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Managing Ethno-cultural Differences in Healthcare Service Delivery in Hospital Settings: the Irish Experience

La prise en compte des différences ethnoculturelles dans la prise en charge du patient à l'hôpital : l'expérience irlandaise

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Abstract

Europe in the 21st century is a continent of cultural and ethnic diversity. Recent enlargement of the European Union to 27 states, constant flows of free trade and the migration of people have resulted in an increasingly diverse Europe. National health systems face the challenge of accommodating the cultural diversity of healthcare providers and service users. The Irish health system is an example of a national health system which has attempted to implement adequate planning and delivery of care and support services, encompassing the needs of minority ethnic communities (MECs) in a new and rapidly changing multicultural Ireland.

This research focuses on the challenges of recent multiculturalism in Ireland and describes the Irish health sector's process in the construction of the Whole Organisation Approach (WOA) as the framework for Irish hospitals to respond to the management of diversity and the provision of culturally sensitive healthcare service delivery to members of MECs.

The aim of the research is to investigate how six hospitals have implemented the Whole Organisation Approach as recommended in the Irish Health Services Executive's National Intercultural Health Strategy 2007-2012. Research findings indicate to what extent the Irish strategy has been implemented in each hospital and outline factors that promote and impede successful implementation at a hospital level and analyses how each of the three strands, i.e. organisational ethos, workplace environment and service elements necessary to support intercultural training, of the WOA have been implemented across the 6 hospitals. The findings contribute to the management of ethno-cultural differences in Irish hospitals by issuing a series of recommendations to healthcare management. Furthermore, a principal contribution of this research is the proposition of an evolved WOA framework which is useful from two perspectives. Firstly the construction of a more complex WOA with 93 parameters adapted to the Irish context that can facilitate the management of ethno-cultural differences in service users. Secondly, the evolution of a WOA framework that is adaptable to the contextual needs of individual hospitals.

Résumé

La prise en compte des différences ethnoculturelles dans la prise en charge du patient à l'hôpital : l'expérience irlandaise

L'élargissement de l'Union Européenne à vingt-sept états membres, les flux commerciaux constants et la migration des peuples ont engendré une forte diversité ethnique et culturelle au sein de cet espace géographique. La diversité ethnoculturelle croissante se répercute sur les différents systèmes de santé qui sont confrontés au défi de s'adapter à la diversité des prestataires de services médicaux et de leur personnel, ainsi qu'à la diversité des usagers des services médicaux.

Nos travaux ont comme point de départ le multiculturalisme apparu en Irlande dans les années 1990 et le processus suivi pour mettre en place une stratégie d'ensemble, ou « Whole Organisation Approach » (WOA), qui sert de cadre aux hôpitaux afin de répondre au mieux à la diversité de leur personnel et à la diversité ethnoculturelle de leurs usagers. Le système de santé en République d'Irlande est intéressant, car il a tenté de planifier et de mettre en œuvre des services de soins et de soutiens qui tiennent compte des besoins spécifiques des minorités ethniques présentes dans un état nouvellement multiculturel.

Nos travaux analysent l'étendue de la mise en œuvre de la WOA pour la gestion de la diversité ethnoculturelle dans six hôpitaux en Irlande grâce à la recherche qualitative et identifient les facteurs qui favorisent et freinent la bonne mise en œuvre des trois volets de la stratégie adoptée par l'Irlande qui sont la déclinaison organisationnelle des valeurs de l'organisation, l'environnement de travail et les éléments de service nécessaires à la formation interculturelle. Cela nous a permis de caractériser les effets de la diversité ethnoculturelle des usagers sur le fonctionnement des hôpitaux et de souligner les priorités des hôpitaux irlandais en ce qui concerne l'application de la WOA dans la prise en compte des différences ethnoculturelles des patients. L'analyse des moyens existants pour gérer la diversité des patients dans les hôpitaux, en comparant et en analysant les différentes stratégies élaborées par des institutions internationales pour gérer la diversité dans les systèmes de santé, permet de comprendre le concept de compétences culturelles en milieu hospitalier et le rôle de la formation interculturelle.

En conclusion, une évolution de la WOA pour la gestion de la diversité ethnoculturelle en milieu hospitalier serait utile sous deux aspects. Tout d'abord, l'émergence de quatre-vingt-treize paramètres, établis en fonction du contexte irlandais et répartis en trois volets, peut faciliter la gestion de la diversité ethnoculturelle des patients. Ensuite, une évolution du modèle d'approche globale de l'organisation basée sur les besoins spécifiques à chaque établissement viendrait renforcer la mise en œuvre des mesures envisagées.

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Index of Acronyms and Abbreviations

AA	Affirmative Action
AIM	All-Inclusive Multicultural approach
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHIC	Children's Hospital Information Centre
CLAS	National Standards on Culturally and Linguistically Appropriate Services
EEO	Equal Employment Opportunity
EMFHP	European Migrant Friendly Hospital Project
EO	Equal Opportunity
ESOL	English for speakers of other languages
EU	European Union
HCO	Health Care Organisation
HFHP	Hospice Friendly Hospital Programme
HIQA	Health Information and Quality Authority
HRM	Human Resource Management
HR	Human Resource
HPHN	Health Promoting Hospitals Network
HSE	Health Service Executive
HSIG	Health Services Intercultural Guide
IBEC	Irish Business Employers' Confederation
IHPHN	International Health Promoting Hospitals Network
JCI	Joint Commission International
MD	Managing Diversity
MEC(s)	Minority Ethnic Communities
MEC	Minority Ethnic Community
MF	Migrant Friendly
MFH	Migrant Friendly Hospitals
MFQ	Migrant Friendly Questionnaire
MFQQ	Migrant Friendliness Quality Questionnaire
MFHP	Migrant Friendly Hospital Project (or EMFHP)
NCCRI	National Consultative Committee on Racism and Interculturalism
NIHI	National Intercultural Hospitals Initiative
NIHP	National Intercultural Health Project

NIHS	National Intercultural Health Strategy
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
ROI	Republic of Ireland
TFMFCCH	Task Force on Migrant-Friendly and Culturally Competent Health Care
UNDESA	United Nations Department of Economics and Social Affairs
WHO	World Health Organisation
WHO-HPH TFMFCCH	The World Health Organisation's Health Promoting Hospital's, Task Force on Migrant-Friendly and Culturally Competent Health Care
WOA	Whole Organisation Approach

Chapter 1

Introduction

1. Introduction

Europe in the 21st century is a continent of ethnic and cultural diversity. The recent enlargement of the European Union to 27 states and the evolution of an interdependent and interconnected global economic society have influenced the migration of people and promoted diversity in Europe. Such diversity has resulted in public and private service providers having to adapt their service provision accordingly. This includes national health systems throughout the world having to face the challenge of accommodating the ethno-cultural diversity involving healthcare providers and service users.

1.1 Author's background in subject

The author is an Irish national who has studied, worked and lived in Ireland, USA, Japan and France and has a professional and academic career associated with intercultural experience and cross-cultural training and scholarship. Having left an economically poor Ireland in 1988 to spend 9 years studying international business and working in the intercultural training field in the USA and Japan, the author repatriated in 1997 to a new and much changed prosperous Irish landscape. Having completed a master degree, he secured a Human Resource Executive position for the Irish Business Employers Confederation (IBEC) responsible for advising Irish management, and particularly the hospital sector on Human Resources, Industrial Relations, Employee Relations and Employment Law. During this time Ireland was experiencing unprecedented inward migration due to a booming economy and the Irish health sector was recruiting non-Irish nationals to bridge the gap in employment shortages. The author was solicited to consult hospitals on the recruitment and integration of non-Irish nationals into the health system. On emigrating to France, a country renowned for having a world class health system and with a history of inward migration the author decided to investigate how Ireland, as a relatively recent country to experience rapid inward migration had managed such ethno-cultural diversity in its health system, given the magnitude and speed of the changes and the importance of the sector. This research draws on the author's interest in the subject of cultural competence, migration and healthcare management.

1.1.1 Globalisation, Europe, migration and health care

Political conflicts, regime changes, political and economic unions, globalization, new border arrangements, free trade agreements, the cyclical economic booms and busts of capitalistic societies are just some of the reasons that have resulted in the increase of migration flows across borders worldwide. These migrant flows have led to increased ethno-cultural diversity in societies across the globe. According to the University of Pécs Medical School[1], host of the 3rd Conference on Migrant and Ethnic Minority Health in Europe in 2010, an estimated 200 million people are living outside their native countries. Continents such as North America and Europe have historically proved to be highly desired destinations and have experienced large inward flows of ethnic populations in recent decades mainly due to the host nation's economically favourable circumstances. In 2008, 3.8 million people migrated between the 27 EU member states, Eurostat (2011). Also there were approximately between 36 and 39 million legal and irregular immigrants in Switzerland, Iceland, Norway and Liechtenstein and the EU, according to the International Organization for Migration (2005). In addition Chiarenza (2005) the noted migrant friendly Italian advocate, and representative of the WHO-HPH [2] Task Force on Migrant-friendly hospitals and Culturally Competent Health Care , in his presentation to WHO Europe, Actions towards Health Equity Thirteenth Annual Conference, Katowice, Poland, in 2005, stated that 500,000 illegal migrants are estimated to enter Europe every year.

1.1.2 An overview of the problems of migration on public services and health care

Such inward migration has resulted in more ethnically diverse cities and towns which in turn have resulted in both positive and negative consequences for the public and private sectors of host societies. The health sector, by its very nature and obligation to provide essential healthcare services to populations is in the front-line of rising to the challenge of adequately managing ethno-cultural diversity and ensuring efficient and effective management of its hospitals and services. According to the Migrant Friendly Hospital Project (MFHP), a European Commission sponsored initiative for the promotion of migrant friendly hospitals in an ethno-culturally diverse Europe, migrants are in danger of not having access to the same standards of health care that the majority of the host population receives and that the healthcare needs of minorities are generally not met by national healthcare systems.

[1] University of Pécs, Medical School http://infektologia.aok.pte.hu/congress/

[2] The World Health Organisation's Health Promoting Hospital's, Task Force on Migrant-Friendly and Culturally Competent Health Care (TFMFCCH) was established in the framework of the World Health Organisation's Network on Health Promoting Hospitals to promote health and health literacy of migrants and improving culturally competent healthcare services

Chiarenza (2005) argues that migrants and minority groups are more prone to illness and poor health due to their low socio-economic status, both in their native and host country, and more importantly, are vulnerable to traumatic experiences, feelings of social exclusion, and suffer from inadequate social support and inappropriate or non existent social integration and out of date health policies. This can result in discrimination and mental health issues. According to the Migration in Europe report (Eurostat 2011), migrants have lower income levels, with higher risk of poverty and social exclusion and are more prone to less favourable housing conditions and overcrowding. Chiarenza in his presentation to the WHO Europe conference in 2005 stated that “even when services are available and access is granted, migrants might not use them because they do not know about or understand them, or because the services offered are not adequate to their cultural and religious beliefs, or because of low levels of cultural competence among health professionals”.

Research on migration has highlighted the correlation between higher negative health outcomes and migration (Public Health Alliance Ireland, 2004). Migrants while arriving in the host country in good health are at higher risk to suffer health deterioration particularly in mental health (Helman, 2007; Kelly, 2004), due to problems related to individual identity, lack of social network support, intimidation, stress, racism, employment difficulties, financial issues, and difficulty to access public services. Several countries and their respective health ministries have been confronted with the challenges of managing diversity and providing healthcare services to multi-ethnic populations. The EU Health council in 2007 recommended that EU member states needed to acknowledge the higher propensity of lower health standards of migrants and encourage health systems across the union to promote and protect the welfare, well-being and health of migrants.

1.2 Context and origins of research in Ireland

Unlike “old” immigration countries such as France, the UK or the Netherlands, the Republic of Ireland is one of the most recent examples of a “new” immigrant country that has experienced a significantly rapid increase in the ethnic diversity of its population. Consequently the Irish health sector has had to respond quickly to revise and devise new policies and strategies to ensure the provision of quality health care to MECs and to manage its workforce diversity. The Irish health system is an example of a national health system

which has attempted to implement adequate planning and delivery of care and support services, encompassing the needs of MECs in a new multicultural Ireland.

It is thus of interest to explore what conclusions can be drawn from countries such as Ireland, that have attempted to tackle ethno-cultural diversity issues in its health sector by implementing intercultural health strategies which address a new multicultural population. What lessons can be learnt from the Irish experience for future health sectors around the world who may undoubtedly be confronted by the challenges of managing ethno-cultural diversity in the decades to come?

This thesis therefore identifies the critical issues concerning the management of ethno-cultural diversity in the Irish healthcare sector and examines to what extent six Irish hospitals have been successful in implementing a national strategy in order to provide quality health care service delivery to MECs. Conclusions and lessons learnt are drawn from the detailed experience of the six Irish hospitals. The results of this study serve as a first evaluation of the implementation of the Irish health system's Whole Organisation Approach (WOA) initiative.

1.3 Ireland and new multiculturalism

During the period between 1995 and 2007, the Republic of Ireland experienced strong rapid economic prosperity and changes in population. The reasons for this economic growth were Ireland's success in attracting US foreign direct investment, its membership in the European Union and the internationalization of the Irish economy. This period of economic success referred to in the media and press as the "Celtic Tiger" economy, led to fundamental changes in Irish society, catapulting the Irish economy from a once stagnant inward economy to a modern, open multicultural economy. Following this success, Ireland which was once considered a country plagued with high unemployment, economic hardships and centuries of high emigration became, during the early 2000s, a country of prosperity with almost full employment and net immigration. Irish employers and government agencies actively recruited non-Irish nationals to meet the needs of rapid economic growth which in turn helped create a more multiethnic fabric of Irish society.

Consequently Ireland in 2000 had high proportions of foreign-born people as a percentage of its population, even overtaking traditionally diverse societies such as the UK and the Netherlands (OECD Fact book, 2006). In 2002, the first year that the population census

included a question on nationality, just below 6% of the total population usually resident in Ireland had non-Irish nationality.

According to the Central Statistics Office of Ireland's Census of 2006[3], approximately 10% of the Irish population consisted of non-Irish nationals representing an increase of approximately 4.2% from 2002. Ireland is unique in that a high proportion of immigrants are from within Europe unlike countries that have historic links with certain countries through colonization. This indeed represents a serious challenge for a country that unlike its European neighbors was more or less heterogeneous throughout its long history. Barrett et al. (2006), and Fanning (2002; 2007), have written extensively on subjects relating to the impact of immigration on social change, racism and the labor market in Ireland. Kennedy and Murphy-Lawless (2001) and Fanning (2002), have discussed the challenges and difficulties posed to the Irish health services with regard to new multiethnic communities. Tuohy et al. (2008) referring to Boyle (2000) and the NCCRI (2003) states that Ireland being historically more disposed to being a mono-cultural society "hardly acknowledged the ethnic communities (travelers and non-Irish nationals) that have always existed within Irish society" p 165, and "the dominant settled mainly white Christian population dictated Irish social norms, values and policies" p166. Watt and McGaughey (2006), in their report for the NCCRI on improving government service delivery to minority ethnic groups observed a lack of culturally appropriate services and policies in Irish society during this time. Nursing care, according to Boyle (1999) was delivered through a western biomedical model and Irish nurses were not trained to provide culturally competent healthcare. Lyons et al. (2008) refers to maternity services struggling with ethnic and cultural diversity issues in Irish hospitals in terms of communication, traditions, customs, misunderstandings with the medical model of care and racism. Maternity services were particularly sensitive as "The Good Friday Agreement"[4] (Northern Ireland Office, 2008) allowed for children who were born on the island of Ireland to be granted citizenship. This led to a large influx of non-Irish national women coming to Ireland to give birth.

[3] Census Ireland 2006 www.cso.ie/Census

[4] The Good Friday Agreement or Belfast Agreement, 1998 also sometimes called the Stormont Agreement — was a major political development in the Northern Ireland peace process of the 1990s. a multi-party agreement by most of Northern Ireland's political parties, and an international agreement between the British and Irish governments.

1.3.1 Profiles of non-Irish nationals

There are 420,000 foreign nationals representing 188 different nationalities living in Ireland according to the Census of 2006. Demographic trends estimate further increases from 10.4% to 18% in non-nationals living in Ireland by 2030, Health Service Executive's National Intercultural Health Strategy (NIHS, 2007) p6. This suggests that ethno-cultural diversity and immigration is a feature of Irish society and is foreseeable for the long term. International trends indicate that the increased mobility of people and global business will continue to drive the phenomenon (UNDESA, 2004). The profile of minority ethnic groups in Ireland are comprised of refugees, asylum seekers, family reunification, migrants and migrant workers, undocumented migrant workers, travelers and foreign students.

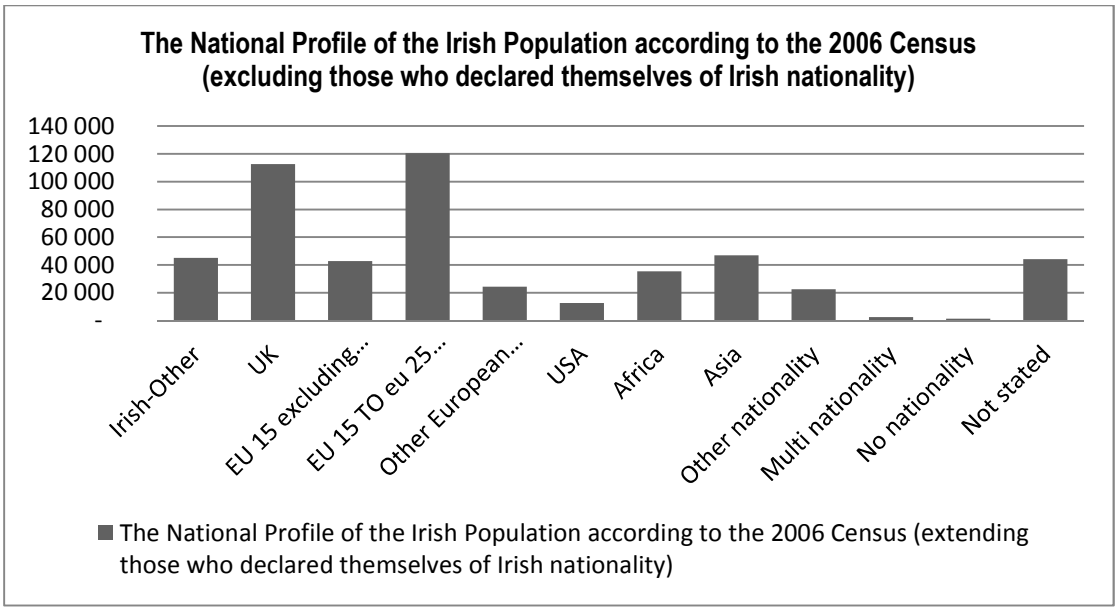
1.3.2 Inward migration

The last decade has seen a significant increase in net immigration in the Republic of Ireland. A constant flow of immigrants from the UK, and the USA, came to the country with the quantity of immigrants from the UK peaking in 1999 and from the USA in 2001. Migration from the EU 15 peaked in 2004 and immigration from other countries rose rapidly from 2004 onwards around the time when the Celtic Tiger was in full boom. At the beginning the flows of immigration were driven by returning Irish emigrants. In 1996 to 2005, the population increased by approximately 10% and the early 2000s, saw the second flow of immigration which was driven by people seeking asylum or refugees and people coming from non-European countries. Then, after the two last EU enlargements in 2004 and 2007, the number of immigrants coming from the new European countries to Ireland increased significantly. This was mainly due to the fact that Ireland was one of the 3 European countries that granted unrestricted access to their labor market. Levels of immigration from outside the EU-15 in 2009 were significantly higher than in 1999, almost trebling from approximately 10,000 to 30,000.

1.3.3 Nationality

According to the Census of 2006 the population of the Republic of Ireland was 4,172,013 and 87.8% (3,661,560) were of Irish nationality. Of the remaining 12.2%, the nationalities are broken down as illustrated in the figure 1.1. They include 25% from EU-15 to EU accession countries, 22% from the UK, 7% from Africa, 8% from EU-15 excluding the UK, 9% from Asia, 9% Irish-other and 9% didn't state their nationality.

