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Providing best care whilst respecting family dynamics and cultural considerations.

Caring Better Together

The importance of cultural respect

Culturally appropriate care is about being sensitive to people's cultural identity or heritage and being responsive to cultural beliefs.

Cultural respect means taking into consideration the belief system of an individual and can play an important role for building relationships.

Being culturally aware can improve access to high-quality care that is respectful and responsive, leading to positive patient outcomes.

Links to the concept of person-centric care and is an integral part of professional codes of conduct and standards.

Northeast England ethnicity

Ethnic group	North East %	North West %	London %	West midlands %
White	**93.1**	85.6	53.7	77
Asian	**3.6**	8.4	20.6	13.4
Black	**1**	2.3	13.5	4.6
Mixed	**1.2**	2.1	5.7	3.1
Other	**1**	1.5	6.3	2.1

Northeast England religion

Religion	North East %	North West %	London %	West midlands %
Christian	**50.8**	52.5	40.6	46.6
Islam	**2.7**	7.6	14.99	9.6
Hinduism	**0.4**	0.7	5.15	1.5
Sikhism	**0.3**	0.4	1.64	2.9
Buddhism	**0.3**	0.3	1	0.3
Judaism	**0.2**	0.2	1.65	0.07
Other	**0.4**	0.4	0.9	0.5
No religion	**40**	32.6	27	32.9

Northeast England immigration

- The Northeast has the 2nd lowest number of migrants (6.2%), 2nd only to Wales. The national average is 14.4%.
- County Durham has the lowest diverse population within the Northeast.
- 37% or migrants are EU born (Poland being the largest population) and 63% non-EU born (India being the largest).
- Historically, Middlesbrough and Gateshead have one of the largest Greek, Irish and Welsh populations. Middlesbrough Irish and Welsh population was 2nd highest after London until 2000's when migration from Ireland/Wales reduced significantly.

Why do these figures matter?

- The Northeast is the least diverse region with regards to different cultures and religions.

- White Christians are the largest group in Northeast England.

Which can mean….

- Health and social care staff may have less knowledge, understanding or awareness of culturaland religious identities/needs, which can impact on the care provided.

- Unconscious cultural and religious bias may be more apparent.

- Stereotyping and bias can lead to unequal treatment.

- In March 2023 in Liverpool, a black pregnant woman died due to cultural bias, which led to delay in care being delivered and care not being escalated.

Case study 1

Patient A

Background: 62-year-old male with a diagnosis of MND (bulbar onset), diagnosed in 2014

Relevant cultural/religious info: PTSD due to involvement in Iraqi war

Situation:

- Unable to communicate in English. Wife speaks some conversational English, but not enough to accurately interpret
- Daughter fluent in English, but concerns around some information being omitted or adapted

Problems encountered:

- Patient unable to accurately relay their wishes, making care planning difficult.
- Family not always translating full information, which led to confusion over treatments/interventions being offered and initially some interventions were not accepted.
- Patient and family felt excluded and not heard.
- Patient often chose not to disclose or inform us of concerns/problems or ask questions due to time and energy it took to communicate.
- Patient losing speech – importance of building relationship quickly
- Patient wouldn't speak to female members of the team and would ask females to sit in seat lower than him.

Solution and learning from the situation:

- Using an interpreter who was able to translate medical information resulted in the conversation flowing easier and the patient could communicate their needs without what they were saying being miss-interpreted or confused
- Patient was able to tell us about their history in Iraq and the traumas they encountered resulting in fear around interventions (NIV etc). Team were able to tailor care inc. providing 24hr care
- Family felt less burdened and anxious at trying to interpret
- Family felt able to express themselves, resulting in new important information being shared
- Patient and family felt more empowered, less fearful and positive
- Family were able to explain their culture in Iraq, particularly in the war period and the male/female dynamic attitude

Case study 2

Carer B

Background: Wife and primary carer of patient with MND who recently died

Relevant cultural/religious info: Jehovah's Witness

Situation:
Mrs B, who was the wife of Mr B contacted the MND team following the death of her husband. Mrs B reported she and Mr B received excellent care and support from the MND nurse and were very complimentary about the service, support and care they received.

Mrs B was particularly grateful for the conversations and documentation around advance care planning and felt Mr B received the care that he wanted. It was noted during these conversations that Mr and Mrs B were Jehovah's witnesses.

Problems encountered:
Following the death of Mr B, Mrs B reiterated that her and Mr B were Jehovah's witnesses and felt we did not consider or respect the beliefs they follow as part of their religion.

Mrs B found this upsetting and tarred the relationship they had built with the MND nurse.

Solution and learning from the situation:

- Approximately 130,000 Jehovah's witnesses in the UK
- The public and most H&SC professionals are aware of the beliefs around blood products/blood transfusions
- According to teachings, Jehovah's Witnesses believe that when a person dies, their life ends. They claim that when a person dies, they do not exist elsewhere. However, they believe that some people will be resurrected during the day of resurrection and will never die again.
- When a person dies, their opinion is that it is a time of reassuring and comforting the family of great hope of resurrection.
- MND nurses re-evaluated the support and care we give following the death of any patient, but taking on board the level of importance that Jehovah's witnesses put on this belief and the need for perhaps more intense support of the family.

Case study 3

Patient C

Background: 45-year-old single male diagnosed with MND and living at home with his mum and sisters.

Relevant cultural/religious info: Islam / Muslim

Situation and problem encountered:

Patient C is a devout follower of Islamic teachings.

He required complex, intimate and personal care. He would not allow outside help.

Patient C is head of the family following the death of his father. He could not allow certain family members to provide this care nor have females providing the care.

Severe spasticity to arms and legs requiring regular oral medication and movements to prevent risk of injury. Patient C felt unable to take these medications during Ramadan, which had consequences to his health/wellbeing. Declined to break fast and subsequently admitted to hospital.

Patient C is very strict on his diet; what he will and wont eat and ONS products which he will accept. As his swallow deteriorated, the foods he was able to swallow became very narrow resulting in significant weight loss.

When leaving the home, patient C's mum hugged a male HCP. We later found out this caused a lot of upset and tension within the family and resulted in the mum no longer being present during assessments.

Solution and learning from the situation:

- Difference between Islam (religion) and muslim (followers of Islam) and a wide range of different ethnicities with different views and beliefs
- Imam at local mosque and Trust chaplaincy are very helpful and supportive
- A review of medication to prevent future complications. Any ill patient requiring any type of medication to improve health (oral, intramuscular, subcutaneous, or intravascular) warrants breaking the fast.
- Team gained an understanding of the beliefs around family, hierarchy, touch & privacy inc. importance of using the right hand (left is felt to be dirty), bathing, diet, medication, health vs illness
- Safeguarding advice/support

Regardless of culture or religious belief….

- Give all patients the opportunity to communicate with you – avoid talking over them and if needed, use medically fluent interpreters who understand the culture.
- Ask the patient and family about their beliefs – they're the expert and often are keen to impart their wisdom! They are unlikely to share this part of themselves unless asked.
- Be respectful, avoid being judgmental and don’t be afraid to apologise for making a cultural mistake – these mistakes often lead to really good, insightful conversations.
- Before meeting a patient or their family, consider their religious or cultural beliefs – Google can quickly tell you the main points to think about.

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Thank you

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