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CRITICAL COMMENTARY

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Decolonizing care of Black, Asian and Minority Ethnic patients in the critical care environment: A practical guide

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1 | BACKGROUND

The year 2020 has been declared and recognized as the International Year of the Nurse and Midwife (IYNM). It is a year that should celebrate the achievements of nursing and midwifery and acknowledge, globally, the contribution of nurses in maintaining and promoting the health of populations. Maintaining health and prevention of disease can take place in primary and secondary care settings; one such setting is the critical care environment. Patients are admitted when their condition is deemed critical, for example, if they need single- or multi-organ support.

This IYNM has been an extraordinary year as the twin plagues of COVID-19 (caused by the novel Severe Acute Respiratory Syndrome Coronavirus [SARS-COV2]) and the killing of George Floyd, a Black American, have forced nurses and midwives to examine systemic racism in the profession and its translation into care.

Racism in health care is not new, and COVID-19 has demonstrated how structural racism is transcribed and enacted in the health of Black, Asian and Minority Ethnic (BAME) people. The incidence of COVID-19 is high in people of Black ethnicity. In the United Kingdom, death rates were the highest among BAME populations, with Bangladeshi people presenting twice the risk of death compared to their White counterparts.[1] Although this analysis did not factor in comorbidities, occupation, or obesity, diabetes was recorded on 21% of death certificates of those who died from COVID-19 and was significantly higher among BAME groups compared to White ethnicities. Similar results were reported regarding hypertension, which is also associated with COVID-19 susceptibility.[2]

We come together as a group of racially different and structurally positioned nurses with a primary specialist background in critical and intensive care nursing to discuss ways through which nurses in this specialism can decolonize care for BAME patients. The link between ethnicity and health outcomes has been documented over the decades, for example, in the Black Report,[3] by Nazroo,[4] and more recently by White et al.[5] Critical care nurses should acknowledge that BAME groups' health is linked to cultural practice and position in society. During pandemic situations, people of ethnic minority backgrounds suffer higher infection rates and exacerbation of symptoms of comorbidities, which can lead to critical care admissions and can result in more deaths than the general population. Power et al[6] cite social and cultural determinants of health and lack of political power held by BAME groups as a contributing factor.

Culture is the accepted way of behaviour for a given group of people[7]; it encompasses a body of common understanding underpinning the way someone thinks, feels, and acts. Accepting differences in others can foster successful relationships in multicultural societies,[8] and this is also applicable to nursing. Learning about a culture extinguishes preconceived judgements, changes perceptions, and allows for tolerance and acceptance of other groups. While it is important for intensive care unit (ICU) nurses to consider a patient's cultural needs, we must be cautious not to stereotype or make assumptions based on how we understand or perceive the patient's culture. Culture and ethnicity are inextricably linked, and failure to consider culture can lead to a deficit in racially appropriate care.

2 | DECOLONIZING CARE

Racism is a product of colonialism, the "othering" of different racial groups. Racism is a key factor in shaping nursing and care systems, which becomes grounded in the colonial construct and embedded in everyday practice and attitudes. The legacy of this can lead to

prejudicing care offered to racially diverse patients. Decolonizing care, therefore, focuses on providing care free from explicit and implicit racism, which can be masked in policies and guidance making it implicit or explicit in the treatment of patients from BAME backgrounds. Nurses working in the critical care environment should provide care that is free from racial prejudice. We urge all nurses to reflect on the following practical care areas to provide non-racist care. Here, we identify four areas of assessment: pain, consciousness, delirium, and family support, and discuss relevant culturally sensitive considerations. We demonstrate how culturally congruent care is an approach to eliminating racist behaviour and can successfully contribute to decolonizing care of BAME people.

Intensive care patients experience pain for various reasons, such as foreign devices in situ, immobility, or prolonged positions. Pain occurs because of actual or potential tissue damage and is expressed as an unpleasant or emotional sensory experience.[9] It is important that pain is assessed with the understanding that it is what the patient says it is and occurs when he/she says it does; its perception, expression, coping, and management vary.[10] Often, when BAME patients express pain, the comment "it's their culture to express pain in this manner" has been made, assuming that the level and intensity of pain is over-reported. This practice needs to stop, and the patient's experience of pain should be acknowledged as non-exaggerated and a clinical need. Viewing the patient's experience as cultural exaggeration is a form of micro-racism, and using an appropriate pain assessment tool, such as the McGill Pain Questionnaire,[11] which includes a vertical visual analogue scale for non-sedated patients and the Behavioural Pain Scale,[12] can change this practice.

