Development of an LGBTQ Policy to Increase Cultural Competence in the Correctional Health Setting

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Background

In 2015, the percentage of individuals falling under the lesbian, gay, bisexual, transgender, transsexual, queer (LGBTQ) category has increased steadily. The U.S. National Survey of Family Growth, identified: 2.5 percent of female participants between the ages of 20 and 44 classified themselves as being bisexual, and 1.4 percent as homosexual. In men, 3.7 percent of male participants classified themselves as gay, and 1.2 percent identified as bisexual (Butler et al., 2016). The research also suggests that approximately nine million people in the United States identify as something other than heterosexual (e.g., gay, lesbian, bisexual, queer, pansexual, etc.) and another 10 million people who identify as heterosexual report involving in sexual behavior with an individual of the same sex. In general, approximately a quarter of Americans report some level of same-sex attraction. This implies that health care providers should adopt skills to make the LGBTQ population part of the whole health care system. According to the Centers of Disease Control and Prevention (CDC), the LGBTQ population has an increased risk of developing preventable health problems like cervical cancer, HIV, gonorrhea, chlamydia, and hepatitis B due to the discrimination these individuals experience when accessing care (Carabez et al., 2015). Additionally, the LGBTQ population faces several other challenges in healthcare settings and social settings. The prevalence of the LGBTQ population falls under the sexual gender minority individuals. Approximately 4.5% (11 million people) of the United States (U.S.) adult population falls under the LGBTQ population (Lim, Johnson & Eliason, 2015). Of the U.S. population, 5.1% and 3.9% of women and men respectively fall under the LGBTQ population (Lim et al., 2015). The prevalence of LGBTQ

individuals is not limited to the U.S. population only. For example, The United Kingdom also has a substantial prevalence of individuals (3.5%) falling under the LGBTQ population (Lim et al., 2015). According to HEI (2019), there was a reported 73% of LGBTQ patients who reported that they believed that they were treated differently due to their LGBTQ status. There is growing evidence of healthcare disparities and negative health outcomes related to the care offered to LGBTQ individuals, especially those in the correctional health setting (Jaffer et al., 2016). It is integral that staff are culturally competent in the care of LGBTQ clients. One way of increasing staff cultural competence of LGBTQ clients is through the implementation of staff educational training and policies.

Research on LGBTQ is limited, and there is very minimal epidemiological data available to support the prevalence of the LGBTQ population. The literature illustrates that the lack of sufficient epidemiologic data has acted as a barrier to researchers and has obstructed research related to LGBTQ individuals (Paradiso & Lally, 2018). The increasing prevalence of the LGBTQ population calls for intense research in this sector to explore training needs, health promotion needs, and strategies to achieve effective and safe care for this population at all stages of transition. Providers in different settings have shown difficulties and discomfort in communicating with LGBTQ patients when delivering care (Paradiso & Lally, 2018). The most affected area of communication relates to meeting the psychological needs of the LGBTQ population. The LGBTQ population comprises of individuals who portray many behavioral health needs. However, a majority of providers are not prepared to meet these needs as they may not be culturally competent in caring for this population and lack understanding, and knowledge regarding the needs of this population (Rowe, Ng, O'Keefe & Crawford, 2017). Rowe et al. (2017) found that when there was an improvement in nurses' attitudes and knowledge; cultural

competence improved. Rowe et al. (2017) found that nurses embraced a more physical welcoming environment after education training about the LGBTQ population. The training program also enhanced providers' knowledge in performing comprehensive physical assessments on patients in this category in a more friendly and professional manner. This illustrates how important it is to enhance Registered Nurses' (RNs) knowledge on LGTBQ individuals (Rowe et al., 2017).

Problem Statement

Enhancing patient health outcomes and decreasing health disparities are among the core objectives of nurses (Paradiso & Lally, 2018). However, a majority of nurses lack the essential skills, knowledge, and cultural competencies to handle the LGBTQ population (Butler et al., 2016). Literature illustrates that nurses continue to receive little or no training or education to advance their knowledge when dealing with LGBTQ individuals (Sekoni, Gale, Manga-Atangana, Bhadhuri & Jolly, 2015). This has led to a lack of cultural competence when caring for the LGBTQ population. The extent of knowledge and sensitivity that nurses have regarding the LGBTQ population impacts the quality of care this population is given. Additionally, the attitude of registered nurses towards the LGBTQ population impacts the accessibility of care by these patients. It is evident from literature that the LGBTQ population experiences structural and personal barriers that interfere with their ability to access care (Sekoni et al., 2017). A majority of these barriers are external and affiliated to health care providers' knowledge, attitudes, and insensitivity towards this population. The most common barriers noticed in the medical field are; isolation, lack of culturally-competent providers, and inadequate social services (Riggs & Bartholomaeus, 2016). Additionally, a majority of healthcare providers experience personal barriers when providing care to the LGBTQ population (Rowe et al., 2017).

Currently there are gaps in healthcare providers' cultural competence in handling the LGBTQ population. Healthcare providers need to advance their cultural competency skills by enhancing their awareness, knowledge, and receptivity through education (Riggs & Bartholomaeus, 2016). Studies conducted in different settings assessing nurses' attitudes towards the LGTBQ population speculate that personal barriers exist among providers towards the LGBTQ population (Haesler, Bauer & Fetherstonhaugh, 2016). These personal barriers are associated with providers' attitudes, beliefs, prejudices, and behaviors (Haesler et al., 2016). A study conducted by Banerjee (2018) exploring healthcare attitudes towards transgender individuals revealed that there exist significant differences in the attitudes held by providers towards transgender individuals. The findings affirmed that a majority of the expressed attitudes were statistically significant and strongly correlated with negative attitudes (Banerjee et al., 2018). For this reason, it is integral to intervene with education about the LGBTQ population for nurses to enhance their knowledge and attitude towards this population. Additionally, the development of a LGBTQ policy in the correctional health setting would be effective for achieving cultural competence.

Purpose Statement

The purpose of this DNP project is to provide staff educational training in a correctional health setting on the LGBTQ population and develop a cultural competence policy as a strategy to increase staff cultural competency. By achieving this process, the result will increase the nurses' attitudes and knowledge regarding the LGBTQ population, while improving cultural competence towards this population in the correctional health setting.

Project Question

The project question is: Would a LGBTQ educational training program and cultural competence policy to registered nurses in a correctional health setting increase cultural competence within the time frame of this DNP project?

The project question inquiry has been formulated upon the problem, intervention, comparison, outcome, and time method (PICOT). The population of interest is the correctional health setting nurses. The intervention is to implement an LGBTQ educational training program and evidence-based triage policy to staff. The comparison is to the current practice of not following a policy. The outcome would be an improvement in staff cultural competency in the LGBTQ population as evidenced by the staffs' perception when compared to before the implementation of the process. The time period will be within the DNP program.

Project Objectives

The objectives for this project will be completed within the timeframe of the DNP program.

1. Develop an evidence-based policy on the cultural care of LGBTQ patients at the practice site.
2. Provide educational training to nursing staff regarding the cultural care of LGBTQ patients and utilization of the cultural care of LGBTQ policy.
3. Evaluate the impact of the use of the LGBTQ training program and policy with a pre and post MCSE-RD tool following the educational intervention.
4. Disseminate the cultural care of LGBTQ policy to all staff who may care for LGBTQ patients.