Figure 1.1 : The National Profile of the Irish Population



1.3.4 Ethnicity

Table 1.1 demonstrates the religious and ethnic breakdown of the Irish population as per the Census 2006. From an ethnic perspective 87.4% of the population are white Irish, with 7.5% of the remaining 12.6% declaring as “any other white background”. 1.3% were Chinese or any other Asian background, 1.1% were African or any other Black background and 1.1% were categorised as “other including mixed background”.

Table 1.1 : Data about the ethnic groups and the different cultures among Ireland

Ethnic Groups		Religion	
Irish	87.4%	Catholic	87.4%
Other whites	7.5%	Church of Ireland	2.9%
Asian	1.3%	Other Christian	0.7%
Black	1.1%	Presbyterian	0.5%
Mixed	1.1%	Muslim	0.8%
Unspecified	1.6%	Orthodox	0.5%
		Methodist	0.3%
		Other religions	1.3%
		Unspecified	1.6%
(2006 census)		None	4.2%

1.3.5 Religion

Table 1.1 above shows the religious breakdown of the population and indicates that the majority of the population is Roman Catholic (87.4%) but figures have remained relatively constant over the years despite significant population growth. There is a relative increase in the number of people who consider themselves non-Catholic. The Church of Ireland and other Christian religions are the second and third largest religions. This has changed somewhat since 2006 with latest estimates in 2011 indicating that the Muslim religion is the third largest religion in the Republic of Ireland.

1.3.6 Asylum seekers

Statistics on the number of applications for refugee status to the Irish department of Justice, Equality and Law Reform indicate constant increases with a record high of 11,634 applications in 2002 compared to 400 in 1995 (Office of Refugee application Commissioner, 2004)[5]. Figures dropped to 4,766 in 2004 and levelled out until a significant further drop to 2,689 in 2009.

1.3.7 Medical and nursing staff

According to the Central Statistics office in 2003 as per Lyons et al. (2008), there were 5,000 work permits issued in Ireland to non-Irish nationals in 1999 and this increased to 45,000 in 2003. Furthermore there was strong inward migration of non-Irish national healthcare professionals. For example from 2005 to 2009 there was an influx of doctors who graduated outside of Ireland from countries such as the UK, Poland, Germany, Hungary, the Czech Republic, Slovakia and Romania (Donohue, 2010). Likewise, from a nursing perspective there was a significant increase of non-Irish nationals notably from India and the Philippines during the period from 2000 to 2006 becoming Irish registered nurses and entering into the Irish system. This was directly due to recruitment drives by the health sector and An Bord Altranis [6], to recruit nurses to fill employment gaps during the booming economy period. Thus workforce and patient diversity has increased due to a new multicultural Ireland. The question of how the Irish health sector has coped with such diversity in the management of hospitals and the provision of healthcare services merits investigation.

[5] Office for Refugee Applications Commissioner,2004. Statistics available from (http://www.orac.ie).

[6] An Bord Altranis is the Irish Nursing Board which is the regulation body for the Irish nursing profession.

1.4 What are the key challenges of managing diversity in the Irish health sector?

According to the NIHS (2007-2012), the Irish Health Service Executive (HSE), the body responsible for providing health and social services in Ireland, must overcome the challenges of accommodating the cultural diversity of their service providers and service users. The Irish health system has a duty to implement adequate planning and delivery of care and support services in a new multicultural Ireland, encompassing the needs of MECs. A preliminary exploratory research was undertaken with nine relevant participants associated with Irish health care to investigate how ethno-cultural diversity has impacted the management of hospitals in Ireland. The purpose was to establish at what levels of the hospital sector ethno-cultural diversity impacted the most. The question as to whether workforce diversity, due to international recruitment initiatives during labour shortages in the Irish health sector, was more of a concern for the management of hospitals than patient diversity issues arising from hundreds of thousands of new immigrants now living in Ireland was the central focus of the preliminary research.

1.4.1 Preliminary research, Ireland

This preliminary research incorporated nine semi-directed interviews with nine separate organizations related to the hospital sector in Ireland in May, 2009. Table 1.2 illustrates the nine organizations contacted which included two universities (nursing schools), four voluntary hospitals, two employers' advisory agencies and one diversity trainer/cross-cultural consultant who had extensive experience in the sector. Exploratory interviews were conducted with hospital Human Resource managers, Directors of Nursing, Training and Development managers, university lecturers, researchers and consultants.

Table 1.2 : Preliminary research respondents

- Trinity College Nursing school (Nursing professor)
- Dublin City University Nursing School (Nursing professor)
- Health Service Executive (employers agency) Industrial Relations Executive
- Irish Business Employers Confederation (Human Resource Executive and Diversity Manager)
- Independent Cross-cultural, diversity consultant (Hospital sector)
- A maternity hospital (Training & Development Manager Chair of Diversity committee
- A general hospital (HR Manager)
- A children's hospital (HR Manager, Director of Nursing)
- An elderly person's hospital (HR Manager)

1.4.2 Conclusions of preliminary research

The conclusion of the preliminary exploratory research revealed that the main issue which was of paramount concern for Irish hospital management in the context of a new multicultural Ireland is the provision of quality patient care taking into consideration the ethno-cultural differences of service users. Hospital management were less concerned with the managing of ethno-cultural differences in workforce behaviours and multicultural healthcare teams. It emerged from the research the assumption by management that that if the patient diversity issues could be successfully managed then workforce diversity challenges would follow and be easier to solve.

A sample of the patient care diversity challenges emerging from the exploratory research interviews included problems related to different behaviours, beliefs, attitudes to building trustful relationships, communication styles, languages, interpretation difficulties, cultural sensitivity, cultural birth rituals, death and mourning rituals, special medical needs, food and diet requirements, religious diversity, gender issues and patient safety. These findings corresponded to authors who have written and researched concerning the challenges of patient ethno-cultural diversity in the academic literature such as Gardenswartz and Rowe (1993), Giger and Davidhizar (1995), Papadopoulos et al. (1998), Cross et al. (1989), Leininger (1999), Brach and Fraser (2000), Alexander (2002), Burchum (2002), Andrews and Boyle (2003), Bischoff (2003), Hayes-Bautista (2003), Walsh (2004), Betancourt et al. (2005), Fox (2005), Hunt (2007) and Wilson-Stronks et al. (2008).

1.4.3 International exploratory research in the USA and France

In order to explore the extent of the problems of providing health services to ethno-culturally diverse populations, the author explored initially two established and sophisticated health systems in a European and North American context. Both systems served nations where both had histories of inward immigration. The countries selected were the United States of America and France. The author living and working in France has researched the French health system's approach to this issue only to find minimal development at a national top down level in the provision of health care to MECs. Table 1.3 indicates the different healthcare organisations and contacts involved in the exploratory research. The research in France involved the organising of a conference at EM Strasbourg in the summer of 2010 with 65 healthcare professionals to discuss how French health settings manage ethno-cultural

differences and by visiting 5 French hospitals in the North East Region of France and interviewing 17 healthcare professionals (see Nobre and MacGabhann, 2011).

Table 1.3 : International exploratory research

Organisation	Contact	Date	Purpose
Kaiser Permanente Buffalo NY USA	Regional HR Director East Coast	April 2010	Exploratory Research
Roswell Cancer Hospital Buffalo NY USA	Director of Diversity	April 2010	Exploratory Research
Py2 Hospital professionals Buffalo NY USA	12 Health care professionals	April 2010	Exploratory Research
Kaiser Permanente Foundation Hospitals Buffalo NY USA	Medical Doctor	April 2010	Exploratory Research
Kaiser Permanente Foundation Hospitals Buffalo NY USA	Nurse	April 2010	Exploratory Research
Conference on Patient Diversity EM Strasbourg, France	65 health care professionals	June 2010	French exploratory research
Oregon Health & Science University Hospital USA	Program manager of diversity and inclusion at Healthcare HR	July 2010	Pilot Interview guide
Diversity in health care specialist Portland Oregon USA	Dr Anita Rowe Author & consultant	July 2010	Pilot Interview guide
Portland Hospital Portland Oregon USA	MD and Head of Diversity for MDs	July 2010	Pilot Interview guide
Intercultural Communication Institute Intercultural Competence in health care workshop Reed Campus, Portland, Oregon USA	6 specialists in cultural competent Health Care who train and are responsible for diversity in Kaiser Permanente Foundation Hospitals in California & Portland	July 2010	Presented exploratory research project to specialists in cultural competence care in Health care

The American based research took place in April and July 2010 and involved a site visit to the Roswell Cancer hospital in Buffalo, New York and consisted of interviews with the Director of Diversity Management and the Regional Human Resource Director of Kaiser Permanente Foundation hospitals which is an organisation responsible for operating hospitals throughout New York state. Also a meeting was held with the Py2 hospital healthcare professionals group of New York, and interviews were conducted with medical professionals including a doctor and nurse from Kaiser Health Foundation hospitals. Research also consisted of attending and presenting research at a workshop on cultural competence in health care with Californian and Oregon healthcare professionals who were specialised in cultural competent healthcare provision in Portland, Oregon. This included exchanges and interviews with medical doctors, diversity managers, nurses and

administrators. In addition, a comprehensive interview was conducted with noted author and practitioner in diversity education in health care, Dr Anita Rowe.

This exploratory research enabled the author to understand the challenges and identify the issues at stake concerning the management of ethno-cultural differences in the hospital context. Furthermore it provided exposure to learn about different national institutional approaches to providing culturally appropriate care in a communitarian and non-communitarian context.

1.5 Problem statement, research objective and research question

This research aims to address the problem of how hospitals manage ethno-cultural differences in providing healthcare service delivery to service users in acute hospitals settings. The study intends to answer the research question of *how healthcare service providers (hospitals) manage ethno-cultural differences in providing healthcare service delivery to (ethnic minority) service users in the Irish healthcare system.*

To answer this question a more refined analysis is undertaken by examining the following specific areas.

1. The approaches and practices that hospitals can utilise in managing ethno-cultural diversity in providing culturally appropriate healthcare service delivery and if there is an overriding framework that can be used in the Irish context?

2. The experiences of individual Irish hospitals in applying such practices/frameworks and how individual hospitals have reacted in general?

3. The extent that the key contents of these practices /frameworks are applied and implemented across Irish hospitals?

In a nutshell this thesis provides an in-depth analysis of what is the Irish approach, and how it is applied in and across hospitals.

1.5.1 Epistemology and research method

In order to answer to the research question and respond to the challenges of the nature of the examination of this study the following research methodology was employed.

The purpose of this research project is descriptive and analytical in nature as it intends to describe how hospitals are managing ethno-cultural differences and analyses how the implementation of the WOA is occurring in Irish hospitals. The research was carried out using phenomenological or qualitative methodology and consisted of 93 in-depth interviews in 6 hospitals, involving exchanges where the reality was investigated from the subjective viewpoint of the interviewee. Given the fact that each hospital exists within its own contextual environment, with different functions and traditions, a qualitative methodology was deemed more appropriate as quantitative methodology tends to focus on measurement alone.

There is a deficit of literature focusing on whole organisation approach models to managing ethno-cultural differences in provision of healthcare services in the Irish context. It was therefore considered that a qualitative approach to investigating this problematic would yield the most appropriate data. This research project is inductive in nature and the 93 interviews with healthcare professionals provided an opportunity to induce inferences identify emerging rationale on how Irish hospitals manage ethno-cultural diversity.

The outcomes and findings of this study aim to be applied and serve hospital management by indicating to what extent appropriate policies and strategies are being implemented with regard to managing ethno-cultural differences in health care settings. Furthermore findings highlight reasons for poor or strong implementation and suggest methods and areas for individual hospital managers to improve their implementation strategies.

1.6 Clarification between "diversity" and "ethno-cultural" differences

This thesis focuses on how hospitals manage ethno-cultural differences in the provision of healthcare service delivery to patients. It is noteworthy to distinguish between diversity and ethno-cultural differences.

1.6.1 The notion of diversity vs. the concept of difference

Dietz (2007) distinguishes between the concept of difference and notion of diversity and argues that the term diversity is preferred as it reflects the complexity and interdependence of human traits. Dietz states that "the concept of difference which suggests the possibility of neatly distinguishing between its respective traits or markers is being gradually substituted by the notion of diversity which in contrast emphasises the multiplicity, overlapping and crossing between sources of human variability", p6. However the term diversity is too often used in a broad ambiguous manner in the context of discussions and discourse on multiculturalism, identity politics, discrimination, education among other topics (Dietz 2007).

Based on selected definitions from noteworthy authors in the field, diversity recognises and values differences in broad terms in a wide scope or agenda incorporating aspects such as age, ability, gender, sexual orientation, culture, ethnicity, race, religion etc. For example Kandola and Fullerton (1994), refer to diversity as "visible and non-visible differences which will include factors such as sex, age, background, race, disability, personality and work style." Point, cited in Barth et Falcoz (2007), in a similar vein, refers to diversity as a co-habitation of differences, which like an iceberg, consist of those elements which are "visible, race, sex, handicap, family name" and those less visible "religious beliefs, political affiliations, sexual orientation and values" p239. Moore (1999) states that diversity is not a simple concept that can be defined objectively but is rather context dependent, selective and relative. It is context dependent as an individual can only be evaluated based on the extent to which they appear similar or different from people in their environment. It is selective as some characteristics such as gender, skin, colour, age, cultural background, accent, and physical ability are used as stronger indicators of diversity and can vary from culture to culture, social group to social group or organisation. From a healthcare perspective Dennis et al. (2003) maintain that "diversity of clients or patients is varied and can relate to gender, age, socioeconomic status, education, physical and mental disabilities, regional locations, sexual-lifestyle, and racial and ethnic backgrounds", p17.

For the purposes of this study, the research focuses on the ethno-cultural aspects (differences) of the wide diversity agenda. The term ethno-cultural is employed to refer to those differences that are widely recognised and can act as a base to understand the often complex relationship in cultural transactions in health care. Let us thus further clarify the meaning of ethno-cultural for the purposes of this research.

1.6.2 "Ethno-cultural" characteristics

Berry et al. (2006) refers to ethno-cultural as the cultural characteristics of ethnic groups and The Oxford dictionary[7] defines ethno-cultural as "relating to a particular ethnic group"**.** Let us first examine the discussion on what is meant by an ethnic group and then concept of cultural characteristics.

The House of Lords in England defines an ethnic group as a group that regards itself or is regarded by others as a distinct community by virtue of certain characteristics that will help to distinguish the group from the surrounding community (Commission for Racial Equality, cited in Watt and McGaughey, 2006).

A Minority Ethnic Group or an Ethnic Minority Group is a standard term used in the European Union to describe all groups whose ethnicity is different to the dominant group. For example in an Irish context the white Irish are the dominant group in the Republic of Ireland. Minority ethnic group can be used to describe different groups in Ireland such as the Jewish, Asian or Eastern European communities (Health Service Executive HSIG, 2009). It is pertinent to examine the discourse on the relationship between culture and ethnic identity in the context of this study.

1.6.3 Culture and cultural characteristics of ethnic groups

Culture is a difficult concept to define, and there are many definitions throughout the literature. Perhaps one of the most cited definitions of culture is Hofstede (1980) who describes culture as "the collective programming of the mind which distinguishes the members of one human group from another", p25. Hofstede explains his definition by stating that "culture in a sense includes systems of values, and values are among the building blocks of culture". Hofstede's definition implies that members of groups are programmed to see the world in certain ways and that there can be shared meanings that act as an invisible glue holding members together. Culture is dynamic and ever changing and is learned and passed on from generation to generation. Culture influences all aspects of life. It influences our belief systems and is the driving force of our behaviors and what we deem to be appropriate behavior. Culture as defined by Nunéz (2000) "shapes how we explain and value our world. It is the lens through which we give our world meaning." Culture is often related to

[7] Oxford Dictionary (http://oxforddictionaries.com/definition/english/ethnocultural?q=ethno-cultural).

ethnic identity. The Greek word ethnos refers to people who share the descent from the same ancestors, but over time has been associated with people who belong to a culturally distinct group. Ethnic identity relates to differences due to culture and lends itself to the idea that the world is multicultural and groups can be distinguished by their culture (O'Carroll 2005).

From a healthcare perspective Hudak (1998), argues that understanding culture is an important aspect in providing care for individuals and their families. Her viewpoint is that healthcare providers and carers need to be culturally sensitive and be able to recognize their own cultural beliefs and characteristics, be open to other cultural beliefs and behaviors, understand one's own values, appreciate other people's cultural beliefs, and listen without imposing one's own cultural beliefs on others.

1.6.4 The scope of the research

The scope of this thesis in referring to ethno-cultural differences will focus solely on those ethno-cultural characteristics of ethnic groups which include ethnicity, race, and nationality, country of origin, religion and language. This limitation of scope aligns with the varying international approaches and guidelines referring to methods of ethnic monitoring that are used internationally (See CLAS 2001, Amsterdam Declaration 2004 in chapter 2). Also the Irish Central Statistics Office for the first time in 2006 in an effort to enumerate and monitor cultural and ethnic related forms of diversity in the Irish population introduced a question on the census questionnaire referring to the above mentioned criteria.

Thus the scope is not based on the entire realm of constructs relevant to the term diversity which include sexual orientation, gender, age, etc. The objective is to discuss the relationship between ethno-cultural differences through the lens of ethnicity, nationality, country of origin, race (skin colour Caucasian), beliefs (religion), language, and health care and use this as a basis to examine how hospitals manage such differences in the provision of health care in the Irish context.

The following presents an explanation and common understanding of these key terms. It is to be noted that the scope of the thesis prohibits an in depth discussion on the complex debates around terms such as ethnicity and race.

1.6.5 Ethnicity

Ethnicity is a social construct that refers to groups that share common heritage including aspects such as language, religion, customs, and geography. It relates to group affinity and gives a collective sense of identity (Bulmer, 1996). It is a system or construct that gives meaning to individuals in the context of contrasting to other groups (Barth, 1990). Ethnicity is characterized by the group identity, belonging and affiliation that one holds about oneself. Ethnic groups share history, ancestry, language and geographic origin. Their shared identity exists independent of nationality (Health Service Executive's HSIG, 2009). Watt and McGaughey (2006) describe ethnicity as shared characteristics such as culture, language, religion, traditions, and so forth contributing to a person's or group's identity.

Ethnicity is the shared characteristics such as culture, language, religion and traditions that contribute to a person's or group's identity. Ethnicity has been described as residing in: "the belief by members of a social group that they are culturally distinctive and different to outsiders, their willingness to find symbolic markers of that difference (food habits, religion, forms of dress, language, and to emphasize their significance. Their willingness to organize relationships with outsiders so that a kind of 'group boundary' is preserved and reproduced", Health Service Executive's HSIG (2009), p127.

1.6.6 Race

Race is a social construct that is used to classify or categorize societies based on the observable differences between people, for example skin colour, Caucasian, eye colour, head shape, hair colour and texture (Hyde et al., 2004). The meanings of terms or social constructs such as race and ethnicity are "heavily context dependent" and are determined from national contexts (Aspinall, 2007). Often constructs derive from national contexts such as the national census. "The term race is a social construct used to classify people. It is problematic as originally, race was based on a false belief that biologically; there were different species of humans, with the implication that some races were superior to others. However, research has proved that there is no single race defining gene and therefore no biological basis for dividing the human population into different races. The term race is still widely used in legislation and has become somewhat embedded", Watt and McGaughey **(**2006), p168. "In Irish equality legislation the 'race' ground is described as race, colour, nationality, ethnic or national origins", Health Service Executive HSIG (2009), p130.

1.6.7 Nationality (country of origin), beliefs (religion) and language

Nationality refers to the status of belonging to a particular nation (or country) through birth or naturalization. The Illustrated Oxford Dictionary (1998), defines nationality as the status of belonging to a particular nation. Country of origin refers to where a person is born.

