healthcare professionals and their interactions with Indigenous Peoples in profoundly negative ways, as the health disparity gap demonstrates. Better healthcare for Indigenous Peoples requires that providers become aware of

the multiple levels of racism that affect Indigenous patients' lives daily (Tomascik et al., 2018).

In nursing education, this is conceptualized and legitimized through cultural safety education.

Defining Cultural Safety

Cultural safety is a relatively new concept in the discourse on healthcare and healthcare

education programs such as nursing. It originated in Aotearoa, New Zealand, in the 1980s,

because of Indigenous Maori nurses' concern for the structural inequities that the Maori people

faced (Nursing Council of New Zealand, 2005; Ramsden, 1990, 1992; Wepa, 2005). During that

time the long-term impacts of colonization were beginning to be linked to the poor health

outcomes of Maori people. At that time the overall culturally inappropriate health services and

negative experiences that Maori people endured within mainstream health services heavily

determined their poor health outcomes (Wepa, 2003). Similar to the effects of colonialism on the

Indigenous population in Canada, colonialism severely disrupted the Maori way of life and their

belief systems, and Maori people suffered a widening health disparity gap (Anderson et al.,

2003; Reimer-Kirkham et al., 2002). Irihapeti Ramsden, a Maori nurse widely credited for the

development and implementation of cultural safety in New Zealand, explained that the concept

of cultural safety emerged with the need to acknowledge the impact of colonization and

understand the effect of colonization on Indigenous populations at all levels of healthcare

(Williamson & Harrison, 2010). This reasoning stemmed from the interactions and observations

of Maori and non-Maori healthcare providers, populations, and researchers that the Indigenous

people of New Zealand avoided using mainstream healthcare services, presented more frequently

at more advanced stages in the disease process, and were more often noncompliant with

treatment plans than their non-Indigenous counterparts (Papps & Ramsden, 1996). This negative

feedback loop created a vicious cycle that added to the already widening health disparity gap similar to the current situation of Canada's Indigenous population.

Cultural safety was conceived because of the need to improve the health outcomes of Maori people by bringing attention to the power imbalances in healthcare that have traditionally privileged those of European-settler descent and to recognize the severe and lasting impacts of colonialism. Ramsden (1990, 1992) affirmed that cultural safety extends the current definitions of cultural competence beyond personal characteristics and that nurses need to understand self, their own culture, and the theory of power relations. Ramsden defined cultural safety as an outcome of nursing care that empowers those who receive healthcare services with the right to safe service. Papps and Ramsden (1996) suggested that cultural safety in nursing

> addresses power relationships between the service provider and the people who use the service. It empowers the users of the service to express degrees of felt risk or safety. Someone who feels unsafe will not be able to take full advantage of the primary health care services offered. (p. 494)

As a result, cultural safety is not only a learning process, but also an outcome of nursing education in which those who will inevitability receive safe care define it. Therefore, cultural safety is meant to reassign power from the healthcare provider to the patient (Ramsden, 2002). The strength of cultural safety as a construct lies in the fact that cultural safety in nursing education focuses education on past and present colonization, the impact on Indigenous people's health, and self-reflection on individual attitudes and assumptions that influence the care that Indigenous Peoples receive (ANAC, 2009a; Papps & Ramsden, 1996). In summary, cultural safety raises awareness of issues that have previously been difficult to discuss, issues such as racism and oppression within healthcare and challenges healthcare providers, specifically nurses, to examine the power differentials that shape the nurse-patient relationship.

Cultural Safety in Canadian Nursing Education

The importance of cultural safety in redressing the health disparities and inequities of Maori people in New Zealand caused its rapid evolution in Canada, because Indigenous Peoples in Canada have faced similar experiences of health inequity and disparity as the Maori People; thus, the notion of cultural safety emerged in Canadian discourses on Indigenous health. Although a cultural safety approach can be applied across diverse populations (Anderson et al., 2003), in Canada, the primary targeted group has been Indigenous populations (Dion-Stout & Downey, 2006). Nurse scholars have widely acknowledged that cultural safety surpasses cultural awareness, sensitivity, and skills-based competencies as it is predicated on an understanding of the racism and the power differentials inherent in healthcare systems (ANAC, 2009a; Anderson et al., 2003; Browne et al., 2009; Rowan et al., 2013). In addition, postsecondary nursing program developers have taken many steps to move cultural safety into the curriculum in Canada. For example, ANAC, in collaboration with CNA and CASN, released a literature review on how to increase the proportion of Aboriginal nurses by integrating cultural safety into nursing education (ANAC, 2009a) and a framework for integration (ANAC, 2009b). These documents are significant to the integration of cultural safety because they specify the official position of both Indigenous nurse leaders and national nursing education bodies on the appropriate way to integrate cultural safety concepts into nursing education. This endorsement is important because CNA and CASN are two important representation and regulatory bodies in nursing practice and education.

However, since the ANAC (2009a, 2009b) documents have been published, the integration of cultural safety concepts into Canadian SONs continues to be marked by considerable variation in integration efforts (Rowan et al., 2013). For example, in a mixed-

method study of SONs in Canada, Rowan et al. (2013) found that a majority of their respondents

incorporated both cultural competency and cultural safety, and that inconsistencies existed when

the respondents integrated cultural competence and excluded cultural safety concepts from

nursing education. This finding means that frameworks of cultural competence can be

incorporated into Canadian nursing curricula without mention or consideration of the important

role of cultural safety in extending cultural competence. For instance, cultural safety and cultural

competency are often used interchangeably; however, advocates of cultural safety have identified

key differences and have major concerns about using them interchangeably. Cultural competence

is often considered the dominant model in nursing practice (Brascoupe & Waters, 2009;

Gustafson, 2005; National Aboriginal Health Organization [NAHO], 2008). Cultural competency

stems from Leininger's (1978, 2002) transcultural nursing theory and is based on

multiculturalism, which promotes the cultural harmonizing of nursing care through inquiry into

cultural differences and similarities that affect the health and well-being of patients and

population groups. Healthcare professionals develop cultural competence by becoming aware of

and sensitive to the distinct differences within and between cultures and applying their

accumulated knowledge and skills in a collaborative approach to meet the needs of the patient

(Mahara, Duncan, Whyte, & Brown, 2011). Brascoupe and Waters argued that cultural

competence reflects a Western culturalist approach to nursing care that situates nurses in a

position of knowing and assumes that they can become truly competent in another culture.

Cultural competence can also be limited, because reducing cultural care to skill development

risks the oversimplification of cultures, lacks the action to address related inequities, and often

ignores power relations and racism in healthcare (ANAC, 2009a; Gustafson, 2005). Therefore,

cultural safety is a necessary approach to promoting health because it authentically addresses the

historic legacy of colonization that has resulted in widespread health inequity among Indigenous populations in Canada.

However, as cultural safety has become a more frequently adopted framework, more reports and guidelines that have been released help to address Indigenous health inequities and racism in healthcare. For example, documents from international (Clark et al., 2011; Douglas et al., 2011), national (CNA, 2010; NAHO, 2008), and provincial/territorial nursing organizations (Arnold, Appleby, & Heaton, 2008; Mahara, Duncan, Whyte, & Brown, 2011) have informed the curricular integration of cultural safety in Canadian SONs. These various sources have resulted in a multitude of definitions, conflicting frameworks, and best-practice guidelines that lack consistency and leave a gap in the knowledge on approaches to integrating cultural safety content in SONs in Canada (Bourque Bearskin, 2011; Browne et al., 2009; DeSouza, 2008; Drevdahl, Canales, & Dorcy, 2008; Guerra & Kurtz, 2017; Rowan et al., 2013; Woods, 2010). The lack of agreement is an important issue in terms of standardizing and mandating terminology because, without a common agreement SONs in Canada are developing and implementing cultural safety curricula in an inconsistent and variant fashion (Guerra & Kurtz, 2017; Rowan et al., 2013).

Challenges to Cultural safety in Nursing Education

This discourse on the shift to cultural safety poses challenges for both students and educators in nursing. Browne and Varcoe (2006) highlighted that educators' perspectives on cultural safety tend to focus more on race and ethnicity and omit the crucial elements of intersectionality and colonization that articulate a more complex understanding of the culture of Indigenous Peoples (Anderson et al., 2003; Brascoupe & Waters, 2009; Dion Stout & Downey, 2006). Misunderstandings of cultural safety tend to stem from nurses' perceptions of culture. Culture can be understood as a "complex, shifting, relational process" (Browne & Varcoe, 2006,

p. 162) that changes over time and is influenced by our history, experiences, and social, professional, and gendered locations. Thus, culture is not limited to ethnicity or race. Increasing our understanding of culture to encompass our history and experiences, for example, invites nurses to consider the complexity of culture and colonization and how these factors influence the health needs of culturally diverse patients (Gray & Thomas, 2006; Vandenberg, 2010). Educators might not clearly understand the definition of culture, because they often confuse cultural safety, because of its complexity, with transcultural nursing theories (Papps & Ramsden, 1996).

This culturalist understanding tends to divert attention away from the root causes of health disparities, and Brascoupe and Waters (2009) have called for better definitions of culture to avoid these misunderstandings. Nurses in their study articulated cultural safety from two points of view: on a continuum or as a paradigm shift (Brascoupe & Waters, 2009). The nurses understood cultural safety on a continuum as the end result of cultural competence. This view indicates that, with training and education on culture, nurses can be deemed culturally competent and thus provide culturally safe care. However, when cultural safety was viewed as a paradigm shift, nurses understood it as redistributed power in the nurse-patient relationship: from the nurse to the patient (Brascoupe & Waters, 2009). As stated previously, this shift in power rebalances the nurse-patient relationship and empowers patients to lead and determine whether the care that they receive is culturally safe. These alternate viewpoints on the definitions can create further complexities in nurse educators' understanding and use of cultural safety concepts.

Furthermore, challenges arise in the classroom for both educators and students because decolonizing topics such as the history of oppression, racist discourses, and commonly held beliefs of Indigenous populations can be sources of pain, resistance, and struggle between the dominant and nondominant discourses (Gibbs, 2005; Wepa, 2003). A key process in the

integration of cultural safety for Indigenous populations is the discussion of historical oppression from European settlers and the lasting effects of trauma; these topics expose and confront the deeply held beliefs of students and educators (ANAC, 2009a). Canadian nurse educators have reported that they need more education and have little support in learning how to engage in such difficult conversations of marginalization, racism, and oppression with their students (Brown et al., 2009). As a result, the ability of nurse educators to integrate cultural safety for Indigenous Peoples into the classroom is limited because they need adequate support and strong facilitation skills to create effective classroom discussion and manage discomfort when conflicts arise (Wepa, 2003).

An important implementation issue linked to cultural safety education is the overall effectiveness in influencing and changing the attitudes and behaviors of nursing faculty. Discussions on effectiveness have revealed the challenges of avoiding the view of cultural safety education as a 'tick-a-box' process, which attests to the need for a long-term commitment to cultural safety (Durey & Thompson, 2012) and the inclusion of an evaluation process on its impact. The necessary commitment and evaluation require that institutions move beyond the awareness that nurse educators can gain from one or several workshops/lectures/seminars on cultural safety. A recent survey of Indigenous healthcare education in Australia, New Zealand, the United States, and Canada revealed little evidence that existing efforts to integrate cultural safety frameworks/concepts have been effective (Ewen, Paul, & Bloom, 2012; Mazel & Anderson, 2011). Horvat et al. (2014) affirmed that this lack of effectiveness is a result of uncertainty about the most successful way to educate healthcare professionals on cultural competency that will improve educators' and students' attitudes, knowledge, and skills and health professionals' performance with regard to providing care for Indigenous Peoples.

Inconsistent measurement approaches, specifically the lack of validated and reliable instruments, have limited progress in this field. A systematic review of 36 articles on Indigenous health curricula revealed the common assumption that enhancing knowledge, skills, and attitudes will improve Indigenous health, rather than focusing on outcomes of cultural safety education such as the effectiveness of teaching in changing students' attitudes and behaviors (Ewen, Paul, & Bloom, 2012). In addition, evaluation has not focused on patient outcomes, and there is no research on the impact of curriculum initiatives on end users (students and/or patients). Evaluating the current integration of cultural safety concepts or approaches is essential to inform the development of a standardized framework with consistent concepts for Indigenous knowledge in the nursing curriculum. A significant part of this process involves examining nurse educators' experiences with and understanding of cultural safety in its current state to fill the gaps or restructure current initiatives so that they progress successfully. However, the literature on nurse educator' experiences, understanding, or use of cultural safety frameworks is limited.

Another challenge in providing culturally safe care is the legitimacy of critical self-reflection in nursing education. In critically self-reflecting, service providers examine the social, political, historical, and cultural backgrounds that shape their own identities to enhance their awareness of the power dynamics at structural and interpersonal levels that disadvantage their Indigenous clients (Durey & Thompson, 2012). For instance, one issue is the question of what makes reflection in cultural safety critical self-reflection. Practices such as journaling are common in nursing and focus on the self; the critique of social positioning might be absent, which results in a limited reflexive practice that is insufficient to ensure cultural safety (Spence, 2005). As Durey and Thompson (2012) argued, willful blindness leads to inaction when individuals in powerful sociocultural groups are indifferent or reluctant to acknowledge their role

in disadvantaging Indigenous Peoples. Critical self-reflection can be a difficult and challenging process that requires that nurses analyze and question themselves in unfamiliar ways. The failure to understand other perspectives and the impact of power, colonialism, and other factors are harmful because they maintain the status quo and result in little fundamental change. Thus, for cultural safety to bring about change, critical self-reflection is necessary and must go beyond the nursing standards of critical self-reflection to refocus specifically on the power dynamics at the structural and interpersonal levels that disadvantage Indigenous Peoples.

Conclusion

   The colonial education system has undeniably shaped the current systems in which nurses are educated, and these institutions reinforce and inflict trauma on Indigenous populations who access them (Hole et al., 2015). Thus, cultural safety in nursing education in Canada is an approach that should be used to address the health disparity gap, prevent further harm, support reconciliation, and create structural change by improving the preparation of future nurses. This review of the literature revealed a lack of guidance and understanding of how educators engage with cultural safety frameworks and concepts in nursing programs. Moreover, the literature has offered little in directly addressing how educators can tackle discussions of racism, oppression, and colonialism in contemporary healthcare education— a discussion that is required for the practice of cultural safety. Research is needed regarding the impacts of incorporating cultural safety concepts and nurse educators' experiences/perspectives into the classroom to develop better cultural safety approaches in nurse-education programs. As noted earlier, many authors included in the literature review have agreed that the lack of standardized cultural safety definitions, frameworks, or guidelines from practice and policy organizations has negatively influenced nurses' understanding of and ability to practice cultural safety (Brascoupé & Waters,

2009; Van Herk et al., 2012). Standardized cultural safety definitions, frameworks, and

guidelines are very much needed and can be achieved only by understanding how end users

integrate and experience cultural safety (Ewen, Paul, & Bloom, 2012; Guerra & Kurtz, 2017;

Rowan et al., 2013). In addition, the lack of outcome indicators for students and educators makes

it unclear whether current efforts to integrate cultural safety concepts and frameworks are

creating culturally safe environments. Thus, more research is needed to understand whether

current cultural safety frameworks and concepts that are being integrated are an effective

approach in SONs and how we can improve the current approaches. This research study will

begin to address this gap in the literature and further illuminate nurse educators' experiences and

understanding of cultural safety in their educational and practice environments.

CHAPTER THREE: METHODOLOGY

Research Design

To answer my research questions, I employed an Indigenous research methodology (IRM) approach. IRM continues to gain considerable uptake from Indigenous researchers who are searching for ways to carry out their work with integrity and attention to innovation (Smith, 1999; Webber-Pillwax, 1999). Steinhauer (2002) explained that "relying upon a methodology that permits and supports the experiences, thoughts, feelings, and spiritualities of Cree pedagogies is a way of honoring the Cree community's knowledge system because it is grounded in their own way of being and knowing" (p. 33). For these reasons I chose to honor my Indigeneity by employing an IRM approach because not only is it mindful and respectful of Indigenous Peoples and their knowledge systems, but it also helped me to develop my Indigenous knowledge within academia. In addition, my Indigenous research process evolved from a *Nēhiyaw* knowledge system, and my colonial experiences from that perspective have resulted in a distinctive frame of reference for my thinking about concepts such as culture, colonization, and Indigeneity.

Margaret Kovach's' (2009) work on IRM was the primary guide in this research process. Kovach situated IRM as an emerging approach that can be situated within the context of qualitative research for Indigenous researchers. She maintained that IRM fits into the landscape of qualitative methods because it encompasses the relational characteristics and qualities of qualitative research, and the philosophical underpinnings flow from a social constructivism paradigm that researchers use to understand the world in which we live. Similar to myself, Kovach used IRM mainly as "a way of upholding Indigenous thought through a personal interpretive tribal lens" (p. 174) and as "an offering to the Indigenous community and members

as a way to conduct research in a respectful way that honors and upholds tribal paradigms"

(p. 19). Her framework positions Indigenous knowledge at the center of her research design.

Kovach described six nonlinear processes that she used in her research study with Indigenous

social workers. The phases on which she focused were aspects of her own individual

preparations and relationships to the research process. I incorporated her six processes of

researcher preparation, research preparation, decolonization of ethics, knowledge gathering,

meaning making, and giving back as a guide in conducting my study (Figure 1).
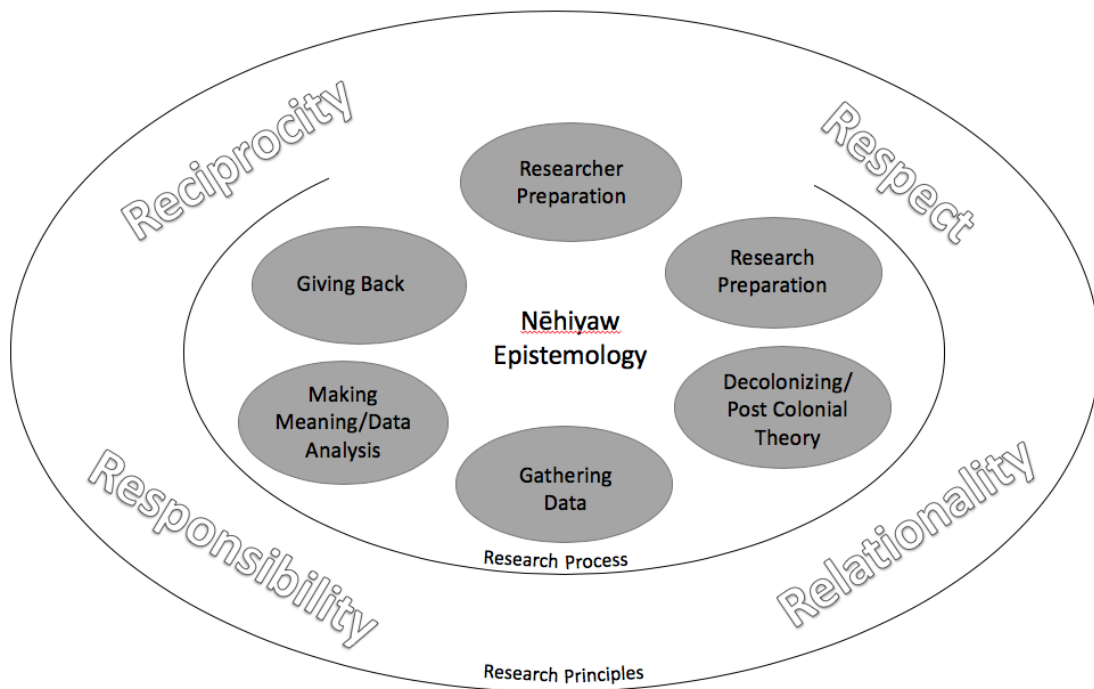
Figure 1. Indigenous research framework (adapted from Kovach, 2009).

I constructed the Indigenous research framework that guided this study (Figure 1) to

mirror a standard research design familiar to qualitative researchers. The epistemic center of this

approach encompassed my *Nēhiyaw* knowledge. I adapted this research model from Kovach's

(2009) *IRM* framework. In line with her framework, I used no arrows or direction lines because

this research process was nonlinear. Rather, it flowed in and out, back and forth, or up and down; whereas *Nēhiyaw* epistemology is nested at the center. *Nēhiyaw* epistemology is a relational approach, and each strand represents a web that is integrated and interdependent with other strands, all of which stemmed from my central *Nēhiyaw* epistemology. The methodological and axiological principles on the outer sphere of the circle symbolize and embrace the wider space of the design and the environment in which I conducted the activities of this study. These four principles—respect, relationality, responsibility, and reciprocity (Kirkness & Barnhardt, 2001)— are therefore the standards to which I held myself accountable as I incorporated them into the research process and strengthened the trustworthiness and rigor of this research. The four Rs refer to

> the need for a higher educational system that respects them [the students] for who they are, that is relevant to their view of the world, that offers reciprocity in their relationships with others, and that helps them exercise responsibility over their own lives. (Kirkness & Barnhardt , 2001, p. 1)

This framework inclusively captures four key components of the entire research process and is based on *Nēhiyaw* understandings of creating respectful research activities; enacting ethical relationships; being responsible for gathering, documenting, and analyzing the data; and ensuring that researchers honor mutual reciprocity.

Drawing on Kovach's (2009) six research processes, I situated myself as a researcher, ensured that the research was appropriate to my participants, committed to decolonizing my thoughts and perceptions as I collected data, and conducted meaningful analyses that are important to the community of nurses and nurse educators to advance the ways of knowing in Indigenous research. The findings from this research inform and give back to nurses and help to establish and maintain relational accountability to both my profession and the populations whom

I serve. The following sections describe in detail the specifics of the six research processes that I identified within my research design and that were the methods of this study.

Theoretical Foundations

In this study a postcolonial paradigm driven by IRM that attends to cultural protocols, values, and behaviors was integral and guided the research process. Eurocentrism has separated Indigenous Peoples from language, land, and histories; and the purpose of a postcolonial lens is to expose Eurocentric and colonizing practices (Anderson et al., 2003; Battiste, 2002). The language within postcolonial theory might suggest that colonialism is a thing of the past because of the prefix *post*. However, as Battiste (2002) explained, colonialism continues to be very much in the present and dominant on the global landscape at micro, macro, and meso levels; therefore, postcolonial theory involves examining and challenging these present-day colonial practices. Smith (1999) noted that a decolonizing approach is effective in analyzing power differentials between healthcare providers and Indigenous Peoples, offers hope for transformation, and creates a role for structural change and personal agency in resistance. In addition, a decolonization process creates an ethical space in everyday academia for Indigenous perspectives without neglecting, dismissing, or shunning them. Because nursing education is positioned in a colonial context, postcolonial standpoints and a decolonization approach are important lenses for nursing research and education to facilitate and understand the manifestation and upholding of colonial discourses in nursing education (Browne et al., 2005).

Adopting this approach enabled a better understanding of the experiences of nurse educators who work towards decolonization and the creation of culturally safe learning environments in nursing education and curriculum. Postcolonial theory critically examines the experiences of colonialism and recognizes it as a contemporary and corrosive force in

institutional systems such as SONs (McGibbon & Etowa, 2009). This IRM approach was fitting

to my study because the key tenets of both decolonization and postcolonial theory highlight the

need to revisit, evoke, and cross-examine the colonial past and its current manifestations in

today's context (Browne et al., 2005; Kovach, 2009). The inclusion of postcolonial theory,

informed by Indigenous ontologies and epistemologies, helps to develop Indigenous researchers'

knowledge when they examine Indigenous ways of knowing and research processes (Battiste

2002; Browne et al., 2005; Smith, 1999; Kovach, 2009). This theory was especially suitable to

my study because nursing education is an institution that is historically rooted in colonial

discourses and perpetuates institutionalized colonial perspectives within an academic setting. In

addition, postcolonial theory is a theoretical underpinning of cultural safety in that self-reflexive

attributes help healthcare providers to critically examine their positions in a postcolonial context

and the influence of their individual location and their patients' experience (ANAC, 2009a;

Anderson et al., 2003).

Researcher Preparation: Situating Myself

Essential to the use of IRM is the ability to situate oneself in the research process as an

Indigenous person and researcher (Weber Pillwax, 1999). In my own research this meant

reflection on and acknowledgment of not only the detrimental effects of colonization, but also

the ways in which I operated within the academy, which privileges Eurocentric values and

priorities and markers of success. This required that I build processes into my study design and

throughout my research activities that allowed me to reflect continually on my location within

the dominant Eurocentric structures, on how I could benefit, and on how it would shape my

research. As Russell-Mundinem states "Bringing the researchers biases and assumptions to light

can only occur if the researchers are able to adequately reflect on their role and are aware of their

own discriminatory processes, personal beliefs and how these originate and are embedded with

the broader context" (2012, p. 3). I therefore had to write myself into the analysis first before I

tried to interpret the stories of others who might have occupied very different spaces within the

same structures.

I used a 'going inward' process by drawing on Indigenous language, metaphors, and

teachings to articulate and apply Indigenous-based ontologies to the academic experience

(Downey, 2015). Furthermore, I approached situating myself through a subjectivity audit.

Inspired by Peshkin (1988) writings, the voice of subjectively is related in the form of an 'I' and

is a systematic and intentional self-audit in the context on one's research. Locating myself in

relation to my own subjectivity involved self-scrutiny and self-discovery to the deepest affect.

The results of my subjectivity audit include the following: The Indigeneity I, the relationality I,

and the equity I. These powerful sentiments emerged into consciousness before my journey in

nursing began and exist in the very core of who I am, how I came to be, and how I manifest these

lenses in my nursing research today.

Indigeneity and I. The Indigeneity that I bring to my practice is situated at the very core

of my being, and I self-identify with it daily. *Wâpikihêw Iskwêw*—which means 'White Eagle

Woman'—is the *Nēhiyaw* name that I received in my naming ceremony. This is how I introduce

myself and where I begin to situate my Indigeneity. I learned through traditional teachings that a

white eagle is a symbol of power and great wisdom, that it is also rare in that in carries special

knowledge, and that it is often a sign of a bountiful year of hunting and harvesting. I feel a

special connection to this name when I consider my journey in academia. Because I was often

one of the few self-identified Indigenous students, I was rare and carried special knowledge in

terms of my experiences as an Indigenous person. I did not see the connection with power, but in

recent years I have seen my power as an Indigenous advocate and the power that I gain when I give a voice to those with limited or no power.

Coming to understand my life experiences as those of a nehiyaw person has reconnected me with my family and our traditional knowledge systems, and I understand how colonization has impacted Indigenous people nationally and globally. However, it was not always present; and it took the better part of my youth to put words to my Indigeneity as I experienced it. During my cultural awakening, I questioned how my mother became disconnected from our ancestors' Indigenous ways of being. Through the years, as I explored this with my mother, she divulged more about her childhood, and I began to learn the truths of pain and brutality that she experienced as a child. Her childhood was filled with forced displacement by government agencies, which resulted in trauma from the effects of residential school and the Sixties Scoop. Separation from her mother and brothers for most of two decades in the foster care system resulted in many dysfunctions, but she continued to survive and thrive. As she shared our family's experience, I began to suffer alongside her as I listened to her truths. Grasping the impact of these experiences on me, I began to understand why my mother shielded me from these truths. Just as she for so long hid the 'Indian' inside, intimately aware of what that meant in society, I have now internalized those feelings and emulated them to a smaller degree.

Consequently, intergenerational trauma is an aspect of my Indigeneity. Once I began to identify with this concept, I was able to begin my journey to 'cultural knowing.' However, the hazards of my Indigenous lens lie in reconciling with Eurocentric ideology. Even though I did not personally experience the horrific history of my Indigenous ancestry, I carry the trauma and sometimes the feelings of animosity in rejecting Western ideology. Thus, I often perceived Indigenous ways of knowing as the only way that I needed to learn—a dichotomy of knowledge.

I was troubled by continuing to lose myself in required readings about Western philosophers and

Western biomedically trained nurses who wrote about dead White male philosophers. In nursing,

I learned to think from binary positions—Western and Indigenous, objective and subjective,

mind versus spirit, and individual over community. This came to a head when I began to

immerse myself in research that involved explorations of the integration of Western and

traditional knowledge. I was challenged in my thinking and reminded of the true essence of

nehiyaw epistemology, which is collective ways of knowing. I learned that valuing one

knowledge system over another was not rejecting Western systems but continuing to explore

through the limited lens of my bias.

      Relationality and I. *Wahkohtowin* is a Cree term that describes 'relationality,' which

means that everything is related; it is an original foundation of Cree life (Bourque Bearskin,

2014). I learned some of these teachings from my mother and her teachers—specifically, John

Crier (a *Nēhiyaw* Elder)—that we are all individuals with specific intellects and an obligation to

share and contribute to the betterment of our world. Each person has a spirit, a special gift, to

nurture and develop; and each must earn the knowledge that goes with the gift. We understand

the connection not only to ourselves, but also to the entirety of our environment. My

interpretation of this teaching is that we cannot acknowledge the *I* without acknowledging the *we*

or the collective aspect of ourselves because we as beings exist in constant relation to the

environment around us. Therefore, we do not exist just as individuals, but as individuals within

collective relationships (Bourque Bearskin, 2014; Weber Pillwax, 1999). Relationality is a

fundamental core value instilled in my belief system. In honoring relationality, I am not the

researcher; we are all co-searchers in creating knowledge, which is a strategy that dissembles the

hierarchy of knowledge development. Thus, we allow the agendas of our co-searchers rather than

our own to dominate the research process. My main criticism of a relational view is that the

nature of these relationships becomes more difficult to evaluate critically—the good, the bad,

and the ugly—when searchers inquire with openness and respect. Specifically, in respecting

relations, we accept the knowledge and experience that are advanced and potentially neglect

alternative views. Therefore, I was mindful of how relationality influenced the research process

negatively and positively.

        Equity seeker and I. As I continued to critically examine my self-understanding, I began

to see the story of nursing. I found that nursing's historical and social struggles were somewhat

similar to the experiences of Indigenous Peoples in at least one respect. The struggles of both

were based on the ideology that men and science govern and legitimize roles in society. They

highlight some of the power dynamics and inequalities between men and women in Western

history because women are not considered equal to men. However, a comparison of Indigenous

and non-Indigenous persons goes much deeper than inequality. Equality assumes that Indigenous

and non-Indigenous, primarily White settlers, are in an equal state; but Canadian history reveals

that this is not the case. The legacy of colonialism has a strong bearing on the health of

Indigenous Peoples today (Browne et al., 2009). The foundation of inequities in Indigenous

people's healthcare is inextricably linked to the impact of colonization in the past; for example,

the system structures in place today, such as those of education and healthcare, which have their

origins in that period.

        Thus, my assumption is that nurses need to lead through the lens of equity to promote

fairness rather than sameness (equity vs. equality). Health equity is based on the concept of

social justice and addresses the social disadvantages that various populations face. To be able to

use a social justice and health equity lens to promote social justice for Indigenous populations, it

is necessary to understand the history and legacy of colonialism. This is an example of how I view the presence of inequity both in nursing and in Indigenous populations. I ask myself whether, in my equity bias, which focuses on equity and the social disadvantages of specific groups, I am blinding myself to the disadvantages that the individual faces. As with any particular culture, ethnicity, religion, gender, and age, the individuals in each group are not uniform. In considering the social contexts of groups, I cannot forget the constructs of the individual. Thus, I defined my participants based on whether they identified with ethnically, culturally or racially and strove not to generalize too broadly to other populations.

