Practising cultural humility to promote person and family-centred care

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DOI:
10.7748/ns.2022.e11880

Document Version
Peer reviewed version

Citation for published version (Harvard):
Kelsall-Knight, L 2022, 'Practising cultural humility to promote person and family-centred care', *Nursing Standard*, vol. 37, no. 1. https://doi.org/10.7748/ns.2022.e11880

Cultural humility as part of person and family-centred care

Abstract

Cultural humility offers nurses an awareness of how people's culture can impact their health behaviours and care needs. This can encourage a person-centred focus on care and ensures patients' needs are more fully met, offering a more positive healthcare experience. This article explores the concept of cultural humility with attention on the diverse and dynamic nature of the family.

Keywords: To be drawn from the Nursing Standard taxonomy

Aims and intended learning outcomes

The aim of this article is to enable nurses to consider their role in relation to cultural humility in the context of person and family-centred care. After reading this article and completing the time out activities you should be able to:

» Understand what is meant by the terms cultural humility, person-centred and family-centred care.

» Identify the patient groups who may require nurses to consider cultural humility.

» Work in partnership with patients and their families to ensure that their cultural needs are recognised.

» Support other members of staff in recognising the importance of cultural humility and the effect that it can have on patients and their families.

» Recognise the relevance of cultural humility in relation to the NMC Code (2018)

Introduction

Patient populations are becoming increasingly diverse, bringing a multitude of health behaviours that are influenced by the patients' background (Prasad et al, 2016). Healthcare professionals may face challenges related to language and/or cultural issues, which in turn could be deemed to threaten an individual patient's safety in healthcare (Kaihlanen et al 2019) and negatively impact their experience of healthcare services. Patient safety can be regarded as the avoidance of unintended or unexpected harm (physical or emotional) to people during the provision of healthcare (NHS, 2021). Therefore

there may be times when a patient may feel that their safety is compromised due a lack of understanding regarding factors such as religious customs or assuming heterosexuality.

In the UK, the Nursing and Midwifery Council (NMC) regulatory Code (2018) is structured into four domains: professional values; communication and interpersonal skills; nursing practice and decision making; leadership, management and team working. The Code represents the standard of care expected, not only of the NMC, but the nursing profession itself and importantly the public. The Code is not a static document but is periodically reviewed, and through consultation with the nursing profession and the public, and seeks to reflect what society expects as the standard of care from nurses. In recent years, areas such as nurses' interaction with social media (NMC 2019), such as in strengthening the professional role and in avoiding unacceptable behaviour, such as inappropriate comments about patients, an emphasis on person-centred care and working in partnership with patients and service users, mirrors a greater expectation, often through legislation, of equality and diversity in society. It may be of value for nurses world-wide to consider how their own regulatory code and/or standards may reflect the wider expectations of society.

Adherence to the four NMC domains seeks to ensure that registrants treat people with a standard of fairness and respect. This is further endorsed through the Equality Diversity and Inclusion (EDI) strategic framework 2020-2025 (NMC, 2020) which states that the NMC are proud to contribute to creating a society in which people are treated fairly and are valued for their diversity. Stenhouse (2021) endorses this and comments that nurses must treat people as individuals, avoid making assumptions about them, recognise diversity and individual choice, and respect and uphold their dignity and human rights.

Therefore, equality in healthcare means that everyone in healthcare settings has equal opportunities, with people having fair access to inclusive services, regardless of their abilities, their background or their lifestyle. Needs may differ, but all should have equity of opportunities. Equality is providing the same level of opportunity and assistance to all segments of society, such as races and genders. Equity may be seen as providing various levels of support and assistance depending on specific needs or abilities and recognises the impact of privilege, inequality and discrimination. Futhermore, it is important that cultural humility is understood and that nurses and other healthcare professionals are fully supported to acquire the knowledge, understanding and implications of cultural humility in relation to person and family-centred care.

Time Out 1: A persons' identity may include diversities such as their age, religion, sexual orientation and disabilities. Consider the population of patients that you care for and their diversities. How can you ensure that they all have equal opportunities in terms of access to healthcare? You might like to think about the use of inclusive language or simple sentences on patient documentation and access to interpreter services.