The Equal Status Acts 2000 and 2004 in Ireland legislate that (beliefs) i.e. religion is one of the areas to be protected from discrimination, which is particularly of relevance in the healthcare sector as patients are systematically asked their religion or spiritual tradition. Religion can impact on ceremonies, practices, rituals, food categories and specific items of clothing (Health Service Executive's HSIG, 2009). Mauk and Schmidt (2004), define religion as a "set of organized beliefs, rituals and practices with which a person identifies and wishes to be associated", p3.

Language plays an important role in interpreting culture and how we communicate with each other in national and international contexts (Sandbacka, 1987).

1.7 Organisation and structure of thesis

The thesis is organised into 6 chapters. Table 1.4 illustrates the design of the study and outlines the overall structure and logic. An explanation of the purpose of each chapter follows:

Table 1.4 : Structure and design of research

Chapter 1	Introduction Context of study, problematic, research scope, research question and management interest
Chapter 2	Literature Review Academic and international approaches to managing ethno-cultural differences The Irish Experience Whole Organisation Approach and exploratory research
Chapter 3	Methodology Research question and sub-research questions 93 semi-structured interviews, sample 6 hospitals Parameters, codification, Likert scale 0-1-2-3

Chapter 4	Presentation of the results of implementation of the WOA in the 6 hospitals
Chapter 5	Analysis, interpretation and prescriptions of results
Chapter 6	Conclusion of study including managerial, methodological and theoretical contributions including a discussion on the limitations of the research and suggestions for future research.

1.7.1 Chapter 1: Introduction

Introduces the background of the subject and describes the general context explaining why the subject should be studied, highlighting the problem, the research question and research objective. This chapter also defines the scope of the research and defines ethno-cultural differences as those related to ethnicity, race, nationality, beliefs and language. The structure and organization of the thesis is outlined and the interest of the subject from a managerial perspective is discussed.

1.7.2 Chapter 2: Literature review

This chapter is designed to review the pertinent academic and professional literature that pertains to the research question and the core focus of this study. Relevant definitions and literature focusing on the challenges and solutions of managing ethno-cultural differences in health care are explored. The role of intercultural training is discussed and the need for healthcare organisations to implement broader policy and system changes is critiqued. A thorough review of the literature focusing on cultural competent health care and diversity management theories and principles, including the relevant academic models and conceptual frameworks in conducted. Furthermore international institutional approaches including the Irish hospital sector response to managing ethno-cultural differences are examined.

1.7.3 Chapter 3: Research methodology

This chapter is designed to describe the methodological approach employed to undertake the research. This includes a review of the problem statement, research objective and an elaboration of the research question and sub-questions. An overview of the general approaches to scientific research is provided and analyses of the different types of research

are reviewed. A description and rationale for the research methodology chosen for this study is outlined and reasons for choosing the research design, process, data collection and data treatment is discussed. Moreover the relevant ethical, reliability and validation considerations are considered.

1.7.4 Chapter 4: Results

This chapter presents a description of the nature of each hospital and the profile of the respondents interviewed on each site. The coded results of the implementation of the WOA framework are presented for each hospital. In addition a complete table illustration of the implementation of the 93 parameters for each of the 6 hospitals is provided indicating those parameters that have been implemented and those that have been omitted. Finally a description of the findings indicating the extent to which the 3 strands of the WOA have been implemented across the hospitals is addressed.

1.7.5 Chapter 5: Analysis and interpretation

This chapter synthesizes, classifies and explains the results of the implementation of the WOA framework for each hospital. 7 key factors that influence to what extent the WOA is implemented are identified and analysed for each hospital. This is followed by an analysis of the implementation of the parameters and an overview of those parameters that are commonly implemented and those that have not been addressed across the 6 hospitals. Furthermore a prescription of actions and areas that each hospital should address in the context of implementing the WOA is provided. In addition the chapter contains an analysis of the three strands by firstly explaining the reasons for the varying extent of the implementation of the WOA in each strand across the 6 hospitals and secondly offering prescriptions for better implementation of each strand. Moreover the results of Irish efforts are interpreted in the context of several academic discourses addressing organisational approaches to managing diversity, emanating from the literature review.

Finally the results of the implementation of the WOA are contrasted with the theoretical research of Gardenswartz and Rowe (1998) and analysed from an academic relevance perspective.

1.7.6 Chapter 6: Conclusion

This chapter concludes the research by summarising the key findings of the study. Conclusions are drawn concerning the managerial, methodological and academic interest and added value of the research. This includes an overview of the evolution of the WOA framework to a more complex framework adaptable to the Irish context and the specific needs of individual hospitals. In addition suggestions for further research are considered and the limitations of the study are addressed.

1.8 Managerial relevance of research

As previously mentioned demographic changes and ethno-cultural diversity are foreseeable for the long term in Irish society. Thus the idea of adapting services and providing appropriate healthcare service delivery to multiethnic service users is relevant to the Irish healthcare sector and will continue to be so in the future. While other national systems, such as the American health system have experienced net immigration and have been pioneers in managing the challenges of providing appropriate health care to ethnic minorities, they have had the luxury to do so over decades through an evolutionary approach.

Few nation states and national health systems have experienced multiculturalism at such a rapid pace and in such short a period of time as that of Ireland. Few have had to react and create appropriate policy as quickly as the Irish healthcare authorities. In the context of a fast moving and constantly changing 21st century, there will be undoubtedly more states like Ireland who historically were homogeneous and due to environmental changes in economic or political circumstances, will experience rapid demographic change and can learn from the Irish experience.

While problems related to ethno-cultural differences have been discussed in the Irish context (Fanning, 2002; Tuohy et al., 2008), there has been little discourse or research on how individual hospitals have approached the problem, and no assessment or discussion of the HSE's top down national effort in managing ethno-cultural differences in service user populations. In addition preliminary research clearly indicated the relevance of the problem in the Irish health sector and how the Irish response at national level was in effect demand driven. This research will attempt to give a picture of the status of Irish hospitals in 2010 in the context of managing ethno-cultural differences in service delivery and provide

perspectives for improvement and highlight barriers and constraints to a top down national approach.

It is envisaged that this research will be of benefit to management in the following ways:

- Will enable hospitals to be classified in terms of their progress regarding the management of ethno-cultural diversity and service provision.
- Allow management to identify where their hospital is advanced and less advanced in implementing the WOA framework and provides an explanatory analysis.
- Each hospital is provided with suggestions to prescribe how to improve the implementation of the various sub-elements of the WOA.
- Will enable the comparison of different Irish experiences in regard to how hospitals have adapted to multicultural patient care populations.
- Provide an overview of the problems and reasons for advancement (pros and cons) encountered by hospitals implementing intercultural policies and strategies i.e. WOA.
- Results of the research can serve for international cross-analysis studies with other countries such as for example how maternity hospitals in Ireland and France have managed patient diversity.
- Lead to the development of the best practices in Ireland on how to efficiently manage and implement diverse patient care service provision.
- Provide a whole organization approach model complete with parameters that can apply to a wide variety of healthcare organisations.

1.9 Chapter summary

This chapter has introduced the subject of managing ethno-cultural differences in healthcare service delivery and overviewed the challenges from a global and Irish perspective. The reasons for the author's decision and interest to undertake the research is outlined and the initial preliminary research process undertaken internationally and in the Irish context is addressed. A description of the new multicultural Ireland and a summary of the associated challenges that Irish hospitals face in managing ethno-cultural differences in Ireland is outlined. The scope of the research is defined as those ethno-cultural differences relating to ethnicity, race, nationality, country of origin, religion and language and the scope does not permit discussion or debate on the broader issues often associated with diversity such as

age, sexual orientation etc. This chapter also outlines the organisation and structure of the research study and explains the relevance of the study from a managerial perspective.

Having established the context and problematic concerning the managing of ethno-cultural diversity in Irish hospitals, it is thus important to review the academic and professional literature to establish a thorough understanding of the terminology, challenges, processes, conceptual and theoretical frameworks and international institutional approaches to overcoming the challenges and bridging the ethno-cultural gap with regard to provision of culturally appropriate healthcare service delivery.

Chapter 2

Literature review

2. Literature review

This thesis employs core terms throughout the document and the glossary of terms presents the explanation and common understanding of key terminology. Terms such as ethno-cultural, race, ethnicity, culture, have been discussed in chapter 1 but other relevant terms in the context of this study such as cultural identity, ethnic minority group, racial discrimination, interculturalism and multiculturalism among others are explained in the glossary. The scope of the study prohibits a comprehensive discussion on these discourses but the objective is to provide broadly accepted viewpoints, which will allow better understanding of the links between culture, health and associated challenges, disparities and the need for cultural competent healthcare provision.

As suggested in chapter one, it is imperative to investigate how Irish hospitals have managed ethno-cultural differences in patient populations. In doing so, the aim of this chapter is to review the literature concerning the management of ethno-cultural differences in healthcare service delivery.

This chapter begins by addressing strands in the literature with regard to the challenges posed by ethno-cultural differences in service user populations, and defines cultural competence in health care as the widely accepted objective to overcome these challenges. A discussion and analysis of theoretical models of cultural competence development from a professional and organisation perspective drawn from the healthcare literature is presented.

The critical role of intercultural training for healthcare professionals and the need for an organised wide system approach to succeed in providing culturally competent health care is summarised and supporting theoretical models and conceptual frameworks presented in the literature are discussed. The chapter includes a discussion of diversity management as a means to providing culturally competent health care and assesses a selection of theoretical models available in the literature which act as a conceptual basis for organisational wide approaches to diversity management. In addition, a comparison of how other international institutions have managed patient diversity is undertaken highlighting different recommendations, standards and guidelines for healthcare provision to ethnic minority communities.

Finally, an analysis of the how the Irish health system has approached the management of ethno-cultural differences is service delivery is outlined followed by a comprehensive explanation of the Irish Health Service Executive's WOA framework.

2.1 Research focus: challenges of managing ethno-cultural differences in health care

2.1.1 How do health systems accommodate ethno-cultural differences of service users? An examination of the key factors associated with the provision of appropriate healthcare service delivery to ethno-culturally diverse patients.

A review of the literature was undertaken to establish what constitutes appropriate culturally sensitive healthcare service delivery to members of MECs and to overview the related challenges, solutions and international practices.

2.1.2 What is appropriate culturally sensitive healthcare service provision?

To understand the elements of quality healthcare service delivery to ethno-culturally diverse patients it is important to first comprehend the challenges of providing appropriate culturally responsive health care and support services to MECs.

2.1.3 Overview of ethno-cultural challenges in provision of healthcare service delivery

The American Nurses Association define cultural diversity as "the differences between people based on a shared ideology and valued set of beliefs, norms, customs and meanings evidenced in a way of life", Wells (2000) p190. Appropriate culturally sensitive healthcare service delivery or "culturally congruent care" as described by Douglas (2003) requires the service provider to have the ability to "integrate the patient's belief system" and "using knowledge regarding cultural beliefs" of the patient in delivering health care. Douglas continues by suggesting that service providers should have the necessary "cross-cultural communication skills and a sensitivity to values and beliefs about life, death and the world around us, that may be different from the ones we hold to be true and inviolate".

According to Gardenswartz and Rowe (1993), cross-cultural communication skills allow service providers to understand different direct and indirect communication styles and administer feedback to patients in a culturally appropriate manner. Furthermore, language skills, assumptions and non-verbal communication, are all culturally relevant. Issues around building relations and trust which are essential in health care are culturally relevant. In addition, different cultures have different beliefs and norms which affect attitudes towards health care. Therefore a significant challenge of providing appropriate culturally sensitive health care service delivery is the ability of service providers to be culturally savvy and competent.

According to Kagawa-Singer and Blackhall (2001) culture in the context of end of life, shapes the manner how people make meaning out of illness, suffering and dying and argue that a "skilled use of cross-cultural understanding and communication techniques increases the likelihood that both the process and outcomes of care are satisfactory for all involved", p2993. Phillips (2003), states that healthcare systems such as the US system must "recognise and learn to respect cultural diversity including diverse health beliefs and practices characterizing the entire patient population", p331. De and Richardson (2008) propose that culture directly affects the safety of patients and refers to an approach developed first in New Zealand for "cultural safety" integrating a nurse's ability to understand their cultural selves and the impact this has on exchanges with patients.

2.1.4 Cultural challenges in healthcare provider and service user relations

The interventions and exchanges between healthcare professionals and service users are shaped by each parties cultural backgrounds and the cultural lens through which they see and interpret the world. Difficulties arising from cross-cultural interactions between patients, their families and healthcare providers can originate from the cultural programming of each party.

A lack of understanding of a patient's religion or culture can create barriers to providing health care, cause stress and cultivate confusion for service providers and service users. A patient's beliefs and assumptions, whether religious or cultural, impact how they cope with events such as birth, death, pain, suffering, loss, grief and various other problems or critical

incidents. Hospital chaplains, nurses and other healthcare professionals are charged with providing care to patients whose religion and culture are starkly different from their own.

Professional healthcare providers have the difficult task of providing comfort, help and support to seriously ill and terminally ill patients, but must do so by recognising and respecting the patient's cultural beliefs and assumptions, and adapting their own behaviours. This is a particularly complicated task as culture is not universal in nature and beliefs and assumptions vary across different societies. Considerations such as religious beliefs, communication issues, dietary concerns, bereavement, birth rituals and pastoral care can be more pronounced in acute and emergency settings.

Effective healthcare provision, especially in acute hospital contexts and critical care settings such as emergency units, requires healthcare providers to have the knowledge, skills and sensitivities to adapt and take into account the patients ethno-cultural differences.

Nurses, for example, must be able to provide care for different cultures and must have the capacity to see patients as unique individuals with complex characteristics that may differ from the norms of the majority (Leininger and McFarland, 2002). Authors such as (Wilson-Stronks et al., 2008; Hunt, 2007; Fox, 2005; Walsh, 2004; Hayes-Bautista, 2003; Alexander, 2002; Burchum 2002, Leininger 1999, Papadopoulous et al., 1998; Davidhizar and Bretchel, 1998; Cross et al., 1989) have focused on research in healthcare provision and the impact that cultural, religious and behavioural differences have on healthcare service delivery.

Gardenswartz and Rowe (1998) adapt ten dimensions of culture that categorize the different experiences of cultural encounters between two parties and apply it to a comparison of the US healthcare culture and other cultures. Table 2.1 indicates the 10 aspects of culture and compares the difference between the US healthcare culture and other cultures with respect to the ten aspects.

Table 2.1 : Comparing cultural norms and values chart

Aspects of Culture	US Healthcare Culture	Other Cultures
Sense of self and space	Informal Handshake	Formal Hugs, bows, handshakes
Communication & Language	Explicit, direct communication Emphasis on content-meaning found in words	Implicit, indirect communication Emphasis on context-meaning found around words
Dress & Appearance	"Dress for success" ideal Wide range in accepted dress More casual	Dress seen as a sign of position, wealth, prestige Religious rules More formal
Food & Eating Habits	Eating as a necessity-fast food	Dining as a social experience Religious rules
Time & Time consciousness	Linear and exact time consciousness Value on promptness Time = money	Elastic and relative time consciousness Time spent on enjoyment of relationships
Relationship, Family & Friends	Focus on nuclear family Responsibility for self Value on youth, age seen as handicap	Focus on extended family Loyalty and responsibility to family Age given status and respect
Values & Norms	Individual orientation Independence Preference for direct confrontation of conflict Emphasis on task	Group orientation Conformity Preference for harmony Emphasis on relationships
Beliefs & Attitudes	Egalitarian Challenging of authority Gender equity	Hierarchical Respect for authority and social order Different roles for men and women
Mental processes & Learning style	Linear, logical Problem solving focus Internal locus of control Individuals control their destiny	Lateral, holistic, simultaneous Accepting of life's difficulties External locus of control Individuals accept their destiny
Work habits & Practices	Work has intrinsic value	Work is a necessity of life

Adapted from Managing Diversity in Health Care, Gardenswartz and Rowe 1998 p 60-61

If we focus on the aspect of differences regarding relationships, family and friends, ethnic groups such as the "Roma"[8] or the "Irish traveller community"[9] have a strong focus on the extended family and are more community minded than those ethnicities that are more nuclear family related. This can result in large numbers of the extended family and

[8] Roma are a subgroup of the Romani people who trace their origin to the Indian subcontinent and live primarily in Central and Eastern Europe.

[9] The Irish Traveller Community is a traditional group of people of ethnic Irish origin, who maintain a set of traditions and a distinct ethnic identity. They speak English, Shelta and other cants. They live mostly in the Republic of Ireland, the United Kingdom and in the United States.

community members insisting on visiting a family or community member in hospital which a hospital may not be able to cater for. This can cause tension between hospital service providers and other patients in the hospital and the specific ethnic group.

How decisions are made about treatment and healthcare intervention varies among cultures. In collective societies decisions regarding health can be the responsibility of the family, or the head of the tribe, or community leader and not just the patient. This may lead to time delays in decision making to undertake certain treatments.

Beliefs and attitudes towards gender ranging from gender equity to different roles for men and women can be challenging in providing health care. In some religions such as Islam the male is accustomed to making key decisions including health related issues for his spouse. Equally, it is preferred that female nurses treat female patients etc. With regard to mental processing and learning style the idea or belief of an external locus of control may view the condition or illness as God's will where only God controls the health of the patient and this is what is meant to be, which may affect the attitude toward treatment. Therefore if cancer is diagnosed in certain Asian cultures, the patients may believe that medical treatment is irrelevant as the issue is in God's hands and only he will decide Gardenswartz and Rowe (1998).

Anne Fadiman's (1997), well renowned book entitled, "The Spirit Catches You and You Fall Down. A Hmong child, her American Doctors and the Collision of Two Cultures" is a prime example of how a clash of cultures and opposing behaviours, attitudes, norms and beliefs between the healthcare provider and the ethno-culturally diverse service user can have tragic outcomes. Values and norms such as individual and group orientation, independence or conformity, direct and indirect communication styles, task or relationship orientations all can impact the delivery of healthcare. Some cultures are relationship oriented and require more relationship building in order to build trust. Likewise, some cultures respect authority and social order and patients will never second guess or question the opinion of the medical doctors.

Gardenswartz and Rowe (1998) argue that there are 5 core cultural values that influence an individual's relationship with medical care. They suggest that healthcare providers need to understand the impact of these values on perceptions of the service user regarding health

care delivery and that they should adapt their expectations, communication process and the method of delivering service accordingly. The following table illustrates the 5 cultural values and compare how each value can have a different impact on healthcare provision in American and other culture healthcare settings.

Table 2.2 : Key Cultural Values and How they Affect Care

5 Core Values	Mainstream US Tendencies	Tendencies in Other Cultures	Implications for Healthcare Providers
Status	Earned through accomplishments; given to celebrity; accompanies certain titles, etc; rarely inherited through family gender or age.	Given through position in family, title, gender, family heritage, and age.	How decisions are made about treatment and who is involved in decisions are affected by status. In cultures, where status is acquired by such things as gender, age, and title, positions must be acknowledged in order to build relationships and trust.
Privacy	On the whole, open to talking about psychological and physiological conditions; even talk shows and newspapers are vehicles for conveying such information.	Respecting privacy and keeping personal matters within the family is a top priority; modesty and shame, particularly for women, also tie into this concept.	A patient's valuing of privacy may make it harder for providers to get necessary information. Relationship building is key, and gaining insight from cultural interpreters can be helpful.
Fatalism	Internal locus of control is dominant. There is a strong sense of control, of shaping one's own destiny, and of accepting responsibility for one's physical health.	External locus of control is more important in many cultures. The sense of fatalism and predestination can be affected by education, socio-economics, and acculturation. May believe that God's will influences health or illness.	For people who are strong fatalists, the idea that a disease or condition is meant to be, or that it is God's will, may affect attitude toward treatment and prevent intervening on their own behalf.
Individual / Group	Though there is currently a strong emphasis on teams, there is also a deeply ingrained emphasis on the individual, particularly related to rewards structures.	In most cultures, individual will, need, and desire are sublimated to the group. The welfare of the family is seen as paramount.	Care facilities will need more spacious waiting rooms for extended families, decisions may be made by a large group, and the patient cannot be considered in isolation.
Access to Information	Right to know is strong; there is a strong sense that information is power. Though some people clearly favour denial and lack of information, most want the straight direct information.	Must take into account perception of the illness and the stigma attached. Is often desirable to withhold information from the patient, particularly when there is a terminal diagnosis.	The healthcare provider who assumes that full information is wanted could be wrong and could negatively affect the patient's psychological well-being. There is a critical need to learn about the patient. Get clues from family and patient before telling all.

