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Cultural Education Provided to Renal Staff Caring for First Nations People in Australia and Similarly Colonized Countries: A Scoping Review

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ABSTRACT

Background: First Nations People receive clinical care by renal staff who may or may not have had access to cultural education. If they have, what this education involves and if it has been co-designed with First Nations People is unknown.

Objective: Conduct a scoping review to examine the range and types of cultural education provided to clinical and professional (nonclinical) renal staff caring for First Nations People in Australia and similarly other colonized countries {Aotearoa/New Zealand (NZ), Canada, and North America}.

Design: Using the JBI methodology for scoping reviews a systematic search of 11 database (Australian Indigenous Health InfoNet, Scopus, APAIS-ATSIS (Informit), CINAHL (EBSCO), Embase (Ovid), Medline (Ovid), Health & Medical Collection (Proquest), Nursing & Allied Health Database (Proquest), Psychology Database (Proquest), Public Health Database (Proquest), and Sociology Database (Proquest) was undertaken. The search included studies published in English from January 1992 to September 2024.

Results: Nineteen papers met the scoping review criteria identifying multiple barriers and effective staff cultural education in renal settings. Sixteen papers were from Australia. Only three papers undertook both cultural education and evaluation. Cultural safety emerged as an education and clinical approach increasingly used internationally to inform positive effects on both care recipients (First Nations People with kidney disease) and staff participants.

Conclusion: There is limited published literature regarding renal-specific cultural education for kidney care staff working with First Nations People. The extent to which First Nations recipients of care have been involved and education effectiveness evaluated is not evident.

1 | Introduction

For over 65,000 years, First Nations People (Aboriginal and/or Torres Strait islanders) have been living in Australia, and are the longest living continuous culture in the world (Pattel-Gray 2023). Custodianship of "Country" in First Nations culture comprises the lands, waterways and skies to which First Nations People are connected through family and ancestral origins. It is home, a place of peace; providing nourishment for body, mind and spirit and is central to health. Disconnection from Country was found to be detrimental to a First Nations person's health and wellbeing (Kennedy et al. 2022; Thorpe et al. 2023).

However, like First Nations People from similarly colonized countries kidney Failure (KF), previously known as End Stage

Kidney Disease (ESKD), is an increasing concern for many First Nations families and communities in Australia with substantial health and wellbeing implications (Australian Institute of Health and Welfare 2011). First Nations People experience KF at higher rates and earlier in life than non-First Nations People (Tonelli et al. 2011). This is directly linked to the continuing effects of colonisation, racism, trauma compounded by intergenerational discriminatory, mainstream health services unequal power imbalances and racist policies (Best and Fredericks 2021; Jansen et al. 2020; Kelly et al. 2024; Kelly et al. 2022; Togni et al. 2017).

Higher incidence and rapid progression of KF requires many First Nations People to travel away from family and Country to receive renal replacement therapy (RRT), a treatment that replaces the normal blood-filtering function of the kidneys via dialysis (haemo or peritoneal) or kidney transplant (Lawton et al. 2015). Dialysis is undertaken in renal replacement environments within in-centre dialysis units (hospital-based), satellite dialysis clinic or home dialysis. These treatments are resource intensive for patients and the healthcare system (Dingwall et al. 2019). KF patients may also experience chronic conditions such as diabetes or coronary heart disease requiring additional specialist support (Hoy et al. 2010). Across Australia the KF treatment rate among First Nations People is at least five times higher than amongst non-First Nations Australians, and higher still for people from remote areas (ANZDATA Registry 2021).

First Nations People are profoundly overrepresented in all chronic diseases, including kidney disease. The dominance of European biomedical perspectives further exacerbates inequities when coupled with institutionalised racism (Rix and Rotumah 2020). Australian health services and organizations, dominated by Eurocentrism and biomedical priorities, also struggle to recognize and respond to ongoing discrimination, interpersonal and institutionalized racism inherent in many policies and practices across treatment and care as described by First Nations authors and also teams of First Nations and non-First Nations authors (Fredericks et al. 2021; Hughes et al. 2023; Kelly et al. 2020; Socha 2021).

The Australian National Safety and Quality Health Service (NSQHS) standards aim to ensure that patients are engaged in the design, delivery and evaluation of healthcare systems and services. All patients are viewed as partners in their own care, and there is a specific emphasis on the provision of safe, high-quality and culturally appropriate clinical care for First Nations patients (Australian Commission on Safety and Quality in Health Care 2021). The Caring for Australian and New Zealanders with Kidney Impairment (CARI) inaugural cultural and clinical kidney care guidelines specifically identify cultural safety as a responsive framework (Tunnicliffe et al. 2022). Cultural safety originating in Aotearoa/NZ specifically responds to the ongoing effects of the remnants of colonisation and inequities (Arnold-Ujvari et al. 2023; Bateman et al. 2023; Hughes et al. 2018; Kelly et al. 2020; Kerrigan et al. 2021a; Rix et al. 2014; Schwartzkopff et al. 2020; Tunnicliffe et al. 2022). Inherent within cultural safety is the premise that care is culturally safe if it is perceived to be so by the recipients of care.

The need for First Nations health professionals and workers who are experts with First Nations languages and cultures is also highlighted by Walker et al. (2012) in Aotearoa/NZ to support community-based kidney care. In Canada, Cultural Safety has also been considered within kidney care with Nelson (2019) identifying relationality, engagement and self-determination as critical to health and well-being. In Northern America Walton (2011) identified the importance of education of health care providers being consistent with Native American Peoples' ways of being and knowing.

