

Developing a Sexual Orientation and Gender Identity Nursing Education Toolkit

Marian Luctkar-Flude, RN, PhD, CCSNE; Jane Tyerman, RN, PhD, CCSNE; Erin Ziegler, RN(EC), PhD, NP-PHC; Benjamin Carroll, RN, MNSc; Chris Shortall, BSc(H), MSc(Med); Lily Chumbley, MA; and Deborah Tregunno, RN, PhD

abstract

Background: Current education lacks lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2S) content for health care providers (HCPs). Providing HCPs with understanding of LGBTQI2S health issues would reduce barriers. The Innovative Thinking to Support LGBTQI2S Health and Wellness trainee award supported the development of a website with virtual simulation games (VSGs) about providing culturally humble care to LGBTQI2S individuals to address this need. **Method:** An online educational toolbox was developed that included VSGs and resources. Development processes included a visioning meeting, development of learning objectives, and using a decision-point map for script writing. Bilingual VSGs were filmed, and the website was developed. **Results:** The Sexual Orientation and Gender Identity Nursing Toolkit was created to advance cultural humility in practice. Learning modules focus on encounters using cultural humility to meet the unique needs of the LGBTQI2S community. **Conclusion:** Our innovative educational toolkit can be used to provide professional development of nurses and other HCPs to care for LGBTQI2S individuals. [*J Contin Educ Nurs.* 2020;51(9):412-419.]

Historically, the education of health care providers (HCPs) has lacked lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2S)–specific content (Institute of Medicine, 2011). White et al. (2015) conducted a survey and found a median of 5 hours of LGBT content was taught in the required medical school curricula in Canada and the United States; whereas, Lim et

al. (2015) found the median time devoted to teaching LGBT health to baccalaureate nursing students in the United States was 2 hours. A recent study exploring curriculum content in baccalaureate nursing programs in Canada found that programs provided limited content, which was not standardized across the institution, thus providing inconsistencies in content delivered (Shortall, 2019). No studies identified the amount of time allotted in nurse practitioner curricula. Rondahl (2009) found that only 10% of nursing students had a basic level of knowledge regarding the LGBT population. Medical and nursing curriculum content specific to queer, intersex, and two-spirit health and wellness was not identified in any published studies.

A major barrier for including LGBTQI2S content into nursing curriculum has been the shortage of faculty who feel prepared (Eliason et al., 2010) and comfortable (Lim

Dr. Luctkar-Flude is Associate Professor, Mr. Carroll is Doctoral Student, and Dr. Tregunno is Associate Professor, Queen's University School of Nursing, Kingston, Ontario; Dr. Tyerman is Assistant Professor, University of Ottawa School of Nursing, Ottawa, Ontario; Dr. Ziegler is Assistant Professor, Ryerson University Daphne Cockwell School of Nursing, Toronto, Ontario; Ms. Chumbley is eLearning Specialist, Trent University, Oshawa, Ontario; and Mr. Shortall is Visiting Researcher, Memorial University, St. John's, Newfoundland, Canada.

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Address correspondence to Marian Luctkar-Flude, RN, PhD, CCSNE, Associate Professor, Queen's University School of Nursing, 92 Barrie Street, Kingston, ON, Canada K7L 3N6; email: mfl1@queensu.ca.

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et al., 2015) to teach the content. Canadian nursing faculty overall felt unqualified to teach about LGBTQI2S health and wellness issues and more specifically, transgender, intersex, and gender nonconforming health issues. Furthermore, limited opportunities for professional development on LGBTQI2S content and a lack of curricular policy left nursing educators trying to determine what content to include (Shortall, 2019). Evidence-informed LGBTQI2S content needs to be integrated into nursing curriculum to improve health outcomes for this vulnerable population (Lim & Hsu, 2016). The addition of LGBTQI2S content threaded through the curricula would better prepare HCPs to provide access to inclusive, evidence-informed, and knowledgeable patient-centered care. A better understanding of LGBTQI2S health issues and inequalities would allow HCPs the opportunity to reduce barriers faced by this population. As a result, individuals who identify as LGBTQI2S could experience optimal health outcomes and feel more comfortable accessing health care on a more regular basis (Mayer et al., 2008).