Adapted from Managing Diversity in Health Care, Gardenswartz and Rowe 1998 p79-80

Table 2.2 highlights the different effects that ethno-cultural differences may have on the patients experience in the healthcare organisation. It follows that healthcare providers must be aware of such cultural differences and have the necessary skills and competences to ensure and minimise the possible negative impacts.

2.1.5 Challenges due to different Worldviews

Different cultures have different worldviews which influence healthcare outcomes. For example fatalism and predetermination can influence certain members of certain cultures with regard to complying to or not complying with healthcare interventions. Table 2.3 illustrates four worldviews that can lead to misunderstandings between service providers and service users in healthcare settings.

Table 2.3 : Four culturally bound Worldviews that influence Perspectives on Health and Illness

Worldview Perspective	Features
Analytic	Detail to time and calculations Values individuality and materialism Visual and written documentation valued as learning style
Relational	Spirituality important Values development of relationships and interactions to function daily Verbal communication valued as learning style
Community	Community needs of higher importance than individual need Respectful approach to interventions and exchanges Mediation and transcendence valued as learning means
Ecological	Sense of responsibility to care for environment and world at large Self seen as being interconnected with world and nature Quiet and minimalist approach to communication Reflection and contemplation preferred learning style

Adapted from Warren BJ, The cultural expression of death and dying. The Case Manager, 2005, Jan/Feb.: 44-47

This table highlights how the different behaviors of health care providers and service users can be opposed depending on the individual's worldview.

The challenge of managing ethno-cultural differences in patients extends beyond the differences in values, norms and worldviews of the service provider and service user. Other areas that are challenging include the following:

2.1.5.1 Communication, language and religious challenges

Communication and language difficulties are often cited as a key problem regarding access to health care, exchange of information and the health of an individual (Bowler, 1993; Flessig, 1993; Bowen, 2001; McLeish, 2002; Robinson, 2002). Problems include the need for more time to communicate, talking slowly and too loudly, not asking yes and no questions, understanding contexts, and correct use of interpretation services.

Religion is often the reason for a clash of cultures in healthcare systems and for example there is much commentary on issues that Muslim patients are confronted with in western health systems (Robertson, 1993; Lawrence et al., 2001; Tsianakas et al., 2002; Mohammadi et al., 2007). This includes gender issues with regard to treatment by same sex service providers and the dominance of the males in decision making.

2.1.5.2 Mental illness

Challenges related to mental health include the risks of mono-cultural beliefs and interpretations being imposed incorrectly when intervening with patients from different cultures. Mental illness can be interpreted differently in different cultures. For example illnesses such as anorexia nervosa are often associated with western or industrialized societies and are absent in other societies (Craig, 1999; Donohue, 2010).

2.1.5.3 Health care and racism

There is evidence in the literature that discrimination takes place in the service provider service user relationship. Discrimination, for example, can occur through stereotyping (Heron, 2006), poor quality communication (De Bocanegra, 2004) and negative profiling and attitudes by physicians towards minority patients (Van Ryn and Burke, 2000). The Traveler Health Unit in their survey of Irish traveling community health in 2004 in the eastern Region of Ireland refer to indirect indiscrimination practices in the Irish healthcare system with regard to the Irish traveler community and refer to cases of travelers being refused access to “General Practitioner” doctors on the basis of their ethnic origins.

2.1.5.4 Culture of medicine

In an encounter between a healthcare service provider and service user there are three cultures at play, namely the culture of the service provider, the service user and indeed the culture of the medical context i.e. the medical training of the service provider and the educational philosophy of medical care. Some healthcare systems value detachment rather than personal interaction between the medical doctor and the service user, resulting in less time spent interacting, and routine approaches to medical examination and use of medical jargon. The comedy drama film “Patch Adams” 1998, directed by Tom Shadyac focused on the life of Dr Hunter “Patch” Adams and based on the book Gesundheit: Good Health is a Laughing Matter, a model for a new system of health care (Adams and Mylander, 1992), illustrated the clash of medical school training culture in the USA and the problems this can cause regarding treating patients in a more personalized individual context. The theme of the movie highlighted the differences in the culture of medicine with regard to the need for medical students to be encouraged to develop compassionate connections with their patients.

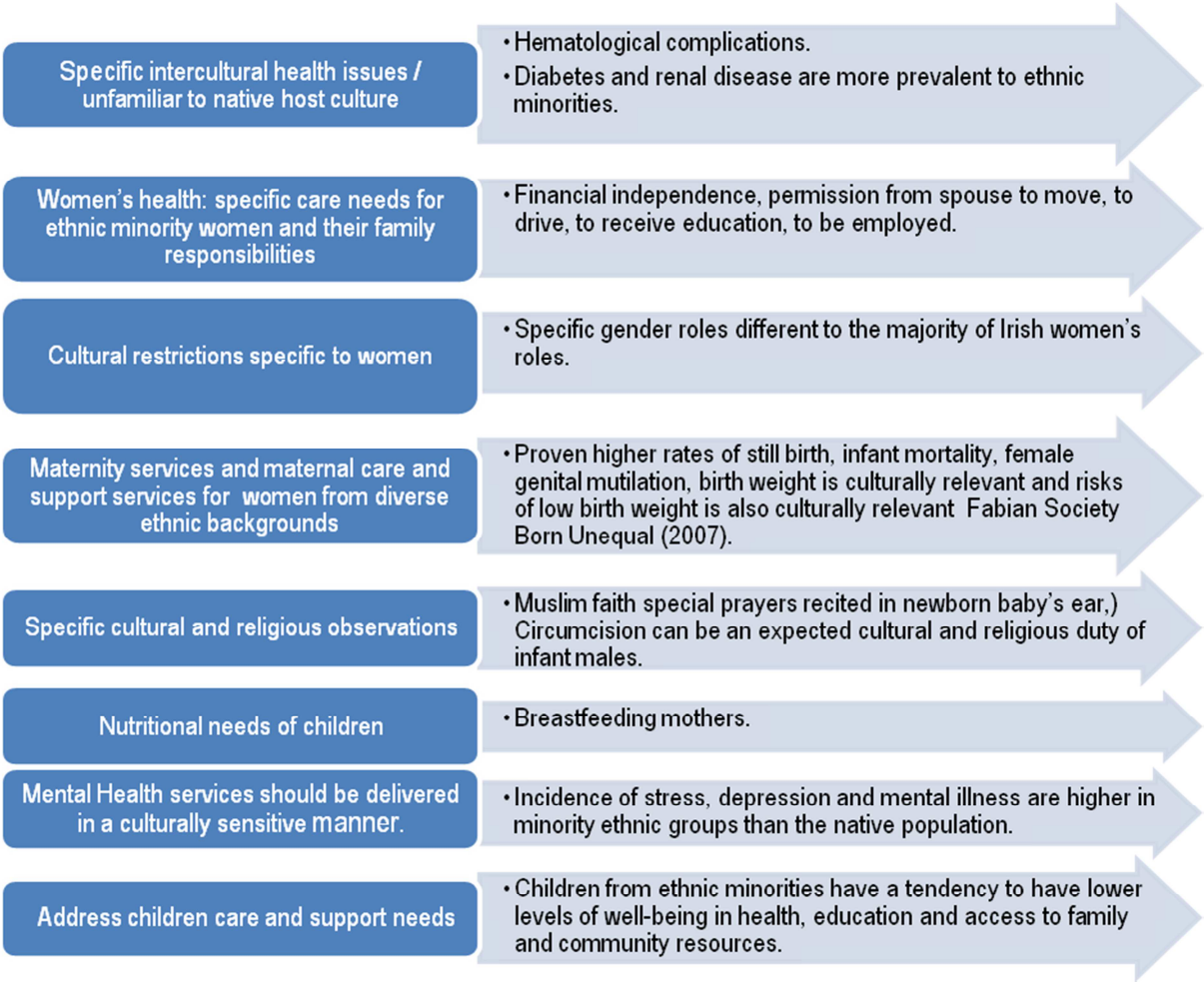
2.1.5.5 Epidemiological challenges

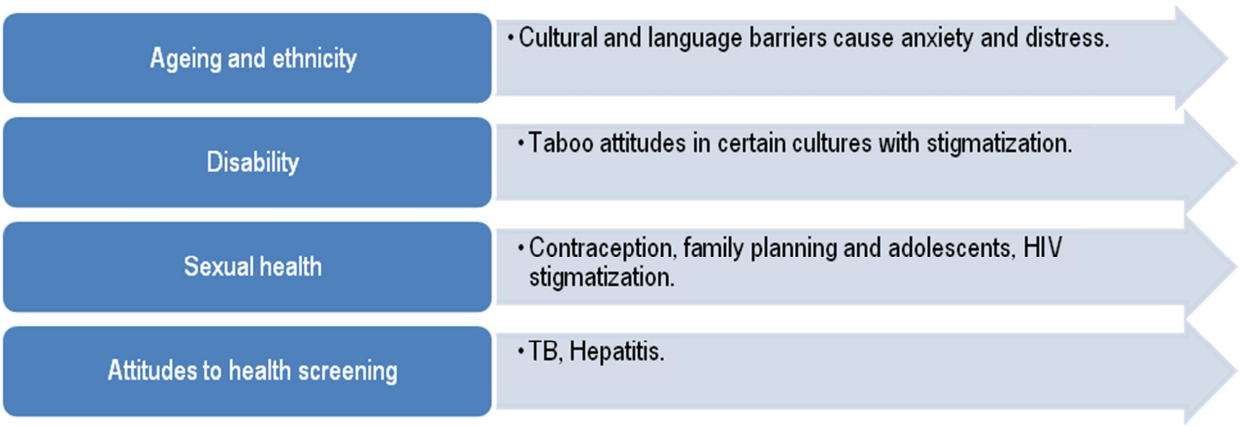
Different cultures may have different epidemiological needs and requirements and certain medical problems may be more prone to specific cultures. Health issues such as hematological complications, diabetes and renal disease, can be more prevalent to ethnic minorities Proven higher rates of still birth, infant mortality, female genital mutilation, birth weight are culturally relevant and risks of low birth weight is also culturally relevant (Health Service Executive’s National Intercultural Health strategy, 2007). According to the Director of Diversity of the Roswell Cancer hospital of Buffalo NY, in 2010, the hospital has recruited and up skilled in prostate cancer treatment for black males as research indicated that prostate cancer incidents were fastest growing in this cohort. Nobre and MacGabhann (2011) refer to various international studies and academic authors that have demonstrated the difficulties that health organisations are confronted with in the provision of health care to ethno-culturally diverse service users. They refer to authors that have published research relating to such challenges from an epidemiological perspective including (Betancourt et al., 2005; Bischoff, 2003; Andrews and Boyle, 2003; Brach and Fraser, 2000; Giger and Davidhizar, 1995; Gardenswartz and Rowe, 1993a).

2.1.6 Overview of the challenges in the provision of health care to ethno-culturally diverse patients in the Irish health care context

Lyons et al. (2008) in their study of health service providers working in Dublin maternity services identified communication difficulties as a main challenge including a lack of proficiency in the English language, and difficulties in the use of formal and informal interpreters. In addition, challenges such as unfamiliarity with and lack of knowledge of Irish maternity services, and cultural differences including a preference for female doctors, coping with labour, breastfeeding, and differences in the death rites and rituals of infants. Furthermore, the challenge of an "Us and Them" approach by service providers, leading to perceived racist tendencies, was observed. Many of the patient diversity issues discussed in the literature correspond to a list of patient diversity challenges that the Irish health system has experienced and outlined in the HSE's National Intercultural Health Strategy. A sample of these challenges is compiled in a non-exhaustive list in the following figure 2.1.

Figure 2.1 : Sample challenges of patient diversity issues in Irish health care





Adapted from National Intercultural Health Strategy (2007)

* Born unequal: why we need a progressive pre-birth agenda, written by Fabian Society and Louise Bamfield (2007)

These challenges, if unattended, lead to negative consequences on the quality of health care, reduce healthcare outcomes and increase disparities between Irish nationals and non-Irish nationals in the provision of health care in general.

Figure 2.2 : Critical observations in healthcare provision to ethno-culturally diverse patients in Ireland

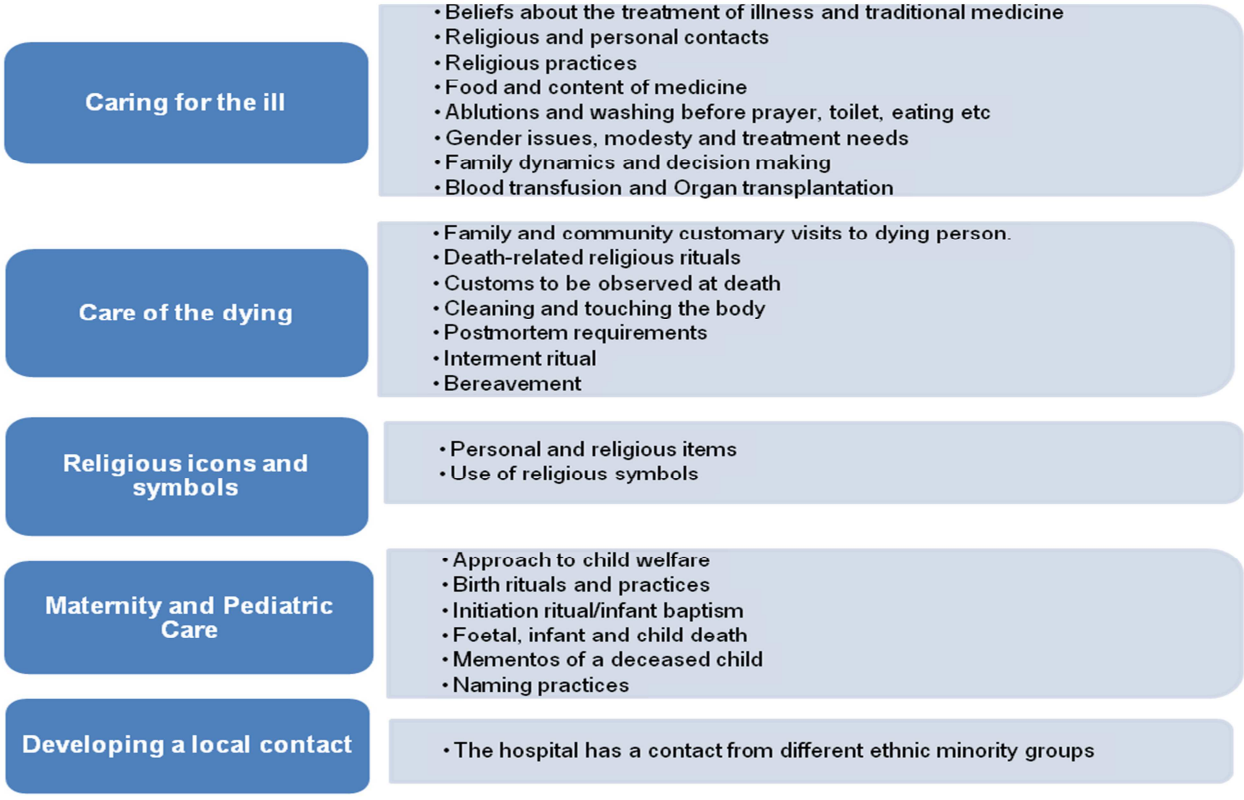


Figure 2.2 was adapted from the HSE's Health Services Intercultural Guide, Responding to the needs of diverse religious communities and cultures in healthcare settings, HSE 2009.

Thus the healthcare service provider needs to be familiar with numerous cultural beliefs, practices, and responses to illnesses that service providers may have. The added challenge for the healthcare professional is to avoid cultural stereotypes and be open-minded and non-judgemental in identifying diagnoses and care plans. Every patient has personal values, perspectives and interpretations of wellness and disease. A lack of familiarity with the diverse patient's unique customs may create barriers to the provision of respectful and appropriate culturally competent health care and lead at best to poor patient satisfaction levels and reduce in some cases, patient safety.

2.2 Cultural competence in health care

2.2.1 Providing appropriate culturally sensitive health care

Having reviewed a variety of challenges relating to service provision to diverse patient populations, we shall now focus on the solutions drawn from the academic literature. An exploration of the literature surrounding the methods and approaches to successfully provide health care and accommodate patients from ethno-culturally diverse backgrounds was undertaken. A key to overcoming these aforementioned challenges lies in the ability of health care institutions to provide culturally competent health care.

A review of the literature focused on culturally competent health care with the view of constructing a best practice or ideal approach for hospitals to deal with ethno-cultural differences in service providers. The literature review focused mainly on the literature in the nursing domain which dates back to the research of Leininger in 1978. This was considered appropriate as nurses represented the majority of the medical practitioners surveyed in the research and the nursing grade/cohort represents the principal body of employees in the frontline of providing health care to ethnic minority service users.

2.2.2 Cultural competence in health care

The concept of cultural competence has been widely studied in health care primarily over the past 30 years. Different disciplines in health care have addressed the concept of cultural competence, for example in the medical discipline (Barzanansky et al., 2000; Saha, Komaromy, Koespell and Bindman 1999), in social work (Patti, 2000; Bonecutter and Gleeson, 1997), in education (Craig Hull Haggart and Perez-Selles, 2000) and in psychology

(Sue and Sue 1999, Sue 1998). All these scholars have examined the concept of cultural competency in their respective healthcare fields.

The concept of cultural competence is often used in medicine, psychology, education and social work as a means to improve service provider, service user relationships and according to Suh (2004) is now a “required characteristic in interactions” between “physician and patient, psychologist and patient, teacher and student, and social worker and care recipient” p94, in the context of ethno-cultural differences in patient populations.

Sue and Sue (1999), Sue and Zane (1987) have acknowledged the role of cultural competence in psychotherapy for effective intercultural communications and relationship building. Green (1982) defines cultural competence in the social work context as “ the ability to conduct professional work in a way that is consistent with the expectations which members of a distinctive culture regard as appropriate among themselves”, p87.

The Association of American Medical Colleges (1998) and Flores (1997), refer to cultural competence as a process that requires both individuals and healthcare systems to have the necessary knowledge, sensitivities and respect for cultural diversity.

2.2.3 Cultural competence at an individual and organisational level

Spector (2004) refers to cultural competence as the ability of healthcare providers and health care organisations to meet the cultural and linguistic needs of service users by having the right knowledge, attributes and skills. According to Walsh (2004) a widely accepted definition of cultural competence in health care is put forward by Cross et al. (1989) as: “Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word “culture” is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic religious or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance

towards the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally-unique needs", p13.

Cross et al's (1989) definition has influenced researchers and has spawned subsequent definitions related to cultural competence in health care. For example, The Office of Minority Health in the USA (2001), define cultural competence as "having the capacity to function effectively as an individual and an organisation within the context of cultural beliefs".

The literature and definitions including Cross's widely cited definition suggests that meeting the challenges of providing culturally competent health care necessitates both individual and institutional changes. Many definitions of cultural competence including Cross's, suggest that there are different systemic levels of cultural competence (The Association American Medical Colleges, 1998; Flores, 1997; Spector, 2004; Cross et al. (1989); The Office of Minority Health, 2001). There seemingly is a need for both culturally competent individuals and organisations. Both systemic levels are important and it can be argued that one compliments the other and are intertwined. Both however have different needs and requirements in order to cultivate a culture of cultural competence in healthcare provision.