There appears to be limited publications identifying the approaches and forms of cultural education being provided to health professionals working in kidney care to assist them to better understand and meet the cultural needs of First Nations People. A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted on 28 January 2024 and no current or underway systematic reviews or scoping reviews on the topic was identified.

Scoping reviews are a useful tool to investigate the design and conduct of research on a topic and allow a broad overview of the topic to be undertaken and identify gaps and/or what is known within a topic (Munn et al. 2018). The objective of this scoping review was to map the extent and types of cultural education provided to clinical and professional staff caring for First Nations People in renal replacement environments within Australia and similarly colonized countries; and the extent to which they address the remnants of colonisation, racism and include First Nations People as partners and recipients of care.

2 | Methods

This scoping review was conducted in accordance with the JBI methodology for scoping reviews (Peters et al. 2020) and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) (Tricco et al. 2018). Quantitative and qualitative studies were reviewed from 1992, as this was when Irihapeti Ramsden (1992) highlighted cultural safety as an issue within published literature. A systematic search of 11 data bases (Australian Indigenous Health InfoNet, Scopus, APAIS-ATSIS (Informit), CINAHL (EBSCO), Embase (Ovid), Medline (Ovid), Health & Medical Collection (Proquest), Nursing & Allied Health Database (Proquest), Psychology Database (Proquest), Public Health Database (Proquest), Sociology Database (Proquest) was completed 29 September 2024. Keywords, Boolean operators and relevant MeSH terms were utilised. The review was guided by the Aboriginal and Torres Strait Islander Quality Appraisal Tool (supplementary material Aboriginal-and-Torres-Strait-Islander-QAT) and a cultural safety framework from (Taylor and Guerin 2019) containing five key principles for practitioners and health services to embed into care: (1) Reflect on one's own practice; (2) Engage in a discourse with the client; (3) Seek to minimise power differentials between yourself and client; (4) Undertake a process of decolonisation, and; (5) ensure, one does not diminish, demean, or disempower others through one's actions.

The scoping review title was registered with the OSF registry [osf.io/5jkn7].

2.1 | Search Strategy

The selected databases were accessed and exact terms used to create the search strategies aligned with each database. Four key categories of terms were included in the search strategy: (1) First Nations/Indigenous Peoples; (2) clinical staff and other professional staff; (3) cultural training; (4) renal replacement environments. The full search strategy is detailed in supplementary search strategy, concepts and terms.

2.2 | Study Selection

The initial screening process identified 3656 studies of which 2043 were duplicates. After screening of titles and abstracts, 111 studies were selected for full text review and on completion of the full text review process, 19 publications were included (Figure 1).

2.3 | Data Extraction

Articles were imported into EndNote 20 (Clarivate Analytics, PA, USA) before being imported into Covidence (Veritas Health Innovation, Melbourne, Australia). Duplicates were removed. Pilot screening of five selected articles was independently undertaken by (MAU, ER, JK) followed by discussion of each article and clarification of any uncertainties. The first author (MAU) and a second reviewer (ER or JK) undertook full-text review and extraction. Conflicts were resolved via a third reviewer (ER or JK). Data from the selected articles were tabulated, and contextual meaning given to the data through a process of collating, summarizing, and reporting. At the full text review stage, the Aboriginal and Torres Strait Islander Quality Appraisal Tool, which consists of 14 questions that assess the quality of health research from the perspective of First Nations People was utilised as a decolonising analysis strategy (Harfield et al. 2020).

