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# The use of Cultural Safety Huddle and Handover guides to improve care delivery for Black, Asian and Minority Ethnic patients

Hannah Alice King

ORIGINAL

## Patient safety in the NHS and maternity

**The National Health Service (NHS) serves an increasingly diverse clientele in terms of ethnicity, culture and religion (Diversity UK 2020). There have been huge developments in terms of improving maternity services which have fortunately reduced maternal and neonatal mortality over the past 10 years, despite increasingly complex patients giving birth and being born in the UK (National Maternity Review 2016). However, it is concerning that, while the overall rates of maternal and neonatal mortality have reduced, certain subgroups (most notably Black and Asian heritage groups) are enduring a disproportionately larger burden of poor health outcomes. These include maternal death (including mortality from COVID-19), neonatal death, preterm birth, neonatal low birth weight and stillbirth; the reasons for these disparities are often unclear and multi-faceted (Garcia et al 2015, Draper et al 2018, Li et al 2019, Knight et al 2019, Knight et al 2020).**

## Discrimination, bias and stereotypes — viewing racism as a determinant of health

There is a long, complex history of discrimination, stereotypes and bias against those of Black and Asian heritage in the UK, which originates in the transatlantic slave trade, imperialism and colonialism (Historic England 2020). Institutional racism has been investigated within the criminal justice system

(MacPherson 1999) but has not been investigated within the NHS in an equivalent, in-depth way.

It is not unreasonable to suggest that the NHS suffers from systemic and institutionalised racism, often presenting in seemingly benign and covert ways, with the potential for mistreatment, negligence and poor health outcomes for non- white patients (Adebowale & Rao 2020). For example, specifically examining the literature surrounding Black women in the Western world, when compared to white women, this group is evidenced to experience:

- poorer postnatal mental health (Grobman et al 2016)
- lower satisfaction with labour care, higher rates of caesarean section as mode of delivery, and less analgesia in labour (National Perinatal Epidemiology Unit (NPEU) 2020)
- higher rates of maternal haemorrhage (Main et al 2020)
- more mistrust of their health care providers (Lyndon 2019)
- more generalised mistreatment such as being threatened or shouted at (Vedam et al 2019)
- higher odds of severe maternal morbidity (Nair et al 2014).

Due to the multifactorial nature of these disparities, it is impossible to blame racism, bias or discrimination entirely, yet it is also impossible to exclude racism entirely as a contributing factor. While causal links cannot be directly inferred, exposure to racism has been evidenced to be significantly related to poor mental and physical health (Paradies et al 2015).

## Is safety culture leaving the most vulnerable patients behind?

Initiatives surrounding patient safety and safety culture have improved the overall standard of care delivered to maternity patients (NHS Improvement 2019a, 2019b). However, a discordance is perpetuated which has exposed not only poorer outcomes for Black and Asian heritage women and their babies, when compared to their white counterparts, but also dissatisfaction and lack of involvement with health care provision (Draper et al 2018, Knight et al 2019, NPEU 2020).

A new inquiry, *The Safety of Maternity Services in England*, will examine the failings in maternity service provision and produce recommendations to address these concerns (Health and Social Care Select Committee 2020). If institutional bias and racism is highlighted as a concern this may further propel the issue to the forefront of the NHS agenda. In this instance, the focus may be shifted towards training patient-facing staff in anti-racism and recognising personal implicit bias to address the institutional and systemic racism which persists in the NHS (Hall et al 2015, FitzGerald & Hurst 2017).

Racism in the NHS is subtle and entrenched and it cannot, therefore, be confidently concluded that the 29 per cent of women in the latest MBRRACE report who assessors judged would have had a changed outcome with improved care, did not experience bias, discrimination or racism on some level (Knight et al 2019, Adebowale and Rao 2020).

## Cultural safety

Cultural safety is an extension of cultural sensitivity and awareness, but instead of entirely examining the patient's culture, cultural safety requires the caregiver to reflect on their own cultural identity and how this may impact the care delivered to the patient (Nursing Council of New Zealand (NCONZ) 2011). The concept was developed to address the large health disparities experienced by the Māori population in New Zealand, within the context of wider social determinants of health, together with this population's dissatisfaction with health care (Ramsden 2002).