Organisational cultural competence or organisations that are considered culturally competent can be defined as those that "require the organisation and their personnel to have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge and adapt to diversity and the cultural contexts of the communities they serve" Goode et al. (2002). Organisations should cultivate the appropriate values and attitudes and put in place the necessary policies and structures to enable employees to work efficiently and effectively from a cross-cultural perspective. Also the organisation should incorporate the ongoing involvement of key stakeholders, including patients and community members.

In defining cultural competence in health care many authors have referred to the need for organisational cultural competence in addition to an individual professional level (Flores, 1997; The Association American Medical Colleges, 1998; Cross et al. (1989); The Office of Minority Health in the USA, 2001 and Spector, 2004).

According to Bhui et al. (2007), “cultural competence at the organisational level must be embedded in the infrastructure and ethos of any service provider”. Organisational values, training and communication, collaborating with the community through religious, spiritual, traditional leaders, or families, individuals and community groups are samples of important domains of organisational cultural competency. Similarly assessment and performance management (Siegal et al., 2003; Kondrat et al., 2002) and available financial resources, and policies are referred to in the literature as organisational support structures (Stork et al., 2001).

2.2.4 Cultural competence in nursing: the individual healthcare provider level

According to Suh (2004) cultural competence began in nursing with Leininger (1978) and her Theory of Cultural Care Diversity and Universality (1985, 1988). According to Burchum (2002), Leininger was the first to have coined the term cultural competence in health care. Leininger used the term cultural congruent care in relation to cultural specific care that is safe and appropriate in nursing care (Leininger, 1985, 1988).

The idea of providing culturally competent health care provision to minority ethnic service users has been the subject of interest and research in all health care areas. Meleis (1996) suggests that a reason for the increased attention for providing culturally competent nursing care is “increasing diversity, increasing disclosure of identities, and increasing inequity in access to health care”, p2. According to Suh (2004) literature focusing on culturally competent nursing care since the late 90s have covered varying nursing practices including institutional care, long and short term care, case management (Remus and Handler, 2001), home health care, (de Savorgnani and Haring, 1999) and provision of formal classes through inclusion of cultural competence on nursing curricula (Reeves 2001).

2.2.5 Definition of cultural competent health care

There are many other definitions of cultural competence in healthcare settings throughout the literature. Leininger (1999), Brach and Fraser (2000), Alexander (2002), Burchum (2002), Frusti, Niesen and Campion (2003) are but some who have contributed to the discourse of cultural competence in healthcare settings.

Leininger (1999) stated that culturally competent care is using specific knowledge about a culture and applying it in a sensitive, creative, and meaningful way when providing care service users from different backgrounds. Purnell and Paulanka (1998) proposed self-awareness, respect and a conscientious thought process as key determinants of cultural competence in health care. The idea of obtaining and learning cultural competence as being a continual journey and not a final destination is portrayed by Andrews and Boyle (1999) who refer to cultural competence in health care as a process and not and an end point. Camphina-Bacote (1999) confirms the idea of process and offers a definition of cultural competence which according to Suh (2004) is the most cited definition of the term in the nursing literature, i.e. “the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community)”, p203.

2.2.6 Critiques of cultural competence in health care

According to St Clair and McKenry (1999), the concept of cultural competence like many concepts implies many different meanings and the scope of understanding is large. Researchers in the nursing literature for example use the term cultural competence interchangeably with terms such as transcultural nursing, cultural congruent nursing care or culturally sensitive nursing care. Certain authors in the medical literature argue that the concept of cultural competence is simplistic and based on the obtainment of a finite body of acknowledge and reductionist in nature (MacDonald, Carnevale and Razack 2007).

2.2.7 Consequences of cultural competence in health care

The consequences and outcomes as a result of cultural competence in healthcare provision are addressed in the research of Suh (2004) and Seright (2007) among others. Suh’s model of cultural competence proposes three categorisations of consequences of cultural competence in the nursing field. These are receiver-based variables, provider-based variables and health-outcome variables.

Receiver based variables are those consequences received by the service user. These include better and more effective care due to the holistic approach to offering care to diverse service users (Philips and Lobar, 1995; Boi, 2000). Also, cultural competence increases the service user’s quality of life (Aday, 1994) and healthcare satisfaction (Rooda, 1993). Also,

service users through cultural competent care have a better perception of service providers (Saha et al., 1999) and have better adherence to prescribed treatments (Ahmann, 1994; St Clair and McKenry, 1999).

Provider-based variables are those aspects that care providers receive or gain as a result of providing cultural competent care. Personal and professional growth, values and nurse related practices (Heuer et al., 1997; Ryan et al., 2000). Also, evidence suggests that nursing students who experienced international dimensions to their nursing education programs had better cognitive development scores, than those students who did not have international experiences (Frisch, 1990).

From a health outcome variables perspective, the quality of the performance of nurses following cultural competent care has been identified by Rooda (1993) and better service provider/ service user relations and treatment effectiveness has been observed by Sue (1998). Moreover, from a business case perspective cultural competence has resulted in cost effectiveness (Remus and Handler, 2001) and there is evidence that cultural competence reduces disparities in health care amongst ethnic groups (Brookins, 1993; Jones et al., 1998).

Seright (2007) refers to the consequences of cultural competent care resulting in improved diagnoses and treatment plans, development of treatment plans that are better followed by the patient and supported by the family, reduction in delays seeking care, better communication, and better compatibility between Western and traditional health practices. In addition, the literature frequently mentions that culturally competent or congruent health care increases safety and quality of healthcare provision. Seright cites the research of Leininger and the work of regulatory agencies in the USA such as The Office of Minority Health and the Joint Commission on Accreditation of Health Care Organisations, as examples of authorities or specialists who link cultural competence to patient safety and quality health care.

Alexander (2002) maintains that in order to manage diversity one must value diversity. Employees at every level within a healthcare organisation regardless of age, sexual orientation, race, ethnic background, or religion have the same fundamental goal to care for the needs of service users. Alexander argues that cultural competence education therefore should be provided to employees at every level of the organisation.

Burchum (2002) similar to Andrews and Boyle (1999) and Camphina-Bacote (1999) refers to cultural competence as an ongoing process that is based on the development of knowledge and skills specific to cultural sensitivity, understanding, interaction and awareness. For nurses, the idea that being culturally competent means that care is individualised and appropriate in regard to the service user's cultural values, beliefs, and practices. Patients are empowered by the service provider's commitment to developing cultural competence. Frusti, Niesen and Campion (2003) stated that diversity competence is "an individuals ability to respect each person's uniqueness", p31.

2.3 Intercultural training and education: the process to intercultural competence for healthcare professionals

Many of the definitions previously referred to regarding cultural competence in health care support the argument (imply) that health professionals need to have education and professional development in cultural competence in order to work effectively with ethno-cultural diverse service users (Leininger, 1999; Purnell and Paulanka, 1998, 2003; Camphina-Bacote, 1999; Alexander, 2002; Burchum, 2002; Frusti, Niesen and Campion, 2003). Models of cultural competence proposed by Papdopoulos et al. (1998) and Campinha-Bacote (1999) suggest that becoming culturally competent is a developmental process that requires certain attitudes and skills to be learned and transmitted over time.

The development of culturally competent knowledge, attitudes and behaviours that are complimented with support from the organisation and health system are deemed necessary in modern health care provision (The Office of Minority Health, 2001). Interventions designed to improve individual professional cultural competence include intercultural training and educational initiatives designed to provide academic knowledge and cultivate the necessary skills in order to apply knowledge and provide health care in a culturally appropriate manner (National Health and Medical Research Council, 2005).

2.3.1 Cultural competence training / intercultural training

Cultural competence training has a critical role in the obtainment of cultural competence skills in health care. Gilbert (2001) undertook a comprehensive research into cultural competence education and training in the USA involving an expert panel and stakeholders throughout the health sector. The publication of this research entitled “Managers Guide to Cultural Competence Education for Healthcare Professionals”, reports that there are two types of training in this domain. There is work force diversity training which is focused on training employees to cultivate better relationships among each other and cultural competence training which focuses on improving the quality of care to diverse service user populations. The aim of cultural competence training is to improve the relationship between the care-giver and the patient and how services are delivered to diverse service users populations.

2.3.2 Benefits of cultural competency training

According to Wright (2008), the positive effects of cultural competency training on care include 6 dimensions consisting of safety, effective care, patient centred care, timely care, efficient and equitable care. Cultural competence can improve patient safety through improved communication and provide effective care by avoiding under-use or over-use of procedures, equipment or services, and resulting in positive outcomes for patients such as satisfaction levels, improved health status, treatment and access. Cultural competence is patient-centred, as it accounts for the patient’s cultural viewpoint towards pain and illness. Furthermore, the proper use of interpreters and translators can improve services and reduce time loss and render services more effective from a time perspective. Care provision can be more efficient through increased productivity and minimal waste of resources and reduce costs in the long run with more efficient overall care. Finally, cultural competence promotes equity in the provision of health care by attempting to provide services that do not differ in quality, according to ethnicity or other diversity characteristics.

Majumdar, Browne, Roberts and Carpio (2004) conducted research in Canada into the effects that cultural sensitivity training had on healthcare providers and service users in community agencies and hospitals. Findings indicated that training resulted in care providers becoming more open-minded, culturally aware and had an improved capacity to communicate with members of ethnic minority groups. Service users who had received care

from trained service providers claimed to have yielded positive health outcomes through better utilization of social resources and an overall improved functional capacity.

2.3.3 Theoretical frameworks for cultural competence training

The overriding goal for cultural competency training is to increase knowledge and awareness, cultivate the appropriate sensitivities and hone the necessary skills. This is accomplished by providing knowledge, exploring attitudes and developing skills (Betancourt, 2003; Seeleman, Suurmond and Stronks, 2009).

Crandall et al. (2003) describe theoretical frameworks to design cultural competence training, course content, and educational experiences to develop knowledge, skills and attitudes. They emphasise the importance of trainers and educators to establish the level of competence appropriate to the development stage of the learner implying an incremental approach to learning.

An incremental or developmental approach (Gilbert 2001) or tiered approach to training allows for trainees to progress in knowledge, skills and attitudes based on the needs of the discipline. Lister's (1999) Taxonomy of Cultural Competence as illustrated in Table 2.4 serves as theoretical justification for a tiered or developmental approach allowing the trainee to progress from one level of competence to the next allowing for appropriate level of training according to the development stage of the learner. This approach is supported by Crandal et al. (2003) and Gilbert (2001).

Table 2.4: Lister's Taxonomy of Cultural Competence

Cultural Awareness:	The staff member is able to describe how beliefs and values are shaped by culture, and those different cultures, subcultures and ethnicities may validate different beliefs and values.
Cultural Knowledge:	The staff member begins to show familiarity with the broad differences similarities and inequalities in experience, beliefs, values and practices within many groupings in society.
Cultural Understanding:	The staff member recognises the problems and issues faced by individuals and groups when their values beliefs and practices are compromised by a dominant culture.

Cultural Sensitivity:	The staff members show regard for an individual client's beliefs, values and practices within a cultural context and show awareness of how their own cultural background may be influencing professional practice.
Cultural Competence:	The staff member provides or facilitates care which respects the values, beliefs and practices of the client, and which addresses disadvantages arising from the client's position in relations to networks of power.

Adapted from Lister (1999), A Taxonomy for Developing Cultural Competence

"Lister's Taxonomy of Cultural Competence model highlights the fact that depending on the amount of contact a staff member has with minority ethnic communities the staff members need for cultural competence will vary. Lister's model serves by illustrating that a tiered approach to training is necessary to respond to the different needs of staff depending on their contact/exposure to ethnic minority communities," Thrive Consulting (2005).

Lister's taxonomy of cultural competence provides a method for planning, learning and training activities that will allow the healthcare provider to understand the importance of the role of culture in healthcare provision.

2.3.4 Critiques of cultural competence

Some authors, MacDonald, Carnevale and Razack (2007) have criticised cultural competence training because culture can be portrayed as a finite body of knowledge, where the learner must try and master the concept. This, according to them, does not reflect the anthropological nature of culture and oversimplifies and minimises difference and perpetuates stereotypes, the checklist approach listing traits and characteristics of specific ethnic groups minimises the complexity and fluidity of cultural identity in heterogeneous populations (Fuller 2002, Taylor 2003).

2.3.5 Methods of cultural competence training in health care

The key elements concerning the structure and components of cultural competence training programmes are summarised in table 2.5.

Table 2.5: Summary of the key elements concerning the structure and components of cultural competence training programmes in health care

- Cultural competence training involves attitude changes including the examining of personal biases and stereotypes as an initial step to acquiring the skills and competencies necessary for quality cross-cultural care.
- There is no "quick fix" in cultural competence training
- Healthcare Managers need to adopt a long term developmental approach to cultural competency training.
- Training should not be seen as one-time only offerings, but as on-going development opportunities that build upon each other.
- Certain training at introduction levels to have mixed healthcare professionals in attendance to encourage exchanges of the importance of cultural competent skills in their reciprocal fields.
- Certain training needs to be focused on specific practices for different disciplines such as pharmacists, physicians, nurses, social workers and educators.
- The need for trainers to be willing to team up with others to focus on specific needs of particular groups.
- The need for management and medical / administrative directors to attend training programmes to contribute with their expertise and to validate and promote the acceptance of the training programme to those being trained.

The structure of training programmes should include:

- Introductionary conference or symposium or workshop with knowledgeable speakers on general topics underlying cultural competence.
- Follow up training to include shorter profession-focused workshops.
- Complementary approaches to include integrating cultural competence training into other educational offerings e.g. diabetes training with reference to ethnic groups.
- Training on how to work with interpreters.
- Training incorporated into staff meetings and lunch time sessions.
- Community leaders from various population groups invited to discuss health care issues facing their represented communities including different beliefs etc.
- Management send healthcare professionals to workshops, symposia, conferences on cultural competence in healthcare.
- Offer 'train the trainer' courses that allow persons to acquire the skills to deliver cultural competence training.
- Offer training that is linked to 3rd level continuing education credits.

Adapted from the Managers Guide to Cultural Competence Education for Health care Professionals prepared for The Californian Endowment, Gilbert (2001).

Additional components or methods available for cultural competence training referred in the literature are role modelling, Kachur and Altshuler (2004), online courses, Kutob, Senf and Harris (2009), reflective journals, Crandall et al. (2003) and problem based learning, Azad et al. (2002).

2.3.6 Organisational support for cultural competence training

Research indicates the importance of organisational support necessary for professional cultural competence. The underlying pinning idea is that managers need to be willing and able to put in place the systems and capabilities to support and reinforce trained healthcare professionals in providing culturally competent care. A critical factor is the health organisations ability to assess the size and characteristics of its ethnic populations. This involves identifying and collecting data concerning race, ethnicity, language, national origin, among others. This information can feed back into meeting the needs of the healthcare professional and avoid misperceptions between administration staff who are not in day-to -day contact with populations, and the frontline care provider, who is. The kinds of cultural competence training and the provision of interpretation and translation services are reliant on accurate and appropriate data collection. Incorporating cultural competence into service delivery policies and practices throughout the organisation are a developmental process that cannot be implemented in a short time (Gilbert, 2001).

Comprehensive cultural competence training is a key driver for service providers to obtain the cross-cultural skills required to meet the needs of providing appropriate health care to diverse patient populations. However, the academic literature suggests that training and skills building are insufficient if the results are not complemented by organisation wide development initiatives and broader system changes.

2.4 Organisational involvement, systems and policy changes to manage ethno-cultural differences

The following section examines the importance and necessity of complementary organisational wide development initiatives including system and policy changes required to provide culturally competent healthcare delivery.

2.4.1 Organisation wide approaches, systems and policy changes

The idea of an “organisation wide approach” consisting of intercultural training programmes at an individual level and policy and system changes at an organisational level to meet the needs of providing culturally appropriate health care can be supported by an examination of the literature. The literature suggests that training and skills building are insufficient if the results are not complemented by hospital wide development initiatives and broader system and policy changes in areas such as recruitment, interpretation or support systems for employees. Various authors associated with health care such as LaVeist et al. (2008) who refers to the research of Anderson et al. (2003), Betancourt et al. (2005) and Hayes-Bautista (2003) in stating that “some have argued that while training individuals and assessing their progress in the principles of cross-cultural communication and interaction is beneficial, it may be more efficient and effective to foster an “organisation-wide” culture that is accepting of, supportive of, and prepared to adjust to the changing demands of the increasingly diverse patient population”.

Earlier healthcare authors such as Louie (1996) refer to the idea that cultural development in healthcare requires individual as well as institutional change and hence is a challenging process. Brach and Fraser (2000) defined cultural competency as an “ongoing commitment or institutionalisation of appropriate practice and policies for diverse populations”. They argue that clinicians (physicians, nurses and other health professionals) will only become culturally competent with the support of the health systems in which they participate. They provide 9 techniques gathered from the literature, which they propose will make health systems including practitioners more culturally competent and better able to deliver appropriate health services to diverse populations. These are interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, the inclusion of family/community members, immersion into another culture, and administrative and organisational accommodations.

Weech-Maldonado et al. (2002) maintained that healthcare organisations (HCOs) will need to become culturally competent organisations to respond to the demographic shifts of the workforce and patient population and address racial/ethnic disparities. They conducted a survey of 234 hospitals in Pennsylvania to assess how hospitals were managing racial and ethnic diversity and progressing towards cultural competency. The study shows that HCOs are implementing a wide range of approaches across the organisations beyond training.

Their research indicated four areas that merited special attention and which illustrate a systems wide approach:

1. Establishing diversity training programmes for clinical and staff personnel
2. Instituting human resources practices aimed at the recruitment and retention of minorities at all levels
3. Using structural mechanisms such as task force or equality improvement committee to monitor the racial/ethnic diversity climate
4. Implementing control systems that reward management and clinicians for meeting diversity goals

Betancourt et al. (2003) describe a framework for cultural competence in health care that supports an organisation wide approach by suggesting that HCOs have to approach cultural competence from three vantage points namely clinical, structural and organisational cultural competences. Clinical, referring to the need for cross-cultural training to equip health providers with tools and skills to provide cultural competent service to service users. Structural competence refers to the structures in the healthcare system that provide access to quality care to all patients and include services such as interpretation services and translated health literature and signage etc. Organisational competence refers to leadership and workforce initiatives such as recruitment that ensure representation of patient population. La Viest et al. (2008) supports the idea of Betancourt et al. (2003) by arguing that healthcare leaders must be committed to cultural competency by implementing strategies at the organisational, structural and clinical levels.

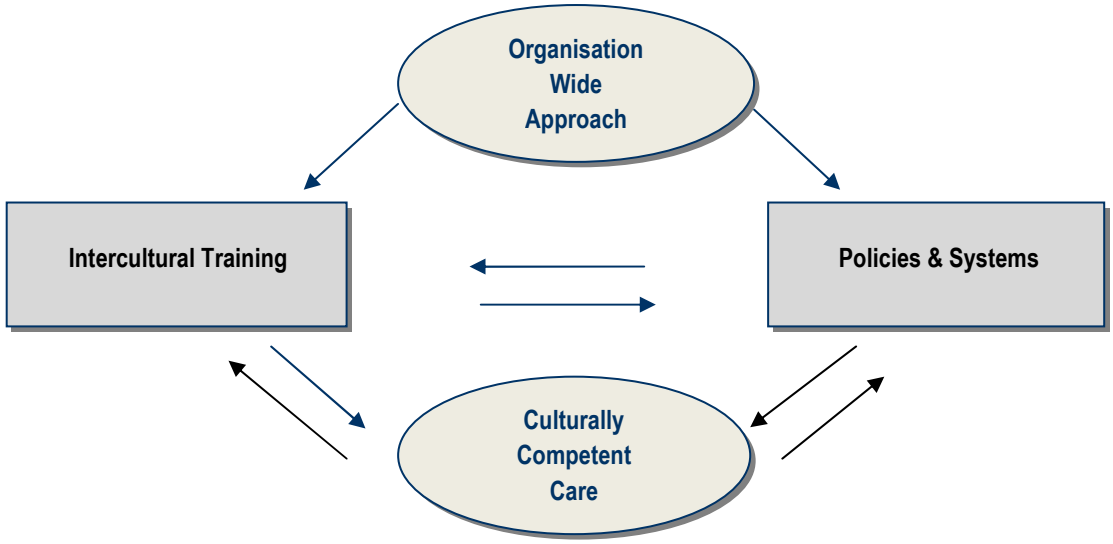
According to the HSE publication *Learning, training and development needs of Health services staff in delivering services to members of minority ethnic communities*, “education, awareness raising and training are without doubt key ingredients in developing a culturally appropriate health service. However, research clearly indicates that training will only be useful and effective when supplemented by other learning and development issues as well as relevant systems changes” Thrive Consulting (2005), p33. It is noteworthy that international practices in other health systems in Europe and North America confirm this view and demonstrate that organisation wide approaches are a common method in developing culturally appropriate health services and will be discussed later in this chapter.