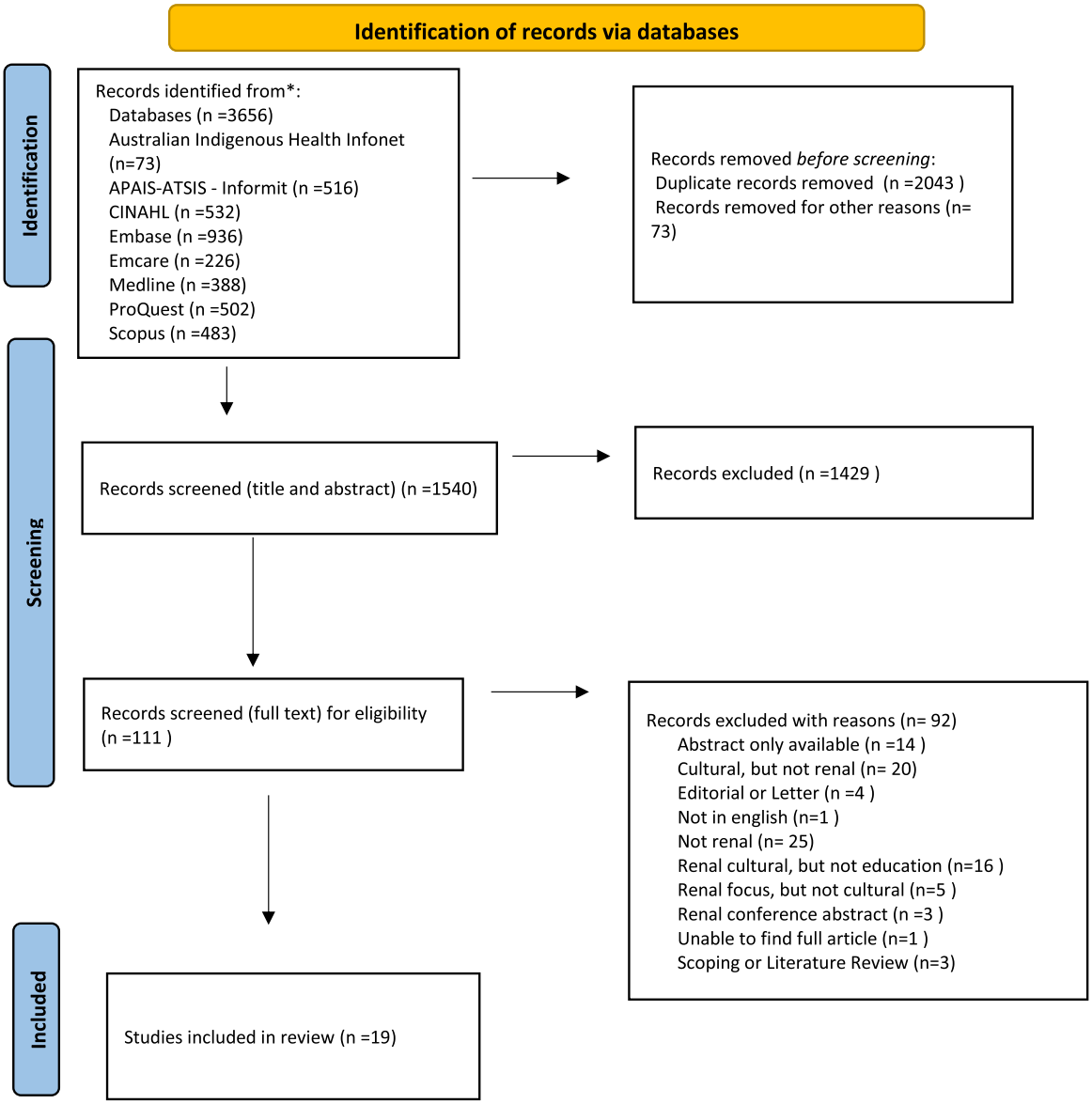

FIGURE 1 | PRISMA flow chart of study selection process HERE.

3 | Results

From our search of the literature, 19 papers emerged which specifically addressed cultural education for renal staff in Australia, Aotearoa/NZ and Canada of which 16 were Australian, two were from Canada, and one was from NZ. There were no articles from the United States that met the criteria. All 19 articles made explicit recommendations for the need for cultural education for renal staff, however, only six papers detailed specific approaches for education, three evaluated the education and only one paper evaluated the education from a First Nation's and patient/recipient of care perspective. This information is detailed in Supporting Information S1: Table 1 methodologies, terminologies, Indigenous involvement and locations.

When reviewing the included papers, the authors noted that collectively we have co-authored 9 of the 19 included papers. We double-checked our search with the university librarian. We also checked Smith et al. (2021) systematic review focusing on cultural safety in kidney care from 2002 to 2020 which contained 15 papers in total, three of which were ours. It became evident that we are key informants in culturally responsive kidney care and education, and there is scant research published in this context overall.

3.1 | Themes

Five overarching themes were identified: (1) cultural terminology, (2) need for education including the effects of (mis) communication and pervasive racism, (3) First Nations involvement and authorship/prioritisation, (4) cultural education, (5) approach and evaluation.

3.2 | Cultural Terminology

There was considerable variation in the terminology used to describe cultural approaches and these changed over time. The earlier papers used a range of terms such as cultural communication (Anderson et al. 2013; Cass, 2002; Neden et al. 2018) security, diversity, appropriateness and these terms were often only mentioned once in the entire paper (Anderson et al. 2013; Neden et al. 2018; Walker et al. 2012). Papers then started to focus on awareness (Rix et al. 2015; Rix et al. 2013), competence (Kelly et al. 2016; Rix et al. 2015; Robinson-Settee et al. 2021; Togni et al. 2017) and knowledge (Conway et al. 2018). From 2014, the papers began to include the terms safe or safety (Conway et al. 2018; Rix et al. 2016; Rix et al. 2014; Togni et al. 2017). From 2018 onwards there is a predominance of the terms safe and safety used across papers, which coincides with when cultural safety principles were added to the new Code of Conduct for Nurses which is governed by the Nursing and Midwifery Board of Australia (NMBA). In 2024 Kelly et al, emphasised the importance of non-First Nations staff requiring lifelong learning in line with principles of cultural safety, and of avoiding the term "cultural competency" to prevent health professionals and students assuming they could become culturally competent in one training session, thus reinforcing the need for lifelong self-reflection and recognition of power imbalances.

3.3 | Need for Education Including the Effects of (Mis)Communication and Pervasive Racism

3.3.1 | (Mis)Communication

All 19 papers identified the need for some form of cross-cultural education for healthcare professionals (Anderson et al. 2013; Blair et al. 2022). In 2002 a lack of staff education in intercultural communication was noted despite miscommunication being pervasive as discussed by a medical doctor reflecting on their own clinical practice; *"You become aware of the issues just through doing what you're doing. Which is poor.... You learn by obstacles and by... causing affront and problems*" (Cass, 2002, pg. 469). In 2018, communication was identified as crucial for improving trust and positive relationships between renal patients and staff. The article highlighted how a mobile dialysis service offered significant cultural learning opportunities and benefits for nursing staff who travelled with First Nations People on dialysis back to their remote communities. The staff noted *"you get to know the patients and they have a bit more of a trust and share a lot more. So, you become a lot more aware of what's important to them" (*Conway et al. 2018, pg. 8*)*. The critical role of language and how this linked to cultural understanding and safety in healthcare was highlighted by Kerrigan et al. (2021a), and these authors strongly advocated for systemic changes to support Aboriginal language speakers (like it supports other language groups that have come from overseas), which can decrease miscommunication. In an additional paper they stated the use of Aboriginal languages improves communication which is "*the life of any relationship*" (Kerrigan et al. 2021b, pg 9). Learning words in language and the laughter when the nurses try to pronounce these words aloud increased the cultural understanding of the nurses and generated much laughter, further building relationships. Culturally safe practice was also noted where community members were teachers and the health professional's role was primarily as a learner, rather than as a health professional (Togni et al. 2017). These were identified as important to include within staff education (Anderson et al. 2013; Blair et al. 2022; Cass, 2002; Conway et al. 2018; Kerrigan et al. 2021b).

