Moral Distress: The Importance Of Support For Black And Brown Nurses After Encountering Racism From Patients And Peers In The Acute Care Setting

Marsha Sinanan
mcrsinanana@gmail.com

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Moral Distress: The importance of support for Black and Brown Nurses after encountering racism from patients and peers in the acute care setting

A Project Submitted to the Doctor of Nursing Practice Faculty of Yale University of Nursing

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Nursing Practice

Marsha Sinanan-Vasishta MBA, MSN, RN NEA-BC, CPXP

Project Advisor: Mary Ann Camilleri JD, RN, FACHE

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This DNP Project is accepted in partial fulfilment of the requirements of the degree of Doctor of Nursing Practice.

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May 13, 2024
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Abstract

Moral Distress: The importance of support for Black and Brown Nurses after encountering racism from patients and peers in the acute care setting

Purpose: This DNP project developed and implemented an online training program to support Black and Brown nurses’ post-racism encounters in the acute care inpatient setting.

Background: Nationally, it is estimated that 25% of nurses experience mistreatment by patients each year, but many fail to report these episodes (Campbell, 2016). The retention of Black and Brown nurses is essential, as cultural congruence or shared experiences among patients and members of their healthcare team can be an important bridge for promoting safety and the best clinical outcomes (Moceri, 2014).

Methods: Approximately 400 RNs were invited to participate in a 15-minute online training program over 12 weeks. The curriculum comprised of education of key definitions of anti-racism terminology, a video on allyship, review of the organization’s antiracism policy and companion pocket guide, peer and patient/family racism case studies, identification of reporting structures and available support services post racism encounter. Pre- and Post -Self-efficacy surveys consisting of 17 five-point Likert scale questions and one open ended question measured the participant’s level of confidence in managing and feeling supported after experiencing a racist encounter in the acute care setting.

Results: Paired-samples t-tests indicated that post-test scores (M= 76.82, SD= 10.03) were significantly higher than pre-tests (M= 67.19, SD= 13.305), t(84) = -5.167, p<.004.

Conclusion: The results support the presence of improvements in self-efficacy post-intervention and indicated that the online training module was successful in raising nurses’ self-efficacy for awareness of reporting and support mechanisms after experiencing racism encounters in the acute care setting.
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Part 1

Moral Distress: The importance of support for Black and Brown Nurses after encountering racism from patients and peers in the acute care setting.

Introduction

Racial discrimination in healthcare emerges is a significant concern that affects care, and the work environment. In the clinical realm, it affects attitudes, beliefs, and behavior in two ways: person to person or personally-mediated, and the internal effect, or how an individual perceives themselves (Williams & Rucker, 2000). This discrimination is accompanied by unfair or disadvantageous treatment to the receiving party, while perceiving them as inferior against their comparison or holding an unconscious bias based on negative stereotypes (Williams & Rucker, 2000). Healthcare organizations must carefully balance their duty to provide high-quality care and attend to vulnerability of patients with their responsibility to cultivate a supportive and respectful work environment. Although crucial to high-quality care, the emphasis on patient-centeredness has unintentionally caused a “patient first” approach at the expense of emotional or physical distress to clinicians. Research from the American Association of Critical Care Nurses states that healthy work environments help to decrease moral distress and increase retention. (https://www.aacn.org/nursing-excellence/healthy-work-environments).

Moral distress is commonly triggered by an end-of-life care situation, work-related pressure, a value conflict, a challenging team dynamic or lack of appropriate resources (Morley, 2018; Sukhera et al., 2021). These triggers, in the setting of a racial experience, may have an impact on behavior, leading to feelings of sadness, burnout, anger, and frustration which cumulatively and negatively impacts care (Sukhera et al., 2021). If not recognized and addressed by healthcare leaders, the problem may be met with silence or avoidance, further exacerbating the problem.
Instead of perpetuating a culture of silence avoidance, or worse, denial, organizational leaders must commit to creating a health care environment where discrimination against both patients and clinicians is unacceptable.

**Problem Statement**

Nationally, it is estimated that 25% of nurses experience mistreatment by patients each year, but many fail to report these episodes (Campbell, 2016). The reasons are complex. Many organizations do not currently ask about the impact of diversity or racism as part of the RN’s decision to leave and there is no clear reporting structure to capture racist encounters.

According to Hawkins et.al. (2022), despite a considerable body of evidence emphasizing job-related predictors of nurses’ intent to leave the job, nurse turnover remains a difficult and common place problem. Notably, research findings reveal higher levels of job dissatisfaction, (Carthon et al., 2021; Doede, 2017) job related stress, and intent to leave, among non-White nurses compared to White nurses. Given the vital reasons to increase the racial diversity of the nursing workforce, these findings suggest the need to understand Black and Brown nurses’ race-based experiences in the workplace, which may lead to their intention to leave the job. The retention of Black and Brown nurses is essential because cultural congruence or shared experiences among patients and members of their healthcare team can be an important bridge for promoting safety and the best clinical outcomes (Moceri, 2014).

The care and support extended to nurses after a racial encounter is critical in determining their decision or intent to stay in an organization (Hawkins et.al, 2022). This DNP project developed and implemented a program to improve the self-efficacy of nurses in managing a racist encounter and accessing available workplace support post-racism encounter in the acute care inpatient setting.
Significance

There are over 2,906,207 Registered Nurses currently employed in the United States. African American registered nurses comprise the largest group of culturally diverse nurses in the United States (Bureau of Health Professionals, 2000), accounting for 9.9% of RNs who are Black or African Americans (non-Hispanic); 8.3% are Asian; 4.8% are Hispanic or Latino; 1.3% categorize themselves as two or more races; and 0.4% are American Indian or Alaskan Native. (https://www.minoritynurse.com). Yet, despite these numbers, and the injurious effects of workplace racism among U.S. workers, little is known of the quantifiable effects of nurses’ negative racialized experiences on their job satisfaction, emotional distress and intent to leave their job. (Hawkins et al., 2022). The potential financial impact of this is significant as recent studies of the costs of nurse turnover have reported results ranging from approximately $22,000 to over $64,000 per nurse turnover across the United States. (Advisory Board, 1999; Jones, 2005; OBrien-Pallas et al., 2006; Stone et al., 2003). Turn-over costs, in general, have been estimated to range between 0.75 to 2.0 times the salary of the departing individual (McConnell, 1999) while nurse turnover costs have been estimated at 1.3 times the salary of a departing nurse (Jones, 2005). Addressing the needs of Black and Brown nurses’ post-racism encounters may mitigate some of this cost and further the development of a robust, diverse nursing workforce.