Hobby (2006) argues that all areas of the healthcare organisation should be adapted to incorporate practices that promote and accommodate inclusion. This involves providing services that are modified to meet the needs of changing demographics of service users. Hospital services at every level of the organisation ranging from the registration functions, to patient recovery services, and encompassing all clinical and administrative services need to be provided in a manner free of bias of any nature. Hobby maintains that HCOs need the necessary authority and resources to execute the necessary plans to bring about the type of organisational change, that results in a culturally competent healthcare delivery systems.

In addition, a study of 60 healthcare organisations in the USA by Wilson-Stronks et al. (2008) explored best practices for addressing patient diversity issues and suggested key organisation areas, such as leadership, quality improvement and data use, workforce implications, patient safety and provision of care, language services and community engagement to be focused on, thus supporting an organisation wide approach to managing patient diversity.

Thus a review of the academic literature supports the concept of an organisation wide approach to providing appropriate health care to vulnerable populations including ethnic minorities. Figure 2.3 illustrates the process required by hospitals to provide culturally competent health care. This involves an organisation wide approach consisting of intercultural training at individual levels and policies and system initiatives at an organisation level.

Figure 2.3: (Process) An Organisation Wide Approach



2.4.2 Theoretical models of cultural competence at an individual level

There are many frameworks and models that assist in evaluating and developing individual or clinical professional cultural competences in varying discipline areas of patient care delivery. Such models aid individual healthcare service providers to understand the complex intertwined characteristics and concepts of culture and how it relates to the provision of culturally competent health care. The most cited models in the academic literature include Leininger's "Theory of Cultural Care Diversity and Universality" (1978, 1985, 1988), "The Transcultural Assessment Model" offered by Giger and Davidhizar (1995), Papadopoulos, Tilki, and Taylor's "Model of Developing Cultural Competence" (1998), "The Process of Cultural Competency in the Delivery of Healthcare Services" from Campinha-Bacote (1999, 2003), "The Continuum of Intercultural Sensitivity" offered by Louie (1996) and "The Cultural Sophistication Framework" offered by Orlandi (1992). The scope of this thesis is focused more on organisation level approaches and prohibits an in-depth comparison of these individual level models.

2.4.3 Theoretical models of cultural competence at an organisational level

There are fewer cultural competency models focusing on organisational cultural competence models. Two such models provide theoretical frameworks by which an organisation can position itself along a continuum of cultural competency. These frameworks serve to indicate if the service provider, either organisational or individual is addressing the challenges of providing appropriate healthcare service delivery to ethnic minorities. The two frameworks include Cross et al. (1989) who proposes a Cultural Competence Continuum and Wells (2000) who offers a Cultural Development Model.

2.4.3.1 Cross et al.'s Cultural Competence Continuum

Cross et al. (1989) proposes a Cultural Competence Continuum (see Figure 2.4), which examines cultural competency as a continual process and serves organisations by allowing them to better position themselves along a continuum regarding cultural competence.

Figure 2.4 : Cross's Cultural Competence Continuum

1. Organisations that are culturally destructive, i.e. attitudes, policies and practices, which are not adapted and discriminate.
2. Organisations are culturally incapacitated and the functioning of such organisations is fundamentally biased, with belief in the superiority of the dominant group and assumes a paternal posture towards lesser groups.
3. Organisations that persist in believing that the system works the same for everyone and ignore the relevance of cultural diversity and are identified as being culturally blind.
4. Cultural pre-competence is evident in organisations that recognise that they have weaknesses in the services they deliver to some communities and make attempts to improve.
5. Organisations that respect differences, continually improve and adapt their diversity policies and training, seek feedback from their diverse client base and ensure that employees from the communities they serve are represented throughout all staffing levels are culturally competent.
6. Cultural proficiency is embedded in expansive organisations that embrace culturally based research and therapeutic approaches, recruit staff, which are specialists in culturally competent practices and advocate for cultural diversity throughout the health care system.

Adapted from: Cross, T, L et al (1989) Towards a Culturally Competent System of care (Vol. 1)

The Cross et al. (1989) model postulates a process or continuum whereby healthcare organisations and institutions can progress from a culturally destructive phase to an attainment of cultural proficiency. The model serves healthcare organisations by allowing management to assess the functioning of the organisation in relation to provision of culturally appropriate care and to subsequently position the healthcare setting along a continuum ranging from culturally destructive to culturally proficient.

2.4.3.2 Cultural Development Model

Well's (2000) Cultural Development Model as illustrated in Figure 2.5, proposes a continuum whereby change occurs as healthcare professionals and their institutions progress from cognitive through affective phase.

Figure 2.5: The Cultural Development Model

A 6-stage continuum for individuals and institutions

Cognitive Phase: Consists of 3 stages, cultural incompetence, cultural knowledge and cultural awareness. During this phase the emphasis is on learning and acquiring knowledge about culture and its manifestations.

Affective Phase: Consists of 3 stages. Cultural sensitivity, cultural competence, and cultural proficiency during this phase the goal is attitudinal and behavioural change through the application of the knowledge acquired in the cognitive phase. This requires actual experience working with members of diverse groups. Progression through these stages requires more of an investment and commitment to cultural diversity by health professionals and institutions.

Source: Wells (2000) Beyond Cultural Competence: A Model for Individual and Institutional Cultural Development, Journal of Community Health Nursing 2000, 17(4), 189-199.

Well's model has similarities to Cross et al's. (1989) in that it consists of a continuum consisting of 6 component stages that healthcare management can, after internal assessment, position their organisation along the continuum ranging from cultural incompetence to cultural proficiency. Wells however divides his continuum into two phases entitled cognitive and affective phase, the former emphasizing the acquiring of relevant knowledge and the latter emphasizing subsequent behavioural change toward delivering culturally competent healthcare.

It is noteworthy that many authors define cultural competence as a continuum whereby professionals and institutions progress which implies the need to evaluate progress continually. The overriding goal for hospitals in the context of patient diversity is to provide culturally competent health care which improves health outcomes, quality of care and reduce ethnic health disparities. The principle solutions to move healthcare settings towards this objective are twofold. Firstly, they involve cultural competency skills obtainment at an

individual level through the use of intercultural education programmes. Secondly, in addition to intercultural education, that cultural competency is obtained at an organisational level through policy and system changes by applying organisation wide frameworks.

2.5 Diversity management: the process to cultural competence in HCOs

The academic literature confirms that any objective to obtain organisational cultural competence involves training healthcare professionals at an individual level and implementing changes in systems and policies at an organisation wide level. The ultimate goal is to have culturally competent individual healthcare professionals and healthcare organisations in order to provide culturally competent health care. The organisation wide process required for healthcare organisations to achieve this objective lies within the field of diversity management.

This idea is supported by diversity scholars such as Svehla, as early as 1994, who is cited in Hunt (2007), states “while cultural competence is the goal, diversity management is the process leading to culturally competent organisations. Diversity management is ‘a strategically driven process’ whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations”.

The relationship between diversity management and the human resource function in order to improve organisational performance in the context of cultural competence cannot be overstated. Weech-Maldonado et al. (2002) maintained that in order to manage diversity effectively, HCOs will need to engage human resources and healthcare delivery practices aimed at recruiting, retaining and managing a more diverse workforce and developing culturally appropriate systems of care. They argue that the ultimate goal of managing diversity is to enhance workforce and customer satisfaction and to ameliorate communication between members of the workforce so as to further improve organisational performance.

This argument supports Cox (1994) and Dreachslin (1996) who previously argued that diversity management and leadership practices enhance workforce and customer satisfaction, and improve communication among members of the workforce, and further improve organisational performance. Dreachslin (1999) defined diversity leadership as being

“responsive to demographic shifts and changing social attitudes among both the patients and the workforce”.

2.5.1 The definition of diversity management

There are many definitions of diversity management in the literature. The definition offered by Kandola and Fullerton (1994) from the UK, who base their definition on a survey of 450 organisations in the UK and Ireland states: “the basic concept of managing diversity accepts that the workforce consists of a diverse population of people. The diversity consists of visible and non-visible differences which will include factors such as sex, age, background, race, disability, personality and work style. It is founded on the premise that harnessing these differences will create a productive environment in which everybody feels valued, where their talents are being fully utilised and in which organisational goals are met.”

According to Lorbiecki and Jack (2000), it is thanks to the research and practitioner background of Kandola and Fullerton that has allowed them to have “played a seminal role in shaping the British version of diversity management” p19. Given that this research project is set in Ireland and the fact that Kandola and Fullerton are widely cited in the Irish and English literature, their definition is particularly relevant.

Many definitions originate from the USA and one such definition proposed by Arredondo (1996) was selected as a representative US definition of diversity management by Lorbiecki and Jack (2000) in their research regarding the evolution of diversity management.

“Diversity management refers to the strategic organisational approach to workforce diversity development, organisational culture change, and the empowerment of the workforce. It represents a shift away from the activities and assumptions defined by affirmative action to management practices that are inclusive, reflecting the workforce diversity and its potential. Ideally, it is a pragmatic approach, in which participants anticipate and plan for change, do not fear human differences or perceive them as a threat, and view the workplace as a forum for individual’s growth and change in skills and performance with direct cost benefits to the organisation”, Arredondo (1996) p7.

In analysing the two definitions both suggest that proper management of diversity will lead to the attainment of organisational goals and higher productivity due to the valuing and empowering of employees and cultivating a readiness for change. Arredondo’s definition

suggests that diversity management is more strategically based, and indicates the North American view that diversity management is embedded in corporate strategy. Also, the reference to affirmative action indicates the contextual differences in the US and UK legal environments.

It is evident that while diversity management tends to focus on workforce diversity initiatives and inputs, a targeted output is to improve organisational performance which in the case of hospital management, is directly associated with providing quality appropriate healthcare delivery to all members of the community. There are 3 categories of diversity management with regard to performance and strategy. These are structural or functional diversity, business diversity and workforce diversity, (DeLucca and McDowell, 1992; Gentile, 1996). Structural or functional diversity relates to organisational functions such as administrative or operations. Business diversity refers to markets, products and services while workforce diversity involves the different types of employees.

Diversity management can be summarised as a means to encourage individual employees to use their own inherent values and beliefs to guide their decision-making and problem solving and not be coerced into fitting into the values and beliefs of the majority (McMillan-Capehart, 2006; Thomas and Ely, 1996).

2.5.2 History of diversity management

The emergence of diversity as a research field started in the 1990s as a result of the challenges of managing the diverse demographic changes in the workforce (Nkomo and Cox, 1996). Much of the early literature focused on different socio-demographic traits such as race and ethnicity and their impact on performance outcomes such as innovation, quality, problem-solving (Milliken and Martins, 1996; Williams and O'Reilly, 1998). Also, issues of discrimination such as wage discrimination, glass-ceilings, segregation or exclusion were addressed by authors such as Cox and Nkomo (1990) and Ibarra (1995).

However it is interesting to note that the term diversity management emerged in the 1980s in the USA after the Hudson Institute published a report entitled, "Workplace 2000", Johnson and Packer (1987). The report indicated the changing nature of the American population and concluded that the white male would become a minority group status, overtaken by a majority of workers who were African American, Hispanic, Native American women and other minority groups. This focused the minds of academics and business people on demographic

changes and their effects on organisations notably in management of human resources (Kandola and Fullerton, 1998). Interest in diversity management was based on demographic changes, and statistical breakdowns of changing demographics was the trend (Hammond and Kleiner 1992). Lorbiecki and Jack (2000) highlighted 4 turning points or evolutions in the idea of diversity management starting with this demographic interest, progressing to a political, then economical and finally, a critical interest.

2.5.2.1 Political interest

The term diversity became mainstream as its inclusive philosophy included “men and women of all ages, from all races, classes, occupations, religious groups, regardless of physical ability and sexual orientation” Lorbiecki and Jack (2000) p20. This according to Lorbiecki and Jack (2000) offered an alternative to affirmative action policies in the USA that were not always well received and aligned better with the ‘political correctness’ lobbies and bridged the gap between left and right wing politics in the 90’s. Also, authors such as Lowery (1995) maintain that diversity was easier to digest in corporate America than affirmative action.

2.5.2.2 Economical interest

The interest in diversity management became predominantly economic when academics and practitioners warned companies that failure to manage diversity in the context of a global market would render their companies at risk. The idea that a firm’s bottom line could be influenced by its ability to manage diversity came to the fore through authors such as Scully (1994), McNerney (1994), Cox and Blake (1991), Ross and Schneider (1992), Kandola and Fullerton (1994). The emergence of the business case for diversity management was born and Segal (1997) and Owens (1997) began writing about turning diversity into an economic concern. There followed an emergence of practitioners in the field of diversity consulting and diversity frameworks such as the MOSAIC, Kandola and Fullerton (1998) or Gardenswartz and Rowe’s (1998), 7 steps for capitalizing on diversity helped organisations to make diversity “do-able” in the words of Prasad and Mills (1997).

2.5.2.3 Critical interest

Lorbiecki and Jack (2000) maintain that the diversity management literature became more critical when diversity management programs started to be implemented in organisations and were perceived as not delivering on equality in the workplace. Academics and practitioners alike began criticising various aspects of the diversity management tenets. These according to Lorbiecki and Jack (2000) include issues relating to the meaning of diversity, Cox (1994), Blommaert and Verschueren (1998), morale and productivity, Thomas and Ely (1996,)

litigation consequences, Lubove (1997), damage to company reputations, Overmyer-Day (1995), and promotion of stereotypes D'Souza (1997), and finally equality, Parekh (1997), Liff and Wajcman (1996).

Approaches to diversity management have progressed in those countries where management has viewed workplace diversity as an important business concern. Initial responses included affirmative action and equal employment opportunity policies in the USA and Europe. Affirmative action requiring employers to target increases in the utilisation of under-represented groups, and equal opportunity which reduced discriminatory practices and policies in workplaces. Progressively, workplaces started to "value diversity" more and more by introducing awareness training programmes and celebrating cultures and ethnicities such as Black History month in the USA (Ospina 1996).

2.5.3 Diversity and human resource management strategy

Modern contemporary workplaces have advanced diversity management initiatives and have linked diversity to organisational strategy. In this regard, diversity management fits into the human resource management strategy in organisations. The management of diversity is seen as a principle of management used to make HR decisions to promote inclusion, (Gilbert et al., 1999). Thompson (1998) refers to "the concept of 'managing diversity' as one that has grown out of HRM and is also a movement away from traditional equal opportunities, policies and practices. It is premised on recognition of diversity and differences as positive attributes of an organisation, rather than as problems to be solved", p195.

2.5.4 Evolution from equal opportunity and affirmative action to managing diversity

The evolution of the management of diversity can be explained best in the American context where the concept originated. Equal Employment opportunity (EEO) requirements emanated from the American Civil rights movement in the 60s in the USA with the landmark legislation being introduced through the Civil Rights Act of 1964. This was followed by Affirmative Action (AA) initiatives and legislation in 1965, requiring employers to increase the representation of minorities in their organisations. As stated it was not until the 1980s that the term diversity began to be used but it was used interchangeably with affirmative action and EEO and was associated with a compliance mentality. As previously mentioned, the landmark study Workforce 2000 published in 1987, focused corporate America's mindset on ethnic diversity in the workplace in the context of globalization and technological change and resulted in a

paradigm shift in thinking from compliance to legislation outlook, to an assimilation of women and ethnic minorities into homogeneous cultures. This assimilation approach reflected the "melting pot" metaphor suggesting that everyone is treated the same, and inferred equal opportunity and aimed at increasing conformity while in actual fact it did the contrary, by not appreciating individual differences. The idea of a "tossed salad" began to emerge where individuals from different cultures were appreciated for who they were.

Today the EEO and AA have significantly moved on to the idea of managing diversity. This new paradigm of managing diversity began to take the place of equal opportunities and represented a shift away from the equal opportunities paradigm (Wilson and Iles, 1999). The management of diversity has developed in the British and Irish context since the early 90s (Kandola and Fullerton, 1994).

2.5.5 Differences between EEO and managing diversity

Ross and Schneider (1992) in analysing this shift propose the following position in the discussion. "instead of looking at (equal opportunities) as something that is imposed from the outside, by for example legislation, employers will find competitive advantage in encouraging diversity at work", p49. Ross and Schneider (1992) introduced 5 principles that they claim indicate the shift from equal opportunities to diversity management as:

- Internally driven, not externally imposed
- Focused on individuals not groups
- Concerned with diversity rather than equality
- Address the total culture, not just the systems
- The responsibility of all, not just the personnel

Managing diversity is the ability for the manager to manage people who are different, and who have different aspirations, and being skilful enough to harness the different perspectives and views to increase the quality of decision making. Kandola and Fullerton (1998) propose that the difference between managing diversity and managing equal opportunities is that the former is about recognising the advantages that differences in employees can bring, and the latter is concerned with legislating against discrimination. Table 2.6 summarises the key differences between equal opportunity (EO) and diversity as proposed by Kandola and Fullerton (1998).

Table 2.6: Differences between equal opportunity and diversity

Equal Opportunity	Diversity
Externally initiated	Internally initiated
Legally driven	Business needs driven
Quantitative focus (improving the numbers)	Qualitative focus (improving the environment)
Problem focused	Opportunity focused
Assumes assimilation	Assumes pluralism
Reactive	Proactive
Race, gender, disability	All differences

Adapted from Kandola and Fullerton (1998) p13

Wilson and Iles (1996) identified 5 main differences between EO and Managing Diversity (MD) and proposed the following paradigmatic models referring to EO as the old paradigm and MD as the new paradigm. Table 2.7 below illustrates a summary of the differences in the two paradigms.

Table 2.7: Difference between the old paradigm of EO and the new paradigm of MD

Equal opportunities- The old paradigm	Managing Diversity- the new paradigm
Externally driven: Rests on moral and legal arguments Perceives EO as a cost	***Internally driven:*** Rests on business case Perceives MD as investment
Operational: Concerned with process Rational organisation model Externally imposed on managers	***Strategic:*** Concerned with outcomes Internalised by managers and employees Systematic understanding Appreciation of organisational culture
Difference perceived as other/problematic: Deficit model Ethnocentric, heterosexist Assimilation advocated Discrimination focus Harassment seen as individual issue	***Difference perceived as asset/richness:*** Model of plenty Celebrates difference Mainstream adaptation advocated Development focus Harassment seen as organisational climate issue
Group focused: Group initiatives Family friendly policies	***Individual focused:*** Universal initiatives Individual development Employee friendly policies/cafeteria benefits
Supported by narrow positivist knowledge base	***Supported by wider pluralistic knowledge base***

Adapted from Wilson and Iles (1996)

Wilson and Iles (1999) examine these five areas of difference between equal opportunities and managing diversity in the context of public sector management in the UK with specific focus on the National Health Service (NHS).