Research Preparation

Study context. In Canada, training in the Bachelor of Science in Nursing (BScN) program prepares nurses for entry into practice (CASN, 2015). Several types of bachelor's degree programs exist to meet the academic needs of students: admission programs with academic prerequisites, accelerated degree programs, and bachelor's degree programs for registered practical nurses. Regardless of the type of program, CASN (2015) sets out the guiding principles and essential elements. In relation to my research, one of these guiding principles is that "programs provide experiential learning experiences to train nurses in safe, competent, compassionate, ethical and culturally safe environments" (p. 13). CASN as the national accreditation body for nursing in Canada has directed that nursing programs incorporate knowledge of cultural competency and safety to enable future nurses to respond to the diversity of the Canadian population.

In 2016 Canada had a total of 113 nursing education programs; 89 were at the undergraduate level and offered the entry-to-practice program (CASN, 2017a). Ontario hosted 16 entry-to-practice programs (CASN, 2017a). Table 1 (CASN, 2017b, p. 47) shows the total

number of nursing faculty in Ontario by title. Nursing faculty encompasses several different

types of nurse educators. CASN (2017b) defined *permanent faculty* as tenured faculty who teach

nursing courses in a university or permanent full-time or permanent part-time faculty who teach

nursing courses in a college. *Full-time faculty* are full-time permanent faculty who teach nursing

courses and full-time contract faculty (who hold contracts of one academic year or longer) who

teach nursing courses. Others who teach nursing courses include part-time contract faculty (who

hold contracts of less than one academic year) and who teach nursing courses (CASN, 2017b).

This report did not include figures on part-time faculty; thus, I have not included them in

Table 1. However, I invited part-time faculty to participate in this study. For the purpose of

clarity, I use the term *nurse educators* throughout this thesis to refer to full-time, part-time,

permanent, or contracted nursing faculty who teach in SONs. As well, I use the term *nursing*

education to encompass the curriculum, policy, and practice aspects of nursing education.

Table 1

Degree-Granting Schools: Full-Time Nursing Faculty in

Ontario

Position	Number
Full-time permanent	
Full professor	39
Associate professor	129
Assistant professor	99
Classroom (theory) instructor or lecturer	15
Full-time contract	
Full professor	N/A
Associate professor	8
Assistant professor	19
Classroom (theory) instructor or lecturer	67
Total	376

Recruitment. I used a purposeful sampling strategy to recruit nurse educators from SONs that I identified as having accredited nursing programs as CASN (2017a) defined them. A total of 15 SONs in Ontario offer a BScN-accredited program: Brock University, Lakehead University, Laurentian University, McMaster University, Nipissing University, Queen's University, Ryerson University, Trent University, University of New Brunswick–Humber College (Humber College offers a collaborative program through the University of New Brunswick), University of Ontario Institute of Technology, University of Ottawa, University of Toronto, Western University, University of Windsor, York University (n = 15; CASN, 2017a). Immediately after I received approval from the Hamilton Integrated Research Ethics Board (HiREB), I recruited participants from each SON listed above by distributing an electronic invitation (Appendix A). To disseminate the invitation rapidly and effectively, I contacted the associate deans and directors at each SON first and asked them to disseminate the invitation to the entire faculty e-mail distribution list. I collected the e-mail addresses of each associate dean or director through the websites of each SON. This recruitment approach allowed the deans and directors to consider the research study, forward it through the appropriate channels, and encourage nurse educators to participate in my study. The faculty wide invitation contained details that included the study purpose, aim, inclusion criteria, and contact information for more information or to participate in the study.

Participants. The criteria for inclusion in the study were (a) a full, associate or assistant professor, or a sessional nursing educator at an accredited SON in Ontario; (b) teaching in the undergraduate nursing program; and (c) ability to communicate orally in English. The exclusion criteria were refusal to participate or be audio-recorded and inability to communicate in English. This purposive sampling strategy attracted 15 nurse educators who were currently teaching in

accredited undergraduate nursing programs in Ontario. This sampling approach was the most

appropriate to gather information-rich data and fully understand the complexity, depth, and

context of the phenomenon (Gentles, Charles, Ploeg, & McKibbon, 2015). Nonprobability

sampling does not require statistical calculations of the sample size but instead requires good

judgement based on experience about what is feasible to estimate an appropriate sample size

(Denscombe, 2010). A recommended minimum sample size for the qualitative phase of this

study was 12 participants (Rowan et al., 2013). However, my goal was to include as many

participants (or as much information) as possible until I achieved saturation in the data analysis.

Gentles, et al (2015) defined *saturation* as the point of informational redundancy where

additional data collection contributes little or nothing new to the study. I met the saturation point

with 15 participants.

Sample demographics. I distributed a pre-interview survey (Appendix B) to all

participants with the purpose of gathering pertinent demographic information relevant to the

study. Table 2 is an overview of the demographics of the study sample. Eleven deans and

directors of the 15 SONs that were contacted responded and then disseminated the invitation to

participate in this research to their faculty/nurse educators. Participating SONs were distributed

across Ontario and included small and large programs. Of the 15 nurse educators who agreed to

participate, a majority were full-time educators with over 10 years of teaching experience. Three

of the participants identified as Indigenous.

Table 2

Results of the Pre-interview Survey: Demographics of the Sample (n = 15)

Demographic	Category	Number
Gender	Female	14
	Male	1
Age	25-34 years old	3
	35-44 years old	3
	45-54 years old	4
	55-64 years old	4
	65 + years old and over	1
Ethnicity	Non-Indigenous	12
	Indigenous	3
Education	Master's	5
	PhD	10
Title	Full Professor	1
	Associate professor	6
	Assistant professor	5
	Sessional Instructor	3
Position	Full Time	12
	Part-time	3
Experience	0-10 years	5
	11-20 years	6
	20+ years	4
Institution	Brock University	1
	Lakehead University	2
	Laurentian University	1
	McMaster University	3
	Queen's University	1
	Ryerson University	1
	Trent University	1
	Humber College	2
	University of Ontario Institute of Technology	1
	University of Toronto	1
	Western University	1
Levels taught	Bachelor	15
	Master's	9
	PhD	3

Data Gathering

      Conversational method. In this study the activity of conversing and listening to personal stories were central to my Indigenous methodology; it was the primary knowledge-seeking method. This conversational method elicits stories through conversation and honors orality (Kovach, 2010). Kovach (2009) highlighted two forms of storytelling that are often included in Indigenous epistemology: stories that hold mythical elements, such as creation stories and personal narratives of place, happenings, and experiences. Both forms are vessels through which to pass along teachings and practices to help members of the collective to gain insight and make sense of the world around them. The narrative nature of stories is not unique to Indigenous methodologies; it is also highly valued within the qualitative landscape, because narratives function as intergenerational knowledge transfer (Kovach, 2009). A key aspect of using conversation to elicit story is honoring 'the talk.' Kovach (2009) described it as providing an opening for narrative. As Kovach and other Indigenous scholars recommended, the best technique to honor and evoke narratives from my participants within the context of this study was to conduct in-depth and conversational interviewing, which involves a less-structured approach. It does not require a set of questions; rather, researchers engage in focused conversations with their participants (Bell, 2018). This process supports relationship building and upholds the relational nature of Indigenous methodologies. In this atmosphere it was possible to identify themes that emerged from the experiences, opinions, values, and feelings that arose in my one-to-one conversations with the participants with regard to the integration and use of cultural safety in nursing education.

      The importance of a less-structured approach to story gathering is the flexibility and power of the stories that the researcher will capture. Doing so allows the stories to 'breathe,' and

the narrator is able to regulate them. The objectives of this research study guided my

conversations and exploration with the participants on the following topics: (a) how nurse

educators engage with the concept of cultural safety in the classroom and in nurse curricula,

(b) the strategies that nurse educators use to integrate cultural safety into their teaching practice,

and (c) possible solutions to facilitate the integration of cultural safety into nursing education.

Collecting the data. I collected data intensively over a one-month period, from February

4, 2019, to March 12, 2019. When I prepared to collect the data, my first contact with potential

participants was via the study invitation that the associate deans and directors had distributed

faculty wide through e-mail (Appendix A). As each potential participant expressed interest in the

study, I forwarded the pre-interview questionnaire (Appendix B) and the consent form

(Appendix C) and arranged for phone calls following the initial contact. These pre-interview

phone calls enabled the participants to ask questions and allowed me to further elaborate on the

study's aim, purpose, and procedures; obtain the participants' consent; explain how I would

maintain their confidentiality; and arrange interview times. In addition, the phone calls helped to

build a trusting relationship with each of the participants. Once we had arranged the interview

times, I sent a reminder e-mail prior to each scheduled appointment to return the signed consent

forms and pre-questionnaires. I individualized each meeting according to the needs of the

participant; for example, if the participants were nearby, I scheduled in-person meetings,

whereas for others I arranged videoconferences. I conducted most of the interviews via

videoconferencing.

On the consent forms I requested permission to digitally record each session and

reaffirmed it at the beginning of each interview; I excluded any from the study who did not

consent. To begin each interview, I explained who I am, where I come from, and what my

intentions were in this study to establish a level of trust and reciprocity. In addition, I established

relationality, which is very important within Nehiyaw customs and protocols. Subsequently, I

asked the participants to share as much as they were comfortable in sharing about who they are,

where they came from, and what their nursing background was. To know where I was going, it

was essential that I understand where I came from, my connections to those around me (i.e., to

my participants in this study), and that I was leading in a good way. I saved each interview

recording on a USB drive (which I stored in a locked office) and a password-protected Google

drive. The only other person besides my supervisor and myself who had access to the password-

protected Google drive, and only during the transcription period, was the transcriptionist, who

had signed a confidentiality agreement prior and returned the transcripts to me in password-

protected electronic files for analysis. Dedoose™ analysis software was used to manage and

organize data in preparation for analysis. Finally, during the data-collection process I maintained

a journal to record my personal reflections, reactions, and concerns to support my analysis of the

data. This journal was also a beginning step into begin data analysis by writing down my initial

interpretations of each interview. I shared this journal with my research supervisor.

Making Meaning

The traditional Western approach to data analysis in qualitative research often creates

complexities in Indigenous forms of inquiry. As Kovach (2009) explained, data analysis is a

process of defining where power resides in the writer; it leaves little room for the Indigenous

value of reciprocity. In addition, she stated that traditional approaches to analysis can fragment

these highly contextualized stories through the process of thematically grouping them. This

results in contradictions in the oral nature of Indigenous inquiry because Indigenous scholars and

Elders designate the analysis as the responsibility of the listeners. Because I needed to attend to

Indigenous methodologies, this created a predicament for me and challenged me to fit a Western

approach into my Indigenous research design. Instead of one or the other, I utilized a harmonized

approach that that included both Indigenous and Western analysis methods, facilitated the

expression of meaning from an Indigenous worldview, and transcended the barriers that I faced

in imposing Western analysis methods.

  A harmonized analysis. In this section I describe from a harmonized perspective how I

drew from both Kovach's (2009, 2010) conversational storytelling methods and Braun and

Clarke's (2006) thematic analysis approach to analyze my research conversations. I began this

process by utilizing thematic analysis, as Braun and Clarke (2006) described it, to inform the

analytic procedures of the analysis of all the conversations of my participants. This method

enables researchers to identify, analyze, describe, and report themes within narrative data in a

rigorous manner (Braun & Clarke, 2006). The process of thematic analysis in this study involved

a constant movement back and forth from the text to the experience to develop an accurate

understanding of the underlying meanings. I began this inductive process at the point of data

collection and maintained it throughout the analysis process. I verified the transcriptions of the

participants' stories by reading each transcript as a whole to become familiar with the data. I

used an open-coding process, then grouped codes to themes and sorted the themes into four

primary narratives of place, happenings, experiences, and practices that aligned with my research

questions. These four primary narratives emerged through the process of familiarization with all

the data and looking back to Kovach's (2009) description of the purpose of storytelling in

holding personal narratives that are vessels to translate teachings into practice. She identified

place, happenings, experiences, and practice as four common narratives in stories, and within the

context of this research these narratives were apparent in how each nurse educator spoke of their

experiences. This storytelling approach attended to the holistic Indigenous worldview in that using these narratives as a guide to understand the stories thematically honors and presents the stories in a holistic way that extends beyond the individual person. Through these four primary narratives I conducted a secondary, more emergent level of coding once I initially coded and collated all of the data; at this level of coding, I grouped various subthemes that emerged into the four primary narratives.

I conducted this iterative process in collaboration with my thesis supervisor until no new themes emerged. This codification involved (a) similar answers, descriptions, or explanations; (b) elements that demonstrated a cause-and-effect relationship; (c) elements that were connected hierarchically; or (d) various explanations for similar events (Guest et al., 2012). The codification led to the creation of a codebook that I also shared with my thesis supervisor to validate my coding; it consisted of a code definition and example. Careful comparison throughout the analysis also led to the development of a thematic map (Figure 2 in chapter five), which Braun and Clarke (2006) described as a less detailed pictorial version of a codebook that is an overall conceptualization of the data patterns and the relationships among them. This schema helped to link themes to facilitate the interpretation of the results. I then brought the identified subthemes together into one common theme. These subthemes, which I have supported with direct quotations from the transcripts, clearly identified the dimensions of the research. I present these results in chapter five.

Now, there are many tensions – which I describe in more detail in the subsection below – that exist when employing a western data analysis approach in IRM. Many Indigenous scholars and knowledge holders likely share my position of presenting data by paying respect to the stories and conversations of participants who share their knowledge. The question then is how to

respect the stories that they shared with me in a harmonized approach. In her PhD dissertation,

Margaret Kovach (2006), the main methodologist from whom I drew inspiration, included large

pieces of her participants' transcripts as is to let them speak for themselves and allow readers or

listeners to interpret their own meanings (Kovach, 2006). With this path laid out, I also kept in

mind that, similarly to Kovach, I had over 100 pages of transcripts. With a total of 15

participants, I could not capture the essence of every participant's story, as she did, in this thesis.

However, as I began the process of listening and reading through the data, I realized that the

stories that my three Indigenous participants shared provided powerful insights into their

experiences with the integration of cultural safety into nursing education from an Indigenous

perspective. In addition, the narratives of the experiences of my non-Indigenous participants

provided important comparative narratives to those of the Indigenous participants. Thus, I

decided to present the condensed conversations of four full-time nurse educators (two Indigenous

and two non-Indigenous) in the natural form of conversation. The process of deciding on the

specific four conversations was focused on the rich and in-depth nature of two Indigenous and

two non-Indigenous conversations in relevance to my research questions. This decision was

made after the familiarization and rereading of all my transcripts to identify the most rich and in-

depth conversations. My voice will be included with reflective commentary at the end of each

conversation. My reflections, which I recorded mainly in my research journal after each

conversation, identify the teachings that were particularly relevant to me and provides further

insight into the reasons behind the choice and presentation of each conversation. As well,

including my reflections helped to bring out my *Nēhiyaw* epistemology during the data-analysis

process. I detail the intricacies of this approach in chapter four.

The result of this harmonized approach is the presentation and analysis of my conversations in two ways: not only the thematic findings of this research study, but also the conversations from which the themes and knowings emerged. In chapter four I present four condensed research conversations with nurse educators, and in chapter five I discuss the thematic findings from all my research conversations.

Mitigating the tensions between two worldviews. Indigenous research methods are emerging in the academic research community; thus, the discourse includes various complex issues and tensions with which I struggled when I harmonized and conducted my data analysis. I will briefly discuss the three main tensions that evolved during this process: fragmentation, confidentiality, and structural tensions.

The first tension was in fragmenting my participants' narratives. Using a conversational storytelling methodology, I collected very contextualized and rich data (Kovach, 2010). As I stated previously, a key aspect of this method is honoring the 'talk' and creating an opening to evoke powerful narratives that the narrator regulates. Using a data-analysis method such as thematic analysis to group parts of narratives thematically fragments the data. Kovach (2010) explained that, with a Western approach to analysis, researchers maintain the power to determine the overall narrative; whereas when they present the participants' stories as data, the stories speak for themselves. Confidentiality added another layer of complexity. In situations in which narrators waive the right to confidentiality, researchers acknowledge the narrators of the stories. This ties in with the relational practices within an Indigenous worldview in that we often position ourselves and the co-creation of knowledge relationally. However, in contexts in which researchers must honor confidentiality, such as in this study, it is difficult to present highly contextualized stories without compromising the confidentiality of the participants. Last,

structural tensions pervasively influence a harmonizing or Western approach to data analysis. Structures such as research ethics boards, whose members are primarily non-Indigenous and have very little to no understanding of Indigenous research methods and worldviews, challenge Indigenous researchers to structure their data analyses in a way that is understood and accepted as valid. Thus, it is problematic for Indigenous researchers to engage in data analysis that adheres to Indigenous worldviews.

Indigenous researchers have acknowledged these dilemmas; however, they have laid out no specific path to resolution. Nonetheless, I persisted for three reasons. These tensions pave the way for other Indigenous students who feel these very real internal conflicts to conduct Indigenous research. Identifying these struggles not only labels structures that are obstacles to Indigenous research methods, but also validates and encourages others to continue to walk this path, even if it does not entirely make sense; trusting our gut instinct is our ancestors speaking directly to us. Second, from a pedagogical perspective as a new researcher and student, I highly value research that is transferable to the classroom. Presenting the thematic groupings from my research in conjunction with stories offers students such as myself multiple ways to engage with the research findings. Third, I am bound to the requirements of the research ethics board, to whom I laid out my plans for my thematic analysis. Harmonizing an Indigenous and Western approach best bridged the tensions. Nevertheless, within Indigenous methodologies, data analysis still requires ongoing conversations because researchers are still exploring the tensions.

Trustworthiness and Rigor

Throughout the methods section I have addressed rigor in different ways within an Indigenous and Western paradigm. Qualitative researchers refer to *validity* as trustworthiness. Lincoln and Guba (1985) redefined the concept according to the criteria of credibility,

transferability, dependability, and confirmability. With regard to Western frameworks of

research, I referred to Lincoln and Guba's criteria to ensure the trustworthiness of the data. To

meet these criteria, I used the following strategies: reflexivity, peer examination, and an audit

trail. Reflexivity is best described as developing transparency on multiple levels within the

research process; for example, the personal, methodological, theoretical, epistemological, ethical,

and political factors that evoke thoughtful, conscious awareness of researchers in relation to their

own subjectivity (Dowling, 2006). I practiced reflexivity by maintaining a reflexive journal to

document the entire research process and assess the influence of my experiences as a researcher

and my perceptions of the research process. Next, peer examination is the process of consultation

with colleagues on the research methods and the congruency among the data, findings, and

interpretations that emerge from the data (Merriam, 2002). My graduate thesis supervisor and

thesis committee conducted peer examinations during the data coding, data analysis, and

identification of the research findings as insights and issues arise. The final strategy to ensure

trustworthiness is to use an audit trail, which consists of the researcher's journal and field notes

from the entire research process; it provides evidence of each of the researcher's and research

team's decisions and choices (Merriam, 2002). As the lead researcher, I maintained an audit trail

by writing in a research journal to document all of my decisions during the study and all of my

sampling, data-collection, and analysis procedures.

　　　With regard to Indigenous research frameworks, I referred to Kirkness and Barnhardt

(2001) four principles—respect, relationality, responsibility, and reciprocity—as standards I held

myself and my research to. I incorporated them into the research process to strengthen the

trustworthiness and rigor of this research, and they are seen in my research design (Figure 1) as

the four outer lying principles. *Respect* is fundamental to a *Nēhiyaw* way of life; I demonstrated

respect, through my respectful activities of listening and following *Nēhiyaw* protocol by offering

tobacco before each conversation. This also included traveling and meeting with the nurse

educators in their own working environments. Steinhauer (2002) pointed out that respect

involves more than knowing and following protocols; it is also about how we carry ourselves in

our relationships with others. Therefore, it was imperative to demonstrate *relationality* that I

establish trusting and mutually respectful relationships with the nurse educators as vital members

of the research team. I also recognized that establishing these relationships would involve

distinct power differentials that would add a layer of complexity to the research. This recognition

necessitated me taking steps such as one on one phone calls to build a trusting relationship and

sharing who I am and my intentions with this research project with not only nurse educators but

their respective associate deans and directors. Next, Steinhauer (2002) explained the importance

of accepting *responsibility* for conducting research as a cognizant awareness to ensure that no

one is harmed and posed a question about the whether a person has the right to conduct this

research. Responsibility was demonstrated through my self-reflection at the beginning of this

chapter. In addition, responsibility can be viewed as an ethical responsibility in which all facets

of this research are conducted ethically as evident in the methods of this research. Lastly,

reciprocity, according to Kirkness and Barnhart (2001), is accomplished through a multilayered

learning process of exchange that is mutually beneficial to both parties. In this case I must ensure

that nurse educators, academic institutions, Indigenous peoples will benefit from this research. I

believe the writing of this thesis is an act of reciprocity, however, the detailed descriptions of my

research methods are the main acts of reciprocity. Specifically, my harmonized analysis and the

descriptions of the tensions of utilizing a harmonized analysis. My hope is that this work will lay

a path for future research and research methods for Indigenous peoples.

CHAPTER FOUR: CONVERSATIONS

As I discussed in chapter three, in this chapter I present not only the thematic findings of this research study, but also the conversations from which those themes and knowings emerged. This chapter includes four (two Indigenous and two non-Indigenous) condensed versions of my research conversations with nurse educators, and I present the thematic findings of all my research conversations in chapter five.

In preparing and writing this chapter, I experienced many conflicting feelings of doubt about whether I was attending to my *Nēhiyaw* ways or privileging my Western ways. As I immersed myself in coding and theme grouping, even with a harmonized approach, I was concerned that the dominance of the thematic analysis might further fragment the Indigenous nurse educators' stories. To uphold my Indigenous methodology and privilege the stories of the Indigenous nurse educators, I decided to present not only this chapter prior to my thematic analysis, but also the condensed conversations of the Indigenous nurse educators prior to those of the non-Indigenous nurse educators. This also advocates for the unique and often marginalized experiences of Indigenous nurse educators and provides a comparative narrative for readers that further amplifies and validates their experiences relative to non-Indigenous participants as they each discuss integrating cultural safety. Again, privileging Indigenous knowledge is important to my IRM and maintaining the decolonizing and postcolonial lenses of this study discussed in chapter three. Finally, the purpose of this chapter is not to make these conversations prescriptive, but rather to allow readers to engage with the narratives and arrive at their own interpretations.

This chapter begins with the *Nēhiyaw* interpretations of the four narrative categories that I described earlier: place, happenings, experiences, and practice. The *Nēhiyawēwin* translation and interpretation of each narrative gives readers an insight into a *Nēhiyaw* worldview; more

specifically, how I began to understand and thematically group my data in the following chapter. Next, I present four conversations in condensed transcript form, followed by a reflective commentary on the reasons that I chose each specific conversation and why they particularly resonated with me. The meanings that I ascribe to them in my reflections have arisen from my own worldview, and I will discuss them more analytically in the chapters that follow. In this chapter I make space in my thesis to honor the talk and follow the traditions of my *Nēhiyaw* ancestors.

Translations of Narratives

At the beginning of this thesis I commented on terminology that I would include *Nēhiyawēwin* as a way of unpacking my thinking and the colonial approaches in this thesis. I am not a fluent *Nēhiyaw* speaker; however, my connection to my community and those who know our language is strong. Les Skinner (personal communication, March 14, 2019) is a fluent *Nēhiyaw* speaker and language teacher who helped me translate and interpret these narratives. I followed *Nēhiyaw* protocol by offering tobacco and explaining my intentions with these translations. To ensure that these words would be appropriately translated, I had in-depth conversations with Les on what I thought each narrative meant in relation to the integration of cultural safety in SONs. These conversations took place after data was completed and provided a foundation and supported my way of thinking about each narrative, which was informed by Les's guidance in interpretation of each translation.

When I asked Les how I should acknowledge him in these writings, he said, "This is our language. I did not think of these words and do not need credit." This was an important reminder of the notion of *experts* in knowledge and the *Nēhiyaw* worldviews about how we should treat knowledge. Acknowledging Les as an expert ascribed ownership to this knowledge, with which

he expressed discomfort, because I also have a right to this knowledge of language. Instead,

aligning with *Nēhiyaw* protocols, I will acknowledge him and our relations and describe our first

meeting.

Les and I met at the annual Beaver Lake PowWow in June 2014. My mother's close

friend Marilyn Gladue, who was the nurse in charge at the Beaver Lake Health Center,

introduced Les to me. Marilyn's son, Cole Gladue, was attending the University of Alberta with

Les. I have known the Gladue family for many years and knew of Les and his deep connection to

our *nēhiyawēwin* because of his close relationship with Cole. In our first meeting I willingly

acknowledge that I was struck by his very white skin. However, Les is the first to admit that

most people, even our own, mistake him for a 'White man,' which, he often lightly jokes, occurs

before they hear him speak better *nēhiyawēwin* than most Elders do. The similarities in our

appearance and differences in our connection to *nēhiyawēwin* once made me feel less *Nēhiyaw*.

However, Les's recollection from stories about his upbringing reminded me of the myriad of

experiences and outcomes that resulted from colonization, such as the disruption of language.

Les's *Nohkum* (grandmother) raised him; she lived in the 'bush' in northern Alberta, where she

had resided most of her life in fear of Indian agents taking away her children and culture. He

attributes this to his being raised in the language and culture away from settler exposure. I am

grateful for our relations and the knowledge that he has given me with regard to translating and

interpreting the *Nēhiyaw* words in this chapter. *Hiy Hiy* (thank you).

*Itê Kâhatoskêhk***: Where the work happens (place).** The first narrative in which I

discuss the integration of cultural safety in SONs is *place*. *Itê kâhatoskêhk* is a *Nēhiyaw* word

that means 'where the work happens.' *Itê* means 'where,' but not as a question. *Kâhatoskêhk*

means 'the works that happens.' In translating from English to *nehiyaw*, it is important to

remember that English words often do not translate directly into *Nehiyaw* because our language

is relationally based: Talk of things is in relation to us rather than at them or individualistically.

Place signifies a location or a particular position. Interpreting 'where the work happens' in this

context denotes a place where cultural safety is integrated, and the SON is the place where the

work is happening.

  Kâhisîcihkêhk: **The culture, the way of things (happenings).** The features of

happenings as a narrative include the contextual and structural components of the institution in

the experience of nurse educators. Within these narratives educators often refer to contextual and

structural components as the inner workings of the institutions. In *Nēhiyaw* this ideal translates to

kâhisîcihkêhk, which means 'the culture, the way of things.' The culture, the way of things in

nursing education refers to the current context and structure of SONs. The contextual elements of

the process include all of the components that frame the integration of cultural safety into

nursing education. Like contextual elements, structural elements might or might not create

favorable conditions for integration; they refer to the infrastructure within institutions that may

support or prevent the integration of cultural safety.

  *Âcimowina***: The stories (experiences).** At the forefront of this research were the

experiences of nurse educators in integrating cultural safety concepts into nursing education. In

the education system, educators are considered leaders who have power and influence over

curriculum development. They are also considered essential to the integration of cultural safety

concepts. In *Nēhiyaw*, *experience* best translates to *âcimowina*, which means 'our stories.'

Experiences and stories share a commonality in that our experiences are often the basis of our

stories. Stories also help us to learn, and they carry intergenerational knowledge. The knowledge

that experiences generate is translated through stories. Thus, the stories of our educators'

experiences provide invaluable insights into the process of the integration of cultural safety into nursing education. This process includes the approaches and strategies that the nurse educators reported with regard to their specific shared experiences with integration.

Itôtamowina: **The customs (practice).** The practice of nursing is intrinsically linked to nursing education, in that standards for nursing practice inform nursing curriculum content. *Nēhiyaw* has no word for practice unless we refer to the process of repeating something until we reach perfection. However, *Itôtamowina* in *Nēhiyawen* means 'customs.' Every culture has customs. They are the widely accepted way of behaving and doing things. Within Indigenous cultures, customs are the standards by which we conduct ourselves. Thus, nursing customs can mean the standards observed in nursing education practice. In relation to this research, practice incorporates the outcomes of all of the above narratives and influences the customs that we accept within the practice of nursing education.

Four Conversations With Nurse Educators

Conversation 1 (Indigenous).

D (Interviewer/Danielle):
I guess to get more of your experience, I wanted to ask you what has your experience with cultural safety in nursing education has been?

I (Interviewee/Participant 5):
Actually our University is a bit ahead of the game when it comes to cultural safety and cultural humility particularly with Indigenous populations. I think part of that is where we are situated in our geography and the sort of lens in which we are working. I was really surprised because I'm doing my PhD [at another university] and I went there, people are not as aware of Indigenous people and the history of colonization and things that are happening. What I find as one of the only Indigenous educators [in my SON] is that a lot of the teaching of cultural safety with Indigenous populations - people ask me to do that, right? When I first started last year, once a month I offered one in-person session where we talked as a group some of the 7 teachings of Indigenous people like the grandfather teachings and we also did some ways to incorporate some of this knowledge and Indigenous world views into our curriculum and how people can teach it in their classes.
I don't know if that's happened or not everywhere. For me, certainly we're using sociology and nursing textbooks that talk about relational nursing practice and are bringing in

that self-awareness and some of the competencies and skills behind cultural competence. But people are still really leery about talking about it, worried about saying the wrong thing, worried about misrepresenting Indigenous people. I feel like that also does a disservice because we can't just not talk about it. It puts a lot of burden on me as an Indigenous educator to be doing all of that extra work. It can be really harmful to my mental health at times because when you're explaining the same things over and over and people aren't getting it, or you feel like you aren't being heard, it gets really frustrating.

D:
Can I ask, at your university, what specific strategies or approaches is the SON taking to integrate cultural safety?

I:
Right now, what's being done is sort of going by whatever the course professor decides. There's no, in my mind, formal way to say this is how we're going to do cultural safety. Particularly, in my first-year course on social determinants, I have students doing the blanket exercise so that they're doing an experiential exercise in learning about the history of Indigenous people in Canada. And then obviously being a social determinants of health course, a lot of the content is on Indigenous status as a social determinant of health. I know we do a lot in that, but within my own practice and within my own teaching, it's the lens in which I live so that's pretty much all of my examples and really trying to get people to reflect on why are they thinking the way they think and know that we're not going to judge if it's good or bad but we're just going to look at it and say "is this truly my thought or is this the thought from society or my parents, do I believe this?" Really focusing on self-reflection and I think in a roundabout way, the self-reflection piece is a huge tenet of our nursing program and many nursing programs, right? It's that self-reflection and understanding where your situated. I think in that way without labeling it as cultural safety, it's doing that but without putting that label on it.

D:
What do you think some barriers are from the institutional side of things?

I:
I think one is the lack of Indigenous educators and certainly that's something - what I didn't realize is the sheer physical presence of me being here disrupts the space which I didn't really truly acknowledge until this year because I felt like "I got to be doing more, I got to be doing more" but just being in the space really opens the doors metaphorically even for other students to say "oh she's Indigenous and she's teaching and she's a nurse and nurse practitioner" they see me as a role model. So not having those [Indigenous educators] is certainly a barrier. I think going back to the lack of having outcomes and knowing what are our measurable goals because we can't really say we're doing it if we don't actually evaluate. I think we can certainly be doing more to provide support for all students to get involved in the culture of Indigenous people, particularly because if you're working [in a northern community] you're going to be working with a large Indigenous population of people. And then some of the faculty feel like they're not prepared or they are afraid to speak to those issues so that would be a barrier too.

D:

How does being Indigenous and teaching these cultural safety concepts influence responses, for instance, how do you mitigate when tensions arise in the classroom? Or does being Indigenous make less tensions in the classroom?