Review of Literature

Search Strategy

were added to ensure the research was focused on the acute care setting within the nursing healthcare workforce. The Boolean operator OR was used with terms that had similar meanings, such as 'racial discrimination' and 'racism', or 'healthcare worker' and 'health worker', 'nurse,' Black nurse’ ‘Brown nurse’ thereby enabling the identification of a larger number of articles on the topic. Articles were included if they had availability of the full text article, and were published in or after the year 2000 in the English language. Exclusion criteria included studies not focused on the acute care setting, studies without emphasis on nurses of color or Black and Brown nurses, and studies focusing on other causes of moral distress without a racism context. The search yielded a total of 700 articles. Duplicate removal yielded 450 articles, and title and abstract review yielded 50 articles. After full text review 30 articles were included in this literature review, and 11 were selected for inclusion in the Evidence Matrix.

**Synthesis of Literature**

Study designs were variable and included mixed methods, qualitative descriptive study designs, and three cross-sectional quantitative designs. Levels of evidence ranged from Levels 1 to 4 using the JBI levels of evidence for meaningfulness. The themes that emerged from the literature included (i) overt and structural racial experience, (ii) support care approach to post racism encounter, and (iii) perception of psychological resilience in racism encounters. The findings illustrate the prevalence of both overt and structural racism encounters in the acute care setting involving nurses of color. For example, Black and Brown nurses experience institutionalized racism in forms that vary from disregard for personhood and poor communication at the management level to democratic disqualification, lack of recognition, missing authentic leadership, and attrition (Iheduru-Anderson et al., 2021).

In terms of support care, the articles highlighted very negligible support care to nurses of color in terms of post racism encounters as nurses are forced to adopt individual coping strategies. Nurses of color expressed significant burden in the emotional labor of trying to cope
and manage psychological resilience in line with the core values and ethics in nursing (Cottingham et al., 2018). The literature reveals the common experience of racial aggression and microaggression toward Black and Brown across contexts in the acute care setting (Hall & Fields 2016). This lack of supportive institutional programming was seen throughout the literature as nurses consistently reported the need to cope on their own with racist encounters. This lack of systemic support was seen as contributing to a severe form of moral distress and psychological breakdown for nurses of color (Garran & Rasmussen, 2019). Limitations included restricted sample sizes and sample characteristics.

Studies suggest that a diverse health workforce is more likely to provide culturally responsive, high-quality healthcare, which in turn helps to reduce health disparities (Moreci, 2014). It is therefore imperative to provide support and a framework for addressing patient and peer-directed racism after Black and Brown nurses experience racism.

**Literature findings**

**Racism-Related Stress in Black/African American Nurses**

Black and African nurses experience common occupational stressors and in 2017, the American Nurses Association (ANA) declared it the “Year of the Healthy Nurse.” During that year, April was hailed as the month for “Combatting Stress” and October was slated to bring awareness about “Moral Resilience/Moral Distress” (American Nurses Association, 2017). However, Black/African American nurses experience a unique social stressor or intersectionality that is superimposed on common occupational, even personal stressors. Intersectionality, a socio-political framework developed by Kimberly Williams Crenshaw, professor at The University of California, Los Angeles and Columbia Law School and Civil Rights scholar describes the complex oppressive systems that affect people who have a combination of minority identities (Crenshaw, 2019).

**Racist experiences in Black and Brown Nurses**
For clinicians, patient bias and discrimination can contribute to emotional exhaustion. While using vignettes during analysis, Cottingham et al. (2018) found that the journals and diaries of Black and Brown nurses revealed that most experiences included racial slurs, non-compliance or refusal of care among patients and an overt delegitimization of authority. Comparatively however, White nurses also confront a questioning of authority from certain patients, but there was an observed distinct racial component as patients question the professional registration authenticity of a nurse of color (Cottingham et al., 2018). Further highlighted was the experience of colleagues going to the extent of constantly casting doubts on the knowledge and skills of nurses of color (Cottingham et al., 2018).

Racial aggression emerged as another form of racism experienced by nurses of color practicing in the acute care setting. Participants highlighted painful experiences when interacting with aggressive, racist patients who would be very abusive, using such vile, derogatory terms as “humpbacked monkey,” and “nurse nigger” toward the nurse while receiving care. (Cottingham et al., 2018). Most Black and Brown nurses believe that subtle, rather than overt, interpersonal racism is on the rise. Predominantly, interpersonal racism is described as microaggressive. Black and Brown nurses’ experience ubiquitous slights, including patronizing behaviors, stereotyping, being ignored by either patients or colleagues, among other insults (Dent et al., 2021). These microaggressions elicit a long-term insidious effect of silencing, invalidating and humiliating the identity and/or voices of the nurses of color. However less obvious, they nevertheless grind down and wear out the victims (Hall & Fields, 2016). Nurses of color experience racial microaggressions from all levels including from patients, patient families, and colleagues, and this happens primarily through assumption of their inferiority and incompetence (Cottingham et al., 2018). Other forms of microaggressions faced by Black and Brown nurses in the acute care setting include microassaults such as name-calling, shunning, and purposeful discrimination. Microinsults include implications of negativity, diminishing the other, and obvious
rude behavior towards nurses of color. Microinvalidations entail minimizing or ignoring the targeted nurse’s feelings and statements, denying racism or oppression, and denying White privilege (Hall & Fields, 2016).

While significant attention has focused on documenting and addressing clinician bias toward patients, incidents of patient bias toward clinicians also occur and are difficult to navigate. Clinicians anecdotally describe their experiences with patient bias, prejudice, and discrimination as profoundly painful and demoralizing (Reynolds, K. 2015). Significantly, while racism may not be vividly expressed in some microaggressions, Black and Brown nurses also experience encounters where patients exhibit noncompliance and uncooperative behavior in response to receiving basic care from black or brown nurses in the acute care setting. This might include basic procedures as wound dressing or even when patients are receiving injections. However, when contrasting vignettes from diaries and journals of White nurses, the analysis concludes that racial microaggression is predominant (Cottingham et al., 2018). In an instance where mentally ill patients are involved, the aggressive and uncooperative tendency may be non-partisan to all nurses regardless of race. But mentally stable racist patients exhibit a biased selective cooperation, especially in regard to nurses of color. Black nurses reported feelings of having to “prove” themselves because their White counterparts were treated as though they were smarter (Cottingham et al., 2018).

Perceived racism contributes to persistent work-related stress leading to reduced healthcare quality. Organizations thus have a responsibility to normalize reporting and support clinicians experiencing discrimination from patients. Quiet acceptance of biased and racist patient behavior is not defensible in healthcare work environments. The lack of policies and training has been pointed out as a perpetrator with a complicit role in structural violence, of white supremacy, white privilege, and racism that side-lines and discriminates against Black and Brown nurses (Brathwaite et al., 2021). Nurses of color were observed to experience different
forms of racism in their working environment that weighed down on their psychological and emotional strength (Iheduru-Anderson et al., 2021).