Literature Review

Review Coverage and Justification

The articles used in this review were obtained from various online databases, including PubMed, Science Direct, and Google Scholar. The electronic search entailed original articles published in English between 2014 and 2019, describing the impact of educating nurses in correctional facilities about the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) population. The search identified 39 abstracts addressing bias-focused educational interventions to curb the bias among providers towards the LGBTQ population. These educational interventions are effective in increasing knowledge regarding the LGBTQ population in healthcare. Some of the search terms that were used to obtain the articles in these sites included; LGBTQ in healthcare, nurses' attitudes in managing LGBTQ patients, LGBTQ knowledge in healthcare, and LGBTQ patients. The articles were filtered using an inclusion criterion and the final articles that remained for review were 14 articles.

The inclusion criterion was; articles published within the last five years, full-text articles, articles that epitomized interventions to increase knowledge regarding the LGBTQ population in healthcare, and articles that included training to promote culturally-competent care for the LGBTQ group. The used inclusion criterion was effective to filter articles that could answer the topic of study in this project. Articles that did not justify the inclusion criteria were excluded. The selected articles were further assessed, and 10 of the articles that contained strong evidence were selected for review in this paper. All the chosen studies elucidate the impact of educational programs on nurses' knowledge and attitudes towards the LGBTQ population. This content capitalizes on the selected topic of study of the project.

Review Synthesis

The LGBTQ community is one of the groups that have not received appropriate care since historic times. This is attributed to the failure of the social and political arenas to fully recognize LGBTQ needs and be able to put systems in place to address this population's health needs (Rowe, Ng, O'Keefe & Crawford, 2017). The LGBTQ community has also experienced perceived discrimination from healthcare workers, a variable that has limited this population's access to healthcare services. Hafeez, Zeshan, Tahir, Jahan, and Naveed (2017) conducted interviews with LGBTQ individuals to determine if they felt discriminated in care settings. 73% of the LGBTQ individuals that were interviewed reported perceived discrimination (Hafeez et al., 2017). The perceived discrimination was attributed to the attitude of nurses when interacting with LGBTQ patients during the care process.

The LGBTQ community presents as a community with complex needs and calls for the additional training to nurses (Butler et al., 2016). LGBTQ individuals have compound needs in physical and emotional aspects. However, a majority of nurses are not adequately prepared to handle this population's needs (Rowe et al., 2017). The complexity of the needs of this population makes it necessary to provide nurses with LGBTQ-sensitive training to improve their ability to address the health issues raised by these individuals (Paradiso & Lally, 2018). Nurses in different care settings have shown discomfort in communicating with LGBTQ patients during the care process (Lim & Hsu, 2016). This has raised concerns of the ability of nurses to cater to the psychological needs of patients from the LGBTQ population. The need to provide culturally-competent care in correctional settings necessitates the implementation of stratagems to improve nurses' cultural competency.

One of the issues of management of LGBTQ individuals that is still under investigation is the issue of nursing attitudes towards LGBTQ matters. Nurses' attitudes create significant challenges in dealing with LGBTQ individuals' issues primarily by making it impossible to foster therapeutic relationships (Lim, Johnson & Eliason, 2015). A therapeutic relationship is basically an establishment of trust between nurses and the LGBTQ individuals, creating room for transparent discussions and subsequent appropriate plans of care (Sabin, Riskind & Nosek, 2015). Researchers are trying to find methods to improve the attitude of nurses towards LGBTQ members to empower their ability to provide culturally-sensitive care.

One issue that has not been addressed when dealing with the LGBTQ community is the concept of resources to empower the role of nurses in LGBTQ care. Nurses need to be provided with additional training to make them culturally prepared and competent to understand LGBTQ issues (Banerjee, 2018). The lack of resources, even within correctional health facilities in the U.S., has made it difficult to provide this knowledge to nurses limiting their ability to respond to LGBTQ health issues. One of the controversial issues that impact the care of the LGBTQ community is the concept of religious beliefs of the healthcare providers (Carabez et al., 2015). Nurses are bound to have a religious standpoint commonly, Christian or Islam in the U.S. A religious standpoint could interfere with the ability of nurses to provide care to the LGBTQ population, as it would be against the ethical standards of these nurses to support LGBTQ activities, which have been demonized by different religious factions.

Review of Study Methods

The study methods that have been used in the literature analyzed in the literature review section are qualitative research designs. The qualitative research designs are aimed at finding out the perspectives, attitudes, and knowledge of nurses working to provide care to LGBTQ

individuals. One of the techniques used in the collection of data necessary for the qualitative studies is interviews. The relevance of this study design is to have a non-numerical response to the research problem of attitudes of nurses and their level of knowledge of the LGBTQ population's needs. The study design is also directly related to the project's aim of preparing nurses to be culturally-competent when dealing with LGBTQ individuals. Assessing the attitude and the knowledge level of nurses is important to determine the appropriate approach for training for cultural competence.

Significance of Evidence to Profession

Although LGBTQ has been identified as one of the increasing groups, homophobic reactions, and increasing discrimination in the healthcare settings surrounding this population have been noted. This identifies the significance of the problem in healthcare, an issue that needs to be addressed. As outlined by the American Nurses' Association Code of Ethics, nurses ought to practice with compassion, dignity, and uniqueness of each individual, unbiased by considerations of cultural affiliations including religion, nature of the health issues, sexual affiliations, and economic status (Dorsen & Van Devanter, 2016). The Institute of Medicine (IOM) further outlines a vision suggesting that care should be safe, effective, given on time, but also patient-centered to address patients' specific needs (Dorsen & Van Devanter, 2016). Patient-centered care outlines that the process should encompass patients' particular preferences, needs, and values regardless of gender or sexual orientation. Improving cultural competence in healthcare would support these aims hence improving patients' experiences and also reducing health disparities in healthcare. This project is, therefore, significant in identifying ways to cultivate a more culturally-competent nursing workforce in the correctional facilities to effectively address the health needs of the LGBTQ population.

Theoretical Framework

Historical Development of the Theory

Jean Watson's Theory of Human Caring is one of the most important theories in nursing education and practice (Appendix A). Watson contemplated and documented this theory between 1975 and 1979 to promote a holistic approach to patient care (Gonzalo, 2016). Watson's theory was first published in 1988 and is used for academic and clinical purposes. Watson discovered the potential of human caring and the application to boosting human health and interpersonal relationships in her personal experiences and practice. Watson conceptualized the potential of human caring in clinical practice and nursing education to improve patients 'outcomes (Gonzalo, 2016). In addition, Watson stated that it is the role of nurses to promote health, prevent, and also treat diseases to improve the well-being of patients (Gonzalo, 2016). Watson believed that the role of nurses would have a better outcome if nurses portray compassion for patients rather than focusing on tasks, such as providing medication or taking blood pressure (Gonzalo, 2016). According to Watson, caring for the patient entails addressing the psychological and physical being of the patient, which is a key step towards providing holistic care (Zamanzadeh, Jasemi, Valizadeh, Keogh, & Taleghani, 2015).

Applicability of Theory to Current Practice

Jean Watson's Theory of Human Caring can be implemented into nursing practice and education (Zamanzadeh et al., 2015). The use of this theory will allow the nurse to engage their own emotions to the caring relationship of patients while looking into the wellness and psychological needs; which can focus on the cultural preferences of patients (Zamanzadeh et al., 2015). In addition, Watson's theory is relevant to the current practice of nursing as it seeks to improve the ability of nurses to address the health issues posed by patients. Human caring brings

out an aspect of psychological care that would otherwise be left out when care is only focused on a medical issue (Zamanzadeh et al., 2015).