3.3.2 | Addressing Pervasive Racism

The majority of papers identified that educational programmes require healthcare providers to engage in learning about systemic racism and the ongoing legacy of colonisation, in recognition that racism significantly and negatively affects First Nations Peoples' care experiences and perception of healthcare systems, eroding trust, see for example (Blair et al. 2022; Kerrigan et al. 2021a; Kerrigan et al. 2021b; Rix et al. 2015; Smith et al. 2021; Robinson-Settee, 2021). However, none of the papers really spoke to whiteness or white privilege. Ensuring cultural education also focuses on the power and knowledge imbalances that occur between healthcare staff and patients is also highlighted (Cass, 2002; Neden et al. 2018; Robinson-Settee

et al. 2021), as evidenced by a patient statement "*we want to not be continually faced by institutionalised and personal racism when we access treatment*" (Arnold-Ujvari et al. 2023, pg 99). The need to address institutional racism was discussed across multiple papers (Arnold-Ujvari et al. 2023; Kelly et al. 2024; Kerrigan et al. 2021a; Kerrigan et al. 2021b; Rix et al. 2015; Rix et al. 2013; Rix et al. 2016; Robinson-Settee et al. 2021). The rigidity of health service design was identified as an institutional barrier. Cultural and family obligations are often prioritized by First Nations patients over medical treatment, necessitating flexible service designs (Rix et al. 2015; Rix et al. 2013). This may not be understood or prioritised by staff, leading to further disconnection Rix et al. (2013): "*half the time their attitude towards Aboriginal issues and values keeps Aboriginals away*" (pg. 84). In contrast, renal staff supporting cultural practices and commitments through flexible scheduling and use of local First Nations consumer knowledge was identified as an institutional enabler, underpinned by effective two-way learning (Conway et al. 2018).

3.4 | First Nations Involvement and Authorship/Prioritisation

3.4.1 | Involvement of First Nations Peoples and Recipients of Care

Six papers identified the need for collaborative codesign of kidney services and models of care to improve care experiences and outcomes. Staff need skills in having two way discussions and deeper understanding to build strong, positive relationships with First Nations People and recipients of care to respond to their priorities and to ensure that care is accessible, effective, and culturally responsive (Arnold-Ujvari et al. 2023; Blair et al. 2022; Kelly et al. 2024; Kelly et al. 2022; Rix et al. 2016; Togni et al. 2017).

3.4.2 | Authorship/Prioritisation

Over time, there was an increasing engagement of First Nations People in (1) the studies being undertaken, (2) cultural education programmes, and (3) authorship of publications. Eight papers identify First Nations authorship. The first paper is Cass (2002) with two of seven authors identified as First Nations, the next is 2014 when (Rix et al. 2014) identifies First Nations authorship again. Interestingly, the same five authors are in a subsequent paper in 2015, and none are attributed as First Nations (Rix et al). In 2016 (Rix et al.) identified three of the four authors as First Nations. Three subsequent papers identify nearly half of the authors as First Nations (Kelly et al. 2024; Kelly et al. 2022; Togni et al. 2017), and (Kerrigan et al. 2021a; Kerrigan et al. 2021b) identify two out of nine authors as First Nations. The remaining 11 papers do not identify First Nations authorship. First Nations authors who are identified in the eight papers come from diverse backgrounds, including recipients of care (kidney warriors), Elders, community members, interpreters, researchers, and health professionals. To take this concept a step further all authors could identify their cultural backgrounds to stop othering (Figure 2).

3.5 | Cultural Education, Approach & Evaluation

3.5.1 | Cultural Education & Approach

Five papers reported on formal education (Conway et al. 2018; Kelly et al. 2024; Kelly et al. 2016; Neden et al. 2018; Robinson-Settee et al. 2021; Togni et al. 2017), informal education delivered by patients as cultural teachers resulting in "[sharing] *of Indigenous culture …. to their nurses, nurturing shared understandings and trust*" (Conway et al. 2018, pg. 7). Four papers positioned First Nations kidney patients and family members as trainers and experts in formal education (Kelly et al. 2024; Kelly et al. 2016; Robinson-Settee et al. 2021; Togni et al. 2017). Integrative learning on placement occurred but it is unclear if this was First Nations led (Neden et al. (2018).

Six papers reported face-to-face education. Robinson-Settee et al. (2021) reported additional strategies to better support Indigenous knowledges and inclusion of First Nations research ethics and protocols. Strategies included a book club aimed at sustaining conversations post-education, so staff could continue to learn from First Nations stories as part of an ongoing learning pathway.

Education locations varied from hospital sites, away from the clinical environment or unstated location (Kelly et al. 2016; Kelly et al. 2024; Neden et al. 2018; Robinson-Settee et al. 2021; Togni et al. 2017). The other 13 papers were predominantly theoretical with recommendations, but no education had been designed, delivered or evaluated. This is detailed in Supporting Information S1: Table 2 Cultural Education Frameworks & Approach.