Hacking the Knowledge Gap

In 2017, the Canadian Institutes of Health Research (CIHR) Institute of Gender and Health created an initiative to support knowledge transfer and exchange skills development on the theme of Innovative Thinking to Support LGBTQI2S Health and Wellness (CIHR, 2019). Graduate student researchers in the area of LGBTQI2S health from across Canada were teamed up with local HCPs, LGBTQI2S community members, and marketing experts to develop campaigns, services or products to disseminate research evidence to improve health outcomes (Michael Smith Foundation for Health Research, 2018). Three trainees who are now part of our research team (one PhD student, E.Z.; one Master of Nursing Science student, B.C.; and one recent Master of Science graduate, C.S.) developed a plan to create a website to provide education to nurses and students about providing culturally humble care to LGBTQI2S individuals (Ziegler et al., 2020). Together, the trainees developed the idea for the project and put forth a call for proposals to develop the knowledge transfer and exchange initiative. The call was answered by our group of academic nurse researchers (M.L.F., D.T., J.T.) with experience in creating video-based virtual simulation games (VSGs) for nurses and nursing students.

VSG Development Team

Our development team is comprised of nationally recognized nurse educators and researchers who have extensive experience with the development and use of simulation-based educational resources and other web-based applications. We have a highly collaborative ap-

proach to development of educational resources and a strong track record of working with others to develop, test, and implement educational resources across a variety of clinical settings, and for novice-to-expert nurses. We also have extensive experience working with other HCPs and interprofessional teams. A unique aspect of our work is that it is rooted in the theoretical principles of self-regulated learning (SRL). SRL theory asserts that students ultimately have control over their own learning and that it is within the student's purview to direct their cognition and motivation to achieve learning goals (Zimmerman, 2000). Zimmerman's three-phase cyclical model of SRL includes forethought, performance, and self-reflection. Forethought involves task analysis, goal setting, and planning that is consistent with self-efficacy and perceived value of the learning experience. During the performance of the learning activity, learners experiment with self-control and self-observation strategies to maintain engagement and motivation. In the self-reflection phase, learners assess the degree to which they achieved their learning outcome and make causal attributions about success or lack thereof.

Our development team first collaborated on a project funded by the Ontario Ministry of Training, Colleges and Universities in 2013-2014 that resulted in:

- a standardized approach to integrating learning outcomes and assessment tools into simulation development;
- 40 standardized bilingual clinical simulations; and
- an online simulation repository to facilitate national access to the resources (Tregunno et al 2014).

Our simulation work continued through the creation and evolution of the Ontario Simulation Alliance and the Canadian Alliance of Nurse Educators Using Simulation, both of which are communities of practice focused on collaborating for excellence in simulation education and research. In 2017-2018, team members led an e-Campus Ontario grant to examine the cost utility of using VSGs as preparation for clinical simulation. This grant yielded a standardized approach for VSG development and 13 VSGs (Tyerman et al., 2018). This work positioned the development team to respond to the call issued by the CIHR Trainee Award recipients.

METHOD

We developed an educational toolbox that includes VSGs of varying lengths (i.e., short vignettes to full games) and curated educational resources. We relied heavily on consultation with LGBTQI2S researchers and communities to determine the priorities to be addressed. Each VSG included embedded self-assessments, learning outcomes, and targeted resources. The toolbox will be disseminated through an awareness campaign and will be hosted on a

TABLE 1
PROPOSED TOOLKIT LEARNING OBJECTIVES

1. Describe nurses' knowledge and attitudes discussing topics pertaining to sexuality and gender diversity
2. Explore personal values and biases
 - a. how they are systemic
 - b. how to address them in healthy practice
 - c. avoiding heteronormativity and cisgenderism
3. Describe the unique health issues in the lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit population
 - a. gain some perspective of their unique needs
 - b. identify community supports
4. Acquire knowledge and skills for working with sexual and gender diverse identified people
 - a. adapt assessment techniques appropriately
 - b. demonstrate effective, respectful and compassionate communication

website for a minimum of 5 years. The project consists of three sequential phases (design, development, and implementation). This article describes the first two phases that have been completed. Evaluation of the implementation phase will be reported in a future article.