Iheduru-Anderson et al. (2021) indicated that with respect to the disregard of personhood, participants expressed that they not only experienced a feeling of disregard from patients’ family members, but also from colleagues and the department at large. They elaborated that as a nurse, their responses to patient discussions and their treatment opinions were not valued in the overall patient management. Black and Brown nurses experienced less respect compared to their white peers and this would make them “want to disappear” (Iheduru-Anderson et al., 2021). As a result, black nurses spent a considerable amount of time and energy engaging in activities to convince others of their professional worth and competence (Wilson, 2007). Davis and Davis (1998) identified a similar phenomenon in their study of ethnic minority faculty. Several participants in highlighted articles, described unfair and unequal treatment in the workplace and used phrases such as dumped on, with schedules, patient assignments, and even unit assignments being racially determined (Cottingham et al., 2018).

Moreci (2014) utilized a descriptive study design that employed both qualitative and quantitative methods to survey over 100 Hispanic nurses about their experiences with racism and microaggressions in an acute care setting. Several themes emerged such as belonging and “only-ness,” being overlooked, undervalued and having to prove competency. Additionally, Black nurses perceived that they were often “invisible and voiceless” in the workplace. They reported many situations in which their colleagues, other health care providers, and the patients that they cared for openly ignored them (Moreci, 2014). As positive and powerful an experience as connecting with the patient was, so too was proving yourself (Wilson, 2007). Despite all of the positive feelings associated with connecting with the patients, constant perceptions of lack of value and respect by colleagues and sometimes patients, often overshadowed these feelings. These nurses found themselves caught between feeling a sense of pride and accomplishment
at having fulfilled their dream of becoming an RN and their real feelings of lack of full acceptance in their chosen profession. From the retention perspective, it is essential that support is provided to Black and Brown nurses so that they remain in the workforce in order to continue to provide culturally congruent care. The studies reviewed were similar in this regard, each highlighting the premise that retention of a diverse workforce increases trust and outcomes with racial and ethnic minority patient populations.

The majority of Latino nurses in survey studies reported hearing negative comments, including assumptions that they were not qualified, and had patients request other nurses who were not Latino (Moceri, 2014). Interview studies also found that nurses reported that patients also mistook them for healthcare aides or housekeepers, because of their race/ethnicity (Moceri, 2014). In another qualitative study, Black nurses reported a lack of acceptance of their credentials, abilities, expertise, and knowledge by their patients, regardless of their patients' race (Wilson, 2007). A qualitative study on internationally educated nurses reported that they were questioned by their patients about their country of origin, how long they have been practicing, and how long they have been in the U.S. (Wheeler, Foster, & Hepburn, 2014).

Villarruel and Broom (2020) expressed nursing staff’s feeling of utter sadness with the experience of hospital administration extending structural racism, ignited by a patient who refused to be attended to by a nurse of color. The article illustrates that patient satisfaction is paramount and it affects the dynamics of how care is provided by healthcare professionals. However, hospital leadership often focused on finding a compromise rather than a systematic way of handling these situations. These compromises are often perceived as a losing situation to healthcare workers. The challenge arises when patients and staff are forced to work with each other despite patients’ negative expression towards a particular staff member. Similarly, when patients are allowed to dictate the race of a nurse who cares for them, it condones racist behaviors (Villarruel & Broome, 2020).
According to Byers et al., (2021), studies on racism-related stress in nurses were not found in published Nursing research, but have been well-studied in the fields of psychology and Sociology. In a 2009 study of sociodemographic variations in self-reported racism by Black/African American and Latinx persons, Brondo et. al., (2007), highlighted that participants experienced racism regardless of socioeconomic station, which supports the assertion that professionals or persons with higher education (e.g., nurses) are not exempt from exposure to racism. This study also found that Black/African American participants experienced more lifetime, chronic exposure to racism than did Latinx participants.

**Organizational Programming**

The American Association of Colleges of Nursing (AACN) curricular standards for baccalaureate nursing education provided four changes for immediate implementation to overcome structural, individual, and ideological racism (AACN, 2019). Other professions, such as social work, and medicine, have taken steps to address social injustice by integrating anti-racism into their curricula. The National Association of Social Workers (NASW, 2000) advocates for “social justice and social change” and included racism and health equity in its mission to eradicate discrimination, oppression, poverty, and other forms of social injustice. In October 2020, the Association of American Medical Colleges (AAMC) released a four-pillar framework to boldly address racism. Following the social-ecological model, the AAMC framework considers the different levels of human interaction; individual self-reflection, education about structural racism; embracing anti-racist, diverse, equitable, and inclusive thinking within an organization; collaborating with the academic communities for professional development opportunities and workforce diversity and inclusion; and speaking out about systemic racism and expanding their efforts into communities (Addressing and Eliminating Racism and the AAMC and Beyond, 2020). Butler, et al. (2021) suggested that Accreditation Council for Pharmacy Education (ACPE) Standards for Doctor of Pharmacy degree introduce the five-phase framework, Pharmacy Health Equity Anti-Racism Training (Rx-HEART), which provides guidance on how to
accomplish the objectives of antiracist education in their curriculum. Wing et al. (2019), proposed a multipronged approach for response to racism in the acute care setting and suggest that action be organized into four main goals of microinterventions: (a) make the invisible visible, (b) disarm the microaggression, (c) educate the perpetrator, and (d) seek external reinforcement or support. Though several articles describe specific tactics that could help to provide this type of support in our hospitals and healthcare systems, there were no reports of hospital-based programs to achieve this goal.

**Support care approach to post racism encounter**

Psychological support is an important way to increase/help/promote psychological resilience among Black and Brown nurses experiencing racist attacks and prejudice. Cottingham et al., (2018) highlight that Black and Brown nurses adopted various strategies of coping with racist experiences within the care setting. Nurses of color confessed that racist encounters take a toll on them, however, to be able to maintain the ethical values of the nursing profession they are forced to compromise their own emotional frustration resulting from racial encounters, in place of the provision of care (Cottingham et al., 2018). In a common case scenario both microaggressions and White fragility leave Black and Brown nurses in a state of disequilibrium both psychologically, mentally, and the overall perception of oneself.

Organizational support, or the lack thereof, critically shapes the post-racism encounter experience. In an event where the nurse of color works in an environment where the organizational leadership is not willing to address these behaviors, the nurse is left with nowhere to turn for support during and after an incidence of White fragility (Garran & Rasmussen, 2019). For example, a White nurse is discussing a patient’s case with a group of nurses including two Black nurses. The White nurse makes a comment about how the patient’s behavior was typical for someone from a certain racial or ethnic background. The Black nurses feel uncomfortable with this generalization and share their concerns about stereotyping and bias. However, the White nurse becomes defensive and insists that they are just sharing
observations and didn’t mean to offend anyone. The end result is that the Black nurses feel dismissed and frustrated that their concerns are not being taken seriously with the implication that the Black nurses are being overly sensitive.