I:
I actually think it's both. Last year when I taught the same course social determinants of health. Anytime someone is an educator or speaks at all, you're always drawing from your own experiences, right? Whether that be for me, a pediatric nurse or a mental health nurse or an Indigenous person or working with Indigenous populations. Within my student evaluations, there were students who put on there that there was too much Indigenous content and that this was not an Indigenous course. I was really upset by that because being a social determinants of health course, that's one of the determinants. My colleague who taught another section, I said "did anyone put in your comments that your course had too much obstetrics content because that's what all your examples are from?" And they said "of course not." There's still a lot of issue with discrimination and racism that happens, particularly in an avenue where people can be anonymous in writing their evaluations. I think sometimes, in my experience doing stuff with my lead position, is actually having an Indigenous person and non-Indigenous person doing those things together because that creates less tension I find. Some people feel like when you're hearing it from an Indigenous person, there's almost a shame when they hear it from you.

D:
Mhmm yes. My mom is a nurse educator as well, and I remember talking to her about how upset she was after reading student evaluations too. Especially when you're talking about your area of expertise and you're getting really negative things back from not just students.

I:
Yeah guilt like you're trying to tell them all the things that they did wrong or whatever, which is not the case. Sometimes it's scary or it's dangerous to speak out about things because you never know what's going to happen to your career. It's pretty scary.

D:
How you feel about being so vocal as an Indigenous advocate? You talk about that in your public life, but do you fear or have feelings that you can't be as vocal as an Indigenous educator or faculty member?

I:
Yeah and I feel like in some ways - I'm trying to say this in the right way. So we'll have meetings and I'm the only First Nations faculty member and there is a Metis faculty member as well. The interesting thing is with her being a Metis faculty member, she feels like she doesn't have as much credibility as me being a First Nations person which I think is insane. We often have conversations about that but we both feel it, we're both working in this colonized institution and we're all colonized and trying to make any changes or speak up about how we want to bring Indigenous world views and it's really not listened to. When the director of the program feels that they're doing something good for Indigenous people, it's like, everybody looks at us like "oh we're going to be doing this partnership with so and so community" and then all of a sudden

everybody looks at us. It's like we're very "othered" and I don't think people are doing it purposefully to be unkind but it's just, you really feel that you are not part of the group.

D:
When you say "othered" do you feel like you're being siloed out?

I:
Yeah I'll be sitting there having a discussion about curriculum or whatever and we're all on the same level talking about the same stuff. But the second it comes to Indigenous content, right away it's like we know that we're not part of the group we know that we are being "othered." We're not all saying "oh isn't this great" and looking at everyone and saying "we're going to work with Indigenous communities" instead we're going to look at the 2 Indigenous people in the room. Just the spotlight on us as being not part of mainstream.

D:
And you were talking about your one colleague feels that she's not credible. Do you feel like, being a colonized Indigenous person in Academia, do you feel like you aren't credible in some way?

I:
Definitely. I often explain this to be people too. I feel like I walk in 2 worlds, right? In one way, I grew up in foster care and I grew up pretty disparaged. I was put into foster care and I was able to get access to more services and supports and I know that that's really helped me get to where I am today. But in my Indigenous community, for me to come in there as a person who is well educated and who has money now, I get looked down upon. It's like "who do you think you are" and there's a lot of lateral violence there where I don't feel good enough per se or Indigenous enough for my community. On the other stage, I'm in this academic life where it's very Western and trying to pull in my Indigenous world views. I almost feel like I have to try harder and I'm held to a higher standard than someone who is non-Indigenous. The stakes are higher. If I fail or do something wrong, it's like "well what did we expect she's Indigenous." Or people feel like "well you just got here because you got the Indigenous seat." It's like you kind of don't fit into either world, even though we walk in one world. At the same time, I want to be able to educate my colleagues, my friends, my family, my community to make it a better place for my daughter.

D:
Do you find any subtle or hidden racism within the school of nursing that affect cultural safety integration? Like with the policies I guess it's something you have to step out of to self-reflect on to even identify.

I:
Of course there is, I'm sure there's a big piece of it when it comes to what's viewed as scholarly. I know I just got my annual report back from the dean. I had created, like I said, these modules and group sessions where I brought in the faculty to help give them some cultural relationship building and also to create some teamwork. Essentially to me that's like creating a course. I was doing that to educate my fellow faculty and was going to offer it to students and

that wasn't even brought up in my review. That showed me that that's not something that's important, I feel like it is a form of racism and what was important to the team was that [the dean] couldn't find one of my published things. The benefit of me publishing a paper and the benefit of me providing training within the school of nursing and being ready to offer it to whoever else wants it is less important to them, less valuable which is really sad.

Also, we're following our leadership and when we're trying to do different things—particularly in the University setting—the biggest piece of looking for tenure or renewal or promotion is actually research. It's less focused on teaching and it's even less focused on service. Service is really important and for me, service is more important than research particularly when it comes to Indigenous populations and we know the history behind Indigenous research. Trying to shape that idea within the university setting is not an easy thing to do where you're trying to show and prove that the community work that you're doing and the service is really beneficial and it actually creates better partnerships with everyone. When people aren't finding that as anything important, then of course you're not going to do that as much cultural safety integration because you want to get promoted you're like "I'm going to focus on the grants, I'm going to focus less on creating cultural safety content for my courses and less on community engagement and instead focus on research because I need to live." I think there's lots of systemic issues that really put people in a difficult position.

D:

It sounds like a struggle to hold different views on how to include cultural safety in education?

I:

Exactly. That's what I've been really struggling with and I think maybe that goes a bit to the other piece where it's like, you're expected to speak on behalf of all the Indigenous people in the world. It's like no, I can speak on my own experience as an Anishnaabe but that's going to be different from another woman that's from there and another man that's from there and an elder that's from there. Nothing that I can say can be translated for every Indigenous person. That happens a lot too so I have to take stock in what committees am I taking part in and what working groups to see if this is tokenism or true authentic engagement.

D:

Lastly, what are approaches do you use or other educators are using to integrate?

I:

I've been really looking at what do words actually mean and in that way, it's like we're just taking whatever mainstream is and we're just slapping on a medicine wheel and we're saying that's been indigenized now. That is the approach I see most. In most respects, most people don't even understand what colonization is. To decolonize something, you actually have to understand what colonization is. Just because you let someone identify in a classroom doesn't mean your decolonizing. Indigenous people are not the only people who are colonized. We are all colonized. We are all living under these rules and regulations and it's not like we can just - I don't know they're just terms that have been used so much that they've lost all meaning and all sense to me. Instead of just saying "we're going to decolonize our curriculum" what does that really mean? Let's not even say that. Let's just say "we're going to review the curriculum and

we're going to look at ways that we can be more inclusive or look at ways that we can encourage or produce cultural safety or cultural humility."

  Reflective comments. One reason that I began with this conversation was the participant's insights into the SON's geographic location as a factor in the level of integration and the influence on the institution's readiness to integrate. I came to this research with the assumption that the visibility of Indigenous populations in certain areas will influence the nature of cultural safety integration within SON. This participant added that this visibility makes it harder for SONs to ignore Indigenous people and actually influences the philosophy or mandate of SONs to meet Indigenous peoples' needs. In listening to (and reading) participant 5's thoughts, I heard a resounding affirmation that cultural safety integration is underway in SONs as a result of Indigenous visibility. However, the conversation also highlights that it is occurring in a very fragmented fashion as a result of the lack of direction and understanding of decision makers and the leadership.

  Part of the conversation spoke to me on a deeply personal level and as someone who has struggled with similar experiences. This nurse educator's passion for advocating for and educating on Indigenous Peoples' health and history was present and heartfelt. Advocacy can be very exhausting work, and the expressed frustration about the lack recognition of their added service in taking on this extra work resonated with me. As a student I experienced this in the form of constantly being called upon to represent all Indigenous peoples and trying to explain our culture to educators and classmates. At first, I did not think much about it, because I felt honored to have the opportunity, then, as time went on I began to feel more frustrated and as I realized the true weight of this responsibility. Now I am more cognizant of being tokenized as an Indigenous person, and I am more critical of how I give my time to the academic institution. This can be very difficult for Indigenous peoples to navigate in SON's, we occupy spaces that

historically never included our voices or needs. Therefore, when given a platform to speak, we often accept in spite of the risk of being tokenized and the extra burden that it presents.

As participant 5 acknowledged, Indigenous educators previously offered a once-a-month educational workshop for all faculty but stopped after realizing how undervalued this work was. I began to reflect on my upbringing, because my mother worked very hard to instill in me strong value for reciprocity. For example, I remember the many occasions on which I had to give up my bed to host family or friends from distant communities and on which we picked up hitchhikers on the side of the road and bought numerous large bins of food, gifts, and clothing for which we paid ourselves every time we flew back to Iqaluit, NU, where we used to live. This behavior was normal to me and continues today without question; for example, I offer rides, open my home, and donate. Reciprocity is an important value of many Indigenous people. Thus, at the center of who I am, I will always prioritize my people and community and give back. Unfortunately, the narrative for many Indigenous scholars, our worldviews, and what we prioritize as important such as community engagement conflict with the priorities of academia such as research and grants. This is evident in this nurse educators' story when describing how academics tend to focus on getting research grants to get promoted at the sacrifice of community engagement.

I also agree with participant 5 in believing that Indigenous persons in academia walk in two worlds. We often struggle with imposter syndrome,[1] hold ourselves to higher standards within research and education, and feel rejected in both Indigenous and academic communities, which reveals many complex layers that Indigenous scholars have to navigate. These complex layers are important in the process of integrating cultural safety in SONs because Indigenous

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[1] *Impostor syndrome* (also known as impostor phenomenon) is a psychological pattern in which an individual doubts his or her accomplishments and has a persistent internalized fear of being exposed as a 'fraud' (Ramsey & Brown, 2018).

nurse educators are clearly overburdened. The overburdening of Indigenous educators also

becomes a barrier to integration when it is not the institution's priority, but rather the expectation

that we will do so as Indigenous persons. This conversation left both of us invigorated with

affirmation. I believe that the conversation is so special because we found power in each other's

experience.

Conversation 2 (Indigenous).

D (Interviewer/Danielle):
What has your experience been with Indigenous cultural safety in schools of nursing?

I (Interviewee/Participant 14):
Cultural safety is a term that I probably didn't even really hear for the first time until I was doing my Masters and that's where I really became interested because I really have to self-reflect and really sort of go through that cultural humility process that is so important to cultural safety. In that self-reflection, I realized that for lack of better words I felt that I had been really brainwashed and even though I really respect and loved my education in nursing and I really was compelled to be this evidence-based, highly efficient and functional nurse practitioner, I really came to realize that I felt like I really missed the boat in so many ways. I think that was really my personal connection to my community and it was an experience that I went through that really jarred me. I mean we all have our own experiences in our lives that really change us in so many ways and make us see things, I mean they can be really traumatic experiences but in the same they open our eyes to many things that otherwise we might not have known about or respected really.
So what happened was, it was actually in my community I was working and there was an elder in my community who had heart disease and he was just a wonderful person in the community. He was really like a knowledge holder and a traditional person. He could speak the language beautifully that many of us have lost and he knew so much about our culture and traditions and ceremonies. He was really, in my view and I'm sure most of my community would agree, he was like the rock in the community. But sadly he had heart disease and he would often come to me and confide about his health struggles and I would always try to encourage him and support him. And he actually had to have surgery - had to have a CABG procedure. So we sort of coerced him into going ahead with this surgery and then what happened was he passed away during the surgery actually. Even though I had acknowledged that I was only doing what I felt was really important as a nurse to do, to encourage him and to bring forward his fears about the procedure, I really felt in so many ways that I had failed my community. More deeply I was just under this thinking that I failed my community and really what I stood for - this type of healthcare, this nursing - was really failing my community. It was like a thought that took over my whole being and it actually almost made me leave nursing completely at that time.

D:

And this is what led you to being an educator? And focusing on cultural safety integration in nursing?

I:
It was a long process of healing through that but like so many tragedies that happen to us in our lives, it was also a way for me to really learn and change my direction in so many ways. Anyways to make a long story short, after that I was really compelled to work towards nursing that would be more culturally safe and the thing about the term cultural safety that always captures me.me and really I was heavily influenced by a conference I went to where one of the speakers was Dr. Lavalee from the University of Manitoba. He said very clearly and forcefully, that's just his nature his way of speaking, he said "you know cultural safety really is a fancy term for racism" and that's the first time I had heard of it that way. Then I realized "yes I really agree with him in so many ways, what we're really speaking about here is racism and what we're really speaking about is the way we were all educated to really not be aware of this history, this untold history."

D:
How about now? How do see cultural safety being incorporating in nursing education now?

I:
You know I remember working in my community in the early days and wondering "why does everybody have diabetes" and if I looked at the literature back then it was all "oh because people aren't eating right, because they're non-compliant, because they're not exercising, because they're not well-educated" and it was nothing about history, about this untold history. It really made me realize that the mass majority of education and healthcare and nursing education has been really missing, really devoid of that critical piece of education with regards to residential schools and what's happened with the treaties and the untold history that was really there. I realize now that it's really not my fault, it's just because the education was not there and that was really just part of this assimilatory and oppressive process that just took over every form of education. So now it's a real challenge for me to bring that to the floor and articulate it in a way not to have people have their backs up which is really challenging

D:
In terms of nursing curriculum, how is it structured to include cultural safety?

I:
I have to say in all honesty, cultural safety is not threaded comprehensively throughout each course at this point in time. However, I think that there are attempts to do doing that. For instance, just last year with all the course syllabus they're having us put a piece in there with regards to acknowledging the traditional lands of the Anishnaabe and Haudenosaunee that are in this area. But it's still really lacking. However, often with the land acknowledgement I consider that a powerful teaching point because it's an opportunity to ask "what does this land acknowledgement really mean? What will come from acknowledging this land?" And it just opens the door to this kind of very challenging and difficult but most important history. I think

there's really a lack of cultural safety threaded throughout the nursing program. However, I think there's movement towards doing that.

D:
Can you talk about what else could be done from your perspective?

I:
Away from the big, you know, standing in front of 100 students with this power point and giving this lecture style and then maybe having a few students send in a few comments about it or whatever activity. We need to do something that's far deeper than that. It's one thing to thread concepts of cultural safety and cultural humility and to say this land claim acknowledgment before our classes or on our syllabus but it's often done in such a superficial way that really has no jarring of the students. It really needs to be really brought up front and center.

D:
I just wanted to ask you about how you felt, do you feel that the school of nursing is integrating in an authentic way?

I:
Yeah I would say there movement by some to do that but to my knowledge it's still really lacking. I think a lot of schools or nursing they're trying to hire Indigenous faculty members and sort of thinking that it will be those faculty members who bring that in, those Indigenous faculty members. I think that's really important absolutely, we have to have Indigenous faculty members but they are so stretched to do this and they're dealing with almost these racist undertones on a daily basis and a lot of us we just don't survive that. This constant messaging of being devalued and trying to play along in this Neo-liberal sort of way that's really all about greed and money making and following those colonial sorts of values that underline all of our history. It really perpetuates this assimilative, oppressive, and cultural genocide. It is very challenging. There needs to be far more work. I think it's starting to happen but it needs far more effort and support as well.

D:
Of course. At a few Universities they are committees or working groups that are tasked or have this as a priority to integrate cultural safety -

I:
Yeah they're often talking about decolonizing and Indigenizing. However, these words are often spoken in such an obscure way where we don't really understand what they mean and we don't really understand how they can really make a difference within our daily education approaches. There's been such an emphasis on that and again it's usually the tactics - one good thing that the University has done is they started a committee that I am part of. We're trying to bring in activities and influence approaches within the University that really take to the Truth and Reconciliation commission and beyond like cultural safety.

D:

You talked about, you had mentioned the colonial system in nursing and I'm wondering if you could identify anything specific?

I:
Yes absolutely. There's such a lack of dialogic teaching. I find that there's such a - and a lot of it is probably related to the Neo-liberal sort of system that really drives education. For instance, my first class I had over 90 students and you have to ask when you want to do these really sensitive discussions that involve dialogue and self-reflection, how do you do that with such a huge group? That's often how it is within the university systems and it's a lot about because they won't hire for a lack of funding. They won't hire enough teachers or professors to enable those small groups where you have the ability to have those very in-depth dialogues with students. So you have to be so creative and try to enable that effect given the limitations of having to work with really huge group sizes. The lecture style approach I really feel is not conducive to the Calls to Action of the truth and reconciliation in learning. We really need to have that small group dialogue and I really think we need to open-minded and even think about bringing in a more hermeneutic approach so that communication is really being made the priority and where we really involve all those components like storytelling and relational concepts and we really think about what do these Calls to Action really mean for us in healthcare? When you go into a First Nation community and you sit in a home with an elder who's using traditional approaches, how do you act about that? How does that work with the way you were taught as a nurse? You know, questions like that. How do you deal with that? What would be the first thing? So you need that role-playing, you need that hermeneutic dialogue, you need that interpersonal style, that dialogic sort of approach versus this continuance of this mass lecture style and power points.

I guess there's not really one sort of solution or one clear cut way of doing it. It requires multiple ways that have to really be thought out well by a team of really committed and authentic individuals. And that team has to be supported by the University. They should have the funds to bring in guest speakers who they know can articulate extremely well these concepts and make changes in thinking. They should be supported to have lesser research or teaching roads if they're going to engage in projects that further cultural safety or humility and so forth. One thing about our committee that bothers me is that because I think we're only funded or we're only supposed to have this committee for so many years but this needs to be ongoing. This damage that has been done to our people is forever. If we really want to make an improved health and life for everyone who is on this ground right now, we have to work so hard and it can't be just a time limit it has to be ongoing It has to continue.

Reflective comments. When participant 14 spoke of her experiences in nursing

education as centered around the development of an evidenced-based Westernized nurse and

commented that the residue of that experience made them feel that they had failed their

community, I was tearful because their experience resonated with me. I felt the pain in the

participant's voice when they retold a story about the death of a community Elder and their

perceived role in it. Their story made me pause and reflect on how Western and Eurocentric our

nursing education is and whether I have embodied these values in my nursing practice. What

have I done in my practice that has imposed my Western knowledge on a patient? This brings

me back to what Alice Reid, an Indigenous nurse who passed away this year, said to me when I

was first accepted into nursing:

> In nursing they equip you with a Western backpack, a backpack full of nursing skills, but when you work with our people, you have to trade in that backpack for an Indigenous nursing one. In my case, I exchange my backpack for a rifle and rubber boots. The much-needed rubber boots were much more effective walking on the trails rather than the white shoes—an iconic symbol of nursing practice. It was good to carry a rifle to scare off the bears.

Alice's sentiments reflect participant 14's reflection on the need to decolonize her thinking and

make changes to integrate cultural safety into nursing education.

Both Indigenous nurse educators talked about Indigenous faculty being overstretched and

having to face personal challenges with the undertone of racism in SONs and how they affect the

integration of cultural safety. This conversation left me with a distinct impression of the

structural barriers in SONs that are not conducive to the effective integration of cultural safety.

These structural barriers include classroom size, lecture style, and lack of resources and support

for nurse educators.

Conversation 3 (non-Indigenous).

D(Interviewer/Danielle):
How do you integrate cultural safety into your own classroom?

I(Interviewee/Participant 8):
Well, I try and model acceptance curiosity, non-judging and valuing of all my students no matter their history. Most of the time I don't know their history but you never know the stories that we are all walking with. I've had many students from many different places in the world. People who come from very different cultures with very different belief systems about pretty much everything. I find that exciting because I get to learn too. I guess I recognize and probably have increasingly recognized what a white colonial program we might be having here, in spite of our students and the population we serve. How do I do that? I try to be humble. I try to create

openness for people being able to talk about or think about other ways of understanding something or issues in relation to, for instance when we're talking about different cases in our PBL classes.

I think that I may be wrong in this, but my feeling sometimes is that the predominant understanding of cultural safety is about your race. And that in talking about one patient or family with a different background, that we've sort of got it all covered. I'm allergic to that idea and it worries me a lot. I also find in the classroom, we have varying diversity in the classroom but I found that it would be quite possible for a student who has different beliefs and a different experience that they're bringing to things, or different cultural background, that they might not feel free to talk about that in a class.

D:
You mentioned, PBL the people based learning and it's more of a community-style classroom where the peers are guiding the learning. What challenges do you see or experienced that PBL poses when a part of cultural safety is talking about that historical context of Indigenous people -

I:
Yeah I have. I certainly understand and come as a humble Canadian settler to the Indigenous cultures and the need for us to pay attention to the traumas of the past and the rights of Indigenous people in this country. But I see cultural safety as extending beyond Indigenous people. I've had lots of different people from different cultures who have been, and some of them with a very traumatic background like refugees, victims of war, Vietnam, Eastern Europe, Afghanistan, other places. So I think I also need to create space for them and respect so we have mutual respect. But what I notice in the classroom sometimes is that because of our Western program, it's quite possible and unintentional but still happens that we are imposing a Western way of thinking and having people think about their practice.

Another challenge is, I find if we're talking about Indigenous issues in Canada right now and pre- and post-TRC, I think it's really challenging. There's actually not a lot of space in the courses I teach to even raise it. I have introduced that and Indigenous ways of knowing into a nursing course. It's a learning experience for me too, but it opens up a whole lot of things.

D:
Who supports you in that process in introducing these concepts?
I:
Before our Indigenous nursing educator was here, I did it myself and looked for readings. And then they came, so they have come the last 2 years of that class.

D:
And did a lecture on it?
I:
A discussion. I've tried to, because obviously the philosophy that we introduce is pretty much Western philosophy. In the undergraduate program, I don't know where that happens. Maybe in the social determinants of health. Which again, back to my first statements, I think that cultural safety is a way of being and we have a culturally safe environment and that everything we do should be infused with that. It's not just a thing we do today or in this class. It's a way of

being and that comes from the top of the organization down and throughout. I think one of the challenges for our nursing students is then they go out into practice settings that are racist. We are biased and we stereotype all the time. I think our systems are full of that and that would include here probably.

Again, I don't like tokenism so I don't think "here's somebody Indigenous were going to study so we've got that all looked after in year 2 first term." We need to not do that. I've had some of that. I find most students know nothing about a lot of our history. No idea, no idea. That alarms me greatly especially the young ones coming into the undergraduate program. Is this not happening in schools now? I thought we were talking about this and addressing this. I've heard faculty talk like this around "I didn't do anything to them" or "my family came here with nothing" you know?

D:
How do you mitigate that? If you've had experiences where students or faculty say that to you?

I:
In the one faculty situation that I had, I didn't do anything. I was shocked because this person is in a high position. I don't know if they still think that way. Probably a couple of people [think that way] actually. I was very taken aback.

D:
I can imagine that would be stressful to go through?

I:
It's shocking actually. I think, and maybe this is part of the culture change, but I kind of think it's like feminism at the beginning where we're saying "there needs to be more women" or "we need to be talking about this" and it's like "oh here we go, we have to do that" and it's sort of like that around Indigenous issues I think. I could be wrong about that but it kind of feels like that, like we're doing this because we have to rather than because we think it's the right thing to do. But maybe that's how change happens and then eventually people think differently. I think maybe there's a lot of people who feel threatened. Even around opening up our applications around Indigenous students.

D:
Are you referring to the new facilitated indigenous applications?
I:
Mhm yes. I think there is also a fear on the part of many faculty. No one would intentionally want to offend and people are concerned about what's okay. And I get that. In one of my classes, what I found was the students had this true desire to be able to do the right thing and to understand. They were very afraid. I think we had this conversation in our class, maybe near the very beginning. It's like, people say "well, what do we say? Do we say Indigenous? Do we say First Nation? Some call themselves Indian but we can't? What do we do?" And people were so afraid of saying the wrong thing that they just don't say anything. I think we as educators need to be openly addressing this and talking about this and making space for this and then living that way.

D:
Who do you think the responsibility falls on with the integration of cultural safety? You've talked a lot about your own - things that you've went out and your own responsibility you felt to go and provide and include some sort of openness in the classroom.

I:
I'm a believer in systems and as one person in a very complex system, I may have some influence with some person at some time. I think that cultural safety should be a way of being throughout an organization and everybody's responsible. This is also part of how I philosophically and theoretically understand the world, but I think that there's a lot of patterning that goes on. The things that are happening at one level - we do not have a flat level - at one level influences... It's like oppressed group behavior. Do you know about oppressed groups behavior? It's like "you're treated that way so then you do that to other people." I think that we're caught in a big system and then what kind of exposures to students have? I don't know. I think we need to be modelling [something] very inclusive.

D:
What are the supports from the school that you feel you would want in general to support that integration? Because right now we're talking a lot on the individual level which is wonderful.

I:
I think it is something that needs to be infused throughout the organization and that it becomes everybody's responsibility and that we're all committed to it and not threatened by it. There needs to be, I don't know I don't have the answer to this, but there needs to be inclusivity in terms of what kind of place do we want to be? And then how do we live that way? It's very easy to create policies and documents. How do you bring people along and lift them up and out of certain ways of thinking. To me, I think that takes a charismatic leader. I think that people need to respect where the message is coming from. They need to see it as actually making things better for us and not as taking away from us. I think of all our students and all of our faculty do need to do education. I think it should be required. I think the other thing is, so even a course at the beginning in terms of the history. And that that needs to be engaging and not seen as a bird course or easy course or get that out of the way course - that it's tough and serious. And then I think that it takes very skilled people. I certainly wouldn't claim to have enough skill. I can do some conflict, but how do you really work with that in a classroom and in our own faculty? I know that even now people are remarking. Oh one thing I've started doing is the land claim. I love the land claim, I love that it invites us to think. I don't know how you feel about it, but to me it's a respectful thing versus something that you have to do like "don't forget to do that because you have to do that now."

D:
and in terms of what barriers do you perceive in the institution? In this big machine that you speak of, what are some barriers specifically?

I:

I guess there are different levels. I think the things that you've just talked about in terms of educators and our own knowledge and understanding, our ability to address or to include and acknowledge that in our classroom - how do we do that? What would that look like? And what things would we need to do to have people see that this is actually making us better and not taking away. Faculty need time, they need support. If they are given time and support to do something then that something needs to be not flaky. It needs to be significant. And then how to work with or engage with - you know, when cultural related issues become the focus of a conflict, what do we do with that in a positive way? The ultimate would be that everybody gains from that and people learn from that versus people being proven right or wrong. We would have Indigenous faculty, some sort of Indigeneity infused in the program in different ways so it's not just something you do here and then forget about it, checklist and done that. So I think those are things to think about very carefully versus people saying "oh one more thing now we have to go to that." I think also, people are afraid about human rights. I think they're afraid about grievances. I think they're afraid about the enactment of policy that would reveal bias or negative judgement or discrimination. I could be wrong.

D:

I'm just wondering within your 30 years if you can think of your most meaningful experience with integrating cultural safety?

I:

My most powerful experience happened before I was a nurse educator. I was very young. I went to a northern First Nations community for 3 or 4 months. At that time nobody was doing - this was the early 80s - nobody was doing that really. But I had been working in emergency and ICU and I wanted exposure, I was trying to get an education and I wanted to do something different where I'm really learning something different. I was terribly ill-prepared. There was no preparation really and I was in 3 different places up there. I was shocked. It's probably one of the most intense learning periods of my life. I was totally shocked as a Canadian and as a person growing up most of my life in Ontario that this other world could exist. These communities and experiences could exist. I was shocked that you couldn't practice in one of the official languages, that Cree was the language. I had some sort of image that we were equal and that you'd be working with people that were in the communities that we went to and that I was in. The opposite was true. There was sort of, I'm going to say a white community but they weren't all white but they were Westernized dominant community and then the First Nations community and not a lot of interaction and I was really shocked about that. In my little time I got to know some of the people and into their lives, that was powerful for me, understanding that this was part of our Canadian society and how could this be? This is my province and these people were from here and how different their experience of life was. That had a big impact on me and I do feel guilt about that actually. What could I have done? I think it's terrible. I remember riding home, and saying "I'm just shocked, this is Canada how come this is the way it is?" And here we are. Not much has changed.

Reflective comments. I began to see consistent and recurring themes such as the lack of

confidence, the fear of saying the wrong thing as a settler, and the need to talk about cultural

safety. I appreciate this phenomenon, because, as with anything unfamiliar, it can take years of experience and learning to gain a high level of confidence and make mistakes without fear. I can relate this to my culture as I learn the cultural protocols. For instance, I recall that last year at our annual Beaver Lake Pow Wow, a community member called me out as I was recording a video of a whistleblower ceremony. As I learned, the whistleblower ceremony is very sacred and cannot be filmed or photographed. I remember that I was embarrassed and then thankful as I took the opportunity to ask questions about the sacredness and importance of this ceremony to our *Nēhiyaw* people. In that process I not only gained an important piece of sacred knowledge, but also challenged my internal fear of making mistakes.

Participant 8 had a similar understanding with regard to making mistakes. They tried to model curiosity and humility in integrating cultural safety into nursing practice. Their definition of cultural safety was interesting, through more of a diversity lens in that we are all different and need to respect all of our differences. I found it troubling at first, because I understand that cultural safety can be extended beyond Indigenous people, which nurse educators acknowledge. However, this participant specifically believed that the predominant understandings of cultural safety involve race, which they should not. This point raised many questions for me about why I center cultural safety around for Indigenous people in Canada. It is because the notion of cultural safety stemmed from Irihapeti Ramsden, a Maori woman, nursing leader, and advocate for social justice, who tried to mitigate the effects of colonialism on Maori health in New Zealand. The intended focus of cultural safety is less on the benefits of cross-cultural awareness and sensitivity and more on the risks associated with their absence and the power imbalance that results. On reflection, I cannot justify my belief that Indigenous peoples need to be at the forefront of cultural safety in a Canadian context; it is something that I feel.

Another undertone in this conversation was the participant's doubt or hesitancy when they spoke, which is not evident in reading the conversation. For instance, they repeatedly stated, "I might be wrong," which might be because I Identified as Indigenous. They might have felt hindered in sharing their true feelings because of this. However, the conversation ended on a good note when they shared a powerful experience with their first exposure to Indigenous realities. Experiential knowledge is another theme that emerged, and it has the strongest impact on cultural safety engagement in nursing education.

Conversation (non-Indigenous).

D (Interviewer/Danielle):
Tell me a bit about yourself and your experiences with cultural safety?

I (Interviewee/Participant 9):
So I'm originally from the US. I did my undergrad there, so very kind of Eastern and built up, virtually no connection with Indigenous people. Two years after graduation I moved to Canada and was a head nurse of a psych unit. So I knew very little about Canada before I came. Certainly, hadn't seen any Indigenous issues at all, I mean it wasn't on my radar at all. But within this small 8 bed psychiatric unit, 80% of our clients were Indigenous because we were right in the middle of different reserves. So I probably have always been one of those curious lifelong learner kind of people so immediately started to say "okay what's going on here? Why is there such a high population?" Oh well I guess I'm living in the middle of a population but then why are there issues. So I contacted the local bands, I met with elders, I read everything I could read and also started very early on including elders within the care of our patients. But then over time working in different environments, it wasn't so easy but I always reflected on "well of course everybody should know this, why doesn't everybody know about residential schools?" The people I were caring for had been in residential schools so I thought everybody knew it.

D:
It was a shock to find out that lots of people don't?