What is cultural humility?

Cultural humility is 'a process of being aware of how people's culture can impact their health behaviours and, in turn, using this awareness to cultivate sensitive approaches in treating patients' (Miller, 2009, p.92). As a concept, it stems from cultural competence which assumes that healthcare professionals can learn a set of skills, which are attitudinal and communication based, in order to work effectively within the various cultures which are representative of their patients (Prasad et al, 2016). However, the term cultural competency is very broad and there must be an end point for nurses to demonstrate that they are culturally competent by, for example, completing a cultural competency proficiency. Cultural humility also has strong links to reflexivity because it can be argued that practising cultural humility requires an awareness and reflection of what is happening at that given moment, while being present to one's perceptions and internal experience (or conscious and unconscious biases) (Yeager and Bauer-Wu, 2013).

Cultural humility does not have an end point, and whilst demonstration of cultural competence forms an element of cultural humility, it is determined that the latter should be a continuing process which allows the nurse to be self-reflective in the care they provide. Therefore cultural humility allows a nurse to consider the individual patient and also their cultural context in their everyday practice. This will then allow them to consider any potential power imbalances that may occur and thus may affect the outcome for the patient.

Examples of power imbalances could be due to the attributes that nurses possess that place them in a position of power in comparison with their patients. These include professional status and professional knowledge (Corless et al, 2016); for example some nurses' belief that they "know best" and the view that patients lack medical knowledge (Henderson, 2003). Power imbalance may also arise if the patient speaks little or no English or if they are unaware of how the healthcare system works in terms of being referred to varying specialities, or waiting for investigations. In addition power imbalance may arise as a result of assumed privilege due to characteristics such as race, age, gender and sexuality (Burr, 2003; Stemple and Meyer, 2014). By understanding the cultural differences, or

indeed similarities, exhibited by the patient, the nurse is adhering to the NMC Code (2018) and other regulatory frameworks world-wide, by treating people with dignity and respect and by acknowledging the impact that their cultural differences may have on their specific needs. Inevitably, nurses occupy a position of power in relation to their patients, whether this is conscious or unconscious. However, as the person with power within the relationship, the nurse has a responsibility and ability to alleviate or reduce the power imbalance.

Time Out 2: Think about the patients that you care for, do they have differences to you which may result in a power imbalance? Do any of your patients have limited English, cognitive impairment, or are they afraid of healthcare due to previous experiences? Reflect on your own position in terms of power, your approach to caring and your level of understanding from the patients' perspective. Consider how you could reduce the power imbalance and show cultural humility. You may like to think about involving their family or friends in future, use interpreters or even an advocate from their community. All of these ideas may to help restore the power balance between you and your patients.

Intersectionality and micro-aggressions

Intersectionality is linked to power balance and is a lens through which differing diversities, for example race, gender, and other individual characteristics, intersect with one another and overlap (Crenshaw, 1989). It is a theory that asserts that people are often disadvantaged by multiple sources of oppression: their race, class, gender identity, sexual orientation, religion, and other identity markers (Kelsall-Knight, 2021). It is common for a person to have multiple intersections which make up their identity, which increases the likelihood of oppressive practice and micro-aggressions (McCann and Monaghan, 2020).

Micro-aggressions are defined as small acts or remarks that makes someone feel insulted or treated badly because of their race, sex, etc., even though the insult may not have been intended, and that can combine with other similar acts or remarks over time to cause emotional harm (Cambridge English Dictionary, 2021). Some examples of often unrealised micro-aggressions are: comments about your career such as 'you're too clever to be a nurse', judgments about your or your patients' body, demeaning comments about others, perhaps describing people as 'well-spoken'.