3.5.2 | Evaluation

A major gap that was identified when reviewing all 19 papers was the lack of any formal evaluation of staff cultural education by consumers (the patients). Only three papers reported any form of evaluation (Kelly et al. 2024; Neden et al. 2018; Togni et al. 2017). Neden et al. (2018) sourced data from interviews at the mid and endpoint of a 4-month placement where structured education aimed specifically at social work students working in cross-cultural situations was provided. Kelly et al. (2024) undertook clinical yarning and a student survey, but neither paper included First Nations or recipients of care evaluation. For First Nations People, "yarning" is a conversation involving sharing stories and creation of new knowledge via building common ground and interpersonal relationships {social yarn} (Walker et al. 2014). Clinical yarning takes this further, understanding the patient's health journey through a biomedical lens {diagnostic yarn}, and using stories and descriptions to help patients grasp health issues and adopt a collaborative management approach {management yarn} (Lin et al. 2016). The third paper by Togni et al. (2017) discussed the developing partnerships between researchers, First Nations Elders and recipients of care through collaboration in the planning, implementation and evaluation of a cultural education programme, which is one of the principles in culturally safe practice. Togni (2017) highlighted formal evaluation by participants and was the only paper evaluated from a First Nations perspective; however, First Nations research team members did this informally.

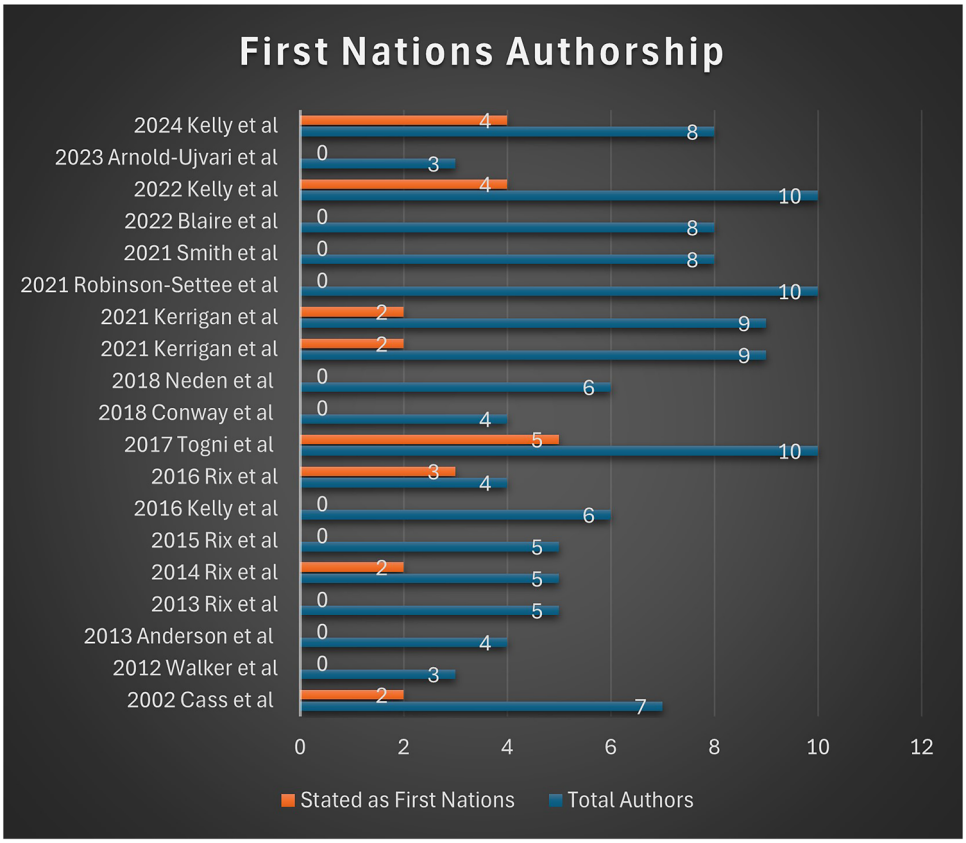

FIGURE 2 | First Nations Authorship HERE.

4 | Discussion

This scoping review identified limited publications reporting on cultural education and evaluation of the education provided to renal staff, with only three including any form of evaluation of effectiveness. These three papers contain participatory action research (PAR) as a methodology, where reviewing effectiveness from the community in the evaluation process to measure its impact is one of the stages, yet none have formally done this from a First Nations perspective (Lenette, 2022). There was minimal evaluation of staff education undertaken within the identified papers. Three papers included evaluation and feedback from staff and student participants, with only one including informal evaluation by First Nations education co-designers who were also recipients of renal care. This raises an important question to what extent does renal staff cultural education lead to improved care for First Nations People? (Street et al. 2022). Effective evaluation requires a First Nations lens, seeking First Nations patients' feedback on the cultural safety skills of their renal nurses (Arnold-Ujvari et al. 2024; Bateman et al. 2023; Ralph et al. 2023). Arguably and including renumerating First Nations People in developing, co-designing-delivering and evaluating cultural education is a crucial step forward in truly partnering with consumers (Australian Commission on Safety and Quality in Health Care 2021) and improving renal care experiences and outcomes (Anderson et al. 2023).