I:
People didn't. It was a shock. Now I'm really focusing on nursing education, at the time [when I first came to this SON] we do problem-based learning and there was one scenario; It was a scenario that we covered and she was an Indigenous child and I think with a single mother. The scenario was lots of stereotypes there embedded into it but it did provide the opportunity to actually at least talk about issues about why were the children being taken? What constituted abuse and was this abuse? Was it neglect? What were the differences? What were the issues in relation to the Indigenous population?

D:
Within the scenario there's tons of these stereotypes?

I:
Yeah, and probably within a few years of being here - so we're going back to maybe the early nineties - we started to look at issues of what was cultural, we didn't call it cultural safety then but even an awareness. We taught Leininger's model. We were a small faculty at that point and we had two people within our faculty who very much influenced us. They really pushed that we needed to look at cultural issues, not necessarily from an Indigenous lens. They were strong so I can remember being in faculty meetings and they'd say "are we doing this right?" Or "you want to look at this tool - a developed tool for doing cultural assessments."

D:
So you talked about Leininger - are those models still being used within the undergraduate curriculum?

I:
Not as much just because nursing theory isn't taught as much. However, when I was in a leadership role, I led a major curriculum revision. So I said we needed to retire that scenario [laughing]. I mean we retired everybody but it was definitely time to retire that scenario. Oh just with teaching with that scenario, we would have standardized patients - So we would have standardized patients come in, who were Indigenous, into our class. But depending on the skills of your tutor, it would depend on the kinds of issues and how students were supported in understanding issues. I still remember - I'm sure traumatic for the standardized patient because we had one of the nursing students, I don't remember their name but I remember their face and they were going to do a cultural assessment. So they asked the mother the person who is portraying the mother, "so do you eat Moose meat? What is it that you do?" And I think she's from an Indigenous community nearby and she was so insulted and we were behind a two-way mirror and I called a time out and I went in and kind of changed things. Having to debrief with her afterwards and saying "how much better they said this to you instead of an actual patient" and now I have an opportunity to actually address how terribly insulting they were. But it was so traumatic that I remember it clearly and it would have happened mid-nineties.

D:
and at that time the resources for these types of things were non-existent, right?

I:
Right. And also it's very much individually based and then the TRC really has raised the awareness across the board. I know that we partnered with people from a first nations community when we designed the new scenarios. I led this curriculum revision and we stayed with young children or labor and delivery and then I think it's done in two years and it's in the second year and the third year so it starts with a normal pregnancy, labor, and delivery and then goes to a family and the child is older. So we're looking at kind of normal things - now they are people that are on reserve but also part of the directions to the tutors is they also need to talk about what it would be for Indigenous people living off-reserve and what would be the differences and to bring up issues.

D:
What do you see as barriers to integration?

I:
Part of it is the - okay there's two things. So I want to make sure I come back to both of them. One has to do with the amount of content. So there's so many hours of instruction that's available so you have competing demands. The other big area still is awareness of faculty. TRC has made a difference, but - Okay so starting first with just the amount of content, Canada is a multicultural environment so I know there's pushback all the time about "yes there's Indigenous people but they're only one group" and then you talk about "yeah but they're the original group." It's that pushback that some of the issues around cultural safety, cultural competence, all of those terminology and the basics of "you need to take culture into perspective, you need to look at context, you need to examine your own values and beliefs against everybody else's" those kinds of things I think are easier to do across the board. But then making sure that there is enough attention to Indigenous issues.

D:
Yeah I understand that too - the content overload - you said multicultural Canada that topic or that theme has come up a lot here within cultural safety -

I:
Um, I think it actually has to do with my next point which is the lack of awareness and the lack of teaching that educators have about Indigenous issues. In some ways I was lucky because I realized when I immigrated to Canada that I knew nothing about Canada. I had to go through an immigrant experience of actively learning about Canada's history. I went to the local library and took out the grade six textbooks, but then realized there were large parts I didn't know. I had the opportunity to look deeper and I was in a place where Indigenous issues were front and center and I needed them [to know about Indigenous issues] professionally. That was easy for me. Here it's so Urban. People's view don't even know [this reserve] is there.
So I'm part of a different group which are not nurse educators but I'm part of the [redacted for anonymity] teaching academy. This is made up of other faculty who have won prestigious teaching awards from the University. So we were doing this retreat and TRC had recently come out. I was saying "we should talk about residential schools" and in this group of award winning faculty, most had no clue. They had heard about TRC but had no clue of the implications and these are the people who were supposed to be the leaders. So we planned this workshop and we got an indigenous faculty to come and a few others and it actually helped change those individuals who were like "oh my word I had no idea." There was just a recent one looking at inviting people to go out and see residential schools. So I went but the people who went were all the ones who were already aware. So it's teaching to the converted, although that is how you always make any change happen is you get the people who have some interest who become your allies who become your leaders and you get more groups. I'm afraid that this is going to be seen as the flavor of the month or the flavor of the year.

D:

In your experience, what would you say is the best way to promote cultural safety integration here?

I:
It is making sure that there is enough people and that it's sustainable. I know that [Indigenous faculty member name redacted for anonymity] being here is a big deal. When I found out an Indigenous faculty member was on campus who wasn't a part of the SON I went and said "for god sakes you should be in the school of nursing." I then went to the associate dean and said "for god sakes we have this person why isn't she here you need to get her here, how can I help get her here." But you need something that's built into the structure. You don't want it to be dependent on just one person. I know now at the moment there's an Indigenous office for health sciences and it's critical that our indigenous faculty member isn't just in nursing but that she's also integrated within all of the faculty of health sciences because that's where the money and the power is. Nursing is very small, we're small potatoes even though we're huge but within the university we're sidelined and within faculty of health sciences we're sidelined. So it's important that it's embedded deeply into the whole faculty not just within nursing.
There's only a few people I can point out and say that's something I can feel and had shared those common things with, whereas with another it's kind of like having to toe the line with them and be like "it's important" you have to convince them and be a leader in that sense. So I think leadership is so important in this whole process because if you don't have it coming from - a lot of people have said it's a top down approach too, right? But right now, we're coming from the bottom up and I see that we have been doing it inconsistently top to bottom. It's been like this because we have leadership and admin that have a real interest in it so it comes from the deans or you know - Currently our president is very interested.

D:
So you have people on the ground like yourself who are really advocating for integrating it into your actual teaching are doing that from the bottom up. So it's very inconsistent. How do we really get from here to there?

I:
So needing to make sure that it's truly done in partnership and not just me saying "okay we need to get rid of that scenario, we need a new scenario" but we could just have easily just had - you know I could have said "you're responsible for developing a new scenario" and they could have done it by themselves instead of what happened which was "yes there's partnership." And you need time to build that in because then in that partnership, your other partner is going to have a different time frame then you do.

D:
You have the resources to - and that was another point you said, who's responsibility is it really to be integrating?

I:
I would say it is the responsibility of the assistant dean because the assistant dean has the responsibility for the quality of the overall curriculum. Of course, you're pulled in multiple directions but also the associate dean, so the one above her in charge of the school is really

responsible to make sure we're accredited. So those two people have to know what the accreditation standards are and have to have an eye on are we meeting them and are we meeting them in a real way or are we doing it as window dressing. Absolutely that's their responsibility to do that. When I was in that position, it was my responsibility but of course it was also across the board looking at are we doing good enough in pathophysiology, are we doing good enough in teaching research.

D:

Yeah of course and then right now, where do you think the responsibility is truly falling like in reality?

I:

I would say it's a status quo like "okay we have something in there okay we've done good enough and that's the indigenous faculty members problem" because we have somebody. Like passing a potato. Right we have somebody who is here and yes that is her role so no we don't need to worry about it anymore. So our institution as a whole, there's now kind of mandatory diversity training. Not necessarily Indigenous, but also there's kind of different cultures. There's a culture that - it's an expectation that faculty constantly are learning and constantly teach themselves. Across a wide range of topics. You know it is an expectation and it's certainly been my expectation of myself that I'm constantly reading and I'm constantly learning something new. If I'm going to teach a course, you know I've taught qualitative research several times. I'm doing a lecture on data analysis and I just pulled off another 15 articles for myself to read prior to doing that talk. But I would say that there's been a cultural shift within faculty that they don't necessarily see that as a responsibility anymore. That may be a generational [thing], you know a work-life balance - so you need leadership to bring us all on the same level regarding cultural safety. Or else it gets left behind.

Reflective comments. What I appreciated most in talking with this participant was her acknowledgement that they are a settler in Canada and their personal endeavor to gain the necessary knowledge to work with Indigenous peoples. Participant 9's level of commitment as a non-Indigenous person was compelling. However, the lack of support and resources from universities and departments is concerning as nurse educators are left to their own devices in integrating cultural safety. For instance, this participant explained that they included material that they sought out, but only as a result of their past experiences. They also talked about the stereotyping in nursing textbooks and scenarios, which again affirms the positive impact of experiential learning opportunities on the mitigation of culturally unsafe behaviors.

This conversation revealed the negative influence of nurse educators' and faculty leaders' lack of awareness and inauthenticity on the successful integration of cultural safety. Initially, I believed that ensuring that SONs and nursing education incorporate cultural safety was the more arduous task, but the more that I listened to nurse educators, the more I realized that ensuring that resistant leaders and educators understand the value of this work on integrating cultural safety is also not easy. Educating, learning, experiencing, and integrating Indigenous cultural safety are significant undertakings that raise the question of where to begin.

Chapter Summary

These four conversations and all the others that I have had are evidence that nursing education is a complex system that requires a multilevel approach to the integration of cultural safety. The Indigenous nurse educators affirmed their unique experiences in this process that continues to marginalize them because of their ethnicity. The comparison with the stories of non-Indigenous nurse educators offer insight into how these educators' lack of confidence and minimal awareness of Indigenous peoples' histories place more accountability on Indigenous nurse educators. On the other hand, the conversations with both of the non-Indigenous nurse educators also revealed their passion and commitment to ensuring the prioritization of cultural safety in nursing education. However, the non-Indigenous nurse educators also had a sense of discomfort and fear of doing or saying the wrong thing. I found it enlightening to hear the meaningful stories of the non-Indigenous nurse educators about their experiences in Indigenous communities that greatly challenged and positively changed their perspectives on Indigenous peoples. It was affirming to realize that experiential learning opportunities can be powerful in the uptake of cultural safety. This chapter reaffirms that both the Indigenous and the non-Indigenous nurse educators' experiences are a measure of progress in nursing education and understanding,

but that they face challenges ahead in broadly and effectively integrating cultural safety theory

into nursing education.

   In the next chapter I thematically group the distinctive aspects of the integration of

cultural safety that emerged from all of the nurse educators' interviews.

CHAPTER FIVE: THEMATIC RESULTS

This chapter presents the themes from the analysis of my 15 conversations with nurse educators. Figure 2 is a thematic map developed from the analysis process. This schema links the themes and facilitates the interpretation of the results. As discussed in chapter four, I identified four narratives—place, happenings, experiences, and practices—that framed the thematic analysis of my conversations with the participants.

Figure 2. Thematic map on the integration of cultural safety into nursing education.
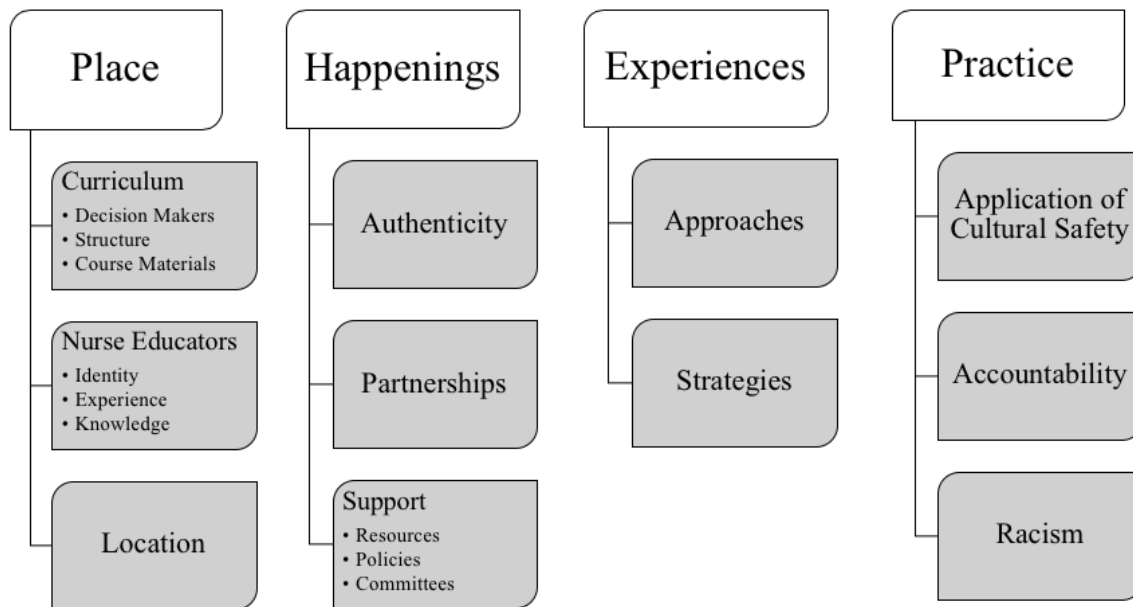
The first narrative, place, refers to the broader colonial context of nursing education and its influences in this process of cultural safety integration. The second narrative, happenings, refers to the contextual and structural elements that frame the integration of cultural safety into nursing education. The third narrative, experiences, offers insight into the current approaches and strategies that nurse educators use in the process of integrating cultural safety into nursing education. The last narrative, practice, is the culmination of these narratives and reveals the

current reality of and practices in the process of integrating cultural safety into nursing

education. I present each of these narratives and the thematic findings in the following

subsections of this chapter.

Place (Where the Work Happens)

I used a postcolonial lens to unpack this narrative to examine nursing education as a

product of a colonial system entrenched in a Eurocentric worldview and knowledge system and

its negative impact on the integration of cultural safety into nursing education. The nurse

educators' conversations illuminated many colonial discourses that are currently present in the

SON where participants were employed and the challenges in integrating cultural safety. The

following excerpts demonstrate these findings:

> *In self-reflection, I realized that for lack of better words, I felt that I had been really brainwashed and even though I really respect and love being a nurse educator, I really was compelled to be this evidence-based, highly efficient, and functional nurse, I really came to realize that I felt like I really missed the boat in so many ways. . . . I realize now that it's really not my fault, it's just because the education was not there and that was really just part of this assimilatory and oppressive process that just took over every form of education. So now it's a real challenge for me to bring that to the floor and articulate it in a way not to have people have their backs up, which is really challenging.* (Participant 14)

> *You would think that our faculty, out of 39 individuals, the majority are white women and that is unacceptable because that does not reflect our student population at all. You wouldn't believe the pushback. I just have to say that I think the colonial viewpoint is so entrenched that individuals who I would consider to be very broad in their thinking and in theory, inclusive, always have to be challenged.* (Participant 6)

The challenges of the colonial system for SONs are very clear. Most nurse educators

recognized the need to target and change the colonial discourses and mindsets that are deeply

rooted in SONs. According to these educators, dismantling colonialism[2] in nursing education is

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[2] Smith (2012) described *dismantling colonialism* as undoing structures or processes that uphold colonial practices and discourses.

essential to the integration of cultural safety. They viewed this process through the lens of

decolonizing the institutions; however, the nurse educators found it difficult to understand this

concept because they were so entrenched in the colonial system, as the following excerpt

demonstrate:

> *I think the idea of decolonizing the institution is much bigger. I think I'm not the right*
> *person to answer that because I'm part of an institution. It's hard for me to step out of*
> *this machine and see areas where colonization is happening. Having said that, I'm 100%*
> *aware that it's happening around me but it's hard to know exactly. I'm sure it's*
> *happening in my classes, I'm sure it's happening in my syllabus, I'm sure it's happening*
> *in my classroom discussions. Like I said earlier, I view it through my lens but my lens*
> *isn't the only lens and it's not the most important lens, it's just the lens that stands in*
> *front of the class.* (Participant 2)

Decolonization[3] is a complex process, and even though nurse educators noted or

described its existence within a colonial system, the heavy influence of the institution limited

their ability to understand and identify colonial practices. Furthermore, nurse educators might be

blinded to colonial discourse in part because they are 'colonized.' As this participant explained:

> *In most respects, most people don't even understand what colonization is. To decolonize*
> *something, you actually have to understand what colonization is. Just because you let*
> *someone identify in a classroom doesn't mean your decolonizing. Indigenous people are*
> *not the only people who are colonized. We are all colonized. We are all living under*
> *these rules and regulations. (Participant 5)*

As part of the conversation, these colonial discourses were most apparent when the nurse

educators discussed the curriculum, educators who teach nursing, and the locations of the SON. I

will discuss each of these subcategories separately.

Curriculum. Curriculum is a key modality in the integration of cultural safety into

nursing education. Both, internal and external factors influence the nursing curriculum.

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[3] According to McGibbon et al. (2014), The decolonization process involves affirming and activating paradigms of Indigenous knowledge to reveal the wealth and wealth of Indigenous languages, worldviews, teachings and experiences, all of which are systematically excluded from history, from contemporary educational institutions, and from Eurocentric knowledge systems. (p. 182)

Participants identified the external influences as decision makers who are responsible for

approving the curriculum and the internal influences as the faculty in the SON who are

responsible for developing the structure of the courses and selecting or developing the course

materials.

     Decision makers. Professional associations and administrators have an important role

(and obligation) for the integration of cultural safety. Professional associations such as CNA and

CASN are instrumental in setting the competency standards for nursing education and

developing and approving nursing curricula for SONs. More specifically, CASN is responsible

for accrediting the SON curriculum. During the interviews nurse educators affirmed the role of

professional associations play in creating a stronger thread of cultural safety theory in nursing

education:

> *When the College of Registered Nurses of Ontario or CASN you know, every few years come to do their evaluation of your program - this was something that was pointed out that we needed to have a stronger thread in. So it's in the works in terms of it being integrated a little more into the curriculum. Both for the students as part of their undergraduate learning as well as for the instructors*. (Participant 1)

Furthermore, documents such as the TRC's (2015b) final report call for urgency with regard to

integration. For many, this report is a trigger for the integration of cultural safety:

> *Personally I feel there's more of an urgency in Indigenous context. . . . Honestly I think it comes out of the Truth and Reconciliation and the calls to action. I think if we're standing in front of a class of students we have an obligation to talk about it. So I think there's an urgency there.* (Participant 2)

Some nurse educators commented on the fact that institutions are bound by the curricular

concepts that professional associations approve, which might or might not include cultural

safety. As this participant pointed out, the professional associations' requirement for and mention

of cultural safety or similar terms is the foundation of and strengthens the rationale to prioritize

integration:

> *We have a cultural competency documents and we're accredited by CASN and our program is approved by the College of Nurses of Ontario. Within these bounds of our accreditation we have to identify where these curricular concepts are taught. So if I can stand up and say yes I'm talking about Indigenous ways of knowing or I'm talking about cultural humility in my philosophy class then I'm bringing that along.* (Participant 3)

Nurse educators also claimed that the lack of consistency among professional associations' with

regard to cultural safety frameworks and concepts impacts what they (nurse educators) are

integrating or have at their disposal. For instance, although professional associations and

regulatory bodies support cultural competency; participants considered it inadequate for nursing

education:

> *So around 2010, the RNAO [Registered Nurses Association of Ontario] had documents about cultural competency for lots of different races and that sort of thing and I found them sort of cookie cutter and inadequate. For me, I shifted then to thinking about that cultural safety piece and the ability for folks in relation with their nurses and their ability to interact with the healthcare system that people should feel safe to be who they are. We certainly have taken the core pieces of that document - the post-colonial understanding for example, that's woven into first and second year.* (Participant 4)

Thus, professional associations or regulatory bodies have not yet reflected nurse educators' shift

in thinking about cultural safety and competency. In addition, the growing evidence for the need

for cultural safety and cultural competency in nursing education includes various position

statements, frameworks, or best-practice guidelines that different nursing associations and

regulatory bodies have published. However, this lack of collaboration on the part of professional

associations in nursing education is not new; in this study nurse educators acknowledged their

influence in siloing the process of integrating cultural safety in a piecemeal fashion.

Finally, many participants observed the lack of leadership from not only professional

associations but also administrators within the SON, which makes the integration of cultural

safety in the nursing curriculum difficult. They considered leadership essential to integration and

the ability of SONs and nurse educators to prioritize cultural safety. As the following excerpts

point out, in some cases the integration of cultural safety is simply not the priority of curriculum

decision-making associations or administrators:

> *The Canadian Indigenous Nurses Association [CINA], several years ago they put out some teaching resources and curriculum resources and I remember going to a meeting about that representing my school. They launched it and provided us with resources and how to use them but then the trick is the person that goes to that meeting it's hard to influence your colleagues and senior administrators like my dean on it. That's essentially what happened.* (Participant 15)

> *I feel like the nursing profession, our deans, our associations, if we were taking it seriously we would be more active in providing it, right? Anyways, I'm not a policy person and I know from my policy and social work colleagues that things take a lot of time and leadership, and as a nurse I want more action on this*. (Participant 15)

Thus, nurse educators recognize the influence of decision makers on integration in that

leadership is necessary to integrate cultural safety. Despite this acknowledgement, the leaders of

professional associations and administrators lack a shared vision and collaboration. The main

factor that the participants identified for this lack of leadership and collaboration was that

decision makers in nursing education do not consider the integration of cultural safety a priority.

   Structure of courses and curriculum. The absence of a shared vision and collaboration

for the integration of cultural safety becomes problematic in decisions on the structure of courses

in nursing education. Nurse educators reiterated that the content prioritized in the nursing

curriculum is based on the biomedical model and other dominant discourses, which decision

makers in nursing education reinforce (or lead). As the following stories from nurse educators

demonstrate, dominant colonial discourses leave little room for the inclusion of cultural safety in

the structure of courses:

I think it's interesting to see how the school has prioritized that aspect of training. For example, infection control practices is mandatory. Some clinical placements are a mandatory 8-hour day to get their computer system training which is all very important but why aren't we making cultural safety training a priority within our program? (Participant 10)

As you can probably remember in your undergraduate curriculum, there are so many topics that need to be covered that it's just one of those things that unfortunately get shifted to the side unless there is a strong push from administration and senior leadership to have specific content in each one of your courses. (Participant 1)

The nurse educators considered the large number of competing topics and the sheer volume of content areas that need to be covered as very challenging. Their conversations shed light on the problematic nature of overloading the curriculum. For instance, it is educators' responsibility to find ways to incorporate cultural safety into the course structure. As the following excerpts show, in setting the curriculum for courses, nurse educators are responsible for the delivery, integration, and evaluation; the curriculum can be inconsistent within a program, pushed aside, or not included at all:

You have new faculty coming onboard and they have a course outline that they're working from and trying to help support them to understand what depth you want to have in the content. It is a challenge. Lots of new faculty are like sponges and they're asking for support and for ideas about who to come and teach and sort of thing. So it works pretty well but every once and a while you come across someone who's not as interested in weaving that content in or not as skilled because they're new and younger or just because they're not interested. So you have a little glitch in the content. . . . Somebody comes in with a really medical model of teaching, you know all the science of nursing in a chronic care nursing course and then the next professor is one that looks at concept-based teaching and talks about things like self-care and grief and totally different things. So it's a challenge in undergraduate nursing programs because of that professorial freedom. (Participant 4)

The integration of cultural safety can take many forms depending on the nursing program's curriculum mandate and philosophy. If it is not mandated or prioritized in the structure of courses, nurse educators omit or minimally include cultural safety. Moreover, nurse educators in this study highlighted that because of the lack of leadership, SON administrators

(and nurse educators) take a selective approach toward including the concepts of cultural safety in the integration into curriculum and courses. This was evident when they referred to "taking core pieces" of documents from professional associations. Ultimately, nurse educators reported that nursing courses are overloaded and organized around priority nursing concepts (informed mainly by the biomedical model) in the curriculum. The interviews revealed that there is no standardization or consistency within curriculum with regard to the integration of cultural safety. This is a serious barrier for nurse educators and does not support the systemwide integration of cultural safety. Thus, cultural safety is integrated sporadically and according to the curricular philosophies, teaching/learning methods, and approaches of each SON or nursing educator.

Course material. Other elements of the curriculum that colonial discourses heavily influence are the course materials that educators use to translate nursing concepts, such as cultural safety. Course materials include nursing theories and textbooks and are the main sources of nursing knowledge, according to the nurse educators. They contended that nursing knowledge is informed by marginalizing and colonial concepts (i.e., the biomedical model), which is manifested in the course materials. In their conversations nurse educators referred mainly to the theories that they teach, the case scenarios that they use to deliver and teach content, and the course textbooks.

The nurse educators acknowledged that nursing education includes many cultural care theories that support and guide the advancement of dominant and Eurocentric forms of nursing knowledge—knowledge that colonial 'settler' academics have historically theorized and that continues to impose considerable colonial ideologies ono nursing education. For instance, one nurse educator criticized many widely accepted cross-cultural theories as not meeting the needs of Indigenous populations because they are informed by the voices and opinions of settlers:

> *So we're going back to maybe the early nineties - we started to look at issues of what was cultural, we didn't call it cultural safety then but even an awareness. We taught Leininger's model. Currently, I mean it's not as much as before, we are still using Leininger's model. Sometimes it makes me cringe to think how nursing puts this white nurse's theory above the voices of our Indigenous populations.* (Participant 9)

The nurse educators also denounced the use of other cross-cultural theories such as transcultural nursing theory and cultural competence. One participant stated that the nature of these theories draws attention away from colonialism and maintains a normative and prescriptive understanding of culture:

> *I've taught nursing theory at the first-year level, there is very specific embodiment of theoretical frameworks for cultural safety. One of our quizzes in the first term is very specific to cultural and all of the factors and variables associated with that experience and developing awareness that the novice nurse will experience in terms of diversity of people. This focus on cultural differences I would say isn't the best cause; it's a very narrow and culturalist way of looking at it.* (Participant 6)

Nurse educators also use case studies or scenarios to educate students on Indigenous issues, which creates an opportunity for the application of nursing theories and cultural safety. However, often embedded in the scenarios is the stereotypical depiction of Indigenous populations. One nurse educator commented:

> *She was a scenario that we covered in 3rd year and she was an Indigenous child and I think with a single mother. She was three. The scenario was, I think she was cooking something for her younger brother and dumped the pot of boiling water on herself so she was burnt. So of course, like there's lots of stereotypes there embedded into it but it did provide the opportunity to actually at least talk about issues about why were the children being taken? What constituted abuse and was this abuse? Was it neglect? What were the differences? What were the issues in relation to the Indigenous population?* (Participant 9)

Although case-study scenarios can perpetuate a negative view of Indigenous people, the nurse educators considered this approach valuable because it offers students a space to discuss issues related to Indigenous health. However, colonial discourses can also sustain the negative and

deficit-based views of Indigenous peoples, and one participant called for the reworking of

inappropriate and colonial language:

> *I am dismayed about some of the labelling that we use with our assignments. . . . It is just inappropriate colonial language and scenarios have to be re-worked. . . . There are some profound fundamental colonial viewpoints that I think have not been unpacked in our curriculum.* (Participant 6)

Nursing textbooks also continue to sustain the negative and stereotypical views of

Indigenous populations as inherently sick and damaged (Allan & Smylie, 2015; Stansfield &

Browne, 2013). In this study, nurse educators affirmed that nursing textbooks are often based on

Eurocentric norms and fail to take into account the cultural, historical, and community contexts

of Indigenous peoples; however, some nurse educators sometimes use them unknowingly. The

following excerpt indicates that nursing textbooks foster a limited understanding of Indigenous

populations based on the perceptions of a settler society:

> *You know I remember working in my community in the early days and wondering "Why does everybody have diabetes?" And if I Iooked at the literature back then it was all "oh because people aren't eating right, because they're non-compliant, because they're not exercising, because they're not well-educated" and it was nothing about history, about this untold history. It really made me realize that the mass majority of education and health care and nursing education has been really missing, really devoid of that critical piece of education with regards to residential schools and what's happened with the treaties and the untold history that was really there. So in a way, it was difficult for me often to not sort of get in this sort of blaming mentality.* (Participant 14)

Another participant added, "I think I lean heavily on my experience and also the textbook I'm

using. I've used pretty racist textbooks, not on purpose, but the writing sort of reflects the

'eighties and maintains a negative view of Indigenous populations" (Participant 2). As the above

excerpts show, a deficit-based approach (which negatively characterizes Indigenous populations

according to health statistics and stereotypes) limits students' exposure to a reality other than that

of colonial discourses in nursing. Thus, the nurse educators recommended the decolonization of

our thinking as well as our textbooks to challenge these colonial discourses. One nurse educator

pointed out that this process seems to be underway:

> *It's called the Canadian Psychiatric Mental Health Nursing a Clinical Approach. I like It because they actually revamped it because of the Truth and Reconciliation commission and they had a chapter called cultural considerations. Because I was new to the university I added a whole session about that and in that session I speak to the Truth and Reconciliation commission and I bring forward the story about doctor Brice and I also show them clips of Dr. Cindy Blackstock and her work with First Nation children. I can see how they're like "I've never learned this I had no idea.* (Participant 14)

In summary, the nurse educators called for the deconstruction and reconstruction of

textbooks to make them more inclusive of Indigenous knowledge and include more culturally

safe material to break down the negative stereotypes and biases about Indigenous populations.

The continued reliance/presence of these colonial theories, case-study scenarios, and textbooks

perpetuates the functioning of the colonial discourses in nursing and limits the integration of

cultural safety. In the absence of nursing course materials that integrate cultural safety from a

noncolonial viewpoint, the materials that nurse educators have at their disposal will continue to

highly influence them.

Nurse educators. At the crux of the integration of cultural safety into nursing education

are nurse educators themselves. As I noted in the above sections on curriculum and its elements

influenced by colonial discourses, often it means that nurse educators have to exert a great deal

of effort to integrate cultural safety. In general, they are in a privileged position to shape and

prioritize specific content in nursing education. Because nurse educators are situated within a

colonial system (i.e., in nursing education), they are not immune to the influences of colonial and

Eurocentric ways of being and thinking. The nurse educators identified that their cultural

identity, personal and professional experiences, and level of knowledge are influenced by the

colonial discourses and factor into the integration of cultural safety into nursing education.