One detailed definition of cultural safety is provided by Curtis et al (2019: online):

*'Cultural safety requires health care professionals and their associated health care organisations to examine themselves and the potential impact of their own culture on clinical interactions and health care service delivery. This requires individual health care professionals and health care organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.*

*In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity.*

*Cultural safety requires health care professionals and their associated health care organisations to influence health care to reduce bias and achieve equity within the workforce and working environment.'*

Cultural safety involves concepts surrounding the basic human rights of respect, dignity, empowerment, safety and autonomy (Phiri et al 2010). It requires the care provider to recognise and redress the power imbalance which may exist between them and the patient, while preserving the patient's rights during an episode of care (Curtis et al 2019). Culturally safe care encourages good working relationships between women and care providers, based on strong communication, and includes patients' cultural preferences, ensuring that lines of communication are culturally acceptable to patients and appropriate

translating services are used (Phiri et al 2010). Patients may request a new care provider if they do not feel 'culturally safe', which elevates the patient to a position of relative power and reduces the power imbalance which often exists between patients and health care professionals (Phiri et al 2010).

## Cultural safety in the context of safety culture

Cultural safety must align with health equity targets, such as those outlined in the *Better births* review, for example to reduce stillbirth rates by 50 per cent by 2025 and to include 75 per cent of women from a Black, Asian or Minority Ethnic (BAME) background, in the continuity of carer (CoC) model (NHS England & NHS Improvement 2020). The success of a cultural safety model may be measured in part by these targets, but also by the reported satisfaction of women relative to their maternity care.

Cultural safety embedded in labour care may be evaluated to capture the patient experience (Churchill 2015). CoC fits well with the cultural safety model as cultural safety is proved to improve working relationships and communication between women and health care professionals (Sandall et al 2016). By embedding a cultural safety huddle and handover within the context of the CoC model, health equity can be prioritised for women from BAME groups.

Safety huddles and effective clinical handovers promote patient safety, improve situational awareness, improve communication within the multi-disciplinary team and improve patient involvement in their own care (NHS Improvement 2019a, 2019b). By applying the concepts of safety culture to cultural safety, the following cultural safety huddle and cultural safety handover is proposed.

## Introduction of the Cultural Safety Huddle and Cultural Safety Handover

The author proposes guidelines for a new Cultural Safety Huddle (see Figure 1) and Cultural Safety Handover (see Figure 2). These combine aspects of cultural safety theory and safety culture theory for use within an obstetric setting, to ensure all patients in labour are:

- able to effectively communicate their concerns and wishes to members of the multi-disciplinary team in a safe way
- be involved as key collaborators and stakeholders in the care they are receiving
- improve the situational awareness of those delivering care.

The Cultural Safety Huddle and Handover guides are designed to be used in all instances, regardless of the patient's ethnic heritage, but specifically designed to provide cultural safety to patients who encounter racial disparities in health, and to benefit these patients the most. By utilising this concept within the theory of proportionate universalism (NHS Health Scotland 2014), birth settings which cater to highly diverse populations, in terms of ethnicity, race, socioeconomics and culture, may benefit the most, whereas birth settings which cater to less diverse populations may benefit the least.

Following the introduction of an implicit bias recognition and anti-racism training package delivered to all patient-facing members of staff, the Cultural Safety Huddle and Handover can be embedded into labour care. Training would also encompass recognition of how, for example,

### Figure 1. Cultural Safety Huddle.

To be used once per shift during handover on labour ward with the clinical leads for midwifery, obstetrics and anaesthetics.