Although clinical/professional staff and health services strive to deliver responsive and coordinated clinical and cultural care for First Nations People with KF, they are often challenged in knowing how best to achieve this (Dwyer et al. 2016; Kelly et al. 2017). In 2016, Rix et al. identified that cultural education increases the cultural responsiveness of nurses caring for First Nations People. This requires moving beyond a clinical focus to actively listening and hearing First Nations Peoples' lived experience and cultural perspectives to shift the power imbalances Cultural Safety is increasingly being mandated in Australia. In a 2021 systematic review, Smith et al confirmed that culturally safe kidney care across similarly colonised countries (Australia, Canada, Aotearoa/NZ and the United States) needs further education and understanding so healthcare workers can translate theory and principles into their everyday practice. Yet there is scant published literature addressing the efficacy of cultural safety education and its effectiveness on improving the outcomes of First Nations recipients of health care in Australia, Aotearoa/NZ, Canada and the United States of America (Australian Pharmacy Council, 2021). Embedding cultural safety in everyday practice is evident, but collaboration and codesign with First Nations patients to achieve this is not apparent. (Table 1)

Over time, the term cultural safety is increasingly used in Australia, Canada and Aotearoa (NZ) renal care papers as identified in Table 2. Cultural safety is a First Nations framework created by Māori nurse Irapiti Ramsden (2002). It contains five key components; (1) Reflect on one's own practice; (2) Engage in a discourse with the client; (3) Seek to minimise power differentials between yourself and client; (4) Undertake a process of decolonisation, and ensure one does not diminish, demean, or disempower others through one's actions. Care is

TABLE 1 | Characteristics of cultural education HERE.

Author (year) country	Aims	Key findings	Cultural education identified/ recommendations made	Cultural education undertaken or prepared	Cultural training undertaken & evaluated
Anderson et al. (2013) Australia	Discusses the value of qualitative research in exploring, understanding, & communicating the impact of Kidney Failure & its treatments on Indigenous people from the views of patients & healthcare staff.	Clinicians need to be aware of challenges for Indigenous people being dislocated from country; not being able to speak the language & scared to approach health care staff.	More Indigenous staff needed & cross-cultural education.	Not identified	Not identified
Arnold-Ujvari et al. (2023) Australia	Reporting on the development of the Caring for Australian & New Zealanders with Kidney Impairment (CARI) guidelines & sharing this with renal nurses.	Need for culturally safe clinical care, address institutional & individual racism & improve cultural safety training for renal service providers.	Collaborate with Indigenous people to ensure appropriate models of kidney care.	Not identified	Not identified
Blair et al. (2022) Canada	Describes traditional protocols & storytelling used which led to a collaborative co-designed process incorporating calls to action in kidney care for First Nations & Metis people. The underpinning philosophy embedded in issues & language that aligns with the five principles of cultural safety.	Importance of cultural safety within kidney care, with improvements considered in education, local community support, traditional practices & cultural competency, & service delivery.	Teachings of respect, reciprocity, responsibility, & relevance critical to ensure the programme was community driven & collaborative.	Not identified	Not identified
Cass et al. (2002) Australia	Identify factors limiting effectiveness of communication between Aboriginal ESKD patients & healthcare workers & identify strategies for improving intercultural communication.	Miscommunication is pervasive. Trained interpreters provide a partial solution.	Educational resources needed to facilitate shared understanding & the inability to deliver optimal care without striking a balance between staff's medical priorities & patients' social needs.	Not identified	Not identified
Conway et al. (2018) Australia	Qualitatively evaluates the dialysis truck programme, its impact on the health & wellbeing of Indigenous patients, the facilitators & barriers to the service.	Importance of two-way learning assists in communication & importance of Indigenous knowledge & cultural needs.	Contributions of Indigenous knowledge for inclusion in education.	Informally identified	Not identified

(Continues)

TABLE 1 | (Continued)

Author (year) country	Aims	Key findings	Cultural education identified/ recommendations made	Cultural education undertaken or prepared	Cultural training undertaken & evaluated
Kelly et al. (2024) Australia	Codesign strategies to address disparities & gaps in care, & cocreate more accessible, responsive, culturally safe & sustainable models of care together.	Co-designed approach is needed & this project provides a working example of how to decolonise health service.	education programmes need to be instigated from the 'ground up'.	Fill in what happened here	Nursing students underwent cultural training and evaluation (N = ?)
Kelly et al. (2022) Australia	Describes experiences, perceptions & suggested improvements in healthcare identified by Aboriginal patients, families & community members living with kidney disease in South Australia.	Participatory Action Research & codesign with Aboriginal people with lived experience of chronic conditions informing the way care is organised & delivered.	Fill in what education was identified and recommendations made here	Not identified	Not identified
Kelly et al. (2016) Australia	Redesigned a renal course education package to include clinical & cultural care aspects. To be more responsive to needs of South Australian Aboriginal patients & families.	Development of a more locally relevant, culturally safe & responsive nursing education approach.	Fill in what education was identified and recommendations made here	Informally identified	Not identified
Kerrigan et al. (2021a) Australia	Highlights a pilot programme of First Nation language interpreters embedded into a medical team in a renal ward for 4 weeks.	The importance of being able to speak in their first language helped patients to make accurate decisions & feel listened to & at ease.	Fill in what education was identified and recommendations made here	Not identified	Not identified
Kerrigan et al. (2021b) Australia	Reporting on use of First Nations language interpreters in a Northern Territory renal unit & improved healthcare outcome.	Interpreter-mediated communication improved the delivery of culturally competent care. Importance of first language & learning about culture & the person.	Fill in what education was identified and recommendations made here	Not identified	Not identified
Neden et al. (2018) Australia	Investigated social work students' confidence & capability, as well as changes in attitudes & knowledge, through integrative learning on placement.	Placement which connects research & practice created a context for learning through the integration of physical, cognitive & social	Fill in what education was identified and recommendations made here	Fill in what happened here	Nursing students underwent cultural training and evaluation (N = ?)