Phase 1: Designing the Online Educational Toolkit

Visioning Meeting. The overarching goal of the project is to advance nursing and other HCPs' cultural humility in practice. Specific objectives proposed for the educational toolkit are outlined in **Table 1**. We convened a 1-day workshop with the three CIHR Award recipients and four community stakeholders from the LGBTQI2S community, during which we planned the process for developing the educational toolkit and VSGs. Our first priority was to gain a deeper understand of the objectives of the project and to collaborate with stakeholders and content experts to determine the following:

- issues of LGBTQI2S individuals seeking and receiving health care
- learning the needs of HCPs
- priority scenario topics
- the number and type of VSGs to be developed
- key content to be included in the educational material

Cultural Humility. The development team and content experts shared their perspectives of the project and the theoretical underpinnings for the project. Globally, there is a call for HCPs' initial and continuing education to incorporate cultural humility practice into clinical skills (Brennan et al., 2012; Clark et al., 2011; Wylie et al., 2016). Cultural humility was developed in response to the non-intersectionality of the more common health care practice of cultural competence (Kirmayer, 2012; Tervalon & Mur-

ray Garcia, 1998). It differs most notably in that cultural competence is an end-state achievement, whereas cultural humility is ongoing and requires continued critical self-reflection as a foundational principle, seeks to understand individual and systemic power imbalances, and is grounded in health equity (Foronda et al., 2016; Johnson & Munch, 2009; Kirmayer, 2012; Tervalon & Murray Garcia). The results of practicing cultural humility are lifelong learning composed of mutual benefit, empowerment, partnerships, respect, and optimal care (Foronda et al., 2016). A cultural humility framework adapted to graduate nursing education outlines specific concerns, issues, skills, and education strategies using cultural humility at the graduate level and in subsequent practice (Clark et al., 2011). Most research describes the application of cultural humility practice on an ad hoc basis to individual courses or activities in health care postsecondary and continuing education (Carabez et al., 2015; Dao et al., 2017; Jernigan et al., 2016; Kumagai & Lypson, 2009; Ontario Public Health Association, 2017; Yingling et al., 2017). There is also a call to include cultural humility in international standards for clinical simulation education (Foronda et al., 2016).

Priority Topics. As a large group, we discussed and agreed on priority topic areas to be addressed, such as specific patient populations, their issues, and their needs, and we linked them to relevant learning needs of HCPs. Breaking into small groups, we outlined four main clinical scenarios to be the focus of the VSGs (**Table 2**) and four rapid-fire focused VSGs to be developed (**Table 3**). Further, we identified four writing teams to work on the scenarios. Each writing team comprised at least one of the development team members and one of the CIHR Award recipients in alignment with their particular content ex-

TABLE 2
SUMMARY OF VIDEO SIMULATION GAME TOPICS

Subject	Issues	Health Care Provider Learning Needs
Wolfgang ^a : Older adult LGB seeing health care provider related to grief following loss of partner	<ul style="list-style-type: none"> • Coming out to provider • Family structure: friend versus partner • Community resources • Suicide risk • Prioritizing needs 	<ul style="list-style-type: none"> • Communication • Heterosexism • Relational practice • Not reinforcing stereotypes • Framing questions as to why
Cody/Olivier: Transgender youth with anxiety	<ul style="list-style-type: none"> • Unsupportive parents • Has not come out to parents (anxiety, mood) • Pregnancy and STI risk • Access to resources 	<ul style="list-style-type: none"> • Creating safe space • HEADSS assessment • Consent • Documentation
Sarah: 24-year-old queer female, feminine presenting to primary care	<ul style="list-style-type: none"> • Pregnancy assumption • Gender-neutral bathroom • Need for PAP smear 	<ul style="list-style-type: none"> • Not making assumptions • Heterosexism • Asking good questions • Intimate partner violence safety assessment • Complete sexual health history taking
Connor: Transgender male (same person as in rapid fire), health problem not related to gender	<ul style="list-style-type: none"> • Person is distraught • File/health card does not match preferred name/gender • Chest binding • Chest assessment requiring radiograph 	<ul style="list-style-type: none"> • Acknowledging, apologizing, and moving on • Recognizing the patient is the expert • How to ask about pregnancy respectfully with a transgender male • How to transfer care to another health care provider • Legal and social transition • Understanding language of transgender person

Note. LGB = lesbian, gay, bisexual; STI = sexually transmitted infection; HEADSS = Home, Education, Activities/Employment, Drugs, Suicidality, Sex.
^a All names are pseudonyms.