In White fragility, the “aggressor” usually becomes the victim and the primary victim who is the nurse of color in this case, is left to manage the emotional consequences on their own without support. Such organizations tend to support the aggressor of White fragility and racial microaggression rather than the primary victim employee who faces the risk of psychological breakdown (Garran & Rasmussen, 2019).

Further, it is highlighted that for an effective support care post-racist encounter, the leadership in any organization or hospital are key. To operationalize the overall anti-racist mission, leadership must ensure that Black and Brown nurses receive appropriate support to prevent psychological breakdown, mental distress, and the ensuing intent to leave among the nurses of color who experience racist incidents (Garran & Rasmussen, 2019).

Support care for employees who face different forms of discrimination including racism, can be in the form of various facilitator lead ‘lunch and learns,’ to bring general awareness of discrimination in the workplace and counselling for those who express that they have had racism related encounters. Individual coaching of staff who are struggling to address racist behaviors and implementing clear consequences for employees who may exhibit racist behaviors are important to embed the mission of anti-racism into practice (Burns, 2022).

**Psychological resilience**

Resilience is the process of effectively coping with adversity, trauma, threats and other significant sources of stress, and the ability to bounce back (APA, 2016). It is also highly dependent on the constructs that exist in various aspects of society (APA, 2016). Compassionate care is a rudimentary principle in nursing care and has been observed to be genuinely therapeutic to patients (Kinman & Leggetter, 2016). It is posited that, despite a combination of hands-on knowledge and technical skills, patients’ satisfaction and perception of
Clinical competence is based on the quality of the compassionate care they receive. Furthermore, the overall satisfaction score is influenced by the quality of interpersonal relationships between the nurses and the patients (Kinman & Leggetter, 2016). In the acute care setting where the mission of compassionate care is foundational, Black and Brown nurses’ struggle with the distress of coping with the emotional labor of handling the psychological effects after a racism encounter and caring for the same patient, or working continuously with a racist colleague. Contingham et al. (2018) highlights that emotional labor entails the management of one’s negative emotions and the cultivation of positive emotions as determined by the nursing role. The nurse is placed in the setting where they are tasked with the need to effectively manage their own emotions and that of others’ including patients, physicians, colleagues and patient’s families’. These skills of emotional intelligence are important so that patients and their families retain a sense that they are receiving calm, confident, and effective care or service (Contingham et al., 2018). Trutt and Snyder (2019), highlight that Black and Brown nurses adopt coping strategies such as consulting with personal support systems, including friends outside of work or family members in order to ease the tension and maintain nursing ethics. Among nurses of color advanced in age, the practice of singing a hymn was also highlighted as a key strategy especially when handling a racially aggressive patient who is in crisis and needs emergency care (Truitt & Snyder, 2019). Carter and Forsyth, (2010), found that participants were most likely to seek support and assistance from close friends and family who had experienced, and believed they had recovered from, the pain of racism-related encounters (Carter & Forsyth, 2010).

According to Byers et al., (2019), there is a significant correlation between participants’ perceived psychological resilience, their ability to assess the nature of the racism related stressor, and their ability to mitigate the resulting harmful effects by identifying and utilizing their coping resources. There was also a negative correlation between racism-related stress and psychological resilience.
Project Model

A logic model was selected as a framework for implementation of this DNP project, which was implemented in four phases. The phased model consisted of inputs, outputs and outcomes. The four phases are briefly described here:

Phase 1 - Planning phase of project: Identification of resources, costs, contributors, decision makers.

Phase 2 - Development of a hospital training program with curriculum materials (online training module) in collaboration with Talent Development and Learning, and Nursing Professional Development

Phase 3 - Training launch and implementation, go live. Developed online module to be launched into the PEAK (internal electronic training system). Developed assessment tools: pre and post self-efficacy survey to determine post-training change in confidence level regarding handling a racism encounter and a five-question program evaluation.

Phase 4 - Review of progress, program evaluation and survey results used bivariate and descriptive statistics. Results were analyzed and recommendations made

Supporting Theoretical Framework

The supporting theoretical framework selected for this project was the Minority Stress Model (Meyer, 2003). The model depicts stress processes experienced by members of the LGBTQ+ community who are affected by homophobia, transphobia, and other discrimination related to their sexual orientation and or gender expression. The basis for minority stress theory is that there are social stressors specific to a minority group, and these stressors are far beyond the stress experienced by those who are not socially stigmatized. While created to help illustrate and depict experiences and needs in the LGBTQ+ community, the Minority Stress Model is generalizable to other socially stigmatized groups. The model was later reconceptualized with Black/African American people as the stigmatized population and racism as the stressor. (Byers, et al 2021). Using this model helped with the understanding of minority stress,
specifically racism-related stress and psychological resilience in nurses. As it relates to Black and Brown nurses who face racism in the acute care setting, this project focused mostly on the Distal Minority, Allosteric and Resilience domains of the model. Within the Distal Minority domain, Black and Brown nurses may experience prejudice, discrimination and violence from patients, families or peers. In the Allosteric domain they experience both the physical and mental effects of racism. The intervention in this pilot focused on the Resilience domain to provide for coping strategies, social support and system or community resources.

**Organizational Assessment**

This hospital system is a large urban academic medical center in New York City, comprised of eight acute care hospitals with over 42,000 employees, more than 400 community and ambulatory locations and 38 institutes, more than 7,000 physicians, including general practitioners and specialists. The health system sees over 133, 283 inpatient admissions, over 3,736, 090 outpatient office visits, 396, 714 emergency department visits with 3,808 beds and 144 combined operating rooms and an annual revenue of $9.3 billion.

**Mission**

The mission of the organization is to provide compassionate patient care with seamless coordination and to advance medicine through unrivaled education, research, and outreach in the many diverse communities we serve.

**Vision**

The vision of the organization is to continue to grow and challenge convention through our pioneering spirit, scientific advancement, forward-thinking leadership, and collaborative approach to providing exceptional patient care in the many unique communities we serve.

**Core Values**

The core values of the organization are Safety, Equity, Agility, Creativity, Empathy, and Teamwork. The most recent addition to the organization’s Core Values was Equity and the goal is to create a diverse and inclusive environment of our patients, students and colleagues, free
from bias, racism and favoritism, in order to foster optimal care and just opportunities based on one’s individual needs.