(Continues)

TABLE 1 | (Continued)

Author (year) country	Aims	Key findings	Cultural education identified/ recommendations made	Cultural education undertaken or prepared	Cultural training undertaken & evaluated
		activities, discourses, & experiences.			
Rix et al. (2015) Australia	Describe & analyse perspectives of Aboriginal patients' & health care providers' experience of renal services, to inform service improvement for rural Aboriginal haemodialysis patients.	Elders delivering cultural education may increase two-way understanding between patients & clinicians.	Current services are not flexible, accessible, or family focused. There is a need for community-driven face-to-face cultural education with Elders.	Not identified	Not identified
Rix et al. (2014) Australia	Describes the experiences of Aboriginal people receiving haemodialysis in rural Australia, to inform strategies for improving renal services.	Identifies need for cultural training delivered by Aboriginal people with lived experience. Racism may be reduced by patients having a higher profile & assisting staff to understand Aboriginal view.	Fill in what education was identified and recommendations made here	Not identified	Not identified
Rix et al. (2013) Australia	Describes service providers' perspectives on health services delivery for Aboriginal HD recipients in a rural region of Australia.	Need to improve cultural awareness to safety training & a better understanding of the lived experience of Aboriginal HD patients can inform service provision to improve clinical outcomes & quality of life.	Fill in what education was identified and recommendations made here	Not identified	Not identified
Rix et al. (2016) Australia	To inform service improvement for Aboriginal renal patients.	The need for different cultural training models & proposes a new model of staff cultural education/ experience which includes Aboriginal HD patients, family members or Elders delivering cultural	Fill in what education was identified and recommendations made here	Not identified	Not identified

(Continues)

TABLE 1 | (Continued)

Author (year) country	Aims	Key findings	Cultural education identified/ recommendations made	Cultural education undertaken or prepared	Cultural training undertaken & evaluated
		education to their own renal clinicians.			
Robinson-Settee et al. (2021) Canada	Create a learning pathway (Wabishki Bizhiko Skaanj) that aims to distil the racism that Indigenous people face, & build cultural competence, within the health sector.	Focused on cultural training for both researchers & health professionals, combines existing programmes with options.	Implementation of the Wabishki Bizhiko Skaanj as a learning pathway that is adaptable for healthcare & research organizations to distil racism & boost cultural competence.	Fill in what happened here	Not identified
Smith et al. (2021) Australia	Aim was to explore the depth of literature regarding how cultural safety occurs within contexts of care for Indigenous people with kidney disease.	Ongoing indigenous research needed that evaluates & sustains culturally safe indigenous kidney care. Health care authorities must engage communities & care recipients in decision making.	Provide time & space to listen, enable Indigenous-driven traditional protocols & approaches.	Not identified	Not identified
Togni et al. (2017) Australia	Collaborate with key stakeholders to develop the Central Australian Renal Voice (CARV) consumer group's vision for a patient-led component of cultural awareness training for renal clinicians.	Co-developed & Aboriginal led education within renal services can lead to positive learnings & changes for both patient's & nurses. Learning some Aboriginal words & using humour decreased the power gap.	Fill in what education was identified and recommendations made here	Fill in what happened here	√ formal by participants & informal by research team
Walker et al. (2012) New Zealand	Considers what pre-dialysis nurses perceive to be key influences on effective pre-dialysis nursing care in New Zealand.	Importance of pre- dialysis nurses supported to provide comprehensive & culturally appropriate care to Indigenous patients & encouraged to advance professionally & be involved in future service development.	Fill in what education was identified and recommendations made here	Not identified	Not identified

TABLE 2 | Five principles of cultural safety HERE.

Author (year) country	1. Critical reflection	2. Engage in a discourse	3. Minimise power imbalance	4. Decolonisation	5. Do not diminish, demean, disempower
Anderson et al. (2013) Australia		√	√		
Arnold-Ujvari et al. (2023) Australia	√		√	√	
Blair et al. (2022) Canada		√		√	
Cass et al. (2002) Australia		√	√	√	√
Conway et al. (2018) Australia	√	√	√		
Kelly et al. (2024) Australia	√	√		√	√
Kelly et al. (2022) Australia		√	√	√	√
Kelly et al. (2016) Australia	√	√			
Kerrigan et al. (2021a) Australia	√	√	√	√	√
Kerrigan et al. (2021b) Australia		√	√		√
Neden et al. (2018) Australia	√	√	√		
Rix et al. (2015) Australia		√	√	√	
Rix et al. (2014) Australia	√	√	√	√	√
Rix et al. (2013) Australia	√	√	√	√	√
Rix et al. (2016) Australia		√	√	√	√
Robinson-Settee et al. (2021) Canada	√		√	√	
Smith et al. (2021) Australia	√	√	√	√	√
Togni et al. (2017) Australia	√	√	√	√	√
Walker et al. (2012) New Zealand		√	√		

considered to be culturally safe if it is perceived to be so by recipients of care. The major difference between cultural safety and all other cultural care frameworks is the need to address power imbalances within care and for non-First Nations staff to focus on decolonising themselves and their professional practice. All papers in the review incorporated at least two of the five principles, with eight of the papers incorporating four or five of the principles. The principles least covered were "undertake a process of decolonisation" and "ensure you do not diminish, demean, or disempower through your actions" (Taylor and Guerin 2019). These are both integral components of relationality which is increasingly recognised as crucial for building positive relationships and two-way understandings in health care (O'Donnell 2006; Smith et al. 2021). According to First Nations scholar Shawn Wilson (2008) "*[relationality is] a collective, it's a group, it's a community. [relationality is] built upon the interconnections, the interrelationships, that binds the group"* (pg. 80). Relational accountability within the cultural safety framework, requires staff to engage with humility and an open mind whilst critically reflecting on their own world views and cultural perspectives. (Taylor and Guerin 2019). Within kidney care relationality between First Nations People and staff involved in their care is crucial as it encourages a holistic approach to health, considers physical as well as emotional and spiritual well-being which aligns with First Nations Peoples' views on health and wellbeing.