2.5.6 Differences in managing diversity in the private and public sector

The management of diversity can be differentiated depending on if the organisation operates in the public or private sector. For example with regard to drivers of change from EO to MD, Wilson and Iles argue that MD originated in the private sector and that there are differences in the extent to which the "business case" argument for MD can be applied in the public sector. They propose that despite MD arguments to recruit, retain and promote diverse employees is a persuasive idea, their research findings in the NHS showed that white males still occupied the majority of senior and top positions. Also, they consider marketing as a key element of the business case argument, and maintain that marketing in the public sector is not the same as the private sector, as customers are more multiple, involving service users, carers, relatives and other professionals. In addition, service users may have no choice and be unwilling in areas such as child protection or criminal justice. Also some services are oversubscribed and hence there is a need for de-marketing. Wilson and Iles also contest the business case argument concerning better decision making and improved creativity and refer to their previous research Wilson and Iles (1996), which questions the validity of these arguments. They maintain that the recruitment of women and ethnic service providers has taken place in the lower grades but not in the higher grades where predominantly white men were making the strategic decisions. A final argument in relation to the business case with regard to public services concerns the over emphasis of the business case as the main motivation for diversity which according to Wilson and IIes (1999) implies "neglect of other justifications" such as those which are moral, ethical and political, p34.

2.5.7 Drivers leading to management of diversity as an organisational imperative

Workplace diversity has become a central issue of HR management in organisations in the 21st century and this has resulted in significant growth in diversity management literature in the last two decades, indicating the importance of the concept. It is relevant to explore the drivers that have led to the growing importance of diversity and how it has developed into an organisational imperative.

The main drivers for linking diversity management to management and organisational objectives at a strategic level are based on the concept of maximising the communicative and cultural skills of employees so as to maximise performance through improved policies, products and customer satisfaction (Rodriguez 2006).

Generally speaking, drivers of diversity in the private sector include changing demographics, the knowledge economy and compliance to legal requirements. In the public sector motivations stemming from internal and external pressures have led to diversity being a kernel interest for management. These include external forces such as legal and regulation pressures, demographic labour changes, and diversifying client or service user bases and may even include social pressure from groups campaigning for specific interests such as representation of certain groups in the workforce or changes in the way products and services are delivered (Ospina, 2001). Globalisation and the knowledge economy and service society have driven organisations to focus on diversity as a performance requirement.

Internal pressures from employees regarding their rights, or perceived unfair practices or discrimination can lead to management addressing diversity initiatives. Negative outcomes including absenteeism, conflict, high turnover rates, lower productivity are just some of the issues that can stimulate or pressurise management from within the organisation to instigate diversity management programs. The existence of a linchpin or a leader or manager who champions employee fairness and well-being in the workplace can motivate organisations to undertake diversity initiatives (Gentile, 1996).

2.5.8 Benefits of managing diversity in the business context

There are direct and indirect benefits of managing diversity. In a business context these benefits can be grouped into three broad areas namely market share, employee relations and organisation responsiveness.

2.5.8.1 Market share

Branding and reputation are important elements to attract customers and obtain market share. Organisations that harness diverse human capital will be more responsive to changing markets and to existing and prospective customers (Monks, 2007). Commitment to diversity can lead to organisations being more attractive to investors as an organisation's commitment to diversity is being factored into return on investment calculations, as integrated workplaces

are more cost efficient and perform better (Johnson and Greening, 1999). Also, companies that cultivate diversity friendly environments will favour retention of existing valued employees and will portray a positive corporate image for recruitment purposes. This is particularly important in the tight labour markets where organisations are competing to attract appropriately skilled labour and talent. Also, by recruiting and retaining staff that reflect diversity of the service user or customer, organisations are positioning themselves to have a greater appreciation of customer needs and produce ideas and enhance market knowledge.

2.5.8.2 Employee relations

Diversity management can lead to improved employee relations resulting in lower absenteeism, stress and dissatisfaction (Monks, 2007) and also, reduce labour costs and disruptions to work. Organisations that introduce family friendly or work-life balance policies, part-time work or flexible work scheduling, or career breaks are promoting flexibility and catering to the diversity in the organisation.

Such flexible approaches accommodate diversity and can, according to a study by Cox and Blake (1991) lead to significant decreases in short and long term absences. The well-being of staff and morale improves as employees feel that their individual talents and skills are more valued and appreciated (O'Connell and Russell, 2005). This in turn has indirect benefits through increased loyalty, stronger commitment, better performance and improved productivity (Flood et al., 2008) and, renders the organisation more appealing to future investors and collaborators. Equally, there are fewer resources wasted on employee turnover, grievances and litigation costs (Mercer, 1988).

Evidence suggests that the likelihood of litigation is reduced in organisations that have diversity management initiatives (Segal, 1997). There is evidence that employees who believe that they are valued in the workplace have higher attendance, commitment and job performance rates (Eisenberger, Falso and Davos, 1990). Such organisations are more aware of diversity issues with their employees and customers and are more equipped to proactively deal and anticipate problems.

2.5.8.3 Organisation responsiveness

Success today depends more and more on the organisation's ability to introduce innovative products and services to the marketplace. The importance of having different perspectives and experiences to produce new ideas, flexibility and creativity and team effectiveness in the workplace has been addressed by authors such as Monks (2007) and Adler (1991). By

reducing conformity of thinking and enhancing choices and options, organisations can improve their decision making and problem solving capacities, and overall performance. Cox et al (1991) determined that ideas formulated from heterogeneous groups were of higher quality than homogenous groups.

There is evidence that ethnicity, age and gender diversity on boards of directors had positive effects on the bottom-line results, return on investment, return on assets and return to shareholders (Monks 2007). Diversity at the top levels of management can be linked to better profits than those organisations that have no diversity (Adler 2001). Thus management of diversity offers organisations the opportunity to meet legal and social obligations and maximise the return on their human capital by tapping into the full potential of the workforce.

2.5.9 The business case for managing diversity

Lorbiecki and Jack (2000) summarized the main arguments for the business case of diversity management based on practitioner literature. They argue that the economic rationale dominated the literature and became centrepiece in the discourse for the business case. The business case or economic rationale for diversity led to diversity management being incorporated into human resource practices and becoming more programmable. The following table 2.8 contrasts the economic rationale to the moral rationale as justification for the business case to managing diversity.

Table 2.8: Diversity management as a business case

Economic rationale	Moral rationale
Improves productivity (Gordon, 1992; D'Souza, 1997; Owens, 1997), it encourages more innovative solutions to problems (Rice, 1994) and thus profits (Segal, 1997).	Promotes interaction between ethnic groups (D'Souza, 1997)
Assists the understanding of a greater number of customer needs (Rice, 1994; Thibadoux et al., 1994; Capowski, 1996) thus increasing the customer base and turnover (Segal, 1997).	Helps foster culture change in the organisation (Thornburg, 1994; Owens 1997).
Enhances corporate competitiveness (McCune, 1996; Capowski, 1996) and continued survival, (Miller, 1994).	Fosters attitude adjustment (Thornburg, 1994) and thus counters prejudice (Smith, 1991)
Helps lower the likelihood of litigation (Segal, 1997)	Can increase attitudinal commitment, particularly amongst women for example (Harris, 1995; Dodd-McCue).
	Creates organisational harmony (Rossett and Bickham, 1994), is socially just and morally desirable (Carnevale and Stone,1994; Rossett and Bickham, 1994).

Adapted from Lorbiecki and Jack (2000)

The academic literature concerning the benefits of diversity in organisations align with those illustrated in table 2.8 above and those previously mentioned. Researchers such as Early and Mosakowski (2000), Ely and Thomas (2001), Polzer, Milton and Swann (2002), Swann, Kwan, Polzer and Milton (2003), Watson, Kumar and Michaelsen (1993) have all published findings showing the benefits of diversity with regard to increased creativity, productivity and quality and view diversity as a resource (Stevens et al., 2008). The idea of leveraging diversity and organisational change to improve individual and organisational performance has been documented by researchers such as Brief (2008), Early and Mosakowski (2000) and Williams and O'Reilly (1998). Managing demographic diversity through organisational change in order to create competitive advantage has been studied by Richard (2000), Wright, Ferris, Hiller and Kroll (1995).

Kandola and Fullerton (1998) reviewed the literature at the time and summarised the benefits of managing diversity by classifying them into three categories. Proven benefits, debateable benefits and indirect benefits. Proven benefits included the recruitment of quality employees, organisational cultures conducive to maximising employee potential, flexible working arrangements, higher employee motivation levels, employees feeling more valued and appreciated and more reluctant to leave the organisation. Debatable benefits referring to the concept of employees giving their best at work, employees being more connected to customers, better customer service, improved innovation, creativity and solving of problems and increased quality. Indirect benefits consisted of a better public image, more satisfying work environment, better staff relations, improved staff morale and individual job satisfaction, increase of productivity and a competitive edge.

Kandola and Fullerton criticise these benefits by claiming that only the proven benefits have the necessary evidence to be supported, arguing that the debatable benefits are based on ambiguous data emanating from team research, and evidence supporting indirect benefits is impossible to collect. They proclaim that more benefits should not be overstated until solid evidence is established.

2.5.9.1 Benefits of diversity management for the public sector

While many of the benefits of managing diversity from the business context can apply to the management of hospitals in the public sector, there are however differences in motives. It can be argued that the major motive for implementing diversity management policies in the private sector is to maximise economic gain and in the public sector is to maximise economic efficiency. Ospina (1996) addresses the potential benefits of addressing diversity

management in the public sector context. She classifies the benefits into ethical, legal, public policy, human resource management and organisational gains. A brief description of each is outlined accordingly.

- Ethical: diversity promotes fairness and justice, economic opportunity and reduces social inequality in the workplace.
- Legal and public policy: diversity promotes greater compliance with HR legal requirements, increased representation and responsiveness in bureaucracy, increased grassroots support for agency programmes and policies.
- HR management benefits include increased competitiveness in recruiting and retention due to better reputation and offering flexible approaches to work.
- Organisational benefits: consist of greater ability to address change, better flexibility in organisational design, decreased discrimination and litigation, increased internal capabilities and enhanced reputation and higher effectiveness.

2.5.9.2 Benefits of diversity management in health care

Diversity strategies can serve healthcare organisations like other public sector institutions by rendering their management and service provision more efficient and effective and increasing public confidence by meeting the needs of changing societies.

Gathers (2003) in his article entitled “Diversity Management: An Imperative for Healthcare Organisations”, outlines the specific benefits for healthcare organisations to implement diversity management strategies as the following:

- Foster better morale, Esty, Griffen and Hirsch (1995)
- Promote heightened creativity
- Improve decision making
- Accomplish social justice

Research carried out by the National Institute of Healthcare (2001) indicated that patients benefit when they are working with diverse professionals who they can better identify with. Gathers states that “diverse groups of employees also bring new outlooks to organisations that affect service delivery and generate productive dialogue”, p15.

Ivancevich and Gilbert (2000) in the public service context, warn of the dangers of defining diversity from a narrow perspective such as gender or skin colour, as it can lead to

incomplete diversity management and inadequate organisational transformation. They propose a definition based on a broader context namely “the commitment on the part of organisations to recruit, retain, reward and promote a heterogeneous mix of productive, motivated, and committed workers including people of colour, whites, females and the physically challenged”, p77.

2.5.9.3 Costs of diversity management

Ospina (1996a) argues that the stakes are high in managing diversity in the public service sector and considers it a requirement to effective management. She maintains that diversity unmanaged can lead to problems such as quality employees exiting the organisation, increased costs in replacing them, low morale, increased conflict, poor organisational reputation as a place to work, legal and punitive costs and diversion of financial and human resources in legal processes.

2.5.10 Critiques of diversity management

Much of the literature has defined diversity in terms of socio-demographic characteristics since the emergence of the subject in the 1990s (Janssens and Zanoni, 2005). Researchers such as Litvin (1997) have criticised the socio-demographic characteristics arguing that they view identity as a fixed essence that does not reflect in the case of gender or race differences in attitudes, personality or behaviour. Also, the construct of diversity is regarded as a group construct and thus individuals are restricted to being members of certain socio-demographic groups that do not account for individual differences within the group (Adler and Graham, 1989; Nkomo, 1995; Nkomo and Cox, 1996; Litvin, 1997). Scholars such as Sackmann (1997) and Goodman, Phillips and Sackmann (1999) critique the fact that diversity studies tend to emphasise one specific socio-demographic element, and ignore the multitude of identities in the organisation. Another major critique of the diversity literature is that by defining diversity through the socio-demographic lens, it minimizes the role that organisational context plays in understanding diversity (Smircich, 1983; Ely, 1995; Foldy, 2002).

Williams and O’Reilly’s (1998) review of research on the effects of diversity on group performance and how it affects organisations show diverging opinions about the benefits of diversity management initiatives. This research studied empirical evidence from studies over a 40-year period and concluded that diversity can lead to positive opportunities such as increased creativity and quality but can be likened to a “double-edged sword” p79. This is

because it can lead to an increase group conflict, more member dissatisfaction, increased turnover of staff and failure to implement ideas. They proclaim that “diversity is a mixed blessing and requires careful and sustained attention to be a positive force in enhancing performance”, p120.

Scholars such as Mannix and Neale (2006), Chatman, Polzer, Barsade and Neale (1998), Jehn et al., (1999), Morrison and Milliken (2000), Westphal and Milton (2000), have published research identifying what Stevens et al. (2008), refers to as the “detrimental influences” of diversity on organisational outcomes. These include problems with process losses, increased conflict, lower social integration, difficulties in decision making and slower change processes.

2.5.11 Limits of diversity management

A limiting factor in embracing diversity is the associated risk when employing people for their specific socio-demographic characteristics e.g. to reflect language or ethnic identity and that their other attributes, skills and competencies are overlooked. Thomas and Ely (1996) argue that a critical limitation of a company’s ability to obtain the expected performance benefits of higher levels of diversity lies in “the leadership’s vision of the purpose of a diversified workforce” p152.

Successful diversity management requires communication skills, listening skills, openness to new thoughts and ideas, ease and willingness towards unfamiliarity, readiness to accept different people and flexibility (Henderson, 1994; Kandola and Fullerton, 1994; Hobman et al., 2004; Rodriguez, 2006).

2.5.12 Overview of approaches to diversity management

In summary, organisations approach diversity management in two ways either by reacting to for example compliance to legislation or by proactively anticipating trends incorporating diversity into the organisational strategy. Organisations that are proactive tend to entrench diversity into the principles and processes throughout the organisation and are part of the human resource strategy (Ospina, 2001).

Thus organisations can foster and manage diversity in various ways. Originally, as previously mentioned initiatives such as affirmative action and equal opportunity aimed at reducing

discriminatory behaviour and promoted employment of minorities. Many organisations introduced diversity initiatives such as diversity days and awareness celebrations and began changing employment practices and procedures. This approach is broadly referred to as 'valuing diversity' as organisations began acknowledging and appreciating the diversity of employees. Twenty first century approaches, have moved from valuing to managing diversity by incorporating diversity into corporate strategy to achieve organisational objectives through changes in work practices and also the realisation that there are different methods to do so (Thomas, 1991).

2.5.12.1 A colorblind approach to diversity management

A colorblind approach to manage diversity in organisations focuses on ignoring cultural identities and instead, cultivating an overarching identity, or organisational identity (Hogg and Terry, 2000). This approach in maximising the individual's organisational identity minimises differences at an individual level (Chatman and Flynn, 2001) and emphasises individual achievements such as qualifications rather than diversity. The colorblind approach is underpinned by the philosophy that everyone is treated the same (Plaut, 2002). However, Markus et al. (2000), propose a critical view by suggesting that minorities view the approach as exclusionary. Those organisations that minimise devalue or ignore racial differences according to Chrobot-Mason and Thomas (2002), experience frustration, conflict and dissatisfaction among members of minorities. Some argue that a colorblind approach is more attractive to majority groups and disenfranchises minority groups by fostering racism (Bonilla-Silva, 2003).

2.5.12.2 The multicultural approach to diversity management

The multicultural approach to diversity promotes the idea that employee differences and diverse workplaces are a source of strength and advantage (Cox, 1991). The basic premise is the acknowledgement and recognition of differences in race, ethnicity, religion and other group identities and backgrounds in the workplace (Plaut et al., 2007; Verkuyten, 2005). The multicultural ideology in organisations manifests itself through initiatives such as diversity training for employees (Paluck, 2006) and networking and mentoring programmes, diversity days, diverse food celebrations, and a variety of workshops focusing on diversity issues (Kidder at al., 2004; Linnehan and Konrad, 1999).

Critiques of the multicultural ideology argue that multiculturalism discriminates against majority groups which cause conflict and disunity. This may lead to non-compliance and

resistance by majority groups (Brief et al., 2005; Kalev et al., 2006; Mannix and Neale 2006; K.M. Thomas, 2008).

Others refer to a backlash to the multicultural approach (Linnehan and Konrad, 1999) that exists at an individual and organisational level. The resisting individual may engage in behaviours including discrimination, use biased language, avoid difference and discredit ideas and individuals. From an organisational perspective, the backlash to multiculturalism may be represented through human resource policies and practices that are prone to discrimination, cultures of silence and slow implementation of diversity initiatives (K.M. Thomas and Plaut, 2008).

2.5.12.3 The All-Inclusive Multicultural approach (AIM)

Stevens, Plaut and Sanchez Burks (2008), acknowledge the benefits of both the colorblind and multicultural approach to managing diversity but agree with criticisms that both approaches exclude different members of organisations. They propose a new AIM approach as an alternative, claiming that such an approach will lead to a more inclusive, positive organisation where employees will reach their full potential through higher quality relationships. Firstly, they acknowledge that the colorblind approach experiences resistance from minorities, as they feel exclusion in day to day operations, while non-minorities feel excluded in a multicultural approach as they feel that diversity initiatives apply only to minorities (Verkuyten, 2005). So both approaches are not satisfactory to minorities or non-minorities with minorities preferring the multiculturalist approach and non-minorities preferring the colorblind approach. Hence they offer an AIM approach that they argue using supportive empirical research, does not face resistance from either minorities or non-minorities. By managing diversity in such a way that recognises and acknowledges differences equally in both minorities and non-minorities in an explicit clear manner, and cultivating individual demographic groups in the context of an 'overarching' larger context. Unlike the 'melting pot approach' the philosophy is more aligned with a 'tossed salad' where all individual groups retain their group identities in the larger context of the organisation identity. The authors argue that only by using an all-inclusive approach can organisations reduce social exclusion, and improve individual and inter-group relations in which in turn improves overall performance. Their model builds on the premises put forward by Davidson and James (2006) and Thomas and Ely (1996) that inclusive organisations should not just appreciate diversity through surface-level strategies but encourage members to have a deeper understanding and appreciation of their own individual diversity and that of others. The authors refer to Davidson and James (2006), by suggesting that an AIM approach will

generate a “capacity for individuals to engage, challenge, and support one another with clarity and confidence”, p139. Likewise, the main tenets of the AIM approach are supported by Spreitzer et al.,(2005), who suggest that open communication and learning lead to employees reaching their full potential and cultivate better relationships overcoming social differences at individual and group levels.

The AIM approach can be cultivated in organisations primarily through carefully selected communication and language strategies and implementing appropriate organisational structures and policies. The former involves avoiding language that may exclude groups indirectly and using “AIM based language” in organisational literature and mission statements which makes clear by explicitly stating the organisation’s position regarding the ideology of inclusion of all employees irrespective of their belonging to a minority or non-minority grouping. The authors suggest the use of AIM when communicating policies such as promotion, recruitment, mentoring or such as soliciting employees to participate in diversity initiatives such as recipe books or multicultural celebrations. Organisations need to invest in structures and introduce appropriate polices which are fundamental to the AIM approach to managing diversity. This involves soliciting minorities and non-minorities to lead and organise diversity activities and initiatives through diversity committees, task forces and in social networking and mentoring programmes.

2.5.13 Characterising diversity management organisational responses

There are several approaches that organisations can undertake to address diversity issues. These response efforts have been classified in various ways by diverse authors. Cox’s typology (1993) for assessing organisations progress in terms of efforts made in managing diversity is widely cited in the diversity management literature. This typology serves organisations to set goals to become ideally, a multicultural organisation inclusive to all employees.