The key external drivers are the regulatory landscape, market share and reimbursement regulations, the impact of COVID-19 pandemic which has strained general systems and resources. The national healthcare labor shortage is evidenced in this system which currently has a nursing turnover of around 18%. This organization also engages in significant strategic support, advisory and consulting services to international partners. Some of these include dedicated oversight of clinical performance, feasibility studies, clinical care and clinical research collaborations, assessment of human resource needs, executive recruitment guidance, advising on clinical and non-clinical governance structures and preparation for Joint Commission International accreditation. Countries with these strategic partnerships include Nigeria, Paraguay, Qatar, El Salvador, Nepal, Ghana, China and Guyana.

**Strengths, Weaknesses, Opportunities & Threats (SWOT)**

A SWOT Analysis was conducted for this project. Looking internally, strengths and weaknesses were identified. This health system’s strengths in this area lie in its reputation as being a leader in the diversity and health equity space, strongly ranked in reputation and care by US News and World Report as number 17 in the nation, and a rich history of caring for and implementing policy related to health equity of marginalized communities. In 2021 the organization developed and began implementing its Roadmap to Antiracism which outlines a strategic plan and process to become an antiracist organization. This project is in alignment with the strategic plan and as action towards advancing implementation of the antiracism roadmap.

Among all of the eight hospitals, one of the strengths of the pilot site organization is that it is a Lean hospital, with an environment grounded in the principles of process improvement and is the home of the system’s Lean Learning Lab. Another strength is that Just Culture is being rolled out as a framework for addressing findings of root cause analyses and corrective
actions for both employee error and systems related issues and errors. Just culture is a concept related to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than solely brought about by the person or persons directly involved (www.outcome.eng.com).

With this said, among the weaknesses in the organization with respect to this project is the lack of uptake and knowledge of a newly developed anti-racism policy about racist patients, a lack of tracking racism experiences encountered by nurses, and no capture of data to know whether or not racist experiences played a role in nurses’ decisions to leave the organization. Additionally, fear of retaliation may also exist for reporting of racist experiences as Just Culture training has not yet been fully available for the bedside nurses, lending to potential underreporting of racist encounters. Not all hospital sites have fully embraced the anti-racist roadmap that was rolled out by the system in 2021. Better leveraging of employee resource groups, maximizing communication through the health system Nurses Against Racism (NAR) committees, better policy dissemination, and strengthening relationships with the Office of Diversity Equity and Inclusion is needed. There a considerable amount of attrition due to the burnout experienced by nurses in general since the COVID-19 pandemic, requiring high-cost agency staffing which adversely impacts hospital finances and may affect the feasibility or sustainability of this project.

External assessment included identification of opportunities and threats. Opportunities lie in creating an environment and image of the system as an anti-racist organization, thus increasing the organization’s ability to recruit and retain black and brown nurses during a time of staffing shortages. There is an opportunity to further enculturate diverse and transcultural nursing care for the populations served and to achieve the Joint Commission’s new Health Equity certification, further extending the organizations cultural competency, While the activities of the union may threaten the hospitals image and finances, this program may present an opportunity to improve relations between the organization with the union and their members.
There are several threats which had the potential to impact this work. The union contract negotiation activities which from time-to-time results in contentious discussions around attrition and retention of nurses can affect the culture and reputation of the organization, its financial stability and resource allocations. Additionally, there are a limited number of experts who provide external consulting and objectivity with regard to antiracism in the acute care patient setting, which may threaten achievement of the organization’s overall antiracism goal.

Also, there is a competitive threat from other hospital systems who are developing similar programs which could enhance their ‘best place to work’ profile and attract nurses.
Part 2
Methods

Overview of Methods

This DNP Quality Improvement project developed and implemented a program to support Black and Brown nurses, post-racism encounters in the acute care inpatient setting.

**Goal and Aims of the Project:**

This DNP project aim was to:

1. To develop a hospital training program for support for nurses after racist encounters in the acute care setting.
2. To implement and evaluate the program
3. To make recommendations for sustainability and scaling of the program

**Aims and Associated Methods**

AIM 1: To develop an online hospital training module for support for nurses after racist encounters

Development

Project Leadership formation:

As part of the foundation for creation of a training module, the Project Manager convened a Steering Committee whose role was to collaborate on the development of the curriculum, approve and allocate resources, oversee progress and receive reports on the overall status of the project implementation and results. This Steering Committee comprised of:

- Director of Nursing Professional Development
- CNO (Project Manager)
- Senior Director Office of Diversity and Inclusion
- Senior Nursing Training Specialist, Talent Development & Learning (TDL)
- Nursing Education Manager

The Steering Committee met bi-weekly in September 2023 and monthly beginning Q4 2023.

Participant Identification:

- The target audience was incumbent RNs
- A total 400 participant incumbent RNs were invited to participate in the online training in Q3/Q4 2023.

Recruitment/Enrollment Plan:

As part of the system requirements, participants received a QI Informational Letter attached to an email invitation from the Project Manager informing them that the education sessions were part of a Quality Improvement Project. The email invitation contained:

- The overall project information
- Voluntary participation requirements
- Average length of time of the training
- QR code with a link for easy access to register for the PEAK online training module

Development of Curriculum:

The program objectives and educational curriculum were developed by the Project Manager and content reviewed for clarity and adherence to objectives in collaboration with the Steering committee by Q1 2023. The components of the training module and curriculum were adjusted based on feedback included:

- Definitions of key words applicable to the subject matter for e.g., moral distress in healthcare, allyship, micro-aggression, implicit and explicit bias, prejudice
- Video on Allyship
- Case scenario of a racism encounter with a patient and family
- Case scenario of a racism encounter with a colleague
- How to report racism encounters (Corporate Compliance Hotline and Safetynet)
- Identification of support and resources present to help cope with feelings after racism encounters (contact information for Employee Assistant Program, Spiritual Care and Center for Stress Resilience and Personal Growth)
- Review of the Pocket Guide for Responding to Discriminatory Patient Behavior
- Nursing Education and the Project Manager will be the keepers of collaboratively shared course learning materials

**Expert panel:**
- An external panel of three national experts were engaged to review final content using the Expert Panel tool during Q1 2023.

**Plan for delivery method and format of sessions:**

Sessions will include:

A 15-minute online education module (for incumbent RNs) was offered on demand via the online learning environment PEAK, (a secure online electronic learning platform for accessible by the organization’s staff only) inclusive of a pre and post- self-efficacy survey. Once developed, it was loaded into the PEAK environment by Q3 2023. The components of this module are listed previously in the curriculum development section.

- Nursing Education and the Project Manager will be the keepers of course learning materials and the participation will be tracked within the PEAK reporting system.