Identity. Faculty in SONs are predominantly of settler backgrounds. In this study, and as

expected, there was a larger presence of settler than Indigenous identity. The contrast between

Indigenous and settler backgrounds offers insights into the notion that identity is a personal

barrier to the integration of cultural safety for non-Indigenous nurse educators and imposes more

responsibility on Indigenous nurse educators. In addition, the nurse educators discussed the

influence of their identity on how they viewed and taught cultural safety and their willingness to

talk about Indigenous-specific content. Nurse educator views on cultural safety varied according

to their nursing lens and ability to recognize inherent biases. One nurse educator stated:

> *I think I'm pretty conscious of the fact that I'm standing in front of the room as a white*
> *male talking about this. I always make sure it's clear to people that it's coming through*
> *my lens. I can read all I want, and talk to all the people I want, and watch all the videos I*
> *want, but I present it through my lens. I guess I'm just consciously aware of that. I'm*
> *aware that my identity is influencing that but I'm also aware that I grew up in [Redacted*
> *for anonymity] and I'm proud of Northern Ontario. (Participant 2)*

The inability of non-Indigenous nurse educators to uncover their inherent biases is a barrier to

integration and continues to impose colonial ideologies on nursing students. However, educators

who are newcomers or immigrants to Canada have a different lens that is more sensitive to the

injustices inflicted on Indigenous peoples. Their impact on the integration of cultural safety can

sometimes be more profound because of their understanding of cultural diversity, as the

following excerpts illustrate:

> *My father was born in Greece and my mom's parents were born in Greece so I'm kind of*
> *in between first and second generation. . . . I'm always very sensitive to people coming*
> *from different cultural backgrounds, other than just general people who have been in*
> *Canada for 100 or 150 years. I always try and approach that sensitively in classes. When*
> *I had a number of international students from the Caribbean and from African nations. I*
> *always tried to make time for those students to have a voice in the class to talk about the*
> *class content that we were going over from their own cultural perspective so we could*
> *generate discussions that were coming from various viewpoints. . . . I just try to have an*
> *open and respectful classroom where I can discuss these issues and hear these different*
> *perspectives. I wouldn't specifically call it a bias. I'm just aware that everybody has a*

different story to share and to make my classes open so that they can feel safe to do so. (Participant 1)

The kinds of health problems as a result of the immigration experience are all named and it's horrifying and upsetting. Who knows what the literature supports but the health of immigrants, their health was better before they arrived in Canada. They can appreciate the experience of Indigenous Canadian Aboriginal persons across the land. (Participant 6)

Furthermore, many of the nurse educators discussed the personal and professional self-reflection on cultural safety required to deconstruct professional power in the classroom. This understanding of identity significantly contributes to the nurse educator's role in the incorporation of cultural safety. Identity also influences nurse educators because it challenges them to talk about cultural safety content from a non-Indigenous perspective. The nurse educators echoed a common feeling of discomfort or fear that accompanied their "whiteness" or settler background:

I'm pretty Indo-European like I'm red headed white skinned green eyes. As a faculty member, even though I have many friends who are Indigenous and I grew up in an area where there's lots of Indigenous presence, I feel like a phony talking about Indigenous health stuff because it's not my experience. That is a challenge. Sometimes faculty don't know the right words to say. You know, you're trying to say something that is useful and in line with decolonized curriculum and you end up saying something that is insulting. So what are the right words to use? What are the right terms to use? What do Indigenous people actually want us to say? That's a challenge figuring that out. (Participant 3)

You've seen my demographic form and you see that I'm Greek-Canadian, white. I don't want to do more damage by doing this incorrectly. I want to be very well-prepared and I want to understand what I need to do before I introduce this into my courses. I feel like I'm ill-equipped to do it unless I train properly which is why I'm seeking this additional training so that I can start to reframe the way I teach my courses. So it's not really an institutional barrier; it's definitely a personal barrier. (Participant 1)

This realization is especially important and challenging for nurse educators who feel ill-prepared to educate students on cultural safety content because of their identity and subsequent fear with regard to the matter. The need to avoid causing further damage within the classroom also caused

many of the nurse educators to rely on Indigenous faculty members to deliver this information. The Indigenous nurse educators raised the issues of identity, cultural background, and sense of responsibility:

> *What I didn't realize is the sheer physical presence of me being here disrupts the colonial space which I didn't really truly acknowledge until this year because I felt like 'I got to be doing more, I got to be doing more' but just being in the space really opens the doors metaphorically even for other students to say 'oh she's Indigenous and she's teaching and she's a nurse and nurse practitioner' they see me as a role model. So not having those [Indigenous educators] is certainly a barrier.* (Participant 5)

This Indigenous nursing educator found power in her identity to disrupt colonial discourses. Ultimately, it is important that nurse educators understand how identity influences colonial discourses in nursing and, consequently, cultural safety. However, their non-Indigenous identity challenges many non-Indigenous nurse educators, and they feel discomfort and fear in teaching cultural safety content.

Experience. The nurse educators identified their personal and professional experience with Indigenous peoples as influential in their role and responsibility in integrating cultural safety. Despite the pervasiveness of colonial discourses in nursing, which positions biomedical hegemony in the curriculum, exposure to Indigenous narratives can equip nurse educators with anticolonial perspectives that help counter these discourses. In addition, they counter the discomfort and fear that non-Indigenous nurse educators feel when they teach cultural safety content; their experiences include caring for Indigenous patients, working in Indigenous communities or places with a large Indigenous presence, having Indigenous colleagues, or growing up exposed to and educated on Indigenous populations. The participants reported that previous experiences with Indigenous narratives increased their awareness and openness to Indigenous knowledge and culture. For example:

> *My most powerful experience happened before I was a nurse educator. I did a post-RN degree. I was very young. I went to the Sioux lookout zone for 3 or 4 months. . . . I was shocked. It's probably one of the most intense learning periods of my life. I was totally shocked as a Canadian and as a person growing up most of my life in Ontario that this other world could exist. These communities and experiences could exist. . . . In my little time I got to know some of the people and into their lives, that was powerful for me. . . . That had a big impact on me and I do feel guilt. What could I have done?* (Participant 8)

Previous personal and professional experience with Indigenous peoples had a positive impact on their ability and confidence in integrating cultural safety. Many of the nurse educators noted that these powerful and shocking awareness of Indigenous history and current-day realities increased their personal interest in learning about and supporting Indigenous populations through education and research. In fact, some acknowledged this interest as their reason for participating in the study:

> *My experiential knowledge has been very robust I think right from the days of growing up and the community I grew up in and the people in my classes in elementary and high school. An inclusivity, although I would suspect it was still pretty colonial in its view, . . . when I was in grade 4 our end of school trip was to go to Brantford and we went to the Mohawk community and to the church. I think that is wonderful but is that not a colonial viewpoint? We didn't go to a pow wow, we went to the Mohawk Church.* (Participant 6)

Ultimately, previous professional and personal experience increased the nurse educators' sense of awareness, knowledge, and responsibility in practicing cultural safety and integrating it into the classroom. However, when they talked about these meaningful experiences as generating greater personal awareness and knowledge of Indigenous realities, they also questioned the depth and colonial perspective of each experience.

Knowledge. The lack of knowledge of nurse educators in general, was a common concern of the participants. Although most of the nurse educators in this study exhibited an increased interest and awareness, a few demonstrated a lack of knowledge in multiple ways, such as the use of language, the lack of understanding of Indigenous issues in Canada, and the importance of

integrating cultural safety into nursing education. For example, as the following excerpt shows,

the language used to describe an Indigenous person is very alarming:

> *The thing is, I'm based [redacted for anonymity] so a lot of my students are from various different cultures. Like there's never 2 students in the same cultural group within like a group of 9 students. However, I never know if someone is Indian or I don't know specifically what they are so I can't really say; I don't know if I've had a native student before but I've had a lot of multicultural students.* (Participant 12)

The use of the term *Indian* to describe an Indigenous person is the result of a colonial perspective

and stems from the Indian Act, government legislation that has historically oppressed and

continues to oppress Indigenous peoples today. The language (or choice of words) highlights the

presence of ignorance regarding who Indigenous populations are and reliance on stereotypical

physical traits to identify an Indigenous person. Nurse educators also reported that many of their

colleagues still do not recognize the value of cultural safety content in nursing education. The

following excerpts offer insight into the problematic mindsets of some nurse educators:

> *It wasn't that long ago that I was speaking to someone about racism for instance and it wasn't that long ago where individuals of color had to sit separately. I don't think people realize that yes that in fact [racism] still happening today. Now-a-days I think it's up in arms with "oh my gosh that is incredibly racist" and I know it's different here in Canada, . . . it's the sheer fact that people talk about and people are up in arms about it pushing for that change.* (Participant 7)

> *Yeah, and I suspect that it's different from place to place in the province and place to place in the country in terms of what we are exposed with and what their attitudes are because I know people think living in the Niagara area that there aren't any Indigenous people because there's no reserve nearby. So it's just like a level of ignorance but on the other hand maybe those who are local in Niagara aren't exposed to some of the generations of negative attitudes and whatever the people who live close to reserves seem to have. Like being free to say things that are just not acceptable.* (Participant 15)

The lack of knowledge and ignorance of nurse educators ultimately continue to create barriers to

the integration of cultural safety in SONs. However, the participants contended that this mindset

might persist because of the extreme level of fear in teaching or even talking about Indigenous

issues:

> *I don't want to say sensitive, but people would almost rather not talk about a topic or just ignore a whole concept or just not talk about a topic then to actually address the issue because everybody seems to be so sensitive. If someone is wondering "okay my peer, are they Indigenous and should I ask them questions because I don't know anything about their culture, should I ask them some questions?" I think they would just stop themselves from doing that in fear of hurting the person or in fear of saying something wrong. Do you know what I mean?* (Participant 9)

> *I think there is also a fear on the part of many faculty. No one would intentionally want to offend and people are concerned about what's okay. And I get that. But I've heard faculty talk like this around "I didn't do anything to them" or "my family came here with nothing" you know?* (Participant 8)

The fear and discomfort that many nurse educators expressed was very common; however, for

many it pointed to the urgency of developing mandatory cultural safety training for all faculty

members to increase their awareness and knowledge of Indigenous peoples in general.

Furthermore, experiential learning opportunities increase awareness and knowledge and counter

the aforementioned attitudes and mindsets. As one nursing educator explained, changing

attitudes and mindsets can be a slow process when it is not mandatory for all faculty:

> *So we planned this workshop and we got an indigenous faculty to come and a few others and it actually helped change those individuals who were like "oh my word I had no idea." . . . There was just a recent one looking at inviting people to go out and see residential schools. So I went but the people who went were all the ones who were already aware. So it's teaching to the converted, although that is how you always make any change happen, is you get the people who have some interest who become your allies who become your leaders and you get more groups. I'm afraid that this is going to be seen as the flavor of the month or the flavor of the year.* (Participant 9)

Even though these opportunities increase the awareness and knowledge of nurse educators, when

they are voluntary, the educators who participate are often those who are already interested in

learning more and have an increased sense of awareness, which makes the change process very

slow. Finally, the lack of awareness and knowledge is not limited to SONs:

> *I'm part of a different group which are not nurse educators but I'm part of the teaching academy here. This is made up of other faculty who have won prestigious teaching awards from the University. So we were tasked to try to say what can we do for educators here. So we were doing this retreat and TRC had recently come out. I was saying "we should talk about residential schools" and in this group of award winning faculty, most had no clue. They had heard about TRC but had no clue of the implications and these are the people who were supposed to be the leaders at the University. (Participant 9)*

Those who have control over what they know and show no interest in knowing more act as colonizers in the academic institution by excluding discourses that counter the dominant colonial ones. This lack of awareness and knowledge in its basic form is ignorance. Thus, educators' attitudes and lack of awareness sustain colonial discourses and prevent or delay the integration of cultural safety in SONs.

Location. Last, a SON's geographic location influences the process of integrating cultural safety. When they discussed geographical location, nurse educators referred to the political environment and visibility of Indigenous populations as factors that influence the integration of cultural safety in SONs. They described these factors as having an impact on relationships and partnerships with Indigenous populations, the mandate and philosophy of their school, and the leadership to prioritize integration. One nursing educator suggested that the political landscape in her city influences the leadership in the community:

> *We're having some serious issues with racism here. I think with the political landscape of what's happening, I think once you see someone in power doing something it almost makes it okay, right? . . . When you see people in positions of power and leadership who are doing these terrible things, then it's like "well it's okay." It's almost like the Wild West, like "it's okay for us to do those things because the police are doing it, they're the ones who are upholding the law and if they're doing these things it gives you free range to do whatever you want." It's pretty terrifying. (Participant 5)*

Although this sentiment reinforces the idea that SONs situated in areas with more reported racism will also have more reports of racism. In this study, the SONs located in communities that the nurse educators openly described as more racist were those that were more

advanced in and committed to integrating cultural safety into nursing education. The following

excerpt from the same nursing educator supported this phenomenon:

> *For me, the places that I've been to and the things I've been a part of, and actually our University is a bit ahead of the game when it comes to cultural safety and cultural humility particularly with Indigenous populations. I think part of that is where we are situated in our geography and the sort of lens in which we are working. I was really surprised because I'm doing my PhD and at my university I went there the people are not as aware of Indigenous people, the history of colonization and things that are happening.* (Participant 5)

Thus, the visibility of Indigenous issues in the broader community positively influences

SONs to integrate cultural safety content and meet the needs of Indigenous populations in their

geographic location. The visibility of Indigenous peoples is an important issue considering that

they have largely been invisible in the past. Comments from the nurse educators suggest that this

either has led to collaboration or strengthened partnerships between Indigenous communities and

SONs:

> *Oh, okay, so the collaboration at [university name redacted for anonymity] is very much, you know runs the curriculum and it's not really a partnership. Ours is really a partnership and the curriculum is jointly decided between us and our partners in here. At our university, they're quite connected with Indigenous groups down there and they're much closer to a big reserve I think one that goes across the border like it's quite big down there.* (Participant 15)

Therefore, a SON's location in an area with a highly visible Indigenous population has a

positive impact on integration because it is harder to ignore Indigenous people's needs.

Furthermore, where SON are situated influenced not only the philosophy of the nursing program,

but also the relationship between the SON and the broader Indigenous community.

Happenings (culture, the way of things)

Happenings is the culture, the way of things, in nursing education; it describes the current

context and structure of SONs in reference to the integration of cultural safety; or, as a nursing

educator termed it, "the inner workings of the institution." These inner working processes can be split into contextual and structural factors that create favorable or unfavorable conditions for the integration of cultural safety. The contextual factors include those that frame the integration of cultural safety. Nurse educators identified authenticity and partnerships as two key contextual factors that frame integration. Structural factors refer to the infrastructure of SONs that is required or currently exists to support cultural safety. The nurse educators identified educator support as a structural component necessary for integration. Support encompasses resources, policies, and committees that are essential to support for educators. I will explore these essential elements in the following sections.

Authenticity. Without genuine and sincere interest from nurse educators in SONs, integration cultural safety will be either superficial or not at all present. Authenticity in this context was described as valuing and understanding the importance of cultural safety in relation to Indigenous populations and understanding the history of Indigenous peoples in Canada. Participant responses highlight several barriers to the creation and maintenance of authenticity, such as lack of interest, leadership, and education. As mentioned previously, the TRC (2015a, 2015b) report has created calls for SONs to integrate cultural safety content into their nursing curricula. However, this precedent leads to a lack of authenticity on the part of leaders and nurse educators. Several nurse educators pointed out that the reasons for integrating cultural safety content into their environment are questionable:

> *I could be wrong about that but it kind of feels like that, like we're doing this because we have to rather than because we think it's the right thing to do. But maybe that's how change happens and then eventually people think differently. I think maybe there's a lot of people who feel threatened.* (Participant 8)

> *It has to be a top-down approach but also, as an instructor, you have to want to find resources and better educate yourself on this issue. But the challenge becomes, for example, for someone who is pre-tenured or someone with a heavy teaching load and is*

> *trying to balance service and research, it's really difficult to make sure that's on the top of your list of priorities. There are all of these competing demands and a person can only work a certain number of hours a week. In an academic position, you are pulled into so many different directions. It has to come from the individual in terms of it being an interest.* (Participant 1)

In other words, certain people integrate cultural safety content into their environment through obligation and not real will or a sincere interest in changing the situation. Participants identified leaders as crucial in creating and maintaining authenticity within SONs. They recognized a top-down approach, in which leaders in roles such as deans need to be sincerely interested in providing appropriate supports and creating partnerships that are conducive to the integration of cultural safety content. In contrast, leaders who lack authenticity negatively influence nurse educators when they do not set a precedent or emphasize the importance of cultural safety content:

> *The director of nursing that I have right now she's really a fantastic person but she basically said you can find something online through Cancer Care Ontario and do that course. So really just lacking that emphasis and when you have that lack of emphasis and sincerity with request to further your education, it's just really like saying "this isn't really important" and there's that lack of respect, and coming from a First Nations background it really hurts because you know that colonialism it's just alive and well.* (Participant 14)

It is difficult for nurse educators to teach cultural safety content when they lack knowledge and a sincere interest in gaining knowledge when leaders do not offer, support, or compel it. Feelings of incompetence or insecurity because of a lack of education can compromise authenticity in teaching cultural safety. Thus, leaders must authentically engage all nurse educators in integrating and learning about cultural safety.

The lack of authenticity also has difficult implications for Indigenous nurse educators in

SONs. If authenticity is absent, Indigenous nurse educators face the issue of tokenism.[4] For

instance, Indigenous nurse educators explained that they have to be extremely mindful of where

to put their energy and efforts because of their fear of being "tokenized":

> *They want you to be part of all these things and be that Indigenous face but that's it, they don't really care beyond that. That's what I've been really struggling with and so I have to take stock in what committees am I taking part in and what working groups to see if this is tokenism or this true authentic engagement.* (Participant 5)

> *I was asked to come and talk about ways that maybe some people for cancer have used traditional methods and I thought; "whoa this is cool I will come talk about it this" but then we come and sit down and that's not what it was about at all. They just wanted to go for Indigenous funding so they wanted to have Indigenous representation on this committee and they had already had the grant written. We are treated like an afterthought.* (Participant 5)

These statements offer insight into the level of authenticity demonstrated in circles within

SONs. Specifically, that non-Indigenous nurse educators and leaders are willing and open to

extending invitations to the Indigenous community, faculty, educators, and so on. However, as

many nurse educators stated, they often reach out to their Indigenous counterparts or other

Indigenous personnel to support their teaching or the integration of cultural safety content.

Although good intentions are evident, authenticity is often lacking. Unfortunately, the lack of

authenticity at all levels, specifically leadership, will continue to do harm in the form of

tokenism and prevent the formation of authentic partnerships with Indigenous peoples.

Partnerships. Authenticity is complex but transcends many issues in the integration of

cultural safety in SONs; it is a necessary component of partnerships with the Indigenous

community. Participants largely discussed partnerships as a structural element in that

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[4] *Tokenism* is a superficial effort to include members of a minority without making the necessary changes to make the environment more inclusive and equitable.

partnerships with Indigenous peoples, communities, and resources within SONs are required to

ensure that appropriate expertise guides the integration of cultural safety content. The nurse

educators considered Indigenous partnerships a modality and an opportunity to access supports

and Indigenous expertise that would otherwise not be available. Nurse educators specifically

identified the benefit of these partnerships in educating not only their students, but also faculty

through guest speakers:

> *At our university, they're quite connected with Indigenous groups. . . . So we did have at our last joint meeting in the Spring, we had speakers come - they have somebody that is responsible in the university for supporting more Indigenous things in curriculum. . . . He was mainly giving us information and not really getting into details on our curriculum. More trying to help us have some basic understanding. So some people were further along than others in that but it was to try and get us all willing to think about "maybe we need to change some of the things that we are doing.* (Participant 15)

However, the Indigenous nurse educators stressed the importance of creating partnerships

in a good way—proactively rather than retroactively:

> *Right now, Indigenous issues are such a hot topic. It's where the funding is at, it is where everyone wants to get involved and that's where the danger happens. . . . It's about making a relationship, that relational practice with people. I said "if you wanted to have Indigenous representation with this, you should have done that before you even started writing anything." So again, it's not the afterthought where we're switching something from a Western model to an Indigenized model. We actually need to start with relationships at the beginning before we create any model because then it's truly done in a good way.* (Participant 5)

Barriers such as mistrust, still exist between these two communities that make it difficult

to create partnerships. Mistrust is the result of the history of the exploitation of Indigenous

peoples for academic purposes such as research. The same participant spoke to the importance of

authenticity in partnerships to overcome mistrust:

> *If things are coming from a meaningful relationship and truly starting things from the base together, then we can really have that reconciliACTION. We can actually do that together but it can't be an afterthought or else you further the mistrust between us.* (Participant 5)

Thus, partnerships must be established with authenticity to fully support the integration of

cultural safety. According to the nurse educators, real efforts are being made to create and utilize

these authentic partnerships. For instance, the nurse educators referred to Indigenous

partnerships as essential in advising curriculum changes with regard to Indigenous health. One

participant explained:

> *So needing to make sure that it's truly done in partnership and not just me saying "okay we need to get rid of this Indigenous scenario and we need a new scenario" but we could just have easily just had - you know I could have said 'you [a non-indigenous person], you're responsible for developing a new scenario' and they could have done it by themselves instead of what happened which was 'yes there's partnership with Indigenous expertise.* (Participant 9)

Last, the lack of equity in knowledge transfer was a general concern in existing or

creating partnerships. Partnerships must be mutually beneficial for both parties to be considered

authentic. Whereas, nurse educators noted that they rely heavily on Indigenous faculty members

(including non-nursing faculty) to develop authentic partnerships. One participant commented:

> *The Indigenous center here provides some leadership but they don't have authority. . . . So they help with teaching and curriculum review and that kind of stuff and they have been tuned into this. And then I guess the other thing is, I'm assuming there are some Indigenous faculty that are being relied on very heavily but that's not within nursing. So it raises concerns who is benefiting more when we are constantly relying on Indigenous peoples to come talk about this stuff over and over again. I'm sure that's not their only role.* (Participant 15)

Establishing effective partnerships requires mechanisms and strategies to ensure

authenticity, as well as implementing and sustaining processes that encourage trust. Building

trust takes time and might involve barriers, including the emotional responses of the parties and

differences in values and cultures; thus, educators require training in cultural safety. The creation

of Indigenous partnerships is undoubtedly a fundamental factor in the integration of cultural

safety into nursing education. Without authentic Indigenous partnerships, integration will be limited and possibly fail.

Support for educators., Structural elements such as policies, resources, and committees are essential to support nurse educators to create authentic partnerships. Support is vital to develop skills, competencies, and the capacity for the integration of cultural safety in SONs, as well as to learn how to integrate cultural safety content into their courses. As mentioned above, almost all of the non-Indigenous nurse educators referred to a host of feelings such as fear, discomfort, and being unprepared for teaching cultural safety content; whereas the Indigenous nurse educators, who often teach Indigenous-related content, reported the need for more support to reduce reliance on them. Collectively nurse educators identified three key areas—policies, committees, and resources—that support encompasses. In addition, they described supports as necessary structural elements that need to be provided or in place in SONs to ensure the success of nurse educators in integrating cultural safety into nursing education.

Policies. SONs require inclusive policies to create an environment in which both non-Indigenous and Indigenous nurse educators can learn about and integrate cultural safety. The nurse educators in this study identified several policies that should be enhanced or implemented to dismantle specific barriers to the integration of cultural safety, such as the hiring of more Indigenous faculty. Specifically, it is important to recognize the value of more Indigenous peoples and diversity in academia to change attitudes and practices:

> *The leadership in the school in the broader faculty of health sciences plays a role is that we have the opportunity to hire faculty who are either visible minority or Indigenous. We have an Indigenous professor here now who we didn't have before and they have changed all of our thinking. If you look at our equity, we are told to make sure the equity of our school of nursing is like the top of the heap. We have men, we have non-binary, we have everything. That's the sort of open-mindedness and sort of the goals of the current administration and faculty and the university, which is a good thing because it breakdowns assumptions and stereotypes.* (Participant 3)

Even within our Indigenous Nursing Entry Program, right now none of our instructors that are working with them are Indigenous. That doesn't make sense to me either. You could have at least one person in there who is a healthy role model who is going to support these undergraduate nursing students. Including faculty too. (Participant 5)

Policies such as hiring more Indigenous faculty members are required to ensure appropriate Indigenous representation. Most of the non-Indigenous nurse educators reported having one or no Indigenous faculty member in their SON. In addition, two of the three Indigenous nurse educators reported being the only Indigenous faculty member. Although a majority of nurse educators referred to having equitable hiring policies at their institution, they were vocal that more needs to be done in terms of leadership, processes, and funding. As one nurse educator explained, challenges still exist externally and internally to the university in terms of hiring policies:

I think most universities are trying to hire someone into this kind of job where it's like an advisor on Indigenizing or that kind of thing. . . . From some of the meetings that I've been at that it is a really long process for agreeing on who to hire and then it would be so few people who would want to do that kind of a job. Like this is not a job that you have job security at necessarily and if you're an academic they want an academic and then you have to give up all your research. . . . I suspect that in Ontario, these budget changes mean that in places that don't have someone hired they are going to be pressed to not hire because they're going to have real budget problems. That's where it comes from within the university. (Participant 15)

Ultimately, a large number of participants counted on the recruitment of Indigenous nurse educators and Indigenous faculty in other supportive roles to ensure the effective integration of cultural safety. They considered it a strategy to relieve the pressure on current Indigenous nurse educators. On the other hand, they suggested that policies that include education or training on cultural safety for all faculty would enhance faculty members' cultural competence and safety. The following excerpt highlights how cultural safety training can mitigate nurse educators' feelings of unpreparedness and discomfort and help them to become more culturally safe:

I'm really looking forward to undergoing that training again and making sure that this is something that's at the forefront of the classroom environment. . . . I believe a number of other colleagues and faculty and staff here have at least undergone the core Indigenous cultural safety training previously and its helped them feel more comfortable talking about it. Even just being more culturally safe. (Participant 1)

The nurse educators also reflected on the physical environment of their SONs and the ways in which academic policies complicate the teaching of cultural safety. For example, large classroom sizes create an environment that is not conducive to education that includes cultural safety content. According to the nurse educators, large numbers of students in classrooms do not facilitate open and self-reflective dialogue during sensitive discussions, which challenges the nurse educators to guide and mitigate these discussions with students within their ability. Policies that target educator-to-student ratios would support the more dialogic environment that teaching cultural safety requires.

Last, one SON in this study had a mandatory Indigenous content policy. As one nurse educator explained, mandating Indigenous content is beneficial in that everyone will become more aware of the need to integrate it:

I also think this university is a pretty good school in terms of the mandatory Indigenous content. It's 45 hours of Indigenous content for every degree so I think that just having that in writing as a policy at here opens people's eyes to the fact that we should be talking about this. (Participant 2)

In conclusion, policy changes can create an environment in SONs that supports the integration of cultural safety. They require leadership and educator engagement. Forming committees that include nurse educators who can lead and engage in this work is one strategy.

Committees. Participating on committees is a form of academic service that is recognized in workload as a contribution in the academic community and can be leveraged to make changes at a structural level. In their conversations nurse educators talked about the role of committees in

leading the integration of cultural safety in a collaborative fashion, as well as guiding SONs

through the process of integration. As the following excerpts demonstrate, committees are an

important structural element in SONs that help nurse educators to integrate cultural safety:

> *When I was on the Senate I was the chair of graduate studies committee and through that I went to meet with a committee in senate called the "One Dish One Spoon" which is the local treaty. They're giving advice to our senate with things to do with Indigenous students or to do with curriculum changes for Indigenous health. . . . So through that and through other committees I've been on I'm also aware of the support and structure it provides to our faculty.* (Participant 15)

> *Our university itself as a broader university has had a commission running as a result of the truth and reconciliation and not just about Indigeneity but across all cultures there's been task forces here looking at how we can make things more equitable and diverse. So it's one of those things that we try to bring into our curriculum all the time.* (Participant 3)

Nurse educators explained that SONs are establishing or in the process of establishing

committees specifically tasked with addressing Indigenous health; a few that they mentioned are

TRC committees or Indigenous health advisory committees. However, one nurse educator was

frustrated about the lack of authenticity of these committees that resulted in a "checkbox"

approach:

> *Within the University, we did have a truth and reconciliation committee that they have which I offered to sit on starting last year and I think we've had 2 meetings. So again, that goes to show the value seen in that. If it's something you're truly striving for, in 2 years you would have more than 2 meetings. I feel like in my mind, it's a checkbox to say "we've created this committee and then just leaving it at that" like it just looks good on paper.* (Participant 5)

In addition, another area of frustration were the time constraints in creating committees

and producing actionable items. One nurse educator considered integration or change a lengthy

process that, without committees, would be less organized:

> *So we're looking actually at 2021 and I shake my head and say "oh my goodness" you know it's a little bit frustrating for me knowing that those calls to action and when they*

*came out and what are we doing about it. . . . I understand that the process takes time-
there are things you have to do you can't just put a course or curricula out right away
but without committees taking this work on it would be more disorganized. . . . So yeah a
lot of the constraints are in terms of how new classes and how courses get passed
through senate or whoever has the red stamp.* (Participant 13)

Committees are an essential part of optimizing the process of integrating cultural safety

into the curriculum in SONs. However, the nurse educators identified constraints that negatively

affect the success and longevity of committees, such as the lack of authenticity, time, and

organization. They recommended more financial and human resources to support the necessary

structural changes to ensure the success of the integration of cultural safety.

Resources. The nurse educators considered access to resources to understand and

integrate cultural safety concepts of great value in SONs. Specific resources reported to have a

positive impact are access to education, literature, and Indigenous expertise:

*I think there's a lot of institutional support here if someone wants it. We have an
Indigenous curriculum coordinator. I've talked to her on e-mail about using some of her
documents and literature to teach these concepts because she has lots of knowledge
about it.* (Participant 2)

*I'm going to be taking the Ontario Core Indigenous cultural safety training, the enhanced
version the new one. So at least it's something there that's formalized that will help
support my learning at a deeper level as opposed to just reading articles and finding
resources myself.* (Participant 1)

*In terms of educators and our own knowledge and understanding, our ability to address
or to include and acknowledge that in our classroom - how do we do that? What would
that look like? And what things would we need to do to have people see that this is
actually making us better and not taking away. I think support in the shape of education
and expertise is necessary.* (Participant 8)

Currently, it is evident that it is hard for nurse educators to navigate or access resources

because the faculty are simply not aware of the resources available to them or do not know how

to access them. For example, one nurse educator shared her experience of wanting to access

Indigenous-specific resources but not knowing where to go:

I'll tell you a funny story. The first time that I reached out to see if we could have an elder talk to us and I did my homework and I realized that in terms of tobacco, that was the gift. I was just like "where I'm going to get that, what am I going to do?" And thinking that would be the appropriate thank you because I usually got my guest speakers something. I ended up thinking "I don't know what to do" and I didn't really have anybody to ask. This is probably 10 years ago or so. I went and bought tobacco, but I don't buy tobacco and then it's like "how much will I give and what will I put it in?" I remember having like a big Ziploc bag or whatever. I felt kind of stupid about that. (Participant 8)

New nurse educators talked about the difficulty of learning and navigating resources when they were new to an institution. Support from peers or fellow colleagues helped them to learn about and navigate resources:

For me as a new staff, I'm really happy to take the Indigenous cultural safety because it is something concrete that somebody has suggested to me rather than me going through the literature and finding out what models there are and what's most appropriate. (Participant 1)

There's not much like even from teaching this professional practice, not even from a cultural standpoint but even just the course resources - it was very hard to navigate. I'm very thankful that I know people that teach the course as well so I was able to lean on them. But in terms of cultural safety resources, I can't speak to anything I've been provided. (Participant 10)

Other faculty mentioned the lack of consistency in communication about available resources. They often learned about opportunities to talk to Elders and view presentations after they occurred, or they were unaware of certain educational opportunities until it was too late:

You might have a cultural advisor who is a real go-getter who connects with us and says "we've got a visiting scholar and we'd love to have them speak in your class and can you fit them in?" And then roles change and people change and the next person posts something on the internet and you miss it and think "shoot there was a visiting elder I would have loved to have that person come but nobody let us know." It's that kind of ongoing communication, and again it's always a little bit of a challenge depending on who is doing what role and how connected they are. When you're trying to tap into folks, they are really busy. (Participant 4)

The lack of time was another barrier to accessing resources. Participants expressed interest in attending professional educational-development opportunities such as workshops but reported that often they could not because of time constraints. The overloaded nature of the curriculum and nurse educators' workload constricts time, then access to resources requires more work from nurse educators to prioritize cultural safety concepts in the curriculum and teaching practice. Many of the nurse educators lamented the lack of time to explore and access resources to support the inclusion of cultural safety content in their teaching:

> *Faculty need time, they need support. If they are given time and support to do something then that something needs to be not flaky. It needs to be significant. And then how to work with or engage with - you know, when cultural related issues become the focus vs pushed to the side from overloading of curriculum.* (Participant 8)

Last, although it is evident that some resources are available to nurse educators in SONs, more effort is required to remove the barriers and improve access to them. Some nurse educators reported that no resources were available to them in their SONs, which left them searching for supplemental resources:

> *There really was nothing specific about cultural safety training within the curriculum of any of the courses I taught. Or anything that was suggested by the department for Indigenous cultural safety, it was always a topic of discussion; for example, at department meetings we needed to do this. But nothing was ever decided upon in terms of "okay this is the exact framework that we are going to be using." Depending on the subject matter you were teaching, it would be up to each individual, professor/instructor to approach that in his or her class in whatever way they felt.* (Participant 1)

Providing resources for nurse educators requires financial support and human commitment from SON administrators and leaders, which is sometimes difficult.