The importance of culturally safe care is also strongly emphasised in the inaugural recommendations for culturally safe and clinical kidney care for First Nations Australians within the CARI guidelines published in 2022 (Tunnicliffe et al. 2022). The development of these Guidelines over 4 years was a community-first approach which reinforced the concept '*nothing about us, without us*' (Funnell et al. 2020). These guidelines and the national cultural bias report (Kelly et al. 2020) emphasise that given the significant levels of First Nations People with renal impairment being cared for by non-First Nations staff; the dominance of Eurocentric culture and priorities within health care, the structural unequal power dynamics, ongoing colonisation and racism, cultural safety is an appropriate cultural education framework to deliver staff education in renal care.

Cultural understanding and responsiveness in the clinical environment are shown to have positive outcomes on the care of First Nations People as it leads to behavioural changes and ongoing reflection by healthcare staff whilst building reciprocal understanding creating strong, positive relationships between patients and staff. (Kerrigan et al. 2021b; Rix et al. 2016; Smith et al. 2021). Nurses learnt of ways to not disempower people through their clinical actions and gained a greater understanding of Aboriginal culture(s), the importance of family/kinship as well as different aspects of Aboriginal worldviews, ways of living, values and beliefs demonstrated by this quote 'nurses are really listening to us and learning from us and our stories' (Togni et al. 2017). A key strength of collaborative embedded participatory action research can be the immediate positive effects for community members, students and health professionals as relationships are built. This ensures that research involving First Nations People is meaningful, and that there is timely response to their needs and priorities (Kelly et al. 2024).

One off education does not create a culturally competent workforce but could increase cultural awareness (Mooney et al. 2005). Whereas continuous education for all renal service providers on culturally safe care can address institutional racism (Kelly et al. 2024; Kerrigan et al. 2021a; Kerrigan et al. 2021b) as patients become '*proactive partners*' instead of '*passive recipients of care*'. This can facilitate shared understanding of medical and cultural concepts (Cass, 2002). The lack of access to cultural education or culturally appropriate resources is seen as an institutional barrier (Rix et al. 2014; Smith et al. 2021; Walker et al. 2012). Kelly (2016) highlighted the importance of decolonising health services and education programmes through collaborative and culturally safe approaches including improving nurses' understanding of both clinical and cultural aspects of care via a locally relevant, culturally safe and responsive nursing education approach

Despite good intentions and rhetoric this is not translating into action. Anecdotally, we know there are pockets of cultural education occurring in kidney care environments. However, this is not appearing in peer-reviewed publications. There is much more to undertaking cultural safety education as a clinical or professional staff member; this study is a lifelong journey of learning and unlearning how to work respectfully in the intercultural space for non-First Nations kidney care staff.

4.1 | Strengths and Limitations

So far, the small number of projects researching cultural education provides limited evidence of the decolonising ways forward in this space. Whilst this may appear to be a limitation, it may also be viewed as a strength and validation of the need for this scoping review. The use of English language only papers is a limitation; however no non-English language papers were identified within the searches.

5 | Conclusion

We presented a scoping review on the cultural education provided to renal staff caring for First Nations People in Australia, Canada and Aotearoa/NZ, as similarly colonized countries. We qualitatively accessed what is occurring via the published literature. As authors, we note there is some progress in the context of cultural education, with researchers and renal health services increasingly prioritizing cultural education for all kidney care nurses and others working with First Nations People accessing renal care. However, there remains little or no progress or prioritization of the evaluation of cultural education and the skills base of nurses from the lens of consumers (First Nations People with kidney failure). The prioritising of First Nations voices in reporting cultural safety issues and concepts is clear, as is the lifelong journey of learning and unlearning for non-First Nations renal care staff.

Author Contributions

Melissa Arnold-Ujvari: conceptualization, formal analysis, investigation, methodology, writing – original draft preparation and review and

editing. **Elizabeth Rix:** conceptualization, formal analysis, supervision, writing – review and editing. **Janet Kelly:** conceptualization, formal analysis, supervision, writing – review and editing. **Kim O'Donnell:** supervision, writing – review and editing.

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Disclosure

KO is a Barkindji/Malyangapa woman and a Public Health researcher with extensive understanding and experience working with Australia's First Peoples in education, health, and governance. ER is a renal nurse and researcher whose doctoral studies focused on addressing systemic racism, with the aim of improving accessibility and acceptability of renal mainstream services for First Nations people receiving dialysis. MAU is a renal nurse, academic and researcher whose focus is on cultural safety and improving health care and outcomes for and with First Nations people. JK is a primary health care nurse, academic and researcher focused on improving health care and outcomes with and for Aboriginal and Torres Strait Islander people. The scoping review title was registered with the OSF registry http://osf.io/3hfc8/.

Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.