**Resources included:**

- IT for technical support
• Digital Design Team representative for design of PEAK module
• Center for Nursing Research and Innovation representative for consultation and training for the use and creation of ReCap survey resource
• Learning Space and computer access:
  • Computer room at the pilot site
  • Unit based desktops for online training

Preparation/choice of outcome assessments/evaluations

Two outcome assessments were used in this project: pre and post self-efficacy surveys and a program evaluation.

  • The first outcome measured, the nurses’ level of confidence and self-efficacy related to awareness of support and resources of nurses who encounter a racist incident was measured by a pre and post self-efficacy survey based on Bandura’s model. The surveys were developed to assess participants’ confidence level regarding handling a racism encounter and understanding of support structures in place in the organization. According to Panc et al. 2012, self-efficacy is a key protective factor against psychological stress. In the socio-cognitive theory proposed by Bandura (1994), perceived self-efficacy is the belief system that people have regarding their performance and capabilities to produce influence over their lives and situations affecting their lives. The survey consisted of 17 five-point Likert scale questions (scored from 1 (low) to 5 (high) for a total scale score of 85 points. Additionally, there was one open ended question for comments.

  • The second outcome measure, a Program Evaluation, was developed to elicit participants’ feedback regarding the program and its effectiveness in meeting
its objectives. It consisted of four 4-point Likert scale questions, one 2-point Likert scale questions for a total of 18 points, and one open ended question.

At the onset of the module (first screen), demographic information (ethnic/race self-identification) was collected. To maintain confidentiality, participants received instructions on how to create a unique alpha-numeric identifier that they used for all surveys. (Participants were also be informed that in order to progress through the education and receive a certificate of completion, they were required to complete the pre-and post self-efficacy surveys and the program evaluation using the same self-selected unique identifier for all surveys.

Data Storage Plan

- Nursing Education and the Project Manager were the keepers of course didactic material. Electronic data was kept on the protected organization server within the PEAK online system, and with the Project Manager via an encrypted hard drive. Project Manager accessed de-identified data for purposes of evaluation of this DNP Project. Survey results were tracked using each participant’s self-assigned unique identifier.

AIM 2: To implement and evaluate the program

Implementation

The pilot launched 3rd quarter 2023 and ran for a total of 12 weeks.

Meetings with Steering Committee team were held according to schedule set in Aim 1.

Senior leadership received bi-monthly to quarterly updates beginning September 2023.

Implementation of the training program

- It was anticipated that a minimum total of 50 participants would enroll in the project.

- All training was voluntary
The online hospital training for incumbents was launched during the 4th quarter 2023 and the email invitation letter was sent weekly from the November 16th 2023 by the Project Manager, to the Nurses email listserv.

Nursing Education was the primary back up for reminder email communications to enrollees, and was sent bi-weekly during 12 week project period, beginning December to 2023, to the Nurses email listserv.

All incumbent RNs were invited to register to take the 15-minute online module in Q3/Q4 2023, which was loaded onto the online learning platform.

Communication about the pilot program was communicated via the employee resource group (NAR), and internal hospital social media app channel.

Administration of evaluations

The pre and post self-efficacy surveys were administered and submitted immediately before and after the module within the online environment.

The Program evaluation was administered to participants after the online module completion.

Evaluation

Descriptive and bivariate statistics were used to evaluate outcomes.

- The pre-and post-self-efficacy surveys were compared using a paired T-test to compare confidence levels regarding management of a racism encounter.
- The program evaluation was analyzed descriptively.
- Evaluation of the data took place during the 1st quarter of 2024.

AIM 3: To make recommendations for scaling and sustainability of the program

After the pilot was completed at the hospital site, evaluation of results were reported to senior management, and decisions were made in collaboration with system and senior leadership as to
whether be made on whether to continue the program as it is structured, whether modifications would be required, and whether to scale to additional hospital sites.

**Sustainability**

The project outcomes were presented to key stakeholders including nursing executive leadership. The presentation included statistical and descriptive findings, program evaluation, and opportunities for improvement. A formal recommendation was made for ongoing sustainability of the program.

A sustainability plan was provided to support the ongoing technical and operational needs of the program. By embedding into orientation via on-demand module, it will become required learning for incumbent and new nursing teams. Instructions will clarify that the module is intended for all nurses and access is not limited by race or ethnicity. In order to ensure ongoing robust evaluation, it is recommended that program evaluation continue with confidentiality safeguards. Recommendations for program adjustments will continue to be collected from nurse participants, employee resource group, Office of Diversity and Inclusion, and from senior leadership.

Periodic review of aggregated data by the Nurses Against Racism Committee and Talent Development and Learning team for program will ensure modification and improvement as needed.

**Scaling**

Results were reviewed with the system Chief Nurse Executive and other leadership and a plan for scaling across the health system is being formulated. At the request of the Office of Equity and Inclusion (ODEI), additional scale is planned with program modification to accomplish education of all health system employees.

**Dissemination**

The project manager submitted abstracts to several conferences and peer reviewed journals for podium and poster presentations for 2025.
Statement related to human subjects

This project was a quality improvement project and posed minimal risk to the participants.
Part 3
Systems, Policy and Business Implications

Systems Overview:

This health is heavily engaged in work to become an anti-racist organization and this project was in alignment with the culture and Roadmap to becoming an Antiracist organization. Several hospital sites are also in the process of submitting Leap Frog quality data for health grades designation and the Office of Diversity Equity and Inclusion is collaborating with all hospitals for an assessment of the new Joint Commission certification for Health Equity. This DNP Project was timely for implementation as it closely aligns with the organization’s mission and vision, its recently added value of Equity and related goals and initiatives. The health system was in the process of an executive search for a new Chief Executive Officer. It is also restructuring the workforce in order to minimize workforce expenses associated with the utilization of agency staffing and the increased salary costs due to recently negotiated Collective Bargaining Agreements. Additionally, a market review and competitor analysis of nurse leader salaries necessitated system-wide nurse manager salary increase as a retention strategy. The latest employee engagement survey was administered in March of 2023 to all the hospital sites; however, due to other business initiatives, the RN engagement component was not administered system-wide. Considering these workforce and budgetary challenges, this DNP project also aligned with recruitment and retention strategies and to ultimately to reduce the costly effects of intent to leave and turnover.

The Business Case and Leadership Engagement

Leadership and Stakeholder Engagement

The Vice President/Chief Nursing Officer, was the Project Manager for the implementation of this project and the development of an online hospital training program that highlighted support for Black and Brown nurses after experiencing racism in an acute care
hospital setting. The most recent addition to the Core Values was Equity and the goal is to create a diverse and inclusive environment of our patients, students and colleagues, free from bias, racism and favoritism, in order to foster optimal care and just opportunities based on one’s individual needs.