TABLE 3
RAPID FIRE TOPICS

Subject	Issue	Health Care Provider Learning Needs
Transgender person at clinic registration, not called by preferred name	<ul style="list-style-type: none"> • Name does not match name on health card 	<ul style="list-style-type: none"> • What you want to be called when and where
Child with fever	<ul style="list-style-type: none"> • Assuming second “mother” is the “aunt” 	<ul style="list-style-type: none"> • Not making assumptions
Inappropriate disclosure	<ul style="list-style-type: none"> • Disclosing sensitive information that is not related to patient care 	<ul style="list-style-type: none"> • Confidentiality • Stigma
Male requesting STI testing	<ul style="list-style-type: none"> • Sexual orientation of patient is unknown 	<ul style="list-style-type: none"> • Not making assumptions • Create safe space • Asking good questions

Note. STI = sexually transmitted infection.

expertise. Teams met via Zoom meetings to work on the individual scenarios. Development team members led content experts through the design process. We also consulted individuals with lived experience to ensure authenticity of the scripts. The process followed the Canadian Alliance of Nurse Educators using Simulation VSG design process (Tyerman et al., 2018). The VSGs consist of video clips of interactions between HCPs and patients filmed from the viewpoint of the HCP, which places the learner “in

the HCP’s shoes.” As a game progresses, the video stops at key points in the scenario and requires the learner to use critical thinking to select the best response to a clinical decision-making question.

Phase 2: Development of VSGs and Sexual Orientation and Gender Identity Nursing Website

When developing a new simulation or VSG, we employ the principle of backward design in which the learning

TABLE 4
SAMPLE LEARNING OUTCOMES WITH LEVELLED INDICATORS

Competency	Competent Learner	Intermediate Learner	Novice Learner
Understands personal assumptions about heterosexism to provide culturally humble care to LGBTQI2S individuals	<ul style="list-style-type: none"> • Consistently avoids heterosexist comments or questions • Consistently interacts with the patient in a way that facilitates open communication • Consistently demonstrates a regard for respecting the patient 	<ul style="list-style-type: none"> • Attempts to avoid heterosexist comments or questions • Attempts to interact with the patient in a way that facilitates open communication • Attempts to demonstrate a regard for respecting the patient 	<ul style="list-style-type: none"> • Does not avoid heterosexist comments or questions • Does not interact with the patient in a way that facilitates open communication • Does not demonstrate a regard for respecting the patient
Comments: Please indicate your rationale for your rating			
Applies principles of cultural humility when asking health assessment questions to establish a therapeutic relationship	<ul style="list-style-type: none"> • Demonstrates nonjudgmental attitude during all interactions • Demonstrates a respectful, client-centered approach during all interactions 	<ul style="list-style-type: none"> • Demonstrates nonjudgmental attitude during some interactions • Demonstrates a respectful, client-centered approach during some interactions 	<ul style="list-style-type: none"> • Does not demonstrate nonjudgmental attitude during interactions • Does not demonstrate a respectful, client-centered approach during interactions
Comments:			
Asks appropriate questions when taking a sexual health history to obtain accurate and complete information	<ul style="list-style-type: none"> • Sets a nonjudgmental tone for all encounters • Asks mostly open-ended questions to ensure inclusivity and avoids assumptions • Always uses specific and straightforward language to inquire about sexual activity and practices 	<ul style="list-style-type: none"> • Sets a nonjudgmental tone for some encounters • Asks some open-ended questions to ensure inclusivity and avoids assumptions • Uses some specific and straightforward language to inquire about sexual activity and practices 	<ul style="list-style-type: none"> • Does not set a nonjudgmental tone for the encounter • Does not ask open-ended questions to ensure inclusivity and avoids assumptions • Does not use specific and straightforward language to inquire about sexual activity and practices
Comments:			
Note. LGBTQI2S = lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit.			

outcomes are identified first (Egan et al., 2014; Luctkar-Flude et al., 2017). The process consisted of writing learning outcomes, rubrics, and decision point maps (Table 3).