Experiences (Stories)

In the previous two narratives for place I examined the colonial discourses within SONs and how their manifestations influence the integration of cultural safety on a broader level.

Similarly for happenings I described the contextual and structural factors that are necessary for

the integration of cultural safety in SONs. As discussed earlier; colonial, contextual, and

structural factors greatly influence the process of integrating cultural safety. As a result, the

current process of integration is not ideal and is constrained by these factors. Within this

narrative, I will examine the experiences of the nurse educators as they shed light on the current

process of integrating cultural safety within SONs. The process of integration includes the

approaches and strategies that nurse educators reported and experienced. The difference between

the approaches and strategies is that the approaches largely focused on the SONs' approaches as

a whole—on the philosophy and structure of the curriculum and courses; whereas strategies are

concentrated on the individual strategies nurse educators employed to integrate cultural safety in

their teaching. For instance, they discussed the current and desired approaches to what is

currently being done in nursing programs to integrate cultural safety. The majority of participants

maintained that cultural safety should be considered a core competency in nursing and that it

should then be woven throughout the curriculum and present in all courses. However, participant

conversations revealed, this is not necessarily the current approach to integrating content into the

curriculum. The specific individual teaching strategies that the nurse educators used were

selective and varied and resulted in a heavy reliance on their Indigenous knowledge.

Current vs. desired approaches. The integration of cultural safety can take many forms,

depending on the curriculum philosophy and structure of the program in question. The nurse

educators frequently discussed the current and desired approaches to integration in nursing

education that are required or should be implemented. Not surprisingly, many nurse educators

considered cultural safety a theme that should be threaded throughout the curriculum and applied

to a broad range of topics and areas: *"Rather than being a topic in itself, . . . it just should be part*

of everything we talk about. It's a cross-cutting theme, and I think that's the only really good

way to get it in there" (Participant 2); and

> *Ideally, the best approach is to try and cross-cut as much as you can because otherwise there's just too much information and we don't want things to get lost and you don't want people to see this is something special or the flavor of the month. It has to be built into everything we do. . . . That would be my approach.* (Participant 3

In addition, participants identified the need to use a cross-cutting approach from a

collectivist or systems perspective. For many nurse educators, this approach would take into

account the complexity of nursing education and thus address the integration of cultural safety as

a multisystem challenge. As the following excerpts demonstrate, cultural safety is 'a way of

being' that requires a systems approach to integration into nursing education; it should be an

obligation throughout the institution and faculty to ensure that it is not ignored:

> *Cultural safety is a way of being and we have a culturally safe environment and that everything we do should be infused with that. It's not just a thing we do today or in this class. It's a way of being and that comes from the top of the organization down and throughout... I'm a believer in systems and as one person in a very complex system, I may have some influence with some person at some time.* (Participant 8)

> *You need something that's built into the structure. You don't want it to be dependent on just one person. . . . Nursing is very small, we're small potatoes even though we're huge but within the university we're sidelined and within faculty of health sciences we're sidelined. So it's important that it's embedded deeply into the whole faculty not just within nursing.* (Participant 9)

The nurse educators asserted that there is no one clear-cut way of approaching the

integration of cultural safety, and that nurse educators require commitment from leaders to

support cultural safety integration. Some of the solutions participants proposed included adding

funding to bring in guest speakers and reducing nurse educators' research or teaching loads to

allow them to engage in projects to further the integration of cultural safety. Another highly

recommended approach and solution to integration was the decolonization and Indigenization[5] of

nursing education. Nurse educators viewed this approach as a way of decolonizing colonial

perspectives within nursing education and fostering an Indigenous perspective to Indigenize the

nursing curriculum. However, one nurse educator criticized this approach that many SONs had

adopted as being misinterpreted and implemented only superficially:

> *It's like we're just taking whatever mainstream is and we're just slapping on a medicine wheel and we're saying that's been indigenized now. You can't make something Indigenous, that's something that's inherent in us it's not something you can make. . . . And then the decolonization, we just want to throw that around because it sounds really good but what does that really mean? In most respects, most people don't even understand what colonization is. To decolonize something, you actually have to understand what colonization is. . . . I don't know they're just terms that have been used so much that they've lost all meaning and all sense to me. Instead of just saying "we're going to decolonize our curriculum" what does that really mean? Let's not even say that. Let's just say "we're going to review the curriculum and we're going to look at ways that we can be more inclusive or look at ways that we can encourage or produce cultural safety or cultural humility. (Participant 5*

On the other hand, the current reality of the different approaches to the integration of

cultural safety were far from the vision of both the Indigenous and non-Indigenous nurse

educators, who expressed frustration with the current state of integration because it is

fragmented, uncoordinated, repetitive, and lacks institution readiness. The following excerpts

demonstrate that the desired approaches that the participants mentioned are not necessarily what

is actually happening within SONs to integrate content:

> *I think that what our challenge is that we're not coordinated in what we're doing to meet the TRC call to action that's the most relevant to us. So our students may be getting the same basic information repeatedly by us thinking "yeah I have to do something about it." I think there's probably three courses where there's guest speakers and my hope is that we're going to move to something where it's not just repeated. (Participant 15)*

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[5] *Indigenization* is a process of integrating Indigenous knowledge systems. In the context of postsecondary education, it involves bringing Indigenous knowledge and approaches together with Western knowledge systems (Bopp, Rob, & Brown, 2017).

>*But it's still, my experience there, it was not quite ready to be integrated just yet. There were maybe little threads here and there in different courses and maybe speakers would come in, but there was no specific model at the university.* (Participant 1)

As I stated above, cultural safety content needs to be threaded consistently throughout the curriculum and built upon to ensure that the concepts are translated from the classroom to practice. However, the lack of structure in the curriculum that includes cultural safety concepts in each year of a program, may lead to introductory themes and material being repeated, failing to advance learning about cultural safety. As the following participants pointed out:

>*I can't have an expectation that any of our students have entered this course knowing anything about the climate in Canada, about colonialism, about the Indigenous historical perspective in Canada (..) so every class and year where I talk at all about Indigenous health, it's very introductory and goes over foundational pieces verse it being built on each year.* (Participant 13)

>*Most importantly, it needs to be start of the curriculum as early on as possible so that it doesn't become an after-thought, we are building culturally safe nurses at the start, and it doesn't become something that "okay this is something that I have to do now." It's integrated right from the beginning so it's something that becomes not automatic, but something that is very natural to do.* (Participant 1)

Although threading the content throughout the curriculum is the desired approach, nurse educators recognized the challenge of deciding which content to include in the absence of leadership or curriculum guidelines on cultural safety. As mentioned above, this has resulted in the selective integration of cultural safety concepts. Participants labeled this approach "cherry picking" and criticized it for its selective process rather than truly threading and building on cultural safety concepts throughout nursing education. One participant argued that a selective approach is not conducive to the development of culturally safe nurses and advocated for a multisystem approach:

>*So originally, every site can try and decide what is best for them, you know where and what they want to implement. . . . but we were concerned that we don't want it to be only focused on historical context. Without guidelines it is very easy to cherry pick certain*

> *aspects. However this approach does not give students a very high level of critical thinking of understanding concepts of cultural safety and Indigenous health before they exit to the workforce.* (Participant 13)

Participants acknowledged that the evaluation of cultural safety approaches, is largely ignored. One offered important insight into the need to establish outcome indicators for cultural safety to help ensure that the effectiveness of these approaches is evaluated so that effective approaches can be identified/developed and validated:

> *I find we have even more cultural safety content in our courses but I'm not really sure how we're quantifying those things. . . . We certainly go through and compile all of our course syllabi and go through what's in it but I have yet to see a specific meeting where we're looking at how many hours of content or how specific things and that might be something that needs to happen soon because we've been doing that with other things. Like how much content is about interdisciplinary professional practice and how much is related to the competencies of the RN. So that might be the next step is to look at what are the outcomes we can measure to show that we've actually been doing these things. But yeah that isn't happening yet. . . . We can't really say we're doing it if we don't actually evaluate.* (Participant 5

In summary, it is evident that most SONs are integrating cultural safety content by using various approaches, however, the consensus of the nurse educators was that the desired cross-cutting and multi-systems approach is not currently in place. Lack of leadership and curriculum guidelines make it the nurse educators' responsibility to include cultural safety content themselves. Consequently, current approaches are barriers to the integration of cultural safety because they are fragmented, repetitive, and selective in nature. Finally, approaches to the integration of cultural safety need to be evaluated and outcome measures established to ensure that they are effective and successful approaches can be disseminated.

Teaching strategies. The individual strategies that nurse educators employ are essential to the integration of cultural safety into the classroom. The specific strategies that the participants used varied and included Indigenous literature, Indigenous knowledge and expertise,

peer-colleague support, experiential learning, and audiovisual methods. However, taking the

opportunity to expose their students to different Indigenous narratives and knowledge through

experiential learning was the favored strategy of nurse educators. As many discussed that

exposure left a lasting impression, when students could experience first-hand Indigenous

knowledge, communities, and current realities. As the following excerpts demonstrate, nurse

educators use these strategies inside and outside the classroom: *"Particularly in my first-year*

course on social determinants, I have students doing the blanket exercise so that they're doing

an experiential exercise in learning about the history of Indigenous people in Canada"

(Participant 5); and

> *We would have standardized patients come in, who were Indigenous. . . . I'm sure*
> *traumatic for the standardized patient because we had one of the nursing students do a*
> *cultural assessment. So he's asking her, the mother the person who is portraying the*
> *mother, "so do you eat Moose meat? What is it that you do?" And she was so insulted*
> *and we were behind a two-way mirror and I called a time out and I went in and kind of*
> *changed things. Having to debrief with her afterwards and saying "how much better he*
> *said this to you instead of an actual patient" and now I have an opportunity to actually*
> *address how terribly insulting he was.* (Participant 9

Many educators identified the benefits of this strategy to learning and even in mitigating

potentially harmful behaviors. However, a majority of the nurse educators recognized that the

challenge in organizing such experiences is the development of preestablished partnerships with

local Indigenous communities, which many SONs lack:

> *The other barrier which we are also looking at is trying to provide for our students and*
> *our faculty some clinical experience in this area and perhaps working up in some of the*
> *Northern regions to get some exposure. . . . So the networking component is huge right*
> *now and getting reliable sources and information for people that want to be involved and*
> *see value in the offer but the preparation of these people is something that is a barrier for*
> *us. We're challenged by it.* (Participant 11)

Although experiential learning was the most desired strategy of the nurse educators, the

lack of opportunities in SONs has resulted in a heavy dependency on Indigenous literature,

knowledge, speakers, and audiovisual materials. Educators commonly use Indigenous literature

and other materials for self-learning and as supplemental reading for students in the classroom.

The nurse educators engage students in meaningful discussions that challenge their Western and

dominant ways of thinking about Indigenous health. The participants highly valued Indigenous

speakers as part of these strategies and affirmed that they benefit students' learning: *"You know,*

as a non-Indigenous person speaking about Indigenous health we tried to bring more awareness

to our students in terms of having someone who can actually bring their narrative bring their

stories to the students" (Participant 13); and

> *Well I would have to say I think the impactful way of getting education across, I think storytelling is hugely effective. Every year we have a guest speaker that comes in and talks to all the nurses during nursing week. I can't tell you how impactful the last few were. I would think sharing experiences and just keep talking about it - because once we stop talking about something it just kind of gets thrown on the back burner and then kind of dies off. I think it's just being creative in how you disseminate that information whether it's storytelling, advertising, events.* (Participant 7)

The Indigenous nurse educators often took it one step further by offering individual

teaching to other faculty and students and used their own experiences and anecdotes to arouse

interest. However, this strategy place a larger responsibility on these educators, who described it

as a source of academic burnout:

> *What I find as one of the only Indigenous educators is that a lot of the teaching of cultural safety with Indigenous populations - people ask me to do that, right? At first I used to but now I am just so over stretched.* (Participant 5)

Finally, nurse educators recognized the integration of cultural safety into nursing

education as a process that requires creativity and commitment from all nurse educators in

SONs. It also requires activities that address stereotypes and negative attitudes toward

Indigenous peoples. However, this can be complex for nurse educators who have had minimal

exposure to cultural safety training and education; within the classroom it requires creating a safe

space for all discussions. The nurse educators discussed cultural humility as a strategy to create a

safe space to implement all strategies:

> *Well, I try and model acceptance and curiosity and non-judging and valuing of all my students no matter their history. . . . I find that exciting because I get to learn too. I guess I recognize and probably have increasingly recognized what a white colonial program we might be having here, in spite of our students and the population we serve. How do I do that? I try to be humble. I try to create openness for people being able to talk about or think about other ways of understanding something or issues in relation to, for instance when we're talking about different cases in our PBL classes.* (Participant 8)

> *What I keep trying to get across is that we need to be humble, that's the cultural humility piece of it. The more we know, the more humble we actually should be because we learn that we don't know very much.* (Participant 5)

Despite the challenges and barriers inherent in this process and in the colonial system,

nurse educators have implemented strategies that demonstrate their commitment to and passion

for education and the integration of cultural safety in SONs. Nurse educators identified teaching

strategies that focus on exposure and experiential learning opportunities as key to the successful

challenge of negative stereotypes and attitudes toward Indigenous peoples. However, the lack of

resources and opportunities for these experiences has resulted in a heavy reliance on Indigenous

nurse educators or Indigenous speakers to relate their experiences and stories. Unfortunately, this

reliance is a factor in the burnout of Indigenous nurse educators as they try to integrate cultural

safety and support colleagues also engaged in this work.

Practice (Customs)

Finally, practice is the customary ways of doing something or behaving that is specific to

a culture; in this case, nursing education. In this narrative, practice refers to the response of all of

the above narratives and how the integration of cultural safety has influenced current practices of

nurse educators. In general responses from nurse educators indicate that the integration of

cultural safety is well received and that efforts are underway in most SONs. However, is is also

important to understand that these efforts and the current process are ultimately occurring within

a colonial environment. The colonial discourses and the above narratives show the influence on

how nurse educators apply cultural safety, who is held accountable, and the presence of

structural racism. In the last section I will examine current customary practices within SONs.

      Application of cultural safety. The meaningful application of cultural safety continues

to be impeded in nursing education because those who teach (e.g., nurse educators) commonly

misunderstand cultural safety. The diversity and variation in understandings of the concepts and

terminology with regard to cultural safety were prominent during conversations. All of the nurse

educators were familiar with the concept of cultural safety and recognized it as an important

factor in meeting the needs of Indigenous populations in nursing education. However, these

nurse educators used a diverse range of terminology that referred to similar but different

concepts in incorporating Indigenous health into nursing education: *"I think there are a lot of*

terms that are confusing: . . . cultural sensitivity, cultural awareness, cultural competence,

cultural humility, cultural safety. So there's so many different terms that I think that for students

and faculty it can be confusing" (Participant 13). The inconsistent use of and variation in

terminology and concepts reflects a nonstandardized approach and definition that frames the

process of the integration of cultural safety. This has resulted in the confusion of concepts related

to cultural safety and which are the appropriate concepts and terminology that nursing programs

and educators should use. To add to the confusion, nurse educators frequently referred to *cultural*

competence as a concept that is complementary to cultural safety in nursing education. The

following excerpt highlights this conceptual confusion:

      Within our program learning outcomes for nursing and our curriculum documents we
      have five major learning outcomes and one has to do with culturally competent care. So
      both are threaded through our curriculum. I know we have some quite long discussions
      with one of our faculty members, this is more of her area about "do we call this cultural

> *safety, or cultural whatever" like how is this called and these things mean different things and that's not my area at all.* (Participant 15)

Although cultural competence is a widely accepted term and concept in nursing programs (as well as in practice, research, and policy), the nurse educators recognized the need for SONs to shift from the use of cultural competency to cultural safety. For instance, some of the nurse educators criticized and doubted the sufficiency of cultural competence and similar terms and concepts to recognize their stereotypes, perspectives, understandings, and interpretations of a culture other than their own:

> *For me, that [cultural safety] works a whole lot better than the idea of cultural competence because I can't be competent in everybody else's culture. I can't. I can look at it from the outside and say "okay I think I understand that there are differences here.* (Participant 3)

> *I talk about cultural sensitivity first and how that's a pretty old way of looking at things. And then we talk about cultural competence and the idea that some people think it means you know everything about someone's culture but that's not the way we should think about it now. And then we talk about cultural safety and the idea that culture is always changing and is being shaped by different things. Like I said, power, privilege, economics and all those kinds of things. I try and really emphasize that it involves a lot of self-reflection and thinking about where they come from and who they are and why they have views and biases and stereotypes. And how their history has influenced that as well. I think that's probably the biggest piece I try and put on there is that you have to go for a long walk in the woods and think about who you are and how that's shaped you.* (Participant 2)

Interrelated terms such as cultural competence and cultural safety can be restrictive and reinforce colonial ideologies in nursing education because they fail to acknowledge the underlying power, privilege, and racism that exists in nursing. As well, they are devoid of the critical self-reflection that cultural safety requires to uncover inherent biases that perpetuate the colonial discourses in nursing. The inconsistent terminology and conceptual confusion become problematic for nurse educators with regard to understanding and integrating cultural safety into nursing education. For instance, the nurse educators often leaned toward adopting an

essentialized view of Indigenous culture: *"I guess in my head I'm separating it because I'm considering Indigenous as still Canadian and then someone from another country as foreign. I don't know if that makes sense"* (Participant 12); and

> *I don't think there's really a difference. I think there's perhaps more of an urgency right now to talk about it more in an Indigenous context. I think it's still equally important in an immigrant health context. . . . In Indigenous health, I think it's maybe more broadly applied or I'd be able to more broadly apply it perhaps. I think there's a similarity but personally I feel there's more of an urgency in Indigenous context.* (Participant 2)

Nurse educators commonly reduced culture to a simplistic and culturalist perspective. For example, many offered a similar culturalist and essentialist understanding and definition of cultural safety; as one commented:

> *In general, my definition of it would be your basic definition. People from different cultural backgrounds and ethnicities, whether they're students or community clients or your acute care clients, that they don't feel like they're "othered." That they feel respected and valued and that they don't feel that based on their race that they're going to be treated any differently than anybody else.* (Participant 1)

Not all of the participants shared this popular understanding and application of cultural safety. One nurse educator also feared that the predominant understanding and application of cultural safety tend to center around race:

> *My feeling sometimes is that the predominant understanding of cultural safety is about your race. And that in talking about one patient or family with a different background, that we've sort of got it all covered. I'm allergic to that idea and it worries me a lot.* (Participant 8)

The evident reduction of culture in cultural safety to race and ethnicity remains a challenge for nurse educators and nursing education overall because it can unintentionally increase the stereotyping by conflating race with culture. In addition to this misunderstanding, some of the nurse educators extended cultural safety beyond the Indigenous context and

specifically described it in an immigrant context. As the following excerpts show, its use in this

form focuses heavily on diversity or multiculturalism:

> *I see cultural safety as extending beyond Indigenous people. I've had lots of different people from different cultures who have been, and some of them with a very traumatic background like refugees, victims of war, Vietnam, Eastern Europe, Afghanistan, other places.* (participant 8)

> *They talk about it together and say "oh okay cultural safety is so important for our refugee and immigrant population" and they almost leave out or forget the Indigenous population. I find that very interesting because this whole Indigenous population versus the immigrant and refugee population and why a lot of our instructors - and I think it has to do with what you mentioned, that fear, that unpreparedness because it's so close with Indigenous people versus immigrant and refugees coming in. "Well they're from a different background than I am so cultural safety is so perfect and fits for them" but then completely forget about Indigenous people and why it was created, some not even knowing that cultural safety was created by and Indigenous Maori nurse in New Zealand.* (Participant 5)

Although cultural safety can theoretically and practically be applied to diverse other

populations, the main tenets of cultural safety must be salient to its use. This requires a sustained,

inherent focus on colonization and Indigenous contexts or risks "othering" Indigenous peoples

and racializing cultural safety. The words of the following nurse educators offered similar

criticisms on cultural safety application and emphasized the importance of an Indigenous

context:

> *Multiculturalism in cultural safety, I really have problems with how it's used. . . . We are not part of that multicultural sphere and that's because of the treaties and the fact that the First Nations people were first on this land and living harmoniously with the land. . . . There's a real misguided perspective out there that continues to be perpetuated through education that First Nations and Indigenous peoples are part of this multicultural concept. You know, separate - the "others" separate from the white Caucasian colonial.* (Participant 14)

> *When I hear cultural safety I only think of it from an Indigenous perspective. I never think of it from a non-indigenous perspective and that's just me. I don't talk about it in diversity, I mean we can and I know that articles do talk about that but I guess that's my lens that I come in with. Especially because it's looking at that colonial historical context where I feel like—and it's not to say people from around the world are not facing the*

same type of or same historical colonialism from countries that they are from. But it [cultural safety] is different. It is different in terms of my understanding of the Canadian history. (Participant 13)

I want to come back to the overall making sure that cultural safety and those basic principles are the same no matter what the difference. You know, if it's a diversity of sexuality, if it's a diversity of ability, if it's a diversity of culture, the same general principle I think is true. (Participant 9)

This lack of knowledge, acknowledgment, and application of cultural safety in an Indigenous context is deeply rooted in the colonial perception that the experiences of immigrants (or other diverse cultural groups) and Indigenous peoples are similar and therefore should be grouped together. Without an in-depth understanding of the main tenets of cultural safety, such as how the historical and contemporary power imbalances, racial discrimination, and cultural oppression are manifested in the individual and collective experiences of Indigenous peoples, nurse educators will continue to neglect to apply cultural safety in a meaningful way. Subsequently, the lack of understanding of colonization will continue to frame cultural safety in nursing at a superficial level and will not challenge the entrenched power relations.

Accountability. The perception of accountability in regard to who should be responsible for the integration of cultural safety in nursing education is a struggle for nurse educators. Participants perceived the need for integration in different ways. Some believed that it is the responsibility of leaders and higher administrators within the university, such as deans and curriculum committees:

I would say it is the responsibility of the assistant dean because the assistant dean has the responsibility for the quality of the overall curriculum. Of course, you're pulled in multiple directions but also the associate dean, so the one above her in charge of the school is really responsible to make sure we're accredited. (Participant 9)

There is a responsibility of the school as well and the curriculum committee on that ongoing monitoring piece. We're supposed to put in a course report at the end of each term about how our course went and what some of the challenges were so our curriculum

committee monitors that. . . . For me, everybody should be thinking about maintaining this piece but a lot of it is individual preference (Participant 4)

Others contended that it should be a shared responsibility of all, with support and leadership from administrators and deans at the university. As one nurse educator pointed out, educators are in a privileged position to shape their teaching content but should be held accountable for integrating cultural safety:

> *I think it's shared. ... But then I also think it's obvious, as a faculty member you're in a privileged position where you can kind of shape the content you want to talk about. I think all people who are teaching have a responsibility to talk about cultural safety for sure.* (Participant 2)

The nurse educators deemed this individual responsibility problematic, because their colleagues or other nurse educators who did not show interest, did not see the value in, or did not consider themselves accountable for integrating cultural safety challenged the acceptance of this responsibility. Some nurse educators feared that talking about Indigenous issues would result in hesitancy and the feeling that it would be easier not to teach cultural safety concepts at all:

> *People are too afraid to just have honest conversations, civil conversations and ask questions to each other because they're just scared. Or on the one hand, people might be overly sensitive and on the other hand, people might be scared of hurting the other one's feelings. So everyone just keeps quiet you know what I mean?* (Participant 12)

> *A lot of the educators feel unprepared to teach topics that they're not comfortable teaching. Cultural safety is on that line of uncomfortability because it's asking educators to do a lot of critical self-reflection with their students talking about post-colonialism which can be a tense subject to talk about especially if you're not familiar with a lot of the Indigenous issues in Canada. So a lot of that either gets pushed onto Indigenous faculty to take on that responsibility or anybody else but them.* (Participant 15)

Nurse educators who did not want to take charge or felt fearful about integrating cultural safety content often shifted or delegated the responsibility to others who were more comfortable or willing. Indigenous educators were not necessarily willing to integrate cultural safety into their

teaching, this shift of accountability increased their teaching load and the rate of exhaustion and

burnout. Their frustration is evident in the following statement from an Indigenous nurse

educator:

> *People are still really leery about talking about it, worried about saying the wrong thing, worried about misrepresenting Indigenous people. I feel like that also does a disservice because we can't just not talk about it. It puts a lot of burden on me as an Indigenous educator to be doing all of that extra work. It can be really harmful to my mental health at times because when you're explaining the same things over and over and people aren't getting it, or you feel like you aren't being heard, it gets really frustrating.* (Participant 5)

The preference for Indigenous nurse educators to teach and integrate cultural safety content

effectively removes all responsibility from non-Indigenous educators. As these nurse educators

explained, this continued practice of averting accountability upholds colonial discourses in

nursing and negates the success of cultural safety in nursing education:

> *I would say it's a status quo like "okay we have something in there okay we've done good enough and that's this Indigenous educators problem" because we have somebody - Like passing a potato. Right we have somebody who is here and yes that is her role so no we don't need to worry about it anymore because we have this Indigenous educator.* (Participant 9)

> *Many acknowledge that they just don't know, you know? But at the same time there comes kind of a problem with that because they sort of always look to me to do those presentations about cultural safety or anything Indigenous. That does pose a problem because it takes the responsibility away from them about really learning and acknowledging that history themselves and their responsibility in bringing forth that learning to their students as well.* (Participant 14)

Regardless of how nurse educators perceive accountability, the responsibility largely falls to

nurse educators to integrate cultural safety into nursing education. This is evident in the

curriculum discussed above, support for educators, and the current approaches to integrating

cultural safety. To reiterate for clarity, the prioritization of the biomedical model and overloaded

curricular content; the lack of resources, policies, and committees to support educators; and the

fragmented approach to integration all create an environment that places the responsibility

almost exclusively on nurse educators and predominately Indigenous nurse educators. Thus, the current practice and custom in SONs is to rely heavily on Indigenous nurse educators to lead integration.

Racism. The focus of my study was on the experiences of nurse educators in integrating cultural safety into nursing education; however limited, the experiences and reports of racism in this process were all too common and telling of the current practices in nursing education. The process of integrating cultural safety into nursing education, which is entrenched in colonial discourses, reveals major systemic problems that result in the practice of covert forms of racism. However, covert racism is subtle in nature and very difficult to identify and explain because it presents in discrete ways at all levels in nursing education. Moreover, the nurse educator participants more commonly experienced and acknowledged this form of racism than they did other more direct or overt forms, as the following excerpts show: *"Nonintentional racism exists. I don't have any experiences as a student or as an educator with direct explicit racism, but I have had experiences, many experiences as a student and educator"* (Participant 12);

Another stated *"I don't see that same racism here. I mean, it's not that it doesn't exist; I just might not be hearing it per se. This is what I see in terms of racism in my workplace: It is very hidden"* (Participant 13); and

> *I quite honestly think racism is all around is and subtler in lots of ways. Overt racism I don't see that. But I think there is subtlety in assumptions. When people make comments "they come from wherever they come from" right? So whatever is in their backpack and they make assumptions and they'll make a comment, not intentionally to be racist.* (Participant 4)

Although both non-Indigenous and Indigenous nurse educators made these very revealing statements, the Indigenous nurse educators described in more detail the covert forms of racism, as the following excerpts demonstrate:

Many experiences actually where as a student and educator people have come to me asking me to speak about Indigenous issues. As an educator, I feel that's a little more appropriate but when I was a student I felt really uncomfortable with this because I didn't feel like I was an expert. I think our culture kind of alludes to when you're a youth and when you're a student you're a learner, you're not expected to be an expert in culture and we really look towards the community leaders and elders for that. As a student that made me feel really uncomfortable. At the time, I didn't really process it or think of it as racism but now when I look back I definitely recognize it as a form of indirect racism. (Participant 10)

I'll be sitting there having a discussion about curriculum or whatever and we're all on the same level talking about the same stuff. But the second it comes to Indigenous content, right away it's like we know that we're not part of the group we know that we are being "othered." We're not all saying "oh isn't this great" and looking at everyone and saying "we're going to work with Indigenous communities" instead we're going to look at the 2 Indigenous people in the room. Just the spotlight on us as being not part of mainstream. (Participant 5)

Covert racism is difficult to identify if it is the experience of only one individual and often acknowledged after the fact. This type of racism undermines the integration of cultural safety when it is embedded in nursing practice and reproduced in health care discourses, which makes it difficult to disrupt.

Summary of Results

In light of the results, the four narratives form a conceptual framework for the current process of integrating cultural safety into nursing education (Figure 3). The results of this thematic analysis demonstrate that the experiences of nurse educators who integrate cultural safety is complex. Chapter five illustrates that the colonial discourses persistent in nursing education influence the integration of cultural safety at all levels, as well as the various strategies that nurse educators use in their effort to integrate it. The conversations with nurse educators reveal several barriers in the process of integration.
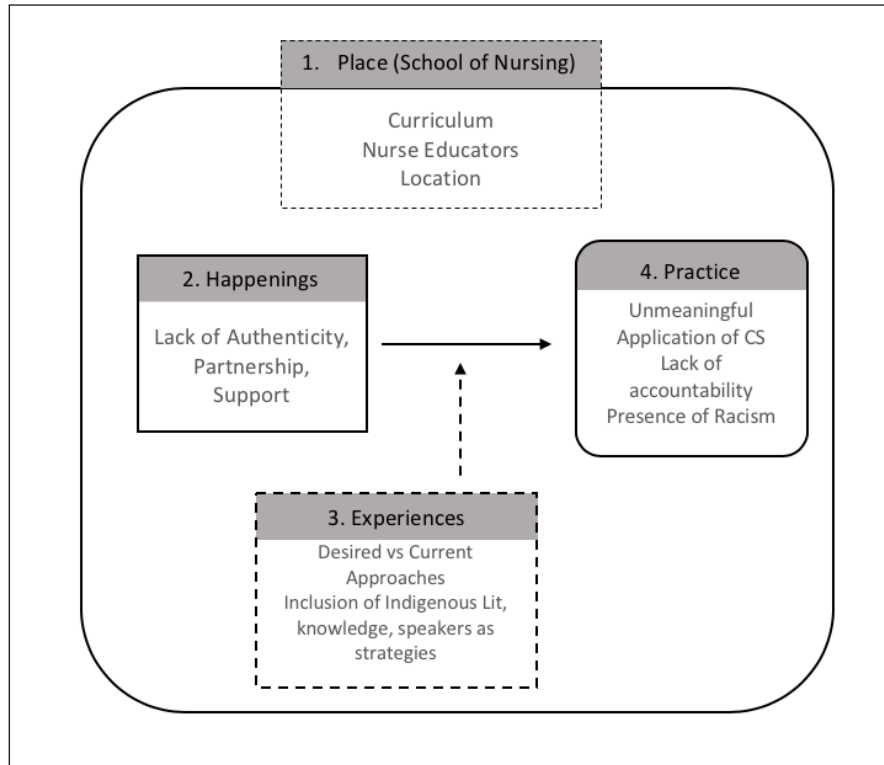
Figure 3. Conceptual framework: Integrating Cultural Safety into
Nursing Education

In the narrative on place, nurse educator participants observed that the colonial discourses

in nursing education that prioritize a dominant Eurocentric knowledge negatively affect the

integration of cultural safety by placing less value, urgency, and place for integration within the

nursing curriculum. This perspective was evident in nurse educators' discussions of the lack of

collaboration and leadership from key decision makers in nursing education, such as those in

professional associations and regulatory bodies external to SONs, and nursing leaders and

administrators within SONs. This lack of collaboration and leadership, coupled with the

overloading of curricular content and prioritization of the biomedical model in nursing

knowledge and courses, led to nurse educators' having greater burden and lack of motivation to

integrate cultural safety concepts. Large class sizes and lecture style presentations are barriers to

achieving this desired approach because they result in a didactic method that does not encourage

sensitive discussions on cultural safety content. In addition, nurse educators felt challenged by

their settler identity and lack of experience with and knowledge of Indigenous peoples and

cultural safety, which manifested in the form of fear and discomfort. Collectively, these factors

support the continued dissemination of colonial discourses throughout all levels of nursing

education and hinder the integration of cultural safety.