The sponsor for this project was the Chief Nurse Executive and stakeholders included:

- RNs at the pilot site
- Talent Development and Learning Training Specialist
- Office of Diversity, Equity and Inclusion (ODI)
- The Hospital President
- Nursing Professional Development
- Department of Digital Technology Partners

Zoom meetings were set up with the Steering Committee, for development of the training and curriculum and with senior leaders for communication of program updates. In using the Human Centered approach to leadership model, this approach begins with the leader’s mind, body and spirit within a larger complex system. The Human-Centered Leader realizes success in nurturing cultures of Excellence, Trust, and Caring by being an Awakener, a Connector and an Upholder. The Project Manager sought to be a Connector to help bridge the current gap in knowledge of support after a Black and Brown nurse experiences racism in the hopes that it can mitigate their intent to leave. According to Leclerc et al. 2020, among the attributes of a Connector is a Collaborator, unifying others around a shared mission and vision, a Nurturer, building communities and an Engineer, ensuring that people are plugged into processes, an Authentic communicator, building mutual respect and trust. The Project Manager ensured alignment with the organization’s culture and approach to being antiracist by checking in and fostering inclusiveness with stakeholders from ODI, sponsor, and by incorporating their
feedback and suggestions. Approaches were adjusted to the training based on suggestions from our Training Specialists if needed as they are experts in the field of learning and delivery of effective teaching for the adult learner. The ODEI stakeholders provided guidance on the use of key terms utilized in the training and shared best practices for development of case studies that discussed content related to diversity and racism.

Nursing Professional Development stakeholders helped to review the learning objectives for the online training module and shared feedback for consideration. The training curriculum was developed and reviewed by an external panel of three experts on the subject matter of antiracism, diversity and equity in healthcare.

**Business and Financial Considerations**

Return on Investment (ROI)

Nationally, it is estimated that 25% of nurses experience mistreatment by patients each year, but many fail to report these episodes (Campbell, 2016). The reasons are complex. Many organizations do not currently ask about the impact of diversity or racism as part of the RN’s decision to leave and there is no clear reporting structure to capture racist encounters. Though recent study results for average costs of nurse turnover is $22,000 to $64,000 (U.S.) per nurse (Advisory Board, 1999; Jones, 2005; OBrien-Pallas et al., 2006; Stone et al., 2003), the turnover cost of a RN at this organization is estimated to be $96,000. In 2021 and 2022 a combined total of 121 Black and Brown nurses resigned, resulting in an estimated $11,616,000 worth of RN turnover costs. Because this organization does not actively ask whether racism played a part in the decision to leave on exit interviews, (collects it only if offered), it is currently unknown whether racism played a role in why any of these nurses left.

The impact of mitigating this as a possible reason for RN resignations can result in significant reduction in RN turnover costs, if even one RN less were to leave the bedside. The Return on Investment (ROI) analysis illustrates minor initial upfront costs with significant indirect
benefit costs of reducing this RN turn over type. Conservatively, with the assumption that if just one Black or Brown nurse stayed after encountering a racism experience, the four-year projected cumulative savings would be at least $384,000.

On the other hand, the cost of this program is $2,694 with the potential to generate a return on investment of $480,000 over five years.

**Risk Assessment and Mitigation Plan**

Though this health system is on the path to becoming an antiracist organization, there is still a level of apprehension from some stakeholders to fully embrace sensitive topics such as racism. The Risk Assessment Matrix outlined the risks for which mitigation strategies were developed. Low risks included stakeholders refusing to engage in planning, disagreement about the project plan, lack of senior executive support, lack of meeting space, and Nursing Education not being available to teach sessions. Low risks were prevented through the planning process which included engagement of stakeholders including senior leaders, creation of structures such as the steering committee and organizational approvals to proceed.

Stakeholder engagement included close communication with the Office of Diversity Equity and Inclusion which was essential to help clarify and incorporate feedback and mitigate any content and training concerns, given their role with the Anti-Racism Roadmap implementation for the organization.

While nurses may or may not have felt safe in speaking up about their encounters at the time of the occurrence, they may feel safe to do so within the context of, or immediately after, the online training sessions. As such, there was a high risk that during the education, nurses may have disclosed being victims of racism by patients or family members, that was previously unknown. The online module included resources which are available to help manage ongoing and or past racism experiences which could have resulted in emotional distress.
There may be perceived legal, labor or employee relations risk assessed as high risk which could have impeded future scaling of the project. To manage these potential risks, Labor Relations and hospital risk management/legal departments were engaged and notified if there were significant findings of the pre-course questionnaire (aggregated data) at the conclusion of this pilot.

There was a high risk that Black and Brown nurse fear of lack of confidentiality and that it will adversely affect the willingness to participate. The risk mitigation strategy was to provide information at the onset of the training session regarding confidentiality of the survey results and any verbatim comments. For those who were un-embracing of the training, the mitigation action was to present the option to not participate and discuss their specific concerns with the project manager. The project manager continued to highlight the project benefits which is fully aligned with the values and the relatively new Anti-Racism Roadmap.

There was a high risk that if a nurse revealed in verbatim comments that a reported experience of racism was not addressed by the leadership team or no support was provided. The risk mitigation strategy was to follow the process for referral of the employee to system resources as noted above, if participant included their contact information. Additionally, there was a medium risk of nurses reporting or remembering past traumatic experiences related to experiencing racism encounters and for this, the mitigation strategy was to include support resources including the Center for Stress Resilience and Personal Growth’s contact information available for anyone who express emotional concerns after taking the training.
PART 4.
RESULTS

Data Analysis

A total of 105 nurses completed the training module and completed the demographic questionnaire. 39% self-identified as Black, 17% as Brown, 13% as White, 9% Asian, 5% Other, 5% as Mixed Race, 4% Latinx, 3% Pacific Islander, 3% Middle Eastern, 2% Filipino. As noted in the Methods, each participant created a self-ascribed identification number and no further demographics were collected to protect participant confidentiality and to limit participant burden.

The project evaluated whether self-efficacy increased for nurses' post-program. Nurse self-efficacy was assessed using a 17-item Likert-scale questionnaire with one open ended question, evaluated before and after the training, and participants were also provided a six question post-course evaluation. A paired samples t-test was used to evaluate if there was a significant difference in mean self-efficacy before and after the program for nurses who participated in the project. Descriptive analyses were also conducted at the item-level on the self-efficacy scale and on the post-training evaluations to provide information on intervention efficacy and areas for further development.

Self-Efficacy findings

Since 85/105 nurses (81% completion rate) provided responses solely to the post-survey, only complete records were used for T-test analysis (n=84).