Furthermore, micro-aggressions emerge out of prejudice and discrimination and result in oppressive practices such as everyday hostile or derogatory behaviours and statements which may be consciously or unconsciously delivered, ordinarily to members of targeted minority social groups such as Lesbian, Gay, Bisexual and Transgender (LGBT) people; people of differing skin colour; women; stigmatized religious groups (Sue, 2010). As a result of micro-aggressions, minority stress (Meyer, 2003) may also

be felt by members of the minority group due to the relationship between minority and dominant values and resultant conflict within various environments, for example, the healthcare environment. The theory of micro-aggressions was introduced in the 1970s and was related to racial micro-aggression. This has now spiralled to include other marginalised groups and has been found to be causally related to mental health issues due to the cumulative effects of subtle prejudice (Farr et al, 2015; Nadal et al, 2016). It is important to note that micro-aggressions exist in a wide context, so can also exist in bullying and harassment episodes between people of identical or low-to-high power groups, such as the bullying of a manager.

What is person-centred care?

Person-centred care considers a person's uniqueness, while doing everything that you can reasonably do to put their needs first (NMC, 2020). In practice, this means that individuals should have their needs assessed holistically, by nurses considering the patient's physical, psychological, spiritual and social needs. This will enable the nurse to identify a patient's concerns, start a conversation about needs, develop a personalised care plan, share the right information at the right times and also signpost to relevant services (Mills, 2017). By having an awareness of all of these components, patients should be able to work in partnership with healthcare professionals so that they are able to make informed decisions about their care and treatment (Gray, 2020; HEE, 2021).

People have a number of segments (or intersections) which make up their individual identities and as nurses, by acknowledging the impact that these have on patients, enables optimum care to be given as it can be tailored to the needs of the individual. When a nurse intentionally delivers care in person-centred way, they focus care with the individual at the centre and ensure that the preferences, needs and values of the individual are considered in order to focus clinical decisions, and provide care that is respectful, responsive and without prejudice (Mills, 2017; HEE, 2021). This co-production of clinical decision making between the individual and healthcare professional has been shown to provide better patient outcomes and to be more cost effective for health and care systems (HEE, 2021).

Examples of improved outcomes are that patients report feeling less anxious, cite a more rapid recovery and they may also have an increased compliance with treatment regimes (Faiman and Tariman, 2019). In addition shared decision making improves communication between professionals and patients, this in turn increases the patients' health literacy as they will have an increased knowledge of their condition, providing that they have received the information in a clear and understandable manner (Faiman and Tariman, 2019). It is important that person-centred care and

cultural humility are considered in tandem in order to improve the quality of healthcare. For a nurse to deliver person-centred and individualised care, they must consider a persons' diversities and perspectives so that joint decision making can take place. It should be noted that person-centred care has the potential to improve equity in the delivery of healthcare, and cultural humility, likewise, could enrich person-centred care.

Family-centred care

In order for a nurse to deliver family-centred and culturally appropriate care, the nurse must be able to work effectively within the cultural context of the patient and their family (Campinha-Bacote, 2009), in that they must be sensitive to the family's values and customs and provide any specific information that the parent needs.

Definitions of "family" are now highly varied. This may include a group with two parents (of any gender mix) and their children living together as a unit, the offspring of a common ancestor, a group of people who are related to each other, such as a mother, a father, and their children (Gil de Lamadrid, 2013), It may also include families from within orthodox faith communities and people for whom English is a second language. However, as societal norms and laws (Adoption and Children Act, 2002) diversify, then so will the definition of a family. Therefore its very existence can be fluid and non-binary (Bauman, 1991) and may include close friends or other people who are deemed to be significant. It is also of great importance to consider how inclusionary the concept of family is within the literature we use in everyday practice.

Family-centred care is a UK government initiative, based within children's healthcare services, which focuses on the collaborative planning, delivery, and evaluation of healthcare between healthcare professionals, patients, and their families (DoH, 2004). It is widely practised within the UK and is a standard and expected exemplar with which to provide care to all families (DoH, 2004). A family-centred approach to children's healthcare holds the belief that the emotional and developmental needs of a child, and the overall wellbeing of the family, are most successfully met when the healthcare system supports the ability of the family to meet the needs of their child, by involving families in the plan of care (Shields et al, 2012).

The principle of family-centred care is to attain a partnership between the patient, families, and healthcare professionals. This is illustrated by mutual respect and dignity, information sharing, and the presence of patients and their family in the care, as well as in decisions about care and treatment options (Ramezani et al, 2014). Family-centred care advocates that parents' participate actively in the care planning and treatment, which in turn increases care satisfaction and confidence (Bastani et al,

2015). Family-centred care therefore places the child or young person in the centre of their care and ensures the needs and dynamics of the family are recognised (Shields, 2015).