Two assessments that require verbal responses are delirium and level of consciousness. The Confusion Assessment Method for the ICU (CAM-ICU)[13] is specifically designed to assess delirium in sedated and ventilated patients and the Glasgow Coma Scale (GCS)[14] for consciousness level assessment. Delirium's cognitive manifestations can last from months to years in critical illness survivors[15] and is strongly related to increased ICU morbidity and mortality.[16] Therefore, timely and effective detection of delirium has a significant impact on improving patient outcomes. Similarly, GCS assessments enable nursing staff to identify deteriorations that may require prompt intervention,[17] particularly for patients with a fluctuating neurology from brain injuries.

The potential drawback of using the CAM-ICU and GCS on non-English-speaking patients is that they require the patient to understand what is being asked. In such cases, there is a predisposition for nurses to inappropriately deem the patient as "unable to assess"[18] or misdiagnose delirium or inaccurately assess consciousness. In situations where the patient and nurse speak different languages, for example, English and Bengali (recorded as London's second most spoken language[19]) or American English and Spanish,[20] the patient's verbal response is often documented as "language barrier," which is an inaccurate assessment. This reflects a lack of cultural intelligence that fosters racial prejudice, which may not be visible to the nurse. It is crucial that the nursing profession moves away from viewing language as a problem but aims to remove these barriers to deliver culturally and racially diverse care.

Although the CAM-ICU tool has been translated into several different languages, its use in practical terms is limited by lack of either interpreters or native speaking staff. When unable to translate, nurses should consider alternative methods, for instance, applying the non-verbal version of the tool.[21] Staff should be offered education and training on its use and methods to assure reliability in their assessments.[22] We add that, for both CAM-ICU and GCS, staff are to be provided with practical cultural training that removes racial bias. Training must incorporate methods for conducting assessments on non-English-speaking patients with the purpose of improving assessments and outcomes in BAME patients.

The pandemic has revealed unprecedented changes to care, for example, the restriction and suspension of family visiting hospitals. We recognize that this had a significant impact on both patients and their family of BAME backgrounds as visits are of high importance to these groups, particularly the physical presence of family at death is linked to cultural practices in BAME groups, which have been greater in England during the peak of the pandemic.[23] The pandemic identified the importance of the position of BAME families as support networks. Understanding a patient's religious, cultural, and spiritual needs is an area that has always challenged nurses—especially how we can facilitate such care in the ICU. Liaising with families during the daily update unearthed patterns of discrimination that critical care nurses fostered by failing to understand that the patient's needs are linked to their culture and ethnicity. Every nurse should be accountable in providing racially appropriate care as this will contribute to good cultural governance. One of the lessons learnt from COVID-19 and Black Lives Matter is that we can easily discriminate on matters of race, and as critical care nurses, we must change our practice to eliminate discrimination that can cause our patients psychological harm that can lead to anxiety, depression, or post-traumatic stress disorder. Nurses need to question their own privilege and how this positions us to care for BAME patients. The ability to facilitate culturally and racially appropriate care in a critical care setting is an accomplishment of an ICU nurse and should form part of ICU care metrics.

3 | CONCLUSION

The COVID-19 pandemic has brought the world together in the most sudden, saddest, and unprecedented of circumstances, and these areas we have identified are screaming silences in everyday critical care nursing practice. In the midst of altruism and do no harm, racism in health care remains prominent and unresolved. Critical care nursing leadership must examine practices to identify care that is etched by colonialism and support their decolonization. Through this approach, they will become accomplices in clarifying and delivering racism-free care. Lessons from COVID-19 must not be an afterthought or consolation to those from BAME communities.

Together, we can create the change we seek to move beyond strong statements and pledges on racism, but in this International Year of the Nurse and Midwife, practical action is the way forward to

decolonizing care for BAME people and eliminating racially biased patient care and treatment.

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