In addition, 6 questions comprising an “awareness of resources” subset was analyzed descriptively as well. These questions assessed participants' knowledge of specific resources in the system.
Results of pre and post self-efficacy survey comparisons

Total score findings on self-efficacy

Paired-samples t-tests indicated that post-test scores (M= 76.82, SD= 10.03) were significantly higher than pre-tests (M= 67.19, SD= 13.305), (t(84) = -5.167, p<.004). These results support the presence of improvements in self-efficacy post-intervention that were of moderate magnitude (Table 2). Overall, there was an average 0.54 data point increase from pre-survey to post-survey responses, with all mean values for questions ranging from 4 (“Agree”) to 5 (“Strongly agree”) (Table 2).

Awareness of resources subset findings

For questions 1, 3, 11, 12, 13, and 14, all mean values increased from pre-survey to post-survey, indicating higher awareness for reporting mechanisms and resources within this health system. Given that post-survey mean values range from 4 to 5 for these questions, participants answered more consistently in the “Agree” and “Strongly Agree” categories in the post-survey. The pre-course mean, median and mean range scores were 3.81, 3.76 and 0.65 respectively, and post course mean, median and mean range scores were 4.35, 4.38 and 0.36 respectively (Table 3).

Program Evaluation findings

Sixty-one respondents of the 85 who participated in the program completed the Post Training Program Evaluation. In response to question one, “The content of this course was easily understandable” and question two, “The terms and definitions were relevant to the topics and helpful in understanding the subject matter”, 41 participants said “Extremely” (67%) and 19 participants said “Mostly” (31%). Only 1 participant responded “Somewhat” (2%). In response to question 3, “This course helped me to better understand the process for reporting racist encounters”, 44 participants responded “Extremely” (72%), 13 participants said “Mostly” (21%),
and 4 participants responded “Somewhat” (7%). In response to question four, “This course helped me to better understand the support provided by the organization if I experience racism while at work”, 39 participants responded “Extremely” (64%), 17 participants said “Mostly” (28%), and 5 participants responded “Somewhat” (8%). In response to question five, length of the course, 59 participants said the length was “Appropriate” (97%). Only one participant responded with “Inappropriate”, and one participant did not answer.
PART 5. DISCUSSION AND CONCLUSION

Discussion

Discussion and Conclusions

The project results demonstrated that the training improved participants’ understanding of the topic of racism, awareness of available support, and how to respond when faced with racism experiences from patients and peers. The program evaluation findings demonstrate that training and awareness of support can help to mitigate moral distress in the acute care setting, after being exposed to these racist experiences. The awareness of resources subset survey findings supported the value of the program in increasing nurses’ knowledge and understanding of resources available to them. The longer-term potential outcome, retention of black and brown nurses, could not be determined in this short-term project. This is a consideration for future longer-term work related to this project topic.

Limitations

Initial survey respondents indicated that because of the title of the project, they did not know that they could also participate if they self-identified with races other than Black or Brown. Once eligibility to take the survey was clarified the participation immediately increased. The initial minimum participation number predicted was 50 participants and though participation in the training module far exceeded this number at 105, not all of these RNS completed the pre and post surveys. Of that number 85 RNs completed both the training module and the pre and post-surveys. This is thought to be as a result of participants having to leave the learning environment window in order to access the survey questions which were housed separately in the RedCap platform. Both items could not be linked onto one platform and participants were reminded of this at the beginning of the course, as well as in the participant email reminders.
61 out 85 nurses completed the program evaluation (72%). Out of the 61 nurses who did complete the program evaluation, nearly half of the nurses (46%) declined to add comments or suggestions. Due to this distribution, those who did provide commentary likely felt strongly about the training which may have skewed this result either negatively or positively. Responses were not collected by RN specialty type, gender or levels of RN experience.

**Review or Modifications for Sustainability**

Modification of the initial survey instructions would specify that the training is open to all nurses employed at the health system. The program evaluations would be reviewed by the Talent Development and Learning team, along with the system co-chairs of the Nurses Against Racism committee on a quarterly basis. This would provide opportunities for suggestions on modifying based on feedback, so that adjustments can be made as needed.

**Recommendations for Modifications and Sustainability**

It is recommended that the current module is sustainable through general orientation embedded on-demand module, required for all incumbent and new nursing teams. Modification of the initial survey instructions is recommended to clarify that the training is open to all nurses employed at the health system, regardless of their race or ethnic origin.

It is recommended that ongoing review of outcomes and program evaluations continue within the purview of the Talent Development and Learning team, along with the system co-chairs of the Nurses Against Racism committee on a quarterly basis. This would provide opportunities for adjustment or modification based on data and feedback received.

**Recommendations for Scalability**

This training program is easily scalable to all hospitals system-wide through the use of the current online learning and data collection platforms. Based on participant feedback within the verbatim comments, system nursing leadership and the ODEI, it is recommended that this training program be scaled system-wide to general nursing orientation and for all incumbent nurses.
Recommendations for additional scale to other disciplines includes modification of case studies modified for application to all employees (not just RNs) and module be made available as an on-demand training within the system’s online learning environment for access by any employee. The video, 5 Tips to Being an Ally video can also be modified to 5 Tips to Being an Ally at the Health System, which would allow applicability to any hospital site.

Policy and Implications

This QI project’s results demonstrated that with the use of a simple yet impactful training program, nurses felt confident that they would be able to handle a racist encounter, how to report it and what types of resources are available for help after such an encounter. Nurses who are equipped with the knowledge and skills to address racism in healthcare settings are better positioned to advocate for policy changes that promote health equity and social justice. With a comprehensive understanding of how racism impacts workforce and healthcare delivery, organizations can advocate for policy changes that address racial disparities in healthcare access, outcomes and appreciate the impact this has on nurse retention and culturally competent care. “The patient is always right” mentality that currently exists in several healthcare organizations can contribute to an organization's culture of silent acceptance of negative behaviors towards nurses and the care team.

Conclusion

In conclusion, a training program inclusive of education on key terms on the topic of DEI and racism, case study examples, the process for reporting racist encounters and awareness to access available resources and support post racism encounter in the workplace, can be an effective resource in improving Black and Brown nurses’ self-efficacy. By providing training on racism, nurses in general can have a better understanding of the issues faced by colleagues who have experienced racism, which creates a more supportive and inclusive environment. Ultimately this can lead to an increased sense of belonging and community thereby leading to
increased job satisfaction and retention. Awareness of support after experiencing racism can help nurses navigate the emotional and psychological impact of such experiences.

By acknowledging and addressing racism within the nursing profession, organizations can work towards creating a more equitable and inclusive workplace. This can impact the long-term goal to improve overall retention rates among nurses of color, which as previously stated, has overarching benefits for both cultural congruence and understanding with diverse patients as well as improving diversity among care teams.
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