Consider the following questions:

1. Can the skill mix cater for all the women in a culturally safe way? *for example:*
   a. are all the patients satisfied with their allocated midwife and/or doctor in terms of cultural safety?
   b. do we need to facilitate a swap of staff?
   c. are we achieving one-to-one midwife-patient care in labour?
   d. are all patients being cared for by members of the multi-disciplinary team (MDT) of appropriate seniority? (medically complex or comorbid women being cared for by more senior members of the team)
   e. are all patients' analgesia needs being met? (predominantly anaesthetist-delivered analgesia)
2. Are there any concerns regarding clinical deterioration of any patients or their babies?
3. Are there any patients who anyone in the team is worried about?

**Ensure that these questions are asked in an environment which encourages psychological safety, whereby power dynamics and intimidation between the team hierarchy are minimised and flattened (NHS Improvement 2019b).**

### Figure 2. Cultural Safety Handover.

To be completed by the midwife, in the presence of, and in collaboration with, the patient and their birth support, on at least one occasion, per episode of care, while being cared for on labour ward at any time in the antenatal, intranatal or postnatal period.

To be repeated when a midwife hands over care to a new midwife at shift change, or when the patient requests. This is a dynamic process and can be readdressed at any time the patient requests.

**Before the cultural safety handover is started, the midwife must consider their own assumptions, stereotypes and biases about the patient, their culture, ethnicity, socioeconomic status, sexual orientation, religion and any disability. This reflection should prevent the care delivery from being affected negatively. The midwife must ensure that communication reflects an equal working relationship with the patient.**

1. Ask if there are any fears, concerns or wishes which the patient wishes to discuss. Listen to any concerns and fears of the patient, especially pain scores and requests for pain relief. These concerns, fears or wishes may be repeated by the patient multiple times.
2. Sensitively ask if there are any cultural or religious needs the patient may have. Ask if there are any religious or cultural concepts which the patient would like to incorporate into the plan of care. This should be facilitated within the realm of providing safe and evidence-based care.
3. Give the patient the option to choose a new midwife if they do not feel 'culturally safe.'
4. Inform the patient that you as the midwife are their advocate and it is your job to keep them safe and comfortable during their pregnancy/birth/point of care.
5. Inform the patient that they are a key stakeholder and collaborator in the plan of care for labour and the postnatal period.
6. Ask if the patient is satisfied and feels safe with the plan of care. If not, investigate this further. What can be done to resolve the patient dissatisfaction?
7. Ask if the patient has any questions. Is there anything which this discussion has missed which the patient would like to bring up?

clinical deterioration may manifest on darker skin tones: cyanosis, rashes, mastitis and pressure ulcers (Mukwende et al 2020). Rapid recognition of acute deterioration is repeatedly mentioned in the MBRRACE report as an area of required improvement (Knight et al 2019). This should now extend to detecting acute clinical deterioration in what we now understand to be the most vulnerable groups of patients (Knight et al 2019). Diversification of the medical curriculum is especially pertinent when considering the tendency to centre medical training on the Eurocentric white 'default' and the lack of representation of ethnic variation in clinical presentations within medical training (Gishen & Lokugamage 2018, Mukwende et al 2020).

It is hoped that a cultural safety huddle and handover will improve maternal satisfaction with care, and also improve collaboration and communication between patients and the multi-disciplinary team (Laverty et al 2017). Improved communication within the multidisciplinary team is evidenced to improve patient safety, situational awareness and ultimately birth outcomes (Knight et al 2019, RCOG 2017).

## Conclusion

In order to address the racial disparities which are perpetuated within BAME groups, a radical, universal and mandatory approach must be taken, to include thorough training packages which include implicit bias awareness and anti-racism content, as well as a tangible, practical approach which allows patients to feel culturally safe when they give birth. The proposed concept can be adapted to the needs of the hospital or birth setting and it is hoped will produce clear lines of communication and collaboration with all patients, benefiting the most marginalised, at risk and vulnerable in terms of racial disparities in health and subsequent poor birth outcomes.

Advocacy in the context of midwifery is central to providing high quality, individualised and patient-centred care (Royal College of Midwives (RCM) 2014). Use of the proposed Cultural Safety Huddle and Cultural Safety Handover guides, would facilitate midwife-led and patient-led advocacy, helping patients to navigate the process of birth, ultimately improving the patient experience and potentially the birth outcome.

## Author

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