Learning Outcomes and Assessment Rubrics. Following identification of two to three learning outcomes for each VSG, we created assessment rubrics for each scenario (Table 4). Indicators for each learning outcome were leveled to the competent, intermediate, and novice learner, based on the first three stages outlined in Benner's novice-to-expert model, which is frequently applied to simulation education (Thomas & Kellgren, 2017).

Decision Point Map. Next, we determined clinical decision-making points for the games that aligned directly with each learning outcome based on the assessment findings encountered in the scenario. We created a grid or decision point map that outlined the assessment findings, decision point questions, and three potential responses that may be selected by the learner (Table 5). We also provided a rationale for why each response was correct or incorrect.

Script Writing. After the decision points were finalized and reviewed by the entire team, we wrote the scripts

that guided the filming of the game videos. The scripts included descriptions of the setting, as well as instructions for actors' movements, behaviors, and dialogue. The VSG scripts were reviewed by our simulation and content experts and consultants prior to filming the VSG clips.

Filming. Although the game videos can be filmed with any video equipment, we used a GoPro camera. Thus, the games were filmed from the perspective of the nurse to promote immersion in the scenario. A short video clip was filmed leading into each decision point and for each response.

Game Assembly. We employed a user-friendly VSG template using Articulate Storyline software that allows us to quickly drop the film clips into the game flow and to add text for the decision points and rationale (Keys et al., 2020) (Figure 1).

Usability Testing. Prior to implementation, the development team reviewed the flow of scenes and wording of responses in each VSG. Further testing by faculty and learners will evaluate usability of the games and website. Feedback provided will be used to guide any needed modifications.

TABLE 5
SAMPLE DECISION POINT MAP

Decision Point	Interim Scene	Question	Response 1 (Correct)	Response 2 (Incorrect)	Response 3 (Incorrect)
1	Transgender male pacing, still visibly upset when NP enters room and introduces self and says hello to "Mary." Patient says, "My name is John, didn't the receptionist tell you?"	What would the NP say next?	Acknowledge patient's distress	Ask why patient is here today	Tell patient to calm down
2	Patient calms and sits, and NP begins history using EHR.	How would the NP proceed?	Clarify pronouns and transition status	Ask why patient is here today	Use patient's legal name
3	NP asks why patient is here today. Patient has cough	When conducting health history of respiratory system, what would the NP need to do?	Clarify patient's naming of own anatomy	Use standard anatomical terms	Avoid anatomical terms
4	Patient reveals they wear a binder, NP asks about taking a deep breath, weight gain	When conducting the health of the respiratory system, what would the NP ask the patient to do?	Remove binder and put on gown	Leave binder on and put on gown	Leave binder and t-shirt on
5	NP summarizes findings and states they would like to send patient for a CXR.	How would the nurse ascertain the pregnancy status of the patient prior to arranging CXR?	Normalize the need to ask pregnancy status	Ask patient if they could be pregnant	Not necessary to ask a transgender man
6	Patient is not pregnant.	How would the NP report gender-specific information when transferring care?	Include gender-specific information	Do not include gender-specific information	Focus on gender-specific information

Note. NP = nurse practitioner; EHR = electronic health record; CXR = chest radiograph.

Debriefing Design. Based on the level of the learners, learning outcomes, and other contexts, we selected a debriefing method deemed appropriate for online delivery. We elected to use a self-debriefing format involving self-assessment with the rubric and self-reflection guided by a series of questions designed to elicit reflection upon personal biases, learning, and practice changes.

Website Development Process. A key requirement of the project was the ability for the games, resources, and content to be widely accessible through a dedicated online presence. The resulting website incorporates a database of independently searchable resources that are also integrated within the learning modules. We followed traditional learning strategies to ensure that modules were consistent with current best practices for the autonomous online learning.

Pedagogical Considerations. Online modules were structured to incorporate best practices in online pedagogy, including learning outcomes, scaffolding, and de-

briefing. Modules and scenarios were developed around learning outcomes directly related to the learning needs (Marsh, 2007), which were determined in the first meeting. Rubrics, quizzes, and the scenarios provide immediate feedback to learners based on their selections, which has been shown to improve learner performance (Leibold & Schwarz, 2015). Each module has a debrief and opportunities for reflection, which assists learners in making real-world connections to content within online learning systems (Guthrie, 2010).