The development, implementation and outcomes of models of care associated with a family-centred perspective may differ according to the population and setting in which the child is cared for. For example, the needs and outcomes for families with a long-term condition who have experienced lengthy stays in hospital may differ from those of families who have a previously healthy young child who has been admitted to a hospital setting for an acute episode. In addition, older children may have an increased understanding and awareness of their health requirements and may also be moving towards being empowered towards taking responsibility for their own healthcare, thus elements of person-centred care may be practiced. Therefore, the application of the continuum of family-centred care may reflect increased participation of the child or young person in their hospital care.

Time Out 3: Revisit your patient group diversities from Time Out and consider the above section. What does the concept of 'family' now mean to you? Moving forward, how will you ensure that you are always 'prioritising people' and practising cultural humility in respect of their differences and needs?

What is the Equality Act (2010)?

The Equality Act (2010) applies in England, Scotland and Wales. The Act protects people from discrimination on the basis of age, gender reassignment, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and disability. These are referred to as the nine protected characteristics (RCN, 2021). Discrimination which happens because of one or more of these characteristics is unlawful under the Act. The Equality Act (2010) protects people from discrimination by employers, businesses and organisations which provide goods or services (including transport) and public bodies (for example government departments and local authorities, including health and education).

The Equality Act (2010) replaced nine major Acts of Parliament and almost a hundred sets of regulations which had been introduced over several decades. It provides a single, consolidated source of discrimination law, covering all the types of discrimination that are unlawful. It simplifies the law by getting rid of anomalies and inconsistencies that had developed over time, and it extends protection against discrimination in certain areas (DfE, 2014). In terms of relating the Equality Act (2010) to healthcare, it must be acknowledged by all healthcare workers and those that access healthcare, that prejudiced and discriminatory practice will not be tolerated, in order to protect

people's dignity. Therefore the Equality Act (2010) protects the workers that provide care and those that receive care from being treated unfairly because of the nine protected characteristics.

Whilst people from the groups who are identified to have protected characteristics are more likely to encounter discrimination (McCann and Monaghan, 2020), it is vital that all patient groups are recognised to have cultural diversities and therefore will expect to have cultural humility practised.

Challenging discriminatory attitudes and behaviours and practise cultural humility: organisations and individuals

The 'Prioritise People' domain in the NMC Code (2018) highlights that nurses (and midwives) should put the interests of people using or needing nursing or midwifery services first and that a patients' care and safety should be the main concern. Regardless of whether a person has protected characteristics, it is important that their dignity is preserved and their needs are recognised, assessed and responded to and assumptions are not made about people. Patients and their families or significant others must receive care with respect, and any discriminatory attitudes and behaviours must be challenged.

It is vital to consider the current diversity landscape within our own organisation, when embracing cultural humility, in terms of organisational and individual viewpoints. For example, whilst many NHS Trusts in England have adopted the Rainbow badge project, a badge alone does not make an inclusive environment as it does not alter the attitudes of all healthcare professionals. In addition, institutional homophobia is apparent and discrimination or 'being treated differently' remains apparent in some healthcare settings, which is endorsed by the rhetoric of institutional forms and documents which showcase opposite gender parents. This highlights the attitudes of the establishment or organisation (Kelsall-Knight, 2021).

Therefore to challenge discriminatory practice and promote cultural humility, it is imperative that leaders set an example to others and reflect upon their own biases and create an open and honest healthcare environment. By showcasing an authentic, respectful, and inclusive leadership style they will bring about a sense of inclusion and belonging within the health setting (Adams, Meyers and Sekaja, 2020). Examples of this, which can then be further practised by other team members, are showing empathy and actively listening to peers, patients and their significant others to establish an understanding of the situation and recognise factors that may impact upon the situation and outcome (Sprik and Gentile, 2019). For example, limited English language, recognition of religious customs or acknowledgement of a family structure that is different from your own perspective.