According to Zamanzadeh et al. (2015), the application of Watson's theory serves to improve the relationship between health workers and patients. A therapeutic association creates a good working and collaborative relationship between patients and the interdisciplinary health team. In general, Watson's theory empowers the ability of nurses to address the health issues posed by patients (Zamanzadeh et al., 2015). While using Watson's theory, nurses provide holistic and patient-centered care, which improves patients 'outcomes (Zamanzadeh et al., 2015). Patient-centered care is focused on the specific needs of patients and these needs can only be achieved through the application of the knowledge of carative factors (Fix et al., 2018).

Nurses who understand the theory of human caring can achieve cultural competency by observing all the needs of patients, including the psychological needs that are complex among the LGBTQ population, while respecting the patients 'cultural affiliations (Gonzalo, 2016).

Discussion of Major Tenets of the Theory

The major tenets of Watson's theory explore four key concepts and ten carative factors. The four key concepts and ten carative factors will be discussed. The key concepts include:

Concept 1: The role of a nurse is to alleviate suffering and illness and to support well-being. The theory of human caring is based on the primary principle that the role of a nurse is to support patients to provide self-care. The theory is based on the core principles of nursing such as beneficence and non-maleficence. The role of the nurse is to ensure that patients receive a caring approach that promotes a holistic recovery and not just the resolution of medical illness (Zamanzadeh et al., 2015). In addition, the role of the nurse is to ensure that no harm comes to patients.

Concept 2: The use of a metaparadigm in nursing as an important concept in understanding the health and well-being of patients (Nikfarid, Hekmat, Vedad, & Rajabi, 2018). The metaparadigm defined by Watson includes nursing, health, and the person (Nikfarid et al., 2018). These factors enable nurses to prepare care that is specific to the patients 'needs. The theory of human caring is based on directly improving the nursing metaparadigm by refining the ability of nurses to care for patients (Nikfarid et al., 2018).

Concept 3: The concept of the hierarchy of needs is a basis for human caring. The hierarchy of needs is important in understanding what needs of a patient have not been fulfilled and how that lack of satisfaction creates a health disparity (Gonzalo, 2016).

Concept 4: Lastly a concept of Watson's theory is the nursing process. The nursing process provides a systematic way in which nurses can approach the care of a patient (Gonzalo, 2016). The nursing process provides an opportunity for nurses to assess patients in all relevant faculties before coming up with an impression and a plan for care (Turkel et al., 2018). The nursing process enables a clear understanding of the patients' issues and provides an opportunity to address all the health issues of the patients (Gonzalo, 2016).

The carative factors of Watson's Theory of Caring includes:

1) Providing hope to patients, which involves "being authentically present" and promoting a belief system and a "subjective life-world of self and one being care for" (Gonzalo, 2016);
2) Being self-sensitive, as well as being sensitive towards the needs of others. This includes the adaptation of one's personal spiritual practice and "transpersonal self beyond the ego self" (Gonzalo, 2016);
3) Using the problem-solving process to make decisions, which involves creatively

searching for solutions through the caring process (Gonzalo, 2016);

4) Promoting an environment of learning, which includes cultivating an environment that promotes a healing, health, and wellness teaching/learning model (Gonzalo, 2016);
5) Promoting an environment of support, which includes "creating a healing environment at all levels; physical, nonphysical, subtle environment of energy and consciousness, wholeness, beauty, dignity, and peace" (Gonzalo, 2016);
6) The furtherance and acceptance of positive and negative feelings, which involves being supportive and embracing the expression of one's feelings, whether positive or negative (Gonzalo, 2016);
7) Assisting patients to fulfill their needs, which involves "assisting with basic human needs, with an intentional caring consciousness" (Gonzalo, 2016);
8) Allowing for existential-phenomenological forces, which involves "opening and attending to spiritual, mysterious, and existential dimensions of one's own life-death" (Gonzalo, 2016);
9) Developing human value systems, which includes the "practice of loving-kindness and equanimity within the context of caring consciousness" (Gonzalo, 2016); and
10) Promoting an expression of emotion and establishing a relationship of trust, which includes "developing and sustaining a helping trusting, authentic caring relationship" (Gonzalo, 2016).

Application of Theory to DNP Project

Watson's theory defines the metaparadigms that influence health and wellness and the cultural needs among the LGBTQ community and can assist nurses with application of cultural

competent care. The use of Watson's theory in this DNP project may assist to identify an individual patients' health and wellness issues, cultural preferences and develop ideas and strategies which can be used when caring for the LGBTQ patient at the practice site. Watson's theory views every patient as a unique individual with needs that may be different to those of other patients (Ozan & Okumuş, 2017). Utilizing Watson's theory in this DNP project makes it possible for the nurses at the practice site to understand and advocate the wellness needs and cultural preferences of the LGBTQ community.

Description of Project Design

This project will utilize a quality improvement (QI) approach. A quality improvement project is a process of examining the values of the system to improve a certain aspect of service which will improve the general output of the institution (Hughes, 2008). QI initiatives seek to improve areas of the system which are perceived to be less than the optimum standards needed to provide quality care (Hughes, 2008). The purpose of this DNP project is to provide staff with an LGBTQ educational training and cultural competence policy as to increase staff cultural competency knowledge and attitudes. Hence the QI project approach is appropriate for this project. The population of interest will be registered nurses at the practice site. The project lead will develop and implement an educational training program and policy on cultural care of the LGBTQ patients and determine if there will be an increase in staff knowledge, skills, and perceptions of cultural competence at the practice site. The Watson's Theory of caring will be used to guide the development and implementation of this DNP project.

Data analysis for this project will include the collection of results from the pre and post multicultural counseling self-efficacy scale-racial diversity (MSCE-RD) tool questionnaires. The independent variable will be the MSCE-RD tool and the dependent variable will be cultural

competence among nurses at the correctional facility. The data will be analyzed by using the Statistical Package for Social Sciences (SPSS) to compare data both pre and post implementation of the MSCE questionnaire tool. In addition, the data will be analyzed using a series of paired/dependent sample *t*-tests.

Population of Interest

The population of interest in this DNP project is registered nurses employed at the practice site. The practice site currently employs 25 registered nurses. The inclusion criteria required that registered are currently employed by the practice site and engaged in direct patient care. Any staff not employed at the practice site or do not directly provide patient care will be excluded from participation in the project. Permission from the project mentor has been granted and obtained in writing for this quality improvement project (Appendix A).

Setting

The setting of this DNP project will be at a correctional health facility in the state of New York. The practice site provides essential care services for clients in the correctional facility. The facility consists of multi-racial clients ages 18 and over within Queens County.

Stakeholders

The stakeholders in this quality improvement project are the nurse administrators, Department of Corrections, Directors of Nursing, human resources administration, nursing educators, and Information Technology (IT) department. During the design stages of the project, there will be collaboration among stakeholders to review current trends on culture competence among LGBTQ. Collaboration and engagement of stakeholders will be needed for a successful implementation of the project.

Recruitment Method

Nurses will be directly recruited through email and in-person communications to provide information about the DNP project. The project will use e-mail, and in-person meetings to provide information about the DNP project. Since this is a QI project, all nurses will be expected to participate in the QI project. There will be no incentives to the nursing staff to recruit for or participate in the project. The nurses will be trained while at work.

Tool and Instrumentation

The tools that will be utilized in this DNP project will include educational materials, MCSE-RD tool questionnaires, and cultural competence policy.