RESULTS

To meet the goals of this project, the Sexual Orientation and Gender Identity Nursing Toolkit was created to advance cultural humility in health care practice. The features of this toolkit include an interactive webpage (<http://www.soginursing.ca>), a quiz to allow for reflection and identification of personal biases, introductory

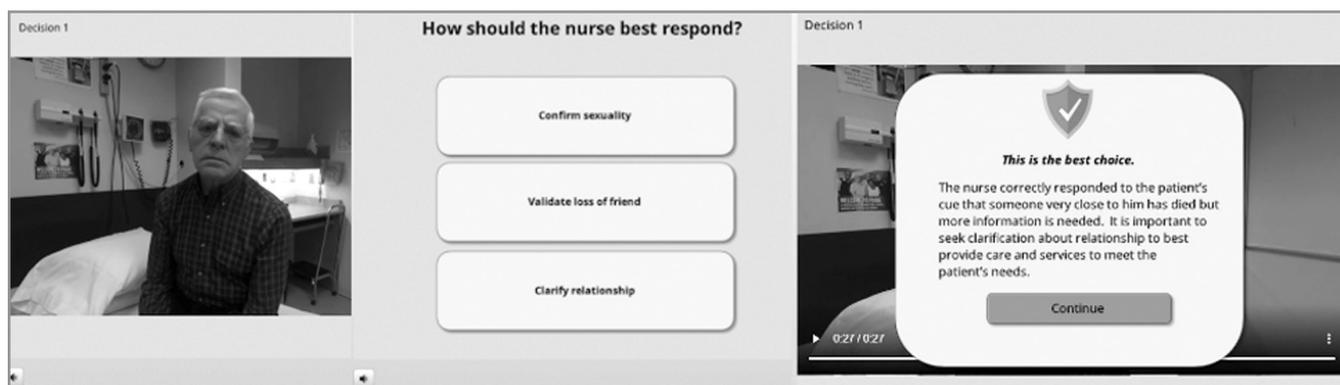


Figure 1. Sample video simulation game screen capture.

lessons about cultural humility, four learning modules, and curated resources. Each learning module centers on a health care encounter that demonstrates the use of cultural humility to meet the unique needs of LGBTQI2S community. The learning modules include an introduction with suggested readings, case summary, module-specific learning outcomes, self-assessment rubric, a five decision-point VSG, debriefing strategies including self-reflective questions, and targeted resources. The self-assessment rubrics and VSGs are also available in French, along with a limited list of francophone resources. Each game has an embedded certificate of completion, and a final certificate will be issued after all four modules are completed. The game topics include current relevant health issues faced by LGBTQI2S individuals across the lifespan. To establish authenticity, LGBTQI2S-identified actors were used whenever possible to portray characters in each VSG.

DISCUSSION

The first two phases of the project have been completed successfully. We have created an online educational toolkit that is accessible to nurses, nursing students, and other HCPs across Canada. Participants will be able to access standalone resources on a variety of topics related to cultural humility and LGBTQI2S issues in accessing and receiving health care. To our knowledge, this is the first attempt to create a focused learning environment to explore nurses' perceptions and biases of providing health care to the LBGQTQI2S community. A novel aspect is the incorporation of VSGs, which allows for application of the principal of cultural humility to common clinical situations.

CONCLUSION

Our innovative educational toolkit can be used in academic and health care settings to provide professional development and to better prepare the next generation

of nurses and other HCPs to care for individuals who identify as LGBTQI2S. Our next step will be to conduct formal usability testing of the website and each VSG in two phases. First, a sample of nurses, nursing students, educators, and content experts will provide feedback on the functionality and ease of use. Next, we will evaluate the implementation of the toolkit with a larger sample of users, followed by a marketing campaign to disseminate the toolkit as widely as possible using traditional and social media methods. Although the mandate of the project was the development and dissemination of the toolkit, we have also created a new research partnership to explore the impact of the toolkit on knowledge and practice. We anticipate that these data will help to guide educational needs.

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