In addition to promoting inclusive leadership, incorporating emotional intelligence into daily life will also promote an inclusive and welcoming environment; by working towards a goal (such as inclusive practice), recognising your own feelings and those of others and having an awareness of how emotions can be managed and how they can impact upon relationships will enable cultural humility to be embraced (Carragher and Gormley, 2017). For example, having an awareness of the effect of micro-aggressions will aid nurses and other healthcare professionals in finding solutions to overcome them.

Within healthcare, micro-aggressions can take many guises and they must be recognised and acted upon, by professionally challenging the perpetrator, ideally at the time of the offence, as a way of eradicating discrimination. While it is not possible to control or predict what someone else says, it is really important that micro-aggressions are reacted to in a sincere and direct manner. It is vital to address the micro-aggression, not the micro-aggressor. A way of addressing this is explain to the micro-aggressor that you have an issue with what they did or said, not the person themselves. It is also important, in this type of situation, to practise inclusive leadership and show empathy to both the perpetrator and the person affected by the micro-aggression as most people are unaware that their comments are inappropriate.

Time Out 4: Reflect on your own stereotypes, prejudices, and discrimination and consider the thoughts you have about people with different characteristics and identities to yourself. Have you encountered micro-aggressions, whether intentional or not? Now that you are aware of the micro-aggressions, how would you respond if you encountered them? Are there any times where you may find it difficult to challenge them? How could you overcome this? Look at the Equality and Diversity policy at your place of employment and familiarise yourself with the process to escalate concerns.

How can nurses support others in relation to cultural humility?

It is important to support patients and other people who are significant to them, as well as other healthcare professionals in order for cultural humility to be practised and an inclusive environment to be created. Patients, significant others, nurses and other healthcare professionals are entwined in the situation of cultural humility, as power relationships aside, all people have diversities which must be acknowledged and supported. Therefore, in order for cultural humility to be practised in a healthcare setting it is vital that the patients and people who are significant to them have their individual needs listened to and acted upon.

They must be treated as partners in care by incorporating shared decision making regarding treatment plans (Mills, 2017) and the nurse should be sensitive to the patient and their family's values and customs by actively listening and asking open-ended questions (questions that allow exploration)

related to specific needs they have such as dietary requirements and having knowledge about people who are important to them. Patients must be provided with the specific information that they need in order to make an informed decision about their needs and everyone, regardless of whether they are patients or staff, should be treated with respect and dignity and must have their voices heard.

If necessary their voices should be amplified by nurses advocating for their patients or colleagues (NMC, 2018). When aligning care to the NMC Code (2018) it is imperative that people recognise and understand diversities and work together in partnership and supporting one another's decision-making, whilst also having an awareness of the cultural context will also ensure the meaningful participation of people in all aspects of care. Moving forward, in order to develop an open and inclusive environment, it is vital that nurses directly interact with people and families with diversity, for example different ethnicities, sexual orientation, single parent families, kinship carers. In turn this will enhance and develop nurses understanding of diversities and communication skills due to developing 'mindful intercultural communications' as they will develop an understanding of an individual or family (Campinha-Bacote, 2009). Lastly, by acting as role models and allies to minority groups and cultivating a compassionate environment by incorporating the above suggestions will enable the development of cultural humility.

Time Out 5: Access the Patient and Family Centred Care toolkit https://www.pointofcarefoundation.org.uk/resource/patient-family-centred-care-toolkit/introduction/more-about-this-toolkit/ and E-Learning for Health Cultural Competence programme https://www.e-lfh.org.uk/programmes/cultural-competence/ , and explore, reflect and review your own understanding and practice of patient and family centred care and cultural competence.

Conclusion

Cultural humility is an ongoing process of self-reflection which the nurse can do by reviewing their own understanding of diversities and discovery in order to build honest and trustworthy relationships within healthcare and all areas of society. An understanding and commitment to cultural humility aims to gather an understanding and eliminate health disparities and to provide optimum patient care in respect of person and family centred care. Cultural humility requires self-awareness of personal and cultural biases, whether they are conscious or unconscious, in addition to a sensitivity and acknowledgement of the cultural issues of others.

Time Out 6: Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

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