MCSE-RD Tool

An effective tool that will be used for this DNP project is the Multicultural counseling self-efficacy scale-racial diversity (MCSE-RD) form. This tool can be used in the assessment and analysis of cultural competence in this quality improvement project. The MCSE-RD tool was originally designed to assess the ability of counselors to understand and maintain cultural sensitivity when providing care to patients of different cultural backgrounds (Sheu, Rigali-Oiler & Lent, 2012). The MCSE-RD tool has several areas which a health worker will answer and the results of cultural competence preparation can be measured (Sheu et al., 2012). The project lead will administer the tool to the nursing staff to complete and the level of their cultural competency will be measured. All the areas measured are related to multicultural concepts in healthcare and the understanding and attitude of the participant regarding these concepts. The MSCE-RD tool's reliability and validity are 95% in measuring the level of cultural awareness (Sheu et al., 2012). The score on the MSCE-RD tool determines the level of cultural competence of health workers. The higher the score, the higher the level and awareness of cultural competency when providing

care to patients. Permission will be sought from the original author to utilize the tool in this project (Appendix F).

Education Materials

The education materials that will be used will be an educational handout that will contain evidence-based content on cultural competency on the LGBTQ population and a policy on cultural care of LGBTQ patients. The project lead will develop the policy (Appendix E) and cultural competency educational handout (Appendix D), which will be used to train the staff on cultural competence. Since this is a QI initiative at the practice site, all staff members are required to participate. The duration of the education session will be about half an hour to one hour.

The content of the handout, discussion, and policy will include evidence-based content on cultural competency. At the end of the educational session, the staff will have the opportunity to ask questions about the QI initiative. The policy is based on the format of the current facility policies. Also, the policy will need to go through committees prior to adoption.

Data Collection Procedures

The data collection procedure will consist of findings from the pre and posttest MCSE-RD tool, which will be completed by the nursing staff. The project lead will conduct the administration of the pre and posttest MCSE-RD questionnaire to nursing staff. Privacy and confidentiality will be maintained as nurses will not be required to self-identify through the process of data collection. The pretest and posttest MCSE-RD assessment is used to determine the effectiveness of teaching and to measure if project objective number three has been met. The data will be compiled into an Excel spreadsheet created by the project lead and analysis will be done using the SPSS software (Hughto et al., 2017).

Intervention/ Project Timeline

Planning is essential in research to identify when to start a project, when to complete each phase of the project, and what to complete during each phase (Gelling & Engward, 2015). The DNP project will be implemented during a four-week time frame. The implementation phase will include implementing the intervention, collecting data, and evaluating the project results. Implementation of the DNP project at the practice site was approved by the nursing supervisor (see Appendix B).

Below is the project timeline:

Date	Activity	Responsible person
Week 1	Provide informational sessions to participants, including defining of timeline for DNP project, obtaining informed consent, and administering pre-test questionnaire	Project lead
Week 2	Initiate educational intervention, including cultural competency training and education to registered nurses, encourage staff discussions and comments	Staff Project lead
Week 3	Initiate educational intervention, including cultural competency training and education to registered nurses, encourage staff discussions and comments	Staff Project lead
Week 4	Wrap up interventions, administering post-test questionnaire. Conclude project and provide thank you letters to participants	Project lead, staff, statistician

Ethics and Human Subjects

The DNP project will be a QI initiative that does not involve direct patient contact. The Touro University Nevada institutional review board (IRB) approval form will be completed to determine if full IRB review is required. When there was no risk to human subjects and the data is de-identified, the project is exempt for IRB review. The project lead anticipates that this DNP project will be considered exempt from the IRB review, since there was minimal risk not beyond

any usual daily activities to the participants. The data will be de-identified as to protect the confidentiality of the participants.

Participants include registered nurses at the practice site. Participants will complete a pre and post MSCE-RD questionnaire. The privacy of the participants will be maintained, as no identifiable information will be collected. There will be no compensation for participating in this quality improvement project. Furthermore, data from the pre and post questionnaires will be collected and reviewed by the project lead.

Analysis and Evaluation Plan

Evaluation is integral in a research project to aid in extracting meaningful information about a topic from the participants (Ott & Longnecker, 2015). Additionally, from the evaluation plan, a researcher can draw meaningful insights necessary in influencing both short and long-term decisions regarding the chosen topic (Ott & Longnecker, 2015). The findings of this DNP project will be analyzed using SPSS version 24 computer program. Data collected from the pre- and post-implementation MSCE-RD questionnaire will be analyzed by entering the results into an excel database and using SPSS version 24 to compare data on nursing staff impact on the LGBQT training program. The pre-implementation questionnaire will be administered immediately before the training program and the post-survey will be administered immediately after the intervention.

The process of SPSS data analysis will involve loading all the complete collected data in the excel app in a tabular form (Larson-Hall, 2015). The SPSS computer program will be used to create frequency tables and pie charts that will necessitate building and validating predictive trends of cultural competency involving the LGBTQ individuals. The raw data will then be imported into the SPSS application from the excel file. The results will then be analyzed either

with tables or graphs, evaluated, and postulated conclusions drawn from the analysis. Evaluation of the data will be conducted, and inferential statistics of the mean, standard deviation, ranges, and proportions deduced. The data will be tested at a 95% confidence interval using Chi-square (Larson-Hall, 2015). The SPSS approach was selected because it is a scientifically-proven tool that is useful and accurate in deciphering and manipulating quantitative data.

Significance and Implication for Nursing

The objective of this DNP project is to develop a policy on cultural care of the patient and a LGBTQ training program based on current literature review and determine if this will increase the impact on staff cultural competence over the four-week implementation phase. The project results are hoped to have a significant implication to the nursing practice. The literature shows that the LGBTQ population is increasing at a rapid rate and the subsequent discrimination of this population has been noted in healthcare (Rowe et al., 2017). This DNP project will, therefore, enhance the concepts of care delivery based on unbiased discrimination related to sexual affiliation. Second, there is a gap in the patient-centered care given to the LGBTQ population (Jaffer et al., 2016). The findings of the DNP project will, therefore, enhance the delivery of LGBTQ patient-centered care that is based on specific patients' interests, needs, and values regardless of the patient's sexual orientation. Third, a huge gap exists in the knowledge and experience that nurses have related to cultural competence affiliated to the LGTBQ population (Sabin et al., 2015). Therefore, the DNP project results will reveal information that will enhance cultural competence in healthcare by endowing nurses with ways to cultivate a healthy and more culturally-competent nursing workforce. Literature illustrates the failure of the social, economic and health arenas to recognize the LGTBQ population (Rowe et al., 2017). The increased discrimination of this population limits those with the LGBTQ

community from accessing quality healthcare. The DNP project results, therefore, will enhance the provision of culturally-competence care, not only in health correctional settings, but also in other healthcare settings. The results will add significance to the existing policies on managing the LGBTQ population at the practice site.

Data Analysis and Results

Demographic Information

All the twenty-five registered nurses in the practice site took part in the project. Out of the 25 participants, 11 (44%) were male while 56% (14) were females.

Table 1: Gender distribution

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	11	44.0	44.0	44.0
	female	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

The average age of the participants was 38.28 years old (*SD= 7.179*). the youngest participant was 27 years old while the eldest participant was 57 years old

Table 2: participants ages

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
age	25	27	57	37.96	6.773
Valid N (listwise)	25				

Reliability Measures

The research instrument contained thirty-seven factors and was used to measure three variables; delivered LGBTQ care, nurses' attitude, and cultural competency level. Delivered LGTBQ care was measured using twelve factors. To determine the internal reliability measure, Cronbach's reliability was performed (Andrew, Pedersen & McEvoy, 2011). The results of the project produced Cronbach's reliability of 0.664. The results show that the sample had a good reliability measure, thus it can be concluded that the factors used to measure delivered LGBTQ care were reliable. The items used were, therefore, suited to measure the variable delivered care.