As discussed in the happenings narrative, the absence of structural elements such as

resources, policies, and committees leaves nurse educators to their own devices to integrate

cultural safety with little support and has resulted in the integration of cultural safety in a

superficial manner because it is often pushed aside or selectively integrated. Furthermore, the

lack of authenticity of nurse educators and leaders is a barrier to the creation of partnerships with

local Indigenous communities' partnerships that could enable access to Indigenous knowledge,

expertise, and support.

The experiences of nurse educators offer insights into desired approaches and strategies

to integrate cultural safety. Participants highly desired that cultural safety be threaded throughout

the curriculum as a cross-cutting theme. They criticized the current state of integration as

fragmented, repetitive, and lacking readiness from the university. Nurse educators identified

teaching strategies that focus on exposure and experiential learning as key to integrating cultural

safety and challenging the entrenched stereotypes and attitudes regarding Indigenous peoples.

However, the lack of preestablished partnerships and opportunities for both educators and

students in SONs is a barrier to this strategy that leads to heavy reliance on Indigenous nurse

educators to supplement the exposure to Indigenous narratives.

Finally, these colonial discourses and the above narratives highlight how nurse educators

are integrating cultural safety and the reality of the current practice of cultural safety in nursing

education in Ontario SONs. For example, current contextual barriers include confusion and inconsistency regarding cultural safety terminology that has left educators with insufficient understanding of cultural safety to challenge the entrenched power relations in nursing education. Furthermore, the meaningful application of cultural safety continues to be impeded because nurse educators themselves have an essentialized and culturalist view of Indigenous culture. For Indigenous teachers, working in a colonial setting and with programs that are deeply focused on biomedical and Eurocentric content implies significant difficulties such as racialization, tokenism, racism, and othering. For these educators, having to assume the responsibility for integrating cultural safety in such a context is a form of indirect racism. This form of racism and heavy reliance on accountability has negative consequences for Indigenous nurse educator health and well-being. In this study, non-Indigenous educators described a level of ignorance that manifests in avoidance and a feeling of unpreparedness in the face of cultural safety content. As a result, they found it difficult to create authentic links with Indigenous peoples and communities within the SON, may have perpetuated racism through their teaching, and reported being poorly equipped to teach cultural safety content. Fear expressed by non-Indigenous nurse educators was also noted and validated by Indigenous educators. Fear may be authentic or insincere and enable avoidance – both perspectives need to be addressed and are beyond the scope of this study.

In summary, nurse educators reported heavy workloads and overloaded curriculum that impedes their ability to proceed with or sufficiently integrate cultural safety. Overall, they report being unprepared, with limited supports and resources, and lofty expectations to meet in this process of integration.

CHAPTER SIX: DISCUSSION AND IMPLICATIONS

The harmonized analysis of the nurse educators' stories revealed common themes and barriers to the integration of cultural safety in nursing education. My research questions were as follows: (a) What is nurse educators' experience of integrating and utilizing cultural safety concepts in Ontario schools of nursing? (b) what behaviors and institutional factors are barriers to the integration of cultural safety in nursing education? (c) what factors support the integration of cultural safety into nursing education? and (d) what strategies or approaches do nurse educators consider successful in the integration of cultural safety in the classroom and into the curriculum?

The perspectives and insights of nurse educators highlight the complexities and intersectionalities experienced in integrating cultural safety with colonial and institutional structures, traditional biomedical models of health, and structural violence and racism within nursing education. These findings suggested four key themes for discussion: (a) the integration of cultural safety is currently incompatible with nursing education, (b) cultural safety is a concept that is not well understood, (c) decolonization and Indigenization are problematic solutions, and (d) micro-reconciliation is a possible pathway to the integration of cultural safety into nursing education. This discussion of the key themes is guided by the postcolonial and decolonization lenses that I described in the methods, and I will relate the findings from the key themes to the research questions and literature that I presented in Chapter Two. Following the discussion, I present the implications derived from this study for nursing education, practice, policy, and directions for future research. The limitations of the study conclude this chapter.

Discussion of Themes

Cultural safety is insufficient within current SON structures and practices. The findings from this study show that the institutional strategies and approaches to integrating cultural safety into nursing education are currently insufficient and incomplete. Health and healthcare are founded on Eurocentric knowledge and the traditional biomedical view that is pervasive in nursing education (Browne et al, 2009). These colonial and biomedical contexts in nursing education (including professional nursing associations and regulatory bodies that govern and guide nursing education) create conditions and barriers that do not allow for the full integration of cultural safety content and frameworks, and result in this process currently being insufficient and incomplete. Participant nurse educators' descriptions of these barriers indicate that the nurse education system and organizational policies and processes of nursing education affect the uptake and integration of cultural safety by nurse educators and in nursing education. Findings from this study also suggest that nurse educators who have inadequate support and resources are integrating cultural safety selectively, superficially and precipitously or not at all. Finally, attempts to integrate cultural safety into nursing education superficially amplify forms of structural violence[6] against Indigenous nurse educators. Indigenous nurse educators labeled such attempts as covert or silent racism that manifests in ways such as tokenism, racialization, and the othering of Indigenous nurse educators.

Although the nurse educators considered cultural safety important and urgent because of the release of the TRC's (2015a) Calls to Action, their conversations revealed that the structural changes necessary to respond to calls to action were not evident. Thus, the integration of cultural

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[6] *Structural violence* in nursing is defined as indirect forms of violence that are inherent within structures and institutions, and includes the persistent, systemic devaluation, marginalization, or exploitation of individuals (Choiniere, MacDonnell, Campbell, & Smele, 2014)

safety into nursing education is a noted priority challenge for nurse educators because of the existing structures in SONs that further constrain their ability to implement the process of integration. In an environment where time and system pressures dominate, a majority of the nurse educators asserted that these pressures have hindered their ability to successfully integrate and prioritize cultural safety content in the classroom. The nurse educators identified system and time pressures that arise from the overloading of content in curriculum, large classroom sizes, and lack of professional time to prepare. These findings corroborate the findings of a similar study on the incorporation of cultural competence and safety in nursing curricula from the perspective of nursing deans. In this study, Rowen et al. (2013) identified parallel system pressures, insufficient resources, and the lack of support from SONs as structural barriers that lead to unsuccessful attempts to integrate cultural competence and safety into nursing curricula. In addition, Bopp, Brown, and Robb (2017) reported that one of the main failures in integrating Indigenous knowledge in academia is the ghettoization of Indigenization processes (such as cultural safety). The authors described ghettoization as underfunding and limited resource allocation in academic environments and identified the perceptions of such processes as temporary or as a "special initiative" (p. 3) outside the normal budget. The ghettoization of cultural safety is currently evident in SONs as a result of structural barriers and the lack of resources and support for nurse educators. A few SONs in which nurse educators reported some degree of funding resources, support, or access to Indigenous expertise demonstrated higher levels of engagement of nurse educators in integrating cultural safety. For instance, this was observed when SON had experiential learning opportunities and partnerships with Indigenous communities. However, these nurse educators also stated that more effort is still required because the existing financial resources and supports are time limited or hard to access.

Lack of leadership is another aspect that continues to ensure cultural safety is not prioritized (and ghettoized) in nursing education. Leadership (in addition to support and resources) in SONs influence the individual efforts of nurse educators and prevents the ghettoization of cultural safety. However, when leadership was absent or lacking, nurse educators reported that they or others in the nursing faculty do not have a sincere interest in integrating cultural safety into nursing education, which they labeled *inauthenticity*. Rowan et al. (2013) stated that leadership in SONs at administrative and faculty levels is important to setting precedence and prioritizing cultural safety in nursing education. The overall lack of leadership, support, and resources in part explains the inauthenticity reported by nurse educators. However, the general lack of awareness of nurse educators and education leaders regarding the importance of cultural safety also results in inauthenticity. As Bopp, Brown, and Robb (2017) stated, those who work in postsecondary institutions do not know enough about Indigenous Peoples in Canada and the role of the history of systemic oppression and cultural genocide in the current realities. Browne et al. (2009) also contended that nurse educators with limited education and lack of support to engage in conversations on marginalization, racism, and oppression (required topics in addressing cultural safety content) are not capable of facilitating culturally safe discussions in the classroom. For instance, the most common themes with the nurse educators in this study were the fear and lack of confidence in teaching cultural safety content that stems from their lack of awareness of and knowledge of Indigenous Peoples. This finding supports Wepa's (2003) study on the experiences of cultural safety educators in New Zealand, where she too identified the feeling of unpreparedness to teach cultural safety as a major barrier.

However, Jeffs (2001) argues that the major difficulty in teaching cultural safety is not related solely to the knowledge and unpreparedness of educators, but also to the lack of support.

For example, the nurse educators in this study viewed the lack of leadership to encourage or

support access to cultural safety training or education in SONs as the reason for the reluctance of

nurse educators to gain the necessary skills and knowledge to increase their confidence in

teaching this subject. Even where institutional support is present, this need for confidence brings

attention to the issue of how to improve and gain skills and knowledge related to cultural safety

or Indigenous health. Ewen, Paul, and Bloom (2012) state a common assumption is that

improving educators' knowledge, skills, and attitudes through cultural safety training or

education will lead to improvements in these areas. Although nurse educators in this study

shared this assumption, many directly linked exposure to Indigenous communities and culture to

bringing about the most effective change in improving their knowledge, skills, and attitudes

toward cultural safety. As the literature and this study have demonstrated, exposure and

experiential learning opportunities are the most critical and impactful actions to achieve positive

outcomes for the integration of cultural safety and prepare nurse educators (Arnold, Appleby, &

Heaton, 2008; Kurtz et al., 2018; Nairn, Hardy, Harling, Parumal, & Narayanasamy 2011).

In addition, researchers reported that authentic partnerships with Indigenous communities

support the integration of cultural safety through the sharing of knowledge, expertise, and

experiential learning, and are essential to enable educators (and students) to gain a deeper

understanding of the colonialism, racism, and discrimination that currently affect Indigenous

Peoples (Bopp, Brown, & Robb, 2017; Guerra & Kurtz, 2017; Rowen et al., 2013). Arnold,

Appleby, and Heaton (2008) specifically highlighted that the creation of these experiential

learning opportunities requires authentic partnerships, trust, and a collaborative process between

the institution and the Indigenous community. Findings from this study suggest that the

inauthenticity of SONs and leadership within, hinders the creation of authentic partnerships with

Indigenous communities. Thus, a possible solution is twofold. First, creating experiential

learning opportunities for educators should be the standard approach, accompanied by cultural

safety training, to address educators' fear and lack of confidence in teaching and integrating

cultural safety content into nursing education. Second, SON leadership at the administrative and

faculty level is critical in giving nurse educators the support and resources they require to access

experiential learning opportunities and create authentic partnerships with Indigenous

communities.

Aside from the institutional constraints, nurse educators continue to work within their

ability to integrate cultural safety into nursing education. However, for the integration of cultural

safety to be successful in nursing education, institutional commitment in the form of leadership

and support is certainly needed to move beyond the knowledge that nurse educators can gain

from one or several training workshops, lectures, or seminars on cultural safety. This shift is

required at the educational level, which involves curriculum, policies, and practices. As the

literature demonstrated, uncertainty exists with regard to the best approaches and strategies to

integrate cultural safety into nursing education (Ewen, Paul, & Bloom, 2012; Horvat et al., 2014;

Mazel & Anderson, 2011). Nurse educators in this study held similar concerns, identifying the

best approach as one that is comprehensively threaded throughout the nursing curriculum and

policies that support cultural safety practices in nursing education. However, the most common

strategy to integrate cultural safety into nursing education is to adopt a selective approach, or to

'cherry-pick' the cultural safety content. The nurse educators described this in their approaches

and teaching strategies, such as including Indigenous literature and inviting Indigenous speakers

selectively and periodically. In the nurse educator narratives, reports of , selectively integrating

cultural safety rather than comprehensively threading it throughout all of the courses and

curriculum is consistent with the literature that Indigenous health concepts tend to be integrated

opportunistically and ad hoc (Ewen, Paul, & Bloom, 2012; Guerra & Kurtz, 2017; Kurtz et al.,

2018). As a consequence, many of the teaching strategies that nurse educators used are a result of

being left to their own devices to implement cultural safety integration with limited support and

little guidance.

Furthermore, nurse educators reported that professional associations' and regulatory

bodies' muddling of cultural safety concepts has added further barriers to and nursing

education's adoption of a less selective approach compared to implementing a systematic

approach to cultural safety integration. The results of this study reaffirm the lack of

standardization of cultural safety concepts and frameworks in nursing education; as a

consequence, nursing education employs various terms associated with cultural safety (Guerra &

Kurtz, 2017; Rowan et al., 2013). Despite the problematic dimensions of cultural competence as

a concept, the limitation of cultural competence to skill development, and the lack of action to

address health inequities or racism in healthcare (ANAC, 2009a; Brascoupe & Water, 2009;

Gustafson, 2005), the literature on cultural competency and its presence in nursing education are

still dominant. Evidence from the literature review and conversations with the nurse educators

reveal that the concurrent use of cultural competence and cultural safety blurs the distinction

between the two concepts and hampers the advancement of integration and the conceptualization

of cultural safety in nursing education. Because this area of knowledge is continuously changing,

and multiple parties rapidly adapt and create concepts, it is challenging for nurse educators to

identify the most appropriate strategies, approaches, or frameworks to integrate cultural safety.

Thus, there is a strong and urgent need for professional associations, regulatory bodies, and

SONs to guide the integration of cultural safety collaboratively, using a standard approach, rather

than leaving nursing education and nurse educators to devise their own approaches and strategies. There is also an opportunity to uphold the leadership and expertise of CINA, specifically with regard to ANAC'S (2009a, 2009b) two documents that include a literature review and framework for the integration of cultural safety into nursing education.

Finally, a consequence of the barriers and inconsistent attempts to integrate cultural safety into nursing education is the larger responsibility placed on Indigenous nurse educators to lead this process. As described above, nurse educators are often left to approach integration in their own way. The fear and lack of confidence of many nurse educators means that the responsibility is almost always placed or passed on to Indigenous nurse educators. The challenges that the Indigenous nurse educators in this study face reflect those in the literature with regard to the responsibility of racialized Indigenous scholars to take on or lead Indigenization initiatives (such as integrating cultural safety or teaching cultural safety content), to meet the needs of Indigenous students, to serve as representatives of their culture, or to act as mediators between Indigenous issues and institutions (Bopp, Brown, & Robb, 2017; Fan, Jeethan, Lao, Luc & Rehal, 2017; Henry et al., 2017; Martinez, Chang & Welton, 2017). The findings of this study confirm the presence of the racialization of Indigenous nurse educators as a form of silent or covert racism. Indigenous nurse educators identified racism, although it is subtle, from their experiences of structural violence, tokenism and othering within their SONs. The Indigenous nurse educators contended that such processes overtax their time and work, yet they are continuously tasked with navigating the space between being educators with a full teaching commitment and being obliged to educate colleagues or others (Martinez, Chang & Welton, 2017). A common perspective was that the representation of Indigenous nurse educators in nursing education is insufficient to address the needs of integrating cultural safety adequately.

Nursing education would certainly benefit from more Indigenous educators, but only if educational institutions do not continue to marginalize them by tokenizing them. However, this is difficult due to the Indigenous diversity gap in postsecondary education as Indigenous Peoples make up only 1.4% of university professors (Smith & Bray, 2019). Because Indigenous faculty members do not form a robust cohort in SONs, Indigenous nurse educators are still at risk of being further racialized, tokenized and experiencing structural violence. Continuing with an approach that focuses only on recruiting more indigenous nurse educators will risk maintaining the status quo of allowing non-indigenous educators to avoid their responsibility to engage in integrating cultural safety rather than developing their knowledge and abilities around cultural safety.

In summary, until the integration of cultural safety into nursing education receives the financial resources and institutional support that it needs, nurse educators will continue to be constrained by the structural and organizational pressures and barriers that do not adequately prepare or support them in doing this work. In addition, the presence of unchallenged dominant colonial discourses that influence and maintain experiences of structural violence and racism by Indigenous nurse educators, cultural safety will continue to exist on the margins of nursing education.

Cultural safety—a concept not well understood. Cultural safety originated from the concept of *biculturalism*, which refers to two distinct cultural groups in New Zealand, Maori and non-Maori, and their relationship with the Crown (Ramsden, 2002). This bicultural relationship is reflected in a definition of cultural safety that counters situations that arise from the disempowerment of or discrimination against one ethnocultural group because of another's actions and healthcare system (Ramsden, 2002; Wepa, 2003, 2005). In the Canadian context,

cultural safety tends to focus on multiculturalism, the presence of many cultural groups often

viewing them as equal in importance (Brascoupe & Waters, 2009; Browne et al., 2009).

However, as the literature has shown, the shift to multiculturalism challenges the integration of

cultural safety into nursing education because of nurse educators' misunderstanding of culture in

cultural safety (Anderson et al., 2003; Brascoupe & Waters, 2009; Browne et al., 2009; Browne

& Varcoe, 2006; Cox, 2016; Dion, Stout & Downey, 2006), which was also noted among nurse

educators in this study. Researchers have stated that these misunderstandings are a result of the

culturalist and egalitarian discourses that multiculturalism promotes. For instance, Browne et al.

argued that the multicultural discourses dominant in Canadian society promote egalitarian and

culturalist discourses that mask the history of the colonization in Canada and their impact on

Indigenous Peoples today. *Culturalist discourses* refers to the processes of viewing people

through the lens of culture; the term is narrowly defined as shared values, beliefs, and practices

(often conflated with ethnicity) and involves the use of stereotyped representations of Indigenous

Peoples as the primary lens for understanding culture in nursing education (Browne & Varcoe,

2006; Gustafson, 2008). Egalitarian discourses situate all cultures as equal, as well as the

coexistence of cultural differences as equal (Brascoupe & Waters, 2009; Browne et al., 2009).

These egalitarian and culturalist discourses hinder nurse educators' meaningful application of

cultural safety to nursing education.

First, culturalism – the reduction of culture in cultural safety to race and ethnicity—

remains a serious obstacle for nurse educators and nursing education overall. According to Gray

and Thomas (2006), the common cultural models or theories in nursing education are

underpinned by more culturalist ideologies that encourage the development of cultural

knowledge and skills regarding race or ethnicity. Although this general information might help to

understand cultural differences, culturalist approaches have the potential to maintain the prescriptive views of culture and perpetuate stereotypes and assumptions harmful to Indigenous populations. In this study, many nurse educators denounced the use of dominant cultural care models and theories, such as Campinha-Bacote's (2002) model of cultural competence and Leininger's (1978) theory of transcultural nursing. A few of the nurse educators contended that these cultural models and theories focus on cultural knowledge and skills and mask the political and historical power inequities and current reality of Indigenous Peoples in Canada today. However, nursing education maintains these culturalist approaches to understanding culture in cultural safety in course materials such as textbooks and case scenarios. My findings show that a shift is occurring to redevelop and rewrite textbooks and case scenarios through a cultural safety lens, but the shift is slow and not occurring concurrently at each SON. For example, the nurse educators describe access to new course material as limited, and both case scenarios and textbooks that are commonly utilized present Indigenous Peoples' culture and health from a deficit-based approach that perpetuates views of Indigenous peoples through their traits, attributes, and health statistics that stereotype all Indigenous peoples as inherently sick and damaged (Allan & Smylie, 2015; Stansfield & Browne, 2013). The implication of using nursing textbooks and case scenarios focused on a deficit-based approach is the unconscious increase in stereotyping through conflating race and ethnicity with culture. As Vandenberg and Kalishuck (2014) explained, these case studies allow students to explore differences, but they do not encourage the critical analysis of how culture is identified and constructed. This limited conceptualization of culture helps to sustain culturalist discourses in nursing and has little impact on the conditions that affect the health of Indigenous people. In other words, current nursing textbooks and case scenarios which SONs rely on do not give nurse educators (or their students)

the tools to critically self-reflect on their own understandings of culture or understand

colonization and its social, political, or economic effects on Indigenous peoples in Canada.

Another cultural discourse harmful to the application of cultural safety in nursing

education is egalitarianism. In this study the nurse educators tended to view cultural safety

through a diversity or multicultural lens. For instance, their predominant understanding of

cultural safety was that it is intended to ensure that people of all cultures and ethnicities feel safe

and that, based on their race, they will not be treated differently. As McGibbon et al (2014)

pointed out, in nursing, acceptance of this widely adopted discourse of multiculturalism prevents

nurse educators from confronting colonialism. Multiculturalism specifies that all are equal and

that cultural differences coexist equally. Yet, hidden within multiculturalism, egalitarianism

eliminates any critical analysis of these differences and their effects on the health of Indigenous

populations (Brascoupe & Waters, 2009; Browne et al., 2009). By treating everyone as equal,

nurse educators might unconsciously assimilate their students into the ways of the dominant

culture. As Browne (2005) explained, it is easier for nurse educators to adopt an egalitarian

discourse in certain circumstances (such as the institutional and organizational barriers noted

above) that does not encourage the critical analysis of the concepts of culture.

Reports from Browne (2005) and McGibbon et al. (2014) corroborate the findings of this

study, in that a majority of the nurse educators favored an egalitarian approach to cultural

safety—one applied to all cultures—rather than addressing how the historical and contemporary

power imbalances, racial discrimination, and cultural oppression are manifested in the individual

and collective experiences of Indigenous Peoples in Canada. Moreover, Brascoupe and Waters

(2009) contended that multicultural perspectives, specifically egalitarianism, make culture

invisible by obscuring and disregarding culture between people and merging it into the notion of

diversity. This lack of acknowledgment and application of cultural safety in an Indigenous context is deeply rooted in the multicultural perception that other diverse cultural groups and Indigenous Peoples' experiences are similar and therefore should be grouped together.

In chapter four of this thesis I stated that I am troubled with the commonly held perspective of our participant nurse educators that extends cultural safety beyond Indigenous populations in a way that almost erases them or groups Indigenous Peoples with immigrants or other diverse cultural groups. Battiste (2013) positioned the experiences of immigrants in relation to assimilative education differently from those of Indigenous Peoples:

> Immigrants, including refugees, make their way to Canada knowing that they will have to learn a particular culture. For some, the choice of living in a culturally similar community or having a school that guides them along the way helps them make this transition. (p. 24)

In addition, many scholars have suggested that paralleling Indigenous colonized experiences to those of immigrants or other diverse groups significantly risks further marginalizing Indigenous Peoples (Brascoupe & Waters, 2009; Browne et al., 2009; Cox, 2016; McGibbon et al., 2014).

It is clear that these cultural discourses do not pay enough attention to the colonial past of Indigenous peoples in Canada that includes, for example, the assimilative policies aimed at stripping away Indigenous culture and identity. Furthermore, Henry et al (2018), highlighted that new immigrants to Canada quickly adopt colonial attitudes that devalue Indigenous Peoples, which is reinforced in their countries of origin where Indigenous Peoples remain the most vulnerable and marginalized globally. To put it simply, adopting cultural safety in a Canadian context mitigates the widening health disparities between Indigenous and non-Indigenous Peoples. Similarly, in New Zealand, cultural safety helped the Maori people to challenge entrenched forms of racism and oppression in healthcare and address the widening health disparities between Maori and non-Maori people. Cultural safety in nursing education is an

avenue through which to educate the next generation of nurses and educators and to challenge racism, discrimination, and unconscious biases that negatively affect Indigenous Peoples' health. For these reasons an Indigenous context must remain the focus in regard to the integration of cultural safety into nursing education in Canada.

However, the question remains, how can nurse educators engage with the concepts of culture without reproducing the culturalist and egalitarian discourses. Browne et al. (2009) argued that in this process of disrupting culturalism, the focus is misplaced on the need for more cultural knowledge: "Without a solid understanding of how culture itself is conceptualized in cultural safety, the risk lies in unintentionally implying that what is needed is more cultural knowledge typically narrowly interpreted in culturalist terms" (p. 173). Thus, the challenge is not to encourage nurse educators to gain more cultural knowledge, but rather to conceptualize cultural understandings that are foundational to cultural safety. Scholars specifically conceptualize culture in cultural safety as not built on knowledge and understanding of Indigenous culture, but instead on the colonial history and political, social, and economic conditions that impact Indigenous Peoples' mistrust of healthcare (Dion Stout & Downey, 2006; Ramsden, 2002). Although cultural safety can be applied to other diverse cultural groups, the main tenets of cultural safety need to remain salient, with a foundation acknowledging the historical colonial Indigenous experience and the root causes of health inequities, and redistributing power imbalances inherent in healthcare and health professional education.

However, even with this push from decades-old literature in which researchers sought to maintain the critical cultural roots of cultural safety, confusion still exists, as this study shows. In Australia, where cultural safety has been applied for over 30 years, Johnstone and Kanitatsaki (2007) reported that the culturalist and egalitarian views of culture in cultural safety were a

problem evident in education and practice at that time. Furthermore, in New Zealand, the birthplace of cultural safety, culture remained confusing for educators because simplistic notions of culture that focus on ethnicity rather than on complex power relationships were dominant and troubling (Ramsden, 2002). Egalitarian and culturalist discourses were identified and examined in nursing and nursing education for more than two decades, yet they persisted and remain mostly unchallenged. Findings from this research confirm the pervasiveness of these discourses in nursing education, through the curriculum, nursing materials, and textbooks, and which nurse educators reported to be a major obstacle to the integration of cultural safety into nursing education. The question is then how to challenge these cultural discourses that continue to exist and hinder the integration of cultural safety into nursing education. Eurocentrism, the colonial nature of nursing, and the shortcomings of nursing cultural care models and theories suggest the best approach might be one that directly challenges the colonial system itself. Many nurse educators suggested the Indigenization and decolonization of nursing education to challenge these cultural and colonial discourses and to further support the integration of cultural safety.

Decolonization and Indigenization, a problematic solution. In order to challenge racism and colonialism in nursing education many scholars, as well as the participants in this study, have pointed to the decolonization and Indigenization of nursing education as a way to integrate cultural safety (McGibbon et al, 2014; Vukic, Gregory, & Martin-Misener, 2012). It is clear that actions are required at both the individual and the system level to address the colonial nature of nursing education —an approach that continues to be grounded in Western biomedical hegemony and culturalist and egalitarian discourses (McGibbon et al., 2015; Stansfield & Browne, 2013). Whether for Indigenization and/or decolonization approaches, the meaning and intentions of these concepts must be unpacked. The literature highlighted that the terms

Indigenization and *decolonization* are often used interchangeably, and multiple definitions have emerged; however, according to Indigenous scholars (Alfred, 2009; Alfred & Corntassel, 2005; Pete, 2015), the terms and concepts represent separate and interrelated processes. As McGibbon et al. (2014) explained, decolonization is a promising solution to help the nursing profession to address the health needs of Indigenous Peoples. These authors defined decolonization as follows:

> The decolonization process involves affirming and activating paradigms of Indigenous knowledge to reveal the wealth of Indigenous languages, world views, teachings and experiences, all of which are systematically excluded from history, from contemporary educational institutions and from Eurocentric knowledge systems. (p. 182)

The goal of decolonization is not to reach a prestate colonialism, but to value and revitalize Indigenous knowledge and approaches, to identify colonial practices, and to surpass the boundaries that colonization imposes (Vukic, Gregory, & Martin-Misener, 2012). In simpler terms, decolonization involves dismantling colonial structures that perpetuate the status quo, problematizing dominant cultural discourses, and addressing unbalanced power dynamics. Indigenization is a process of normalizing Indigenous knowledge systems and making them evident in institutional spaces (Gaudry & Lorenz, 2017). In nursing education, this involves bringing Indigenous knowledge and approaches together with biomedical knowledge systems. It is important to note that Indigenization does not mean making something Indigenous. As one of the participants stated, simply incorporating Indigenous symbols such as the medicine wheel does not equate to Indigenization. Rather, Indigenization involves weaving together two distinct knowledge systems so that learners can come to understand both (Gaudry & Lorenz, 2017). Furthermore, as Antoine et al (2019) stated, "Decolonization is a component of Indigenization, because it means challenging the dominance of Western thought and bringing Indigenous thought to the forefront" (p. 4).

Theoretically, decolonization and Indigenization ensure the success of cultural safety in nursing education because they directly address and dismantle colonial discourses such as culturalism and egalitarianism, which are barriers to the conceptualization and integration of cultural safety. Nurse educators in this study suggested that nursing education be decolonized and Indigenized at different levels, such as at the level of educators, the content of nursing textbooks and scenarios, the academic structure, and professional associations. Decolonizing nurse educators' thinking would uphold the value and integration of Indigenous knowledge to ensure that it is accepted as valid and foster the prioritization of teaching cultural safety content in an Indigenous context. Decolonization and Indigenization would also help to label systemic and covert racism in SONs and address the structural violence experienced by Indigenous nurse educators through a commitment to exposing colonial discourses and structures. Decolonizing the content of textbooks would also integrate Indigenous knowledge from the point of view of the 'colonized.' The creation of authentic partnerships with Indigenous peoples would help decolonize the academic structure and professional associations. In academia, this means recognition of the expertise of individuals who do not necessarily possess qualifications from the Western academic system (e.g., Elders, traditional healers, community health workers, mental health workers, etc.). Decolonization at the level of professional associations means recognition of their expertise and the establishment of genuine partnerships between Indigenous and non-Indigenous associations. Collectively, these initiatives emphasize the incorporation of Indigenous ways of knowing, being, doing, and relating in academic spaces and provide a tangible path for the success of cultural safety in nursing education. However, the conversations with nurse educators highlighted the tensions around these two concepts, Indigenization and

decolonization, and many criticized the lack of meaning behind each concept as a factor in the

shortfall of these concepts in nursing education.