Cox’s typology is based on a diversity continuum with two extreme positions. The first extreme position is what Cox refers to as a monolithic organisation. This is homogeneous and exclusive in nature and usually consists of employees who share the same characteristics and usually rewards only those members who conform to the norms of the dominant group. Also it is discriminatory in practice and access to information, decision making and networks are closed to those not conforming to the dominant group. The next position on the continuum is the plural organisation, which differs with the monolithic position

primarily by employing a mixed corps of employees. However despite this pluralism, the system is still influenced by the values shared by the dominant group, and thus excludes those who do not share and behave according to those values. The third and final position on the continuum is the inclusive multicultural organisation. It is characterised by Cox as those organisations that obtain systems and organisational culture which value and reward differences and view diversity as an asset. Inclusion and fairness are key organisational values and diversity is cultivated at all levels of the organisation. Such organisations foster the values of inclusion and have systems in place to combat exclusion and discrimination.

Cox's multicultural organisation as an ideal type is open to criticism for being too idealistic. Ospina (2001) declares that it is the vision rather than the reality that managers should target. Similarly, Baytos (1995) refers to the idea as being an optimistic vision but argues in defence of Cox that such a vision will help organisations move in the right direction towards diversity success and help set goals.

Essentially Cox's typology allows for organisations to be positioned along a diversity continuum from exclusive to inclusive. Positions will vary depending on the organisation's culture and to what extent the structures, policies, systems and HR practices have been implemented to manage diversity.

Baytos (1995) classified the responses of organisations in the private sector through a basic categorisation of four positions based on the organisation's awareness and extent of action in response to diversity. The four positions are described as follows:

1. Unaware: organisations whose leadership is unaware of diversity issues.
2. Timid or preoccupied: organisations that are aware but do not know how or are too busy surviving.
3. Action oriented: act before establishing a strategy hence minimizing the impact.
4. Seeking a leadership position: organisations, which have implemented actions systemically.

A development approach to managing diversity progressing along a continuum to diversity success is thus supported in the literature by authors such as Cox (1994) and Baytos (1995).

Ospina (2001) proposes that organisations can only progress in their diversity management endeavours if they are aware of their current organisational position in terms of diversity. A

condition for developing appropriate diversity strategies going forward is knowledge of where the organisation strengths and weaknesses currently are. It is in this context that Cox's typology is a welcome starting point for organisations.

Dass and Parker (1999) summarise three broad organisational responses to diversity issues. These are episodic, freestanding or systemic responses and identify three classifications of how organisations manage diversity. Those organisations which undertake diversity initiatives in a once off, sporadic, non-coherent manner, usually responding to a single independent environment pressure and not mainstreamed into the main activities of the organisation can be classified as episodic efforts. Those that respond by formalising regular activities and initiatives in reaction to what is perceived as moderate environmental pressures, but are not integrated in a strategic manner into the main activities of the organisation are viewed as freestanding efforts. However, those organisations that deem environmental pressures significant enough to react by introducing responsibilities for diversity into management, and linking efforts to systems integrated into the core activities of the organisation and are strategically oriented in nature, are classified as systemic efforts.

Thomas and Ely (1996), characterise diversity management efforts in organisations by referring to three paradigms. These are the discrimination and fairness paradigm, the access and legitimacy paradigm, and the learning and effectiveness paradigm**.** This more elaborated characterisation of diversity management efforts of organisations is dependent on the underpinning philosophy of each organisation's management towards diversity.

The discrimination and fairness paradigm is based on the recognition by management that discrimination is wrong and expects all employees to assimilate to the dominant culture. It "idealises assimilation and colour- and- gender- blind conformism", Thomas and Ely (1999, p 121). Thomas and Ely, however criticised this philosophy as being compliance driven, and based on employees, including minorities, being willing to blend in and conform. Also, it assumes that the main competence of employees is dealing with people from similar backgrounds.

The access and legitimacy paradigm "celebrates difference and seeks to target diverse clients, but which can leave employees of different identity-group affiliations feeling marginalised or exploited", Thomas and Ely (1999), p121. This approach targets minority customers but employees are not integrated for their unique contributions but are recognised only for their ability to work effectively with people from similar backgrounds. According to

Thomas and Ely this paradigm “usually emerges from very immediate and often crisis-oriented needs. However, once the organisation appears to achieve goals, the leaders seldom go on to identify and analyse the culturally based skills, beliefs and practices that worked so well. Nor do they consider how the organisation can incorporate and learn from those skills, beliefs or practices in order to capitalise in the long run”, Thomas and Ely (1999), p135.

A third diversity philosophy is proposed by Thomas and Ely who believed that neither of the first two paradigms resulted in organisations maximising effectiveness. Thus, they proposed a new learning and effectiveness paradigm. This third paradigm envisaged employee diversity to be cultivated in such a way as to promote productivity, and develop new systems and strategies leading to better, more innovative decision making and problem solving. Thomas and Ely argue that “like the fairness paradigm it promotes equal opportunity, for all individuals. And like the access paradigm, it acknowledges cultural differences among people and recognises that value in those differences. Yet this new model for managing diversity lets the organisation internalise differences among employees, so that it learns and grows because of them”, Thomas & Ely (1999), p139.

Thomas and Ely (1999) suggest that there are 8 preconditions required to make the necessary paradigm shift to learning and effectiveness.

These preconditions include the following:

1. The leadership needs to understand that a diverse workforce will embody different perspectives and approaches to work, and must truly value variety of opinion and insight.
2. The leadership must recognise both the learning opportunities and challenges that the expression of different perspectives presents for an organisation.
3. The organisational culture must create an expectation of high standards of performance from everyone.
4. The organisational culture must stimulate personal development.
5. The organisational culture must encourage openness.
6. The culture must make workers feel valued.
7. The organisation must have a well articulated and widely understood mission.
8. The organisation must have a relatively egalitarian, non-bureaucratic structure.

Furthermore, Thomas and Ely emphasise the important role that leadership has in diversity management and maintain that leaders need to cultivate open discussion, trust, combat against dominance and subordination that constrain the full contributions of all. They maintain that a key limitation to managing diversity successfully is inadequate leadership that fails to understand the real value and purpose of a diversified workforce. The Discrimination and Fairness paradigm and the Access and Legitimacy paradigm can be correlated to monolithic and pluralist organisations as per Cox's typology. Similarly the Learning and Effectiveness paradigm aligns with the philosophy of a multicultural organisation.

2.5.13.1 Developing an agenda for diversity management

In developing a strategy for diversity management in organisations management must consider certain facts such as a "one size fits all" approach is insufficient. Every organisation is unique, and external and internal forces affect organisations differently. Ospina (1996) referring to public sector civil service agencies states "each organisation's structure and culture has adapted to the broader societal changes at its own pace and with its own idiosyncrasies. Strategies must therefore be carefully crafted to fit the specific characteristics of the agency and its environment", p11.

Thus developing a diversity management strategy involves the systematic evaluation of objectives, understanding diversity gaps and finding solutions and in the absence of a 'one size fits all' approach, each strategy has to be tailored to each individual organisation.

Also despite the fact that implementation of diversity strategies occur at different speeds along different paths, there are shared overriding common goals among organisations. Ospina (1996) states that the common goal is for organisations managing diversity is to "create an organisational climate and a human resources management system where employee diversity becomes a normal condition of organisational life", p11.

Another consideration is that it is apparent that in order for organisations to achieve the goals of diversity management and thus manage diversity effectively, they require the combined efforts of diversity management and the human resource function working in partnership (Thompson 1998; Gilbert et al., 1999).

2.6 Theoretical frameworks for diversity management strategy

There are a multitude of diversity models and frameworks designed do to aid organisations to implement diversity management strategies. These models provide a vision for organisations that endeavour to manage diversity and may be differentiated based on if they emphasise the content or process of a diversity management programme. An analysis of these models can serve this research by identifying the critical components required in implementing a management of diversity strategy with the purpose of improving organisational performance. The following models and frameworks have been identified in chronological order, firstly from the general diversity management literature focusing on a broader business management perspective and secondly from the healthcare literature perspective related to healthcare management.

2.6.1 Framework for guiding organizational change (Cox, 1994)

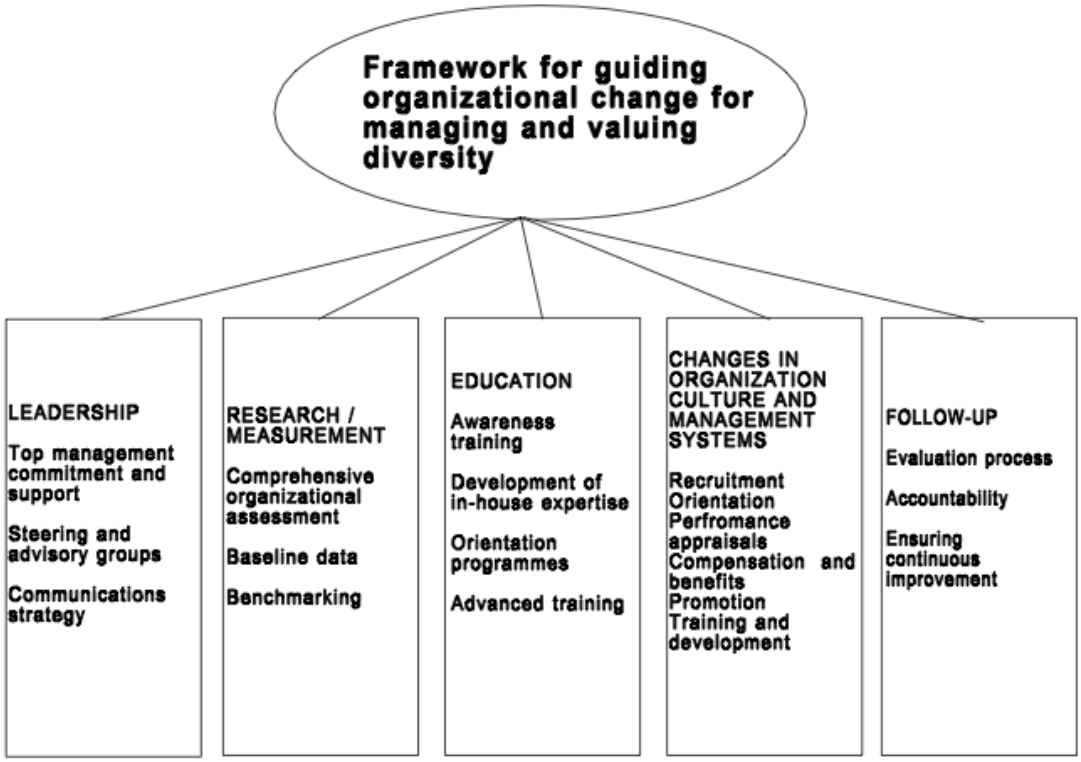
The diversity models and frameworks referred to from the general diversity management literature include Cox's framework for guiding organisational change for managing and valuing diversity (1994), Kandola and Fullerton's (1994), MOSAIC Model, Kellough and Naff's (2004) research concerning the diversity management programs in 160 Federal agencies in the USA, Jane and Dipboye's (2004), 5 steps or strategies for diversity and Hubbard's (2004) Diversity scorecard. Managing diversity is strongly linked to change management in organisations. A strategically planned change process facilitates diversity initiatives to be embedded in the organisational culture (Agars and Kottke, 2004; Friday and Friday, 2003).

2.6.1.1 Presentation and description of the framework for guiding organisational change (Cox, 1994)

A frequently cited model of a planned strategic change process in the diversity management literature and the healthcare literature that outlines the key considerations necessary in formulating a diversity strategy is Cox's framework for guiding organisational change for managing and valuing cultural diversity. This research was first developed in 1994 and revised in 2001 and it can be argued that this model has acted as a reference for subsequent diversity management research.

Cox's framework is a process and content driven approach, beginning with a top down orientation, beginning with leadership, research and measurement, education, changes in organisational culture and management systems and concluding with follow up continual improvement processes. This framework is widely cited in the academic literature and as it is applicable to the broader management community. It is designed to improve the organisations capacity to manage cultural diversity and to transform organisations into becoming multicultural organisations. Figure 2.6 illustrates Cox's framework.

Figure 2.6 : Framework for guiding organisational change Cox, 1994



Adapted from Cox 1994, 2001

This model created in 1994 was adapted in 2001 in Cox's publication 'Creating a Multicultural Organisation', and is composed of five components for a change management strategy: Within each component there are sub-components (see figure 2.6). These 5 components address development, implementation and monitoring of the strategic process and implementing a diversity strategy in an organisation.

Cox's model emphasises the role of leadership and commitment from the top in formulating and designing a diversity management strategy. He proclaims that the diversity management plan and process will not become operational in the organisation if leadership is not

committed to and actively engaged in the process. Cox maintains that an effective diversity strategy requires administrators who are invested at a personal level and avoid delegating the process. Leadership should be engaged personally and ensure that employees understand that the journey to embracing diversity is a long one. Efficient communication through action and words by leaders is required. The contents of the five components are listed as follows:

2.6.1.2 Leadership

Leadership requires diversity champions, such as diversity coordinators or diversity directors at high and low levels of the organisation to plan and organise diversity initiatives, and collaborate with outside consultants, plan, organise training and monitor progress. Leadership requires the commitment of top management, commitment of resources, and that diversity management is included in business strategy. Leadership needs to ensure that HR practices include performance appraisal and compensation systems geared to diversity, and ensure the necessary financial resources and management energy in the long run. Leadership should view diversity as a core value integrating diversity issues into all aspects of the organisation such as quality and safety etc. Good diversity leadership requires the use of diversity steering committees, advisory groups, or diversity task forces made up of interdepartmental teams. Leadership also requires a communication strategy to inform the organisation of diversity development work, to clarify differences between diversity management and affirmative action or equal opportunities, and to recognise performance implications at individual and organisational level through communication tools such as use of newsletters, in-house magazines, staff bulletin boards, staff meetings and intranet postings.

2.6.1.3 Research / measurement

The collection of information and data relating to diversity issues includes measures of the organisational culture, equal opportunity profile data, an analysis of attitudes and perceptions of employees and promotion data will give the organisation a real picture of the manner in which the organisation is operating and indicate problems, identify gaps and target where resources should be concentrated. Research can be carried out through surveys, focus groups and interviews among others. This is useful, as it focuses attention on any particular issues that need to be addressed in training, and it can identify those specific areas such as organisational culture, or management practices where changes need to be made. Evaluating the change effort, by collecting baseline data on key indicators such as workforce differences, absenteeism rates, labour turnover, productivity, grievances, promotion rates,

performance reviews, equality pay, customer satisfaction and external benchmarking, is important. The organisation has to examine its current position to assess how it will achieve its objectives. Auditing and evaluating achievements requires clear data that is required to persuade managers and stakeholders of the value of an integrated workplace.

2.6.1.4 Education

Organisations should implement employee training on awareness and sensitivity to diversity issues for all staff including senior managers. Also use of outside trainers, and in-house expertise to build commitment and cost efficiency is advised. The use of 'train the trainer' programs, specific subject matter expertise training built into new-hire orientation programmes is recommended. Advanced training on specific skills and understanding individual roles in the implementing of a organisational change process is required and management need to view diversity training as an on-going educational process.

2.6.1.5 Changes in organization culture and management systems

A comprehensive assessment of the organisational culture and human resource management systems of the organisation is suggested. This includes assessments in areas such as recruitment, training and development, performance appraisals, promotion, compensation and reward mechanisms etc. The use of culture audits to uncover biases and prejudices in practices and policies that hinder performance and recognition of employees and surface areas where the organisational culture is not compatible with the needs of diverse employees is advised. The cultural audit should be an in-depth investigation into management systems and avoid surface data and be undertaken by an external cultural diversity expert. A cultural audit should assess the organisational values and norms in the context of the diversity of the workforce to see if they align. The goal is to convert the results of the audit into action regarding organisational culture and management systems. Equally the objective is to align management systems with the diversity agenda and focus and ensure that policies and procedures are diversity proofed. This includes areas including recruitment and selection, performance management, career and succession planning and terms and conditions of employment etc.

2.6.1.6 Follow-up

The underpinning philosophy of a diversity management initiative is continuous improvement. The two key areas are accountability for results and evaluation of effectiveness. The change process needs to be monitored and mechanisms put in place to ensure that changes are embedded and mainstreamed into the organisation. It is advised that senior management are

responsible for strategic diversity accountability, while operational diversity responsibility is controlled by the diversity task force or the manager responsible for diversity or the two entities. Essentially, every manager must be responsible and accountability has to be integrated into performance appraisals, reward and recognition policies in the organisation in order to reinforce the importance of diversity. This may include assessment of manager's ability to lead multicultural groups, or to monitor and reward and recognise managers for their management of diversity initiatives. Evaluation of organisational performance involves evaluation of employee outcomes such as career satisfaction, job involvement, and organisational commitment or attitude changes. Also, individual achievement measures such as inter-group performance ratings, promotion rates, and compensation can be factored in. Organisational performance can be evaluated using indicators such as work quality, turnover, productivity, absenteeism, market share and profitability.

2.6.2 Other models for diversity management

2.6.2.1 MOSAIC Model, Kandola and Fullerton (1994)

Kandola and Fullerton (1994) introduced the MOSAIC Model which essentially is a tool that maps an organization regarding diversity and identifies the priorities for a diversity strategy. The process involves the composition of a diversity vision using the MOSAIC as a reference. Then a diagnostic exercise allows the determination of the current position according to this vision. Finally, after having done the evaluation of the organisation, it is necessary to integrate the findings into the development of a strategy and action plan.

The MOSAIC vision describes the diversity orientated organization through different characteristics through the aacronym MOSAIC. According to Kandola and Fullerton the diversity-oriented organization should have:

- Mission and values of the company linked to diversity.
- Objective and fair processes including audits of all the processes such as selection, recruitment, performance appraisals, induction etc.
- Skilled workforce who are aware of the importance of diversity management in reaching organisational goals.
- Active flexibility in working arrangements, policies, practices and procedures reflecting workforce diverse needs.
- Inclusive policies of the organisation to all stakeholders.

- Culture that empowers through equal opportunity, trusting environment, consultation, communication and experimentation.

Kandola and Fullerton (1994), produced an accompanying implementation model called 'The Strategy Web', containing eight action points for the organisation. These include organisational vision, top management commitment, auditing and assessment of needs, clarity of objectives, clear accountability, effective communication, co-ordination of activity and evaluation. The MOSAIC model is criticised from a practical viewpoint and may seem vague and aspirational and difficult to strike a balance between aspiration and detail. The model does not give practical functional advice and lacks content (Crowe 2007) and thus, differs to Cox's model in this regard. The model does emphasise the need for flexibility in workplace arrangements.

2.6.2.2 Kellough and Naff's advice creating better climates of diversity (2004)

Kellough and Naff in their research in 2004 concerning the diversity management programmes in 160 Federal agencies in the USA, drew on the diversity management literature to offer advice that organisations should take "to create better climates for diversity", p66. This advice is explained below with the corresponding scholars who support each notion.

1. Ensuring management accountability: diversity related goals should be a part of performance and compensation for management (Cox, 1994; Fernandez, 1999; Morrison, 1992).
2. Re-examine the organisation's structure, culture and management systems: performance appraisal, career development, selection and promotion criteria should be audited for bias and inequity (Cox 1994; Fernandez 1999; Morrison, 1992; Norton and Fox, 1997; Thomas, 1996).
3. Pay attention to the numbers: monitoring of diverse and representative groups throughout the organisation (Cox, 1994; Morrison, 1992; Norton and Fox, 1997; Thomas, 1996).
4. Provide training: provision of training to provide skills to work effectively in a multicultural workplace environment (Cox 1994; Fernandez 1999; Gardenswartz and Rowe, 1993; Riccucci, 2002; Thomas, 1996).
5. Develop mentoring programmes: provision of mentors to explain promotion and advancement procedures and expectations in the organisation (Cox, 1994; Fernandez, 1999; Morrison, 1992; Thomas and Gabarro, 1999).

6. Promote internal identity or advocacy groups: this involves the establishment of groups representing specific non traditional employees or advisory groups made up of representatives of different diverse groups in the workforce (Cox, 