Table 3: Reliability for delivered LGBTQ care

Cronbach's Alpha	N of Items
.664	12

The variable attitude was measured using nine items from the questionnaire. Cronbach's reliability was performed to determine the internal consistency of the items as used to measure the participants' attitudes. The analysis produced Cronbach's reliability of 0.648. Therefore, in the sample, the variable attitude had acceptable reliability (Ursachi, Horodnic & Zait, 2015). It can therefore be concluded that the items were good for measuring the variable attitude.

Table 4:Reliability for attitude

Cronbach's Alpha	N of Items
.648	9

The third variable that this project targeted to measure was the cultural competency level. This variable was measured using 16 items from the research instrument. Cronbach's reliability was performed to determine its internal consistency. The analysis produced Cronbach's reliability of

0.614. According to Taber (2018), a reliability score of between 0.6 and 0.7 is considered acceptable. Therefore, in the sample, the variable cultural competency had an acceptable reliability, which means that the items could sufficiently be used to measure cultural competency.

Table 5:Reliability for cultural competency

Cronbach's Alpha	N of Items
.614	16

T-test Analysis

Having known the reliability of the items to measure the three factors, the next step of the analysis was to pursue its main goal which was to determine if training the nurses on cultural competencies and policy would improve their cultural competency level and attitude and thus raise the quality of care delivered to LGTBQ patients. The project lead collected data regarding these variables prior to and post-intervention. The project hypothesized that the level of cultural competency, delivered care, the attitude would be higher after intervention than before the intervention. To achieve this goal, the scores for each variable were calculated by averaging the scores of their respective items in each set of data. Thus, the project lead created the variables care1 and care2 to represent delivered care prior to and post-intervention respectively. Attitude1 was used to represent the nurses' attitude before the training while attitude 2 was the post-training attitude. Regarding cultural competency, competency1 and competency 2 represented competency levels prior and post-training respectively.

A paired sample t-test was performed to examine the significance of the difference between the scores before and after training on cultural competency and policy. The first pair compared the level of care delivered to the LGTBQ patients before and after the training

exercise. The results showed that the level of care delivered after the training was significantly higher than the level of care delivery before the training exercise (*t= -16.664, p< 0.05*). The analysis also revealed that the nurses' attitude before training were significantly lower than after training (*t= --14.375, p< 0.05*). Regarding the cultural competency level, the study established that the competency level after training (*M=5.59, SD=0.824*) was significantly higher than the cultural competency level before training (*M=*4.69*, SD=0.875*). The analysis demonstrated that the difference in cultural competency level before and after training was significant (*t*=-28.305, *p= 0.00*).

Table 6: Paired sample t-test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	delivered care before training - care delivered after training	-.85333	.25604	.05121	-.95902	-.74765	-16.664	24	.000
Pair 2	attitude level before training - attitude level after training	-.85778	.29835	.05967	-.98093	-.73463	-14.375	24	.000
Pair 3	cultural competency level before training - cultural competency level after training	-.90250	.15943	.03189	-.96831	-.83669	-28.305	24	.000

Table 7: Descriptive Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	delivered care before training	4.5400	25	1.06206	.21241
	care delivered after training	5.3933	25	.97644	.19529
Pair 2	attitude level before training	4.7067	25	1.19235	.23847
	attitude level after training	5.5644	25	1.08484	.21697
Pair 3	cultural competency level before training	4.6900	25	.87490	.17498
	cultural competency level after training	5.5925	25	.82386	.16477

Based on the analysis, all three measures were significantly higher in the second measurement data than in the first data. This means that care delivery, nurses' attitude, and cultural competency levels were all better after training on cultural competency and policy. It can, therefore, be concluded that training on cultural competency and policy improved the levels of delivered care, nurses' attitude, and nurses' competency levels.

Correlation Analysis

The project had postulated that the nurses' cultural competency level and attitude are associated with the care they deliver to LGTBQ patients. Intrinsically, this project also sought to examine the association that exists between attitude and competency level with the delivered care to LGTBQ patients. To achieve this goal, the pre and post-training scores for each variable were combined and the average calculated. These averages were taken as the overall measures for the variables and thus used in the correlation analysis.

Pearson's product-moment correlation was utilized in exploring the association between attitude and cultural competency level with delivered care. This measure of correlation was used based on the fact that it is best suited for comparing the relationship between continuous data (Rebekić et al, 2015). The data used for the analysis were calculated mathematically from other factors and thus were continuous data. The results revealed that there was a weak association between the care delivered and the nurse's attitude (*r= 0.221*). The association was further found not to be significant (*p= 0.289*). Regarding the relationship between cultural competency level and care delivered, it was revealed that the association, though moderate, was not significant. The association between nurses' attitude and cultural competency level was also found to be very weak and insignificant (*r=0.034, p=*.871). The findings contradict the project's postulation that nurses' attitudes and levels of cultural competency are associated with the services they deliver to LGTBQ patients.

Table 8: Correlation

Correlations

		care delivered	overall attitude score	overall cultural competency score
care delivered	Pearson Correlation	1	.221	.368
	Sig. (2-tailed)		.289	.071
	N	25	25	25
overall attitude score	Pearson Correlation	.221	1	.034
	Sig. (2-tailed)	.289		.871
	N	25	25	25
overall cultural competency score	Pearson Correlation	.368	.034	1
	Sig. (2-tailed)	.071	.871	
	N	25	25	25

Discussion of Findings

The project intervention of a LGBTQ training program and a developed cultural competence policy were successfully implemented at the practice site. The findings showed that there was an improvement in cultural competency by the registered nurses after the training program and use of the policy was significantly higher than that delivered before the educational training program. The findings showed a 4.6900 mean of the cultural competency before the training program and a 5.5925 mean after the program. The findings indicated that the program and the use of a cultural competence policy had a significant effect on enhancing RNs' understanding of the beliefs, norms, and needs of the LGBTQ population and how to address those needs while being culturally-sensitive.

Based on the findings, the mean attitude level of the nurses to LGBTQ patients before the training program was 4.7067. After the training program, the attitude level showed an improvement with a mean of 5.5644. The literature indicates that educating nurses regarding the LGBTQ community enhances their understanding of the needs and issues of this population, hence, an improvement in the attitude while attending to LGBTQ patients (Rowe et al., 2017). Hartley, Raphael, Lovell & Berry (2020) discusses the effective nurse-patient relationship and how it is important for registered nurses to have a positive attitude towards the provision of services to patients as this improves their engagement in care approaches. The attitude of nurses towards patients has an impact on the establishment of a therapeutic relationship (Hartley et al., 2020). The establishment of a therapeutic relationship provides an opportunity to address the holistic needs of the patients (Hartley et al., 2020). This may indicate that the implementation of the training program and the use of a policy on cultural competency among the registered nurses helped to create cultural responsiveness among nurses.

The DNP project findings align with evidence-based literature. According to Felsenstein (2018), training nurses on the LGBTQ population improves their cultural competency and the care delivered to LGBTQ patients. In this study, Felsenstein (2018) established that training the nurses dealing with LGBTQ patients leads to a significant increase in cultural competency scores and the level of preparedness to serve LGBTQ patients. The training of the nurses entailed information on the general needs and culture of the LGBTQ population and how best to address them (Felsenstein, 2018).

Significance of the Project

The significance of this project to the nursing practice can be viewed in two fronts; improved knowledge and cultural competency, and also improved care delivery by RNs to LGBTQ patients. The significance of this project in terms of knowledge and competency relates to the implementation of the training of registered nurses on LGBTQ programs and policies, and ease of access of care delivery by this special population group. The literature indicated a gap in knowledge regarding the cultural competence and attitude of nurses towards LGBTQ patients (Rowe et al., 2017). Cultural competency is paramount in the delivery of care services and the adherence to cultural sensitivity and cultural safety (Felsenstein, 2018). Cultural sensitivity is characterized by the ability to be aware of the culture of a patient and promote its adherence while providing healthcare services. This means that nurses that have undertaken cultural competency training can relate with patients by respecting their culture and avoiding cultural conflict. Cultural sensitivity and competency in the work environment promotes cultural safety (Carabez et al., 2015).

This project indicates that cultural competency may be improved by providing educational training and the use of a cultural competency policy to RNs and may benefit other

practice settings. In addition, the project findings may help to encourage those in nursing leadership and other officials in charge of the healthcare systems to support the need for educational training and the development of a cultural competency policy as a way to improve cultural competency in LGBTQ patient care.

Project Limitations

A limitation of a project can be described as "those characteristics of design or methodology that impacted or influenced the interpretation of the findings from your research" (Price & Murnan, 2004). There are two limitations to this project. The limitations are;

1) The small sample size; and
2) Volunteer sample

The sample size involved in this project was 25 nurses who were working at the correctional facility. The sample size was too small to generalize if the training and use of a cultural competency policy would be increased in other practice settings. Compared to the number of nurses working in correctional facilities, the number 25 is small and very insignificant in a statistical sense to represent the views and practice level of other nurses. A small sample size limits the chance of expression of diverse opinions and this limits the validity of the project results (Dove, Townend, Meslin, Bobrow, Littler, Nicol, ... & Shabani, 2016). The use of a large sample size would support the depth and diversity of the project participants and this would have provided room for a conclusive outcome of the project.

Another limitation of the project is the volunteer sample was from one correctional health facility. (Dove et al., 2016). Using one health correctional facility provides limited opportunities for the staff in volunteering to participate, and this limits the data collection which may affect the diversity of the project. The cultural challenges experienced in one correctional facility may be

different from another correctional facility in a different location. The project may have benefited if there was an opportunity to implement cultural competency training and explore cultural competency policies in more than one facility.

Dissemination of the Project

The project results will be disseminated to the stakeholders at the practice site. By written and oral communication by the project lead. There is a plan for the practice site to include the cultural competency educational training and policy in upcoming orientations for incoming registered nurses. As part of the dissemination, each group of stakeholders will be provided with a summary of the report. The stakeholders played a primary role in the success of the project and should receive the feedback of the project outcomes (Gelling & Engward, 2015). Dissemination will also include presenting DNP project results as a DNP presentation to Touro University Nevada (TUN) nursing faculty and peers of the DNP program followed by the submission of my project to the DNP Project Repository.

The other target group for dissemination of the project information is the professional organizations in nursing and medical practice. The professional organizations can benefit from the information of this project through meetings with the project lead to discuss the project results. The American Nurses Association (ANA) provides opportunities to further give the project lead opportunities to present the project results via a poster or podium presentation. The results would benefit other health care providers and similar practice sites. The project lead will submit an abstract to the American Journal of Nursing, Journal of Nursing Education and other evidence-based nursing journals for possible publication. Additional venues to consider for dissemination include the American Nurse Association, Institute of Medicine (IOM), and the

American Association of Colleges of Nursing (AACN), for a possible podium or poster presentation**.**

Project Sustainability

This QI project implemented a LGBTQ policy and the use of this intervention is a sustainable initiative at the practice site. The use of a LGBTQ policy will benefit the nursing staff by helping improve culturally competent care (Anåker & Elf, 2014). Due to its low cost of implementation and its potential benefits to the healthcare system of the correctional facility, the practice site plans to implement this policy. The facility plans on implementing this policy and the cultural competency training in the nursing orientation for future RNs. The initial expense of the educational training program would be the highest, but the subsequent costs would be lower for ongoing updates. In addition, there would be minimal expense for printing of materials associated with policy implementation, which can cause approximately $500 for printing the policy for stakeholders and including the policy on the facility intranet for stakeholder to view at any time. The use of the LGBTQ policy is important over a long period to ensure that cultural competency on the LGBTQ population is maintained. The use of the LGBTQ policy is important because the findings from the project showed that there was an improvement in cultural competency by the registered nurses after the educational training program implementation. The training program and the use of the LGBTQ policy can be easily duplicated and shared with other correctional facilities.

Conclusion

The project demonstrated the importance of training the nursing staff in a correctional facility on LGBTQ cultural competent care and the implementation of the LGBTQ policy. The project offered solutions, the application of using training and a LGBTQ policy to guide nursing

staff in cultural competent care of this population. The project findings demonstrate that cultural competency in caring for LGBTQ patients may require for further training to nursing staff. These findings attributed to personal barriers of nursing staff in the care of the LGBTQ population. In addition, lack of adequate knowledge of staff also indicated a cause of cultural competency inefficiency in caring for LGBTQ patients at the practice site. The implementation of a-a cultural competency educational training program and the use of a LGBTQ policy has demonstrated to be an effective intervention in improving nurse attitudes and knowledge on cultural competency in the care for the LGBTQ patients. Further dissemination of the project in publication, presentations, and education platforms will provide a basis for promoting the impact of the project on practicing nurses.

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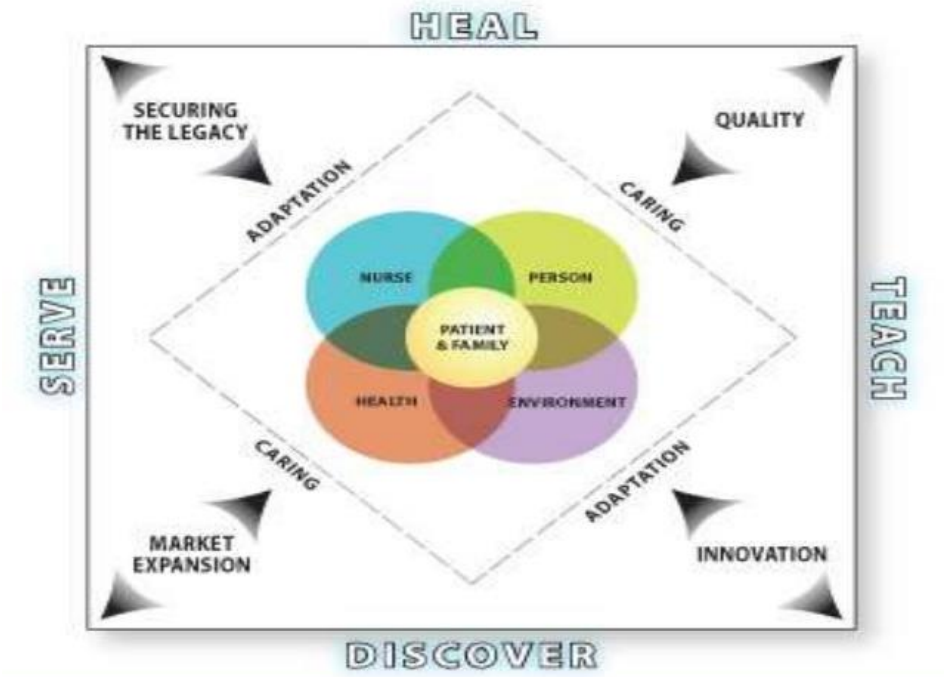
Appendices

Appendix A

Jean Watson's Theory of Human Caring



Appendix B
Project Mentor Permission Letter

NYC
HEALTH+
HOSPITALS

Dr. Judith Carrion
Touro University Nevada
Doctorate of Nursing Practice in Leadership
874 American Pacific Dr.
Henderson, NV 89014

12/5/19

Dear Dr. Carrion,

We are delighted to have Elizabeth Dania conduct her research project at our current location as she is currently employed with us and she has met all the required clearances to execute a project on site. She plans on doing a quality improvement project which will enhance care to the patients that are served in the facility.

Please reach out to me if you have any questions or concerns. I can be reached on my cell (347) 603-6022 or in my office at (347) 774-7506.

Thank you.

Respectfully,

Aleen Boyd-McKoy, DNP, RN
AMKC – C71 Mental Health

Appendix C

Appendix

Multicultural Counseling Self-Efficacy Scale–Racial Diversity© (Sheu et al., 2012)

Edited version for use in correctional facilities

Instructions: The following questionnaire consists of 37 items asking about your perceived ability to perform different care behaviors with individual or family clients who are of a different sexual orientation from you. Using the 0-9 scale, please indicate how much confidence you have in your ability to do each of these activities at the present time, rather than how you might perform in the future. Please circle the number that best reflects your response to each item.

When working with a client who is of a different sexual orientation from yourself, how confident are you that you could do the following tasks effectively over the next week?

	No confidence at all			Some confidence			Complete confidence		
1. Openly discuss cultural differences and similarities between the client and yourself.	0	1	2	3	4	5	6	7	9
2. Address issues of cultural mistrust in ways that can improve the working relationship.	0	1	2	3	4	5	6	7	9
3. Help the client to articulate what she or he has learned from the correctional facility experience.	0	1	2	3	4	5	6	7	9
4. Where appropriate, help the client to explore discrimination in relation to coping with his or her stay in the correctional facility	0	1	2	3	4	5	6	7	9
5. Keep sessions on track and focused with a client who is not familiar with their care process.	0	1	2	3	4	5	6	7	9
6. Respond effectively to the client's feelings related to their stay and illness in the correctional facility	0	1	2	3	4	5	6	7	9
7. Encourage the client to take an active role in their treatment decisions.	0	1	2	3	4	5	6	7	9
8. Evaluate counseling progress in an on-going fashion	0	1	2	3	4	5	6	7	9
9. Identify and integrate the client's culturally specific way of interacting with others.	0	1	2	3	4	5	6	7	9
10. Assess the client's readiness to discuss their health concerns	0	1	2	3	4	5	6	7	9
11. Select culturally appropriate assessment tools according to the client's cultural background	0	1	2	3	4	5	6	7	9
12. Help clients complete their goals in ways sensitive to cultural differences.	0	1	2	3	4	5	6	7	9
13. Deal with power-related disparities (i.e., social worker power versus client powerlessness) with a client who has experienced discrimination.	0	1	2	3	4	5	6	7	9

When working with a client who is of a different sexual orientation from yourself, how confident are you that you could do the following tasks effectively over the next week?

	No confidence at all			Some confidence			Complete confidence		
14. Use non-standardized methods or procedures to assess the client's concerns in a culturally sensitive way.	0	1	2	3	4	5	6	7	9
15. Take into account the impact that family may have on the client in case conceptualization.	0	1	2	3	4	5	6	7	9
16. Assess relevant cultural factors (e.g., the client's acculturation level, sexual identity, cultural values and beliefs).	0	1	2	3	4	5	6	7	9
17. Take into account cultural explanations of the client's presenting issues in case or task conceptualization.	0	1	2	3	4	5	6	7	9
18. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race and sexual orientation into therapy when the client is not ready to discuss).	0	1	2	3	4	5	6	7	9
19. Conduct a mental status examination in a culturally-sensitive way.	0	1	2	3	4	5	6	7	9
20. Help the client to develop culturally appropriate ways to deal with systems (e.g., hospitals, the legal system) that affect him or her.	0	1	2	3	4	5	6	7	9
21. Manage your own anxiety due to cross-cultural impasses that arise.	0	1	2	3	4	5	6	7	9
22. Assess culture-bound beliefs around sexual orientation for clients.	0	1	2	3	4	5	6	7	9
23. Help the client to set goals that take into account expectations from her or his family.	0	1	2	3	4	5	6	7	9
24. Help the client to identify how cultural factors (e.g. sexual orientation, acculturation, racial identity) may relate to his or her maladaptive relational patterns.	0	1	2	3	4	5	6	7	9
25. Manage your own racially or culturally based countertransference toward the client (e.g., over-identification with the client because of his or her sexual orientation).	0	1	2	3	4	5	6	7	9
26. Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses.	0	1	2	3	4	5	6	7	9
27. Assess the salience and meaningfulness of culture in the client's life.	0	1	2	3	4	5	6	7	9
28. Take into account multicultural constructs (e.g., acculturation, sexual identity) when conceptualizing the client's presenting problems.	0	1	2	3	4	5	6	7	9

When working with a client who is of a different sexual orientation from yourself, how confident are you that you could do the following tasks effectively over the next week?

	No confidence at all			Some confidence			Complete confidence		
29. Help the client to clarify how cultural factors (e.g., racism, acculturation, sexual identity) may relate to her or his maladaptive beliefs and conflicted feelings.	0	1	2	3	4	5	6	7	9
30. Respond in a therapeutic way when the client challenges your multicultural care competency.	0	1	2	3	4	5	6	7	9
31. Admit and accept responsibility when you, as the nurse, have initiated the cross-cultural impasse.	0	1	2	3	4	5	6	7	9
32. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background.	0	1	2	3	4	5	6	7	9
33. Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation).	0	1	2	3	4	5	6	7	9
34. Remain flexible and accepting in resolving cross-cultural strains or impasses.	0	1	2	3	4	5	6	7	9
35. Facilitate culture-bound aspects for sexually-diverse clients.	0	1	2	3	4	5	6	7	9
36. Help the client to utilize family/community resources to reach her or his goals.	0	1	2	3	4	5	6	7	9
37. Deliver treatment to a client who prefers a different care style (i.e., directive versus non-directive).	0	1	2	3	4	5	6	7	9

Appendix D

Cultural Competency Educational Handout

- Cultural competency is an important skill among health workers especially nurses in their engagement with patients and to provide appropriate care.
- The LGBTQ community is a unique and vulnerable population with a unique sexual orientation, and this means that their health needs are also specific. The needs of the LGBTQ individuals are not only physical, but also psychological in nature and therefore, it is important for nurses to consider the holistic approach when providing care for this population.
- The uniqueness of the LGBTQ culture is based on its sexual nature and sexual differences to the heterosexual individuals. This is an aspect of patients' histories that nurses should be keen of.
- Within correctional facilities, LGBTQ inmates present with a higher risk to infectious diseases such as sexually transmitted diseases. Chlamydia and syphilis are common within correctional facilities and health workers need to understand these risks when providing health education to LGBTQ patients.
- It is important to understand the LGBTQ culture to provide nursing care with sensitivity as the LGBTQ individuals experience high rates of perceived discrimination. In understanding their culture, nurses can engage the LGBTQ patients in a manner that addresses the risk for the development of negative attitudes.

- Understanding the LGBTQ culture influences the comfort of the LGBTQ patients receiving care and this increases their level of satisfaction, which is an indicator of quality care.

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Appendix E

Correctional Health Services LGBTQ Policy

Title: Correctional Health Services LGBTQ Policy

Policy Number: Section 3.2

Policy: The Correctional Health services is committed to providing a workplace free from discrimination, and as such prohibits the discrimination of any individual based on their sexual preference. This policy focuses on improving cultural competence of registered nurses who work with members of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community.

Purpose: In accordance with guidelines issued by the American Medical Association (AMA) (2020) on health care needs of LGBTQ populations, discrimination of any individual based on their sexual preference, sexual orientation, sexual behaviors, and gender identities is prohibited in the correctional health setting. Registered nurses are required to respect all LGBTQ individual's culture during the care process; and provide nonjudgmental recognition of LGBTQ patient identities while engaging in care within the correctional health setting. Proper history taking without discrimination, while putting aside personal views must be adhered to. The LGBTQ patients' needs should be address without discrimination. Holistic care to LGTBQ population should be offered within this setting.

Scope: This policy applies to all registered nurses employed in Correctional Health Services. The company shall cooperate with federal, state, and

local government agencies that have the responsibility to ensure our compliance with various laws relating to LGBTQ health equity. Questions or comments related to this policy should be directed to the Director of Nursing (DON).

Responsibilities: Nurse leaders and Directors of Nursing, individually and collectively, has the overall responsibility of carrying out the facility's LGBTQ policy in their respective work areas.

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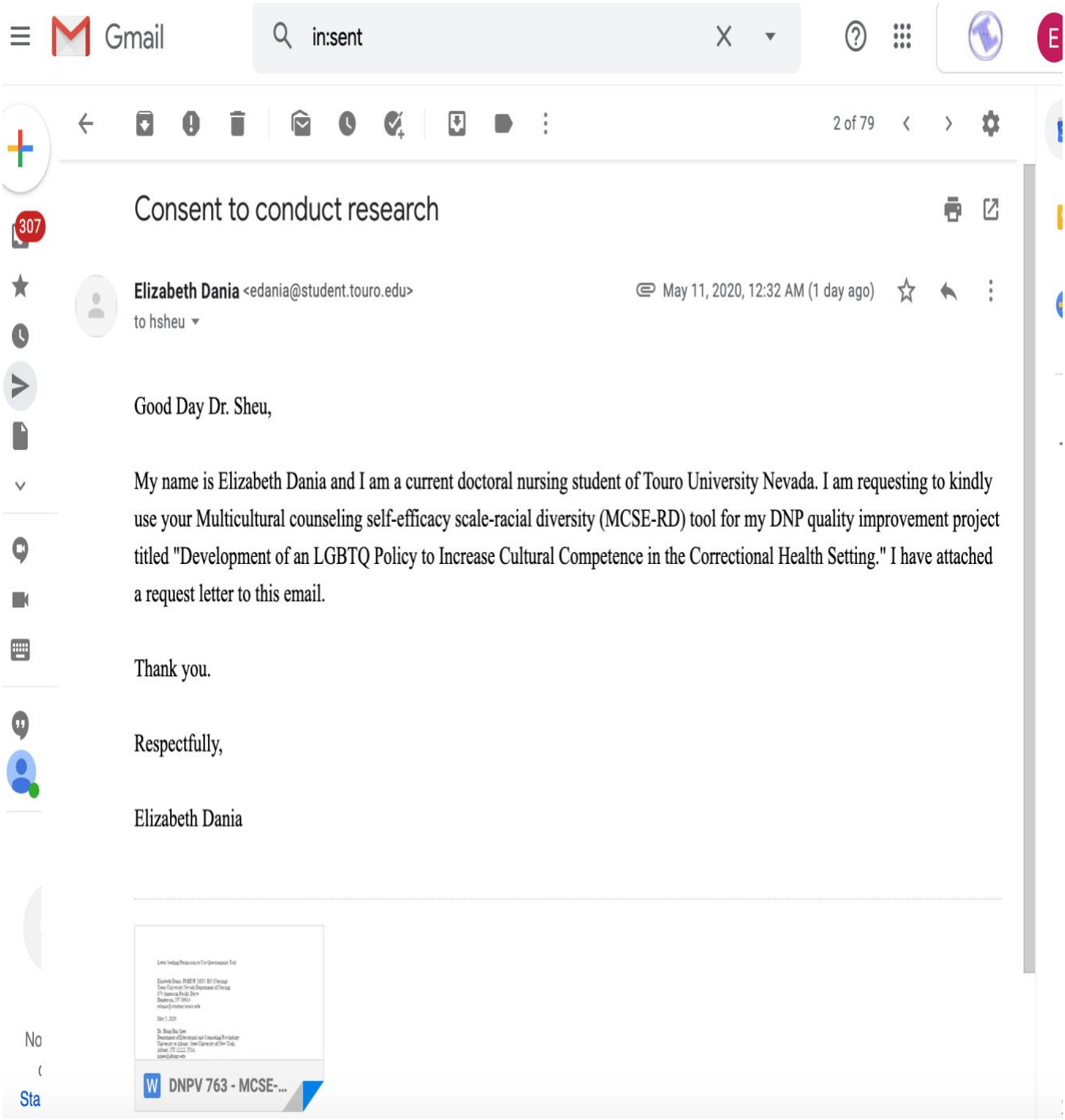
Appendix F

MCSE-RD Tool Author Permission Letter



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in:sent

2 of 79

Consent to conduct research

Elizabeth Dania <edania@student.touro.edu>
to hsheu

May 11, 2020, 12:32 AM (1 day ago)

Good Day Dr. Sheu,

My name is Elizabeth Dania and I am a current doctoral nursing student of Touro University Nevada. I am requesting to kindly use your Multicultural counseling self-efficacy scale-racial diversity (MCSE-RD) tool for my DNP quality improvement project titled "Development of an LGBTQ Policy to Increase Cultural Competence in the Correctional Health Setting." I have attached a request letter to this email.

Thank you.

Respectfully,

Elizabeth Dania

DNPV 763 - MCSE-...

Letter Seeking Permission to Use Questionnaire Tool

Elizabeth Dania, PMHNP, MSN, RN (Nursing)
Touro University Nevada Department of Nursing
874 American Pacific Drive
Henderson, NV 89014
edania@student.touro.edu

May 5, 2020

Dr. Hung-Bin Sheu
Department of Educational and Counseling Psychology
University at Albany, State University of New York,
Albany, NY 12222, USA
hsheu@albany.edu

Dear Dr. Sheu,

I am a current student pursuing a doctoral of nursing practice degree (DNP) from Touro University Nevada, currently working on my DNP project titled "Development of an LGBTQ Policy to Increase Cultural Competence in the Correctional Health Setting." This is a quality improvement study to provide registered nursing staff educational training in a correctional health setting on the LGBTQ population and to develop a cultural competence policy as a strategy to increase staff cultural competency. Under the direction of my project committee chaired by Dr. Judith Carrion, EdD., MSN/Ed, MSHS, RN, ACUE, Assistant Professor, who can be reached at Phone: 702-777-3997; Email: Judith.carrion@tun.touro.edu, I would like your permission to use the Multicultural counseling self-efficacy scale-racial diversity (MCSE-RD) assessment tool.

I will use the tool only for my research study and will not sell or use it with any compensated activities.

I will send a copy of my completed research study to your attention upon completion of the study. If these are acceptable terms and conditions, please indicate so by replying to me through e-mail: edania@student.touro.edu.

Thank you.

Respectfully,

Elizabeth Dania.