The problematic nature of decolonization and Indigenization is not with the concepts

themselves, but rather with the way in which postsecondary institutions (including SONs) have

taken them up. Tuck and Yang (2012) articulated the problematic nature of decolonization as a

metaphor in academia:

> We want to be sure to clarify that decolonization is not a metaphor. When metaphor
> invades decolonization, it kills the very possibility of decolonization; it recenters
> whiteness, it resettles theory, it extends innocence to the settler, it entertains a settler
> future. Decolonize (a verb) and decolonization (a noun) cannot easily be grafted onto pre-
> existing discourses/frameworks, even if they are critical, even if they are anti-racist, even
> if they are justice frameworks. The easy absorption, adoption, and transposing of
> decolonization is yet another form of settler appropriation. (p. 3)

This critical perspective on decolonization contests the very way that nurse educators approach

decolonization and Indigenization, and described it as re-centering its focus on White settler guilt

and fragility. For instance, the perspectives of the nurse educators on the use of these processes

as approaches to the integration of cultural safety into nursing education could be perceived as

their attempt to reconcile their own White settler guilt with colonization. Furthermore, we cannot

underestimate the complexity of nursing education that nurse educators described and where

decolonization and Indigenization best fit in nursing education is also complex and multilayered.

For instance, Bopp, Brown, and Robb (2017) explained that

> complex is like raising a child or ending AIDS in South Africa. There are many variables
> that cannot be predicted or controlled. There are subtle undercurrents that can sweep
> aside diligent efforts to reach a goal, . . . and Indigenization within a post-secondary
> institution in 21st-century Canada is a complex adaptive systems transformation problem.
> (p. 5)

The subtle undercurrents are the colonial discourses in nursing education. Thus, the view that

nursing education can easily adopt decolonization and Indigenization processes to dismantle and

disrupt these colonial discourses is problematic because it supports Tuck and Yangs's (2012) discussion of the problematic nature of decolonization as a metaphor with simplistic strategies and work on behalf of settler academics' desire to quickly reconcile.

Although, the concepts of decolonization and Indigenization are part of my discussion of approaches, strategies, and solutions to integrate cultural safety into nursing education, the findings are limited because the examination and critique of these concepts were not the aim of my research with nurse educators. However, some voiced a similar criticism that attempts to decolonize and Indigenize nursing education are superficial. This superficiality is supported in the literature, where many scholars have criticized the current forms of Indigenization and decolonization as superficial and meaningless because of the lack of consideration of their complexity and the systems approach that these processes require (Bopp, Brown, & Robb, 2017; Gaudry & Lorenz, 2017; Tuck & Yang, 2012). Furthermore, Courchene (2019) described decolonization and Indigenization as buzzwords that benefit the colonizer and settler culture to enable them to claim a commitment to reconciliation, but they will not create the change needed for cultural safety. To further illustrate and support these statements, I present an example of an experience that my mother, an associate professor in nursing, recently had while smudging at her office in a SON. Before smudging, she had asked every person in her office for permission to smudge behind closed doors. She did not have to ask each individual for permission because the institution allows the practice of smudging on campus. Once she received it, she closed the door, opened the window, and began to pray during her smudge. Her sacred moment of prayer was abruptly interrupted shortly after she began when she noticed exaggerated sounds of coughing and people pacing outside her door. Confused at the sudden turn of events, she continued but was interrupted again shortly thereafter when campus security appeared outside her window. When

my mother put her smudge away and opened her door, she found a blanket covering the floor

outside the door. Even though she was frustrated with her colleagues' behavior, my mother, an

empathic woman, e-mailed everyone in her office to apologize for smudging. Although her

university's policy supported smudging, the dean of her department sent her an e-mail with

concerns about a colleague's allergies and requested that my mother smudge outside. Even more

frustrated, she did not want to create further problems, so she complied with the dean's request.

This narrative is not unique to my mother. Indigenous people still have to seek

permission to smudge and pray in these colonial spaces. Even spaces in which smudging is

allowed are subject to further rules and regulations. As this example illustrates, institutions that

may have taken up the efforts of Indigenization and decolonization are ultimately still located

within colonial spaces and can be easily dismantled by other settler individuals. Such

experiences ultimately raise doubt about whether SON can truly be decolonized or Indigenized

in a way that makes space for Indigenous ways of knowing, being, and doing and ensures that

the barriers to the integration of cultural safety will be eliminated without shifting the focus to a

settler fragility or guilt.

Micro-reconciliation: A path to cultural safety. The review of decolonization and

Indigenization indicates that they have a place in nursing education and in the process of

integrating cultural safety into nursing education. As mentioned above, decolonization and

Indigenization help to dismantle the colonial discourses that create barriers to cultural safety in

nursing education. However, with the identified critiques of these processes in actually

improving reconciliation, nurse educators need to start thinking about solutions that improve the

relationships between Indigenous and non-Indigenous Peoples. Embedded within TRC's Calls to

Action are micro-level calls that emphasize transformative actions of interpersonal relationships

with Indigenous and non-Indigenous peoples in Canada. Tait, Henry, and Mussell (2019) label this shift as 'micro-reconciliation'. The authors describe micro-reconciliation as a necessary and supportive approach to enhancing and advancing cultural safety within educational institutions, as well as across the human service sector, because the aim is to challenge and diminish the racism, inequality, and inequity that Indigenous peoples experience. However micro-reconciliation also focuses on the intersections of entrenched structural racism and the psychological and emotional roots of discrimination. Specifically, it offers nursing education an applied pathway for the successful integration of cultural safety as an approach that directly addresses the embodiment of structural racism and how colonial ideologies have been and continue to be normalized, it also empowers individuals at all levels within the educational institution to understand the aforementioned processes. Tait et al. proposed transformative action through three intersubjective and intersecting spheres: acknowledgement, witnessing, and moral courage.

Acknowledgement involves "the genuine inter-subjective acknowledgement in local settings of the degree and impact of trauma and injustices experienced by Indigenous Peoples" (Tait et al., 2019, p. 11). In nursing education, acknowledgement requires an authentic commitment to reconciliation as an institutional priority and the recognition of oppressive and discriminatory policies and practices that continue to influence the current educational environment. As this study highlights, this would include the acknowledgement of structural violence experienced by Indigenous nurse educators, the ghettoization of cultural safety, and the presence of egalitarian and culturalist discourses that result in the erasure of Indigenous Peoples' experiences and the perpetuation of stereotyped Indigenous narratives within nursing education. Altering attitudes is complicated by the ideology of multiculturalism that celebrates diversity and

equity but suppresses the individual and collective experiences of Indigenous Peoples and maintains systems that disadvantage Indigenous peoples. In addition, culturalism enables accounts of Indigenous Peoples as the disparate 'other.' Thus, many settler Canadians, including nurse educators, do not fully accept the 'truth' in truth and reconciliation because of the normalization of the oppression of Indigenous Peoples (Tait et al., 2019). A commitment to education and training on cultural safety requires continuous critical self-reflection on Eurocentrism, which situates nurse educators in positions of privilege and power founded on the colonial oppression of Indigenous Peoples. Acknowledgement also requires that education comes from a place of empowerment rather than shame or guilt to empower the collective to have the confidence to acknowledge and challenge entrenched forms of institutional racism. Tait et al. stated that the process of acknowledgement will enable nurse educators to unlearn and relearn through an antiracist pedagogy that places cultural safety at the center of individual relationships and interactions to improve institutional structures and processes from the bottom up. In addition, this may help non-Indigenous educators acknowledge their part in integrating cultural safety rather than leaving this responsibility on Indigenous nurse educators.

The second sphere, witnessing, involves the ability of the collective (nurse educators in addition to everyone else involved in nursing education) to critically examine the unchallenged assumptions about Indigenous Peoples that are inherent in institutional structures and daily practices (Blackstock, 2011; Tait et al., 2019). In addition, the TRC (2015b) described witnessing as being keepers of history (TRC, 2015b). Again, as Tait et al. explained, this requires support from all levels of administration to implement transformative change. Nurse educators' acknowledgement and bearing witness create an environment in which everyday assumptions, attitudes, behaviors, and structures that can create or become barriers to new ways of thinking

and change are recognized. More important, in the integration of cultural safety into nursing education, witnessing has the ability to influence and identify leaders to lead the process. Cultural safety taught through the lens of micro-reconciliation emphasizes relational accountability and self-awareness and challenges nurse educators and administrators to uncover their own inherent biases and assumptions that are supported within Eurocentric educational structures (Tait et al., 2019). The process of nurse educators' and administrators' witnessing places them in solidarity, rather than in an adversarial position, with Indigenous Peoples and offers a shared responsibility to integrate cultural safety into nursing education.

Last, moral courage is the courage to name and speak about what is known to be true (Tait et al., 2019). Acknowledging and bearing witness to the root causes of social and health inequities that shape the lived experiences of Indigenous people require that those who work in these systems have moral courage. Micro-reconciliation requires a supportive and safe environment for individuals to speak up and be empowered to challenge institutional racism and to move toward transformative dialogue and structural change. According to Tait et al., Indigenous knowledge holders should facilitate this process, because to speak and affirm truth can only be understood by those who suffer. In other words, we need to listen to the experiences of Indigenous nurse educators and act to create safe spaces in nursing education that do not continue to racialize and overburden Indigenous nurse educators. The expectation of micro-reconciliation in integrating cultural safety is that the environment within nursing education will be facilitated and supported to allow Indigenous voices to be heard and respected and to place Indigenous Peoples in positions of leadership and influence (Tait et al., 2019). Ultimately, the power of moral courage in the process of integrating cultural safety lies in moral conversations that label the problems and challenges in nursing education.

In summary, micro-reconciliation offers nursing education a way collectively to foster an

understanding of a shared history and responsibility between Indigenous and non-Indigenous

Peoples of Canada and provides a pathway for successful education on cultural safety across

nursing education. Micro-reconciliation also fills the gaps when decolonization and

Indigenization processes fall short in supporting the integration of cultural safety.

Recommendations

The findings from this study demonstrate that the integration of cultural safety must be

facilitated and supported at all levels of nursing education, which requires a systemic and

reconciliatory approach. This overarching recommendation implies that influencing systemic and

reconciliatory transformation to ensure the sustainability of cultural safety in nursing education

demands, at a minimum, the consideration of four intersecting facets: (providing) sufficient

resources and support to nurse educators; (addressing) the systemic underrepresentation and

racialization of Indigenous educators in nursing education; (changing) the structure by way of

decision making; and (changing) the structure of curriculum within SONs.

Recommendations for nursing education are presented in three components, curriculum,

practice, and policy (see Table 3). The following subsections present a brief discussion of these

recommendations to integrate cultural safety into nursing education as well as of future

directions for research in this area.

Curriculum. The recommendations for curriculum focus on the structure and course

materials required to support and integrate cultural safety content. Although in the organization

of themes I included decision makers as an important part of curriculum, I will address decision

makers under policy. As a result of the TRC's (2015a) Calls to Action, we are now witnessing a

new era of reconciliation, with increased attention on addressing gaps with regard to cultural

safety in nursing curricula. The findings from this research identify the current gaps and barriers

such as the overloading of curriculum content, the structure of courses and classes, and the lack

of course materials that include cultural safety. Findings from this study highlight that, cultural

safety must be a priority and comprehensively threaded throughout the nursing curriculum.

Table 3

Recommendations for Nursing Education

Area	Recommendation
Curriculum	- Thread cultural safety content throughout undergraduate nursing curriculum - Mandate hours for cultural safety content in all courses - Mandate Indigenous authors/content into course syllabus - Decrease class sizes - Rewrite and redevelop nursing textbooks and case sceneries to include Indigenous knowledge from a strengths-based approach
Practice	- Enable educators and students access to Indigenous communities for experiential learning - Create authentic partnerships with Indigenous communities for experiential learning - Mandate cultural safety training for all nursing faculty - Allow space and time for educators to learn about Indigenous peoples and culture - Take a micro-reconciliation approach to ensure co-accountability from non-Indigenous educators
Policy	Academic institutions - Hire and appoint more Indigenous Peoples to university leadership and decision-making positions in all areas, not just Indigenous studies - Hire an Indigenous curriculum specialist focused on Indigenous cultural safety - Revise budget to include more financial support for committees and working groups aimed at cultural safety, decolonization, or Indigenization initiatives - Offer more financial resources and educational support to enable non-Indigenous educators to access training in cultural safety - Establish protective policies for Indigenous educators who are asked to sit on multiple committees/working groups and teach Indigenous content - Develop a review committee to integrate Indigenous or cultural safety content into curriculum that is comprised of Indigenous Peoples (including Indigenous knowledge holders, Elders, students, and educators) Professional associations - Create an MOU between CASN, CNA, and CINA - Mandate consultation with CINA as the expert in Indigenous nursing in all accredited nursing programs - Integrate Indigenous cultural safety throughout all accredited nursing

	programs in Canada • Write a position statement on Indigenous cultural safety in nursing education to ensure more standardization of concepts • Include land recognition in collective agreements and constitutions

Cultural safety was commonly treated as a supplementary topic rather than as a core competency within the curriculum. The standard approach to integrating cultural safety into curriculum was to mandate a singular core course that covered Indigenous health and was recognized by study participants as inadequate. It is clear that comprehensive changes are needed for curriculum and education practice. First that the curriculum shift to include cultural safety concepts in every course. Second, that the structures of courses and classes include cultural safety and educators be enabled to prioritize this content. For example, smaller class sizes and mandated hours of cultural safety content will allow conversations to occur safely and educators to facilitate them appropriately. Third, that course materials such as textbooks and case scenarios that educators use to translate this knowledge be redeveloped to include Indigenous knowledge from a strengths-based approach to educate students on Indigenous people's history, health, and culture. However, the integration of cultural safety does not mean simply adding Indigenous perspectives and content to existing nursing curricula. In addition, the process of integrating cultural safety in nursing education requires dialogue and a deep understanding of the history of colonization to improve the relationship between Indigenous and non-Indigenous Peoples in Canada.

Nursing education practice. Recommendations for nursing practice are aimed at the approaches and strategies that nurse educators use to integrate cultural safety. Fear was a recurring barrier for non-indigenous nurse educators, their fear and discomfort in teaching cultural safety content because of their lack of awareness and knowledge of Indigenous peoples. Mandating and enabling cultural safety training for all faculty to improve their level of

awareness and knowledge may reduce their fear and enable them to accept more responsibility in integrating cultural safety in nursing education, reducing the burden on Indigenous educators. However, as discussed previously, one or several training sessions, seminars, or workshops will be not be enough to change knowledge, attitudes, or skills. Building the capacity of leaders, nurse educators, and the whole institution with committed resources and support and addressing the organizational barriers that constrain nurse educators should be the overarching approach to ensure the success of the integration of cultural safety into nursing education. First, experiential learning opportunities with Indigenous communities for educators must become the standard approach, to further strengthen cultural safety training, to address educators' fear and lack of confidence in teaching and integrating cultural safety content into nursing education. This will require partnerships with Indigenous communities. Second, that leaders in SONs at the administrative and faculty level provide support and resources to nurse educators to enable them to access experiential learning opportunities or other resources and to create authentic partnerships with Indigenous communities. In regard to the culturalist and egalitarian discourses evident within nursing, challenging these discourses requires not only education and training, but also changing the structures in nursing education that uphold this culture. These recommendations will support non-Indigenous educators and students with the space and time that they need to learn about Indigenous history and culture, which the integration of cultural safety requires.

Finally, Indigenous nurse educators' experiences of structural forms of violence and racism must be addressed. The heavy burden on Indigenous nurse educators to be accountable for integration should not be the sole responsibility of Indigenous nurse educators; integration requires a combined effort from everyone. Thus, I recommend that a micro-reconciliation

approach be taken to ensure the co-accountability of non-Indigenous nurse educators. As

discussed above, the three spheres of micro-reconciliation of acknowledging, witnessing, and

moral courage create an institutional pathway in nursing education and for nurse educators to

ensure dialogue and a deep understanding for the meaningful integration of cultural safety.

     Nursing policy. Recommendations for professional nursing associations and academia

stem from the results of this study which suggest a call for action on the part of leaders of

professional associations and academic institutions (see Table 3). The policy recommendations

are presented under those headings. First, that professional associations, regulatory bodies, and

key decision makers in SONs work collaboratively with their Indigenous counterparts to lead

and guide the process of integration. A collaborative approach with the expertise of Indigenous

health organizations will ensure the standardization of cultural concepts and frameworks and

support the comprehensive threading of cultural safety concepts into curriculum and courses.

That SONs create working groups that include both Indigenous and non-Indigenous faculty, with

a focus on the integration of Indigenous culture into nursing curricula. The guiding principles of

these working groups would be to help non-Indigenous educators to lead and take accountability

for the integration of cultural safety and not to further overburden Indigenous nurse educators,

but rather to guide and support them. In addition, protective policies for Indigenous nurse

educator time are also needed. Second, that SONs ensure that the necessary resources, such as

available educational resources, professional development workshops and training, and support

and administrative staff, be made available not only to nurse educators, but also to all faculty and

students. Third, that resources be provided to hire Indigenous curriculum specialists to help nurse

educators develop pedagogical skills and knowledge focused on cultural safety. Dedicated

financial resources are needed to sustain these curriculum committees and working groups

focused on the integration of cultural safety to ensure that they no longer remain temporary or special initiatives.

Fourth, that leaders in SONs ensure that cultural safety remains a priority in nursing education, especially with Indigenous leadership at the decision-making level. The lack of Indigenous Peoples in decision making processes and leadership positions is pervasive among SONs and educational institutions, a situation that continues to marginalize the integration of cultural safety. As previously stated, micro-reconciliation requires that Indigenous knowledge holders (such as Indigenous nurse educators) play an important role in implementing the required changes to nursing education as they assume the position of truth tellers and that their experiences be heard and acted upon. Steps include appointing more Indigenous people to university boards of governors and senates and hiring them in key senior decision-making roles within and external to the SON.

Collectively, these recommendations are a first step in a systematic approach as they will ensure that engagement with cultural safety in nursing education is meaningful and a priority. For nurses and nursing education to be culturally safe, nursing education practices and policies must move beyond those driven by technology and cost savings and move towards relational engagement (Bourque-Bearskin, 2011). This complex process will require open, honest dialogue and a committed effort to change institutional culture.

Future Directions for Research

Implications for future research include many areas for exploration and evaluation in relation to cultural safety in nursing education and practice. In this study I explored only nurse educators' views, but researchers must also explore the perspectives of nursing students, faculty, and administrators to gain a comprehensive understanding and document the experiences of

everyone affected by the integration of cultural safety. This includes an assessment of all of the integrated content to determine and discuss which approaches are most effective. Furthermore, research that fosters an understanding of the advantages and disadvantages of the application of cultural safety in the classroom and practice is required to improve cultural safety frameworks and establish better practices in SONs. Because of the renewed level of urgency for reconciliation in education, there is no doubt that further research must include Indigenization and decolonization processes in nursing education.

Researchers should conduct their studies by using a co-creation approach with Indigenous scholars to evaluate the changes in academic policy aimed at Indigenization and decolonization efforts and cultural safety integration. In addition, a mixed-methods approach would facilitate the evaluation of outcomes and the effectiveness of interventions such as cultural safety training, workshops, and speakers. In terms of the outcomes of the integration of cultural safety into nursing education, there is a need to monitor and evaluate the effects on students. There is currently a gap in the literature on whether cultural safety training is effective in improving cultural safety practices among healthcare providers, students, and the Indigenous Peoples who access care. Thus, researchers need to focus on evaluating the cultural safety outcomes for healthcare providers and students and establish cultural safety indicators. Finally, inquiry into and evaluation of Indigenous Peoples' perspectives and experiences of cultural safety in education, research, and practice are also required. Whether they include Indigenous students, educators, healthcare providers, or patients, a study of Indigenous experiences is required to further guide cultural safety concepts, frameworks, and integration efforts.

Strengths and Limitations

This study has several strengths and limitations. First, the small number of Indigenous nurse educators did not facilitate an exhaustive exploration of their experiences with integrating cultural safety into nursing education. However, the methods of analysis privileged their experiences compared to those of non-Indigenous educators. Some might consider this a limitation, but it was an appropriate decision and strength of this study. Another strength is the collective provincial voice of 11 of the 14 accredited SONs in Ontario, with nurse educators from 11 SON, this study was able to explore educators' experiences from a wide range of SONs with many different approaches to cultural safety integration.

Limitations include the inclusion of part-time or sessional faculty in the study sample. Although, the sample included a majority of full-time nurse educators, part-time and sessional educators are less immersed or familiar in institutional and curricular initiatives and would not have the same experiences or challenges as full-time educators. Second, further opportunities to observe and participate in classroom experiences with nurse educators would have strengthened this study. However, the timeframe and limitations of a master's thesis limited my ability to explore these opportunities. Finally, the exclusion of nursing student and administrators views and voices also limited the study. Including conversations from these groups could have permitted further comparison and contrast and deepened the understanding of cultural safety in nursing education.

Conclusion

The purpose of this study was to identify strategies, barriers, and possible approaches to integration. The harmonized data analysis approach highlighted the complexity of integrating cultural safety content into the academic environment in which nursing education exists. In

summary, nurse educators' attempts to integrate cultural safety into nursing education are incompatible with and insufficient in the current colonial and biomedical discourses that are still dominant in nursing education. Finding more barriers than enabling strategies highlights the urgent need for leadership, resources, and institutional support. The ghettoization of cultural safety leaves nurse educators to their own means, skills, and knowledge as they attempt to integrate cultural safety often quickly and superficially. Findings from this research support the need to increase awareness and knowledge of not only nurse educators, but also all faculty and university leaders with regard to Indigenous Peoples' history and current-day realities. The successful preparation of nurse educators to teach cultural safety must go beyond a single workshop or training course and shift to experiential learning and the creation of authentic partnerships with Indigenous communities to support these opportunities for educators and students. This will require leadership, resources, and support from all levels within SONs.

In addition, the reports of silent or covert racism and racialization of Indigenous nurse educators in this study suggest that SONs themselves cannot fully respond to the TRC's (2015a) Call to Action #24 or integrate cultural safety sufficiently. For example, during my writing of this thesis, several Indigenous leaders at universities across Canada resigned from their positions, citing systemic racism as the primary reason ("U of M Indigenous Leaders Resign," 2018). These resignations draw attention to the ongoing structural forms of violence and racism in academia that further challenge Indigenous nurse educators' attempts to disrupt these entrenched forms of racism. Ultimately, integration is not possible until the colonial discourses in nursing education that create barriers to cultural safety are dismantled. Micro-reconciliation is a solution that supports both the decolonization and the Indigenization of SONs to ensure the success of cultural safety in nursing education. The three spheres of micro-reconciliation—acknowledging,

witnessing, and moral courage—challenge nurse educators to adopt strategies that directly label and address structural racism. In addition, they create a pathway to the understanding that it is not possible to achieve reconciliation without recognition of the role of nursing in upholding colonial discourses. In this era of reconciliation, it is essential that the health needs of Indigenous Peoples be addressed through the education of future health professionals. Without micro-reconciliation, the nursing discipline will remain a tool of colonialism and will continue to restrain cultural safety at the margins of nursing education.

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APPENDIX A: E-MAIL INVITATION

Hello,

We are currently looking for nurse educators who are interested in participating to a study on the cultural safety integration within nursing programs.

PROJECT TITLE: Integrating Cultural Safety into Schools of Nursing:
An Indigenous Inquiry of Nurse Educators Experiences

Researchers: Danielle Bourque, BScN, RN, MSN student and Dr. Olive Wahoush, RN, PhD, thesis supervisor.

Purpose of the study: To explore the educators' experience of the cultural safety integration in nursing programs, while also documenting this experience through a pre-interview survey of approximately 10 minutes and a face-to-face, phone or videoconference interviews of approximately 60 minutes.

To qualify as a participant, you must:
1) Be a full, associate, or assistant nursing professor;
2) Be able to communicate verbally in English.

For more information:
Danielle Bourque, BScN, RN
MSN student
School of Nursing
Faculty of Health Sciences
McMaster University
Email: bourqued@mcmaster.ca

APPENDIX B: PRE-INTERVIEW QUESTIONNAIRE

1. To which of the following gender do you identify?
   ___ I am a man
   ___ I am a woman
   ___ I am a transgender man
   ___ I am a transgender woman
   ___ Other (please specify) _____

2. How old are you?
   ___ 25 – 34 years old
   ___ 35 – 44 years old
   ___ 45 – 54 years old
   ___ 55 – 64 years old
   ___ 65 years old or over

3. What is your ethnicity?
   ___ Caucasian
   ___ Canadian of African heritage
   ___ Canadian of American or Hispanic heritage
   ___ Canadian of Asian heritage
   ___ Indigenous (First Nations, Inuit, or Métis)
   ___ Other (please specify) _____

4. What is the highest level of education you have you completed?
   ___ Bachelor's degree
   ___ Master's degree
   ___ PhD
   ___ Other (please specify) _____

5. What is your title?
   ___ Full professor
   ___ Associate professor
   ___ Assistant professor

6. Is your position permanent or contractual?
   ___ Permanent
   ___ Contractual

7. How many years of experience do you have as a professor?
   ___ 0 – 5 years
   ___ 5 – 10 years
   ___ 10 – 15 years
   ___ 15 – 20 years
   ___ 20 – 25 years
   ___ 25 years or more

8. At which academic institution do you work?
   ___ Brock University
   ___ Lakehead University
   ___ Laurentian University
   ___ McMaster University
   ___ Nipissing University
   ___ University of Ontario Institute of Technology (UOIT)
   ___ University of Ottawa
   ___ Queen's University
   ___ Ryerson University
   ___ University of Toronto
   ___ Trent University
   ___ Western University
   ___ University of Windsor
   ___ York University

9. What is the level (or levels) of the nursing program(s) offered by your academic institute?
   ___ Bachelor's degree
   ___ Master's degree
   ___ PhD

10. Which level do you teach?
   ___ Bachelor's degree
   ___ Master's degree
   ___ PhD

APPENDIX C: LETTER OF CONSENT

Master's Study Title: An Indigenous Inquiry of Nursing Faculty Experiences with Utilizing Cultural Safety in Canadian Schools of Nursing

Investigators:

Local Principal Investigator:	**Student Investigator:**
Olive Wahoush, RN, RScN, MSc, PhD	Danielle Bourque, RN, BScN
Associate Professor	Master's in Nursing Student
School of Nursing	School of Nursing
Faculty of Health Sciences	Faculty of Health Sciences
McMaster University	McMaster University
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Invitation to participate in this study

I am invited to participate in this study conducted by Danielle Bourque and Dr. Olive Wahoush at the School of Nursing, McMaster University. This document will inform me about the nature of the master's research project and the type of participation required if I wish to become involved. In addition, the consent form provides me with an opportunity to clarify my rights as a study participant and to understand how the researcher will ensure these rights throughout the study. Members of the research team are available between 8:00 and 20:00 to answer my questions and if needed, to clarify the information contained in this document.

Purpose of the study

As a participant, I understand that the goal of this study is to explore my experience of the cultural safety integration in nursing programs, while also documenting this experience through an interview that may be face-to-face, phone or videoconference and take up to approximately 60 minutes.

Participation

To qualify as a participant, I must:
1) Hold a full, associate, assistant or sessional nursing position at an accredited SON in Ontario;
2) Teach within the undergraduate nursing program; and
3) Be able to communicate in English.

As a participant in this study, I will be scheduled to do an interview with a member of the research team and will be asked to fill a short questionnaire (approximate time: 10 minutes). One or more face to face, telephone, or skype interview will be scheduled and should last approximately 60

minutes. I understand that follow up conversations will occur with the researcher after the initial interview to ensure information shared stays true to my original intentions. Any follow up contact will occur before April 15th, 2019. Lastly, the interview will take based on my preferences. The interview will be scheduled for my convenience.

I am aware that Danielle Bourque will be present during the interview and will be digitally recording my statements unless I decline. If I do not wish to be recorded, notes will be taken during the interview to capture my verbal account. Following the interview, the research team will remain available to answer my questions and document my comments.

Risks

Personal schedule: I may also have to change my personal schedule to participate in this study. However, I understand that the interview will be scheduled to minimize this possibility.

Confidentiality: I will be asked to share personal information during the interview. I am aware that the confidentiality of the information shared during the interview will be maintained at all times during the study and after the study is completed.

Benefits

By participating in this research project, I will contribute to the development of knowledge in the field of nursing education. This study is an opportunity for me to share my personal experience with the integration of cultural Safety in nursing. By taking part in the study, I will contribute to more research being conducted on this topic, the improvement of nursing education and the advancement of cultural safety for future health care professionals.

Confidentiality and anonymity

I am aware that the following strategies will be used to ensure the confidentiality of my statements and the preservation of my anonymity:

The nature and content of the interview will be audio-recorded in a way that preserves my confidentiality. The audio-files and the transcription of the interview will be identified using an alphanumerical code and will not contain any of my personal information. My name will not appear on the research material. My anonymity will be preserved with the creation of an alphanumerical code, and will replace the files and transcriptions' names ex : M-1 (Male – Participant no 1) or F-1 (Female – Participant no 1). Only the main researcher and her research director will know my identity. Thus, my rights to anonymity and confidentiality will be respected. Data transcription will be performed by a professional, who will sign a confidentiality agreement before starting this work. The alphanumerical code will prevent any link possible between my statements and my identity, and it will only be accessible to the research team. In addition, I understand that the researcher will censor any information (names, city, university) that may lead to my identification to maintain anonymity. Finally, any information (names, city, university) that may lead to identify an individual mentioned during my interview will be censored by the researcher. Therefore, this censorship will help prevent my identification and/or the identification of individuals mentioned during my interview.

Storage of research material

I understand that all the research data (audio-files, transcriptions, notes) will be stored in a locked unit within the researchers' office at McMaster University. I am aware that the data collected will

be kept for a period of 5 years in order to be analyzed, after which they will be destroyed. Only the research team will have access to the research material.

Authorization of the utilization of research results
By participating in this study, I accept that the data collected during the interview will be used for the conclusion of this research and integrated for scientific, professional and educational purposes. It is possible that my statements be cited in publications and/or presentations. However, I understand that my confidentiality will be respected always and that the research team will use all the necessary strategies to promote my anonymity.

Withdrawal from the study
It is clear that my participation in this research project is done on a voluntary basis. I can choose not to answer any questions. It is also clear that I can withdraw from the research at any time, without having to justify why I chose to do so. The content of my interview will be destroyed (transcriptions will be shredded and audio-files permanently deleted) if I choose to withdraw from the study and the information I provided will not be used in the analysis, as long as the withdrawal occurs before analysis starts.

Questions regarding the study
If I have any questions regarding this study (before, during or after), I am aware that I can communicate at any time with the researchers. Full contact information for both researchers are provided on the first page of the consent form.

Ethics
This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

Participant consent
I consent to participate in this study being conducted by Danielle Bourque from the School of Nursing, Faculty of Health Sciences, McMaster University, who is supervised by Dr. Olive Wahoush, associate professor and researcher at McMaster University.

I have been informed that the purpose of the research is to explore the experience of the integration of cultural safety in nursing.

I understand that I am free to withdraw my consent and discontinue my participation at any time without negative consequences.

I also understand that my participation in this study is confidential and that study findings will preserve my anonymity.

I accept to be audio-recorded: yes ☐   no ☐

I accept to be quoted directly as mentioned above: yes ☐ no ☐

I HAVE CAREFULLY STUDIED THE FORM AND UNDERSTAND ITS CONTENT.
I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

There are two copies of the consent form, one of which is mine to keep.

NAME (please print)

_____

SIGNATURE - PARTICIPANT

_____

CODE – PARTICIPANT

_____

SIGNATURE – RESEARCH TEAM MEMBER

_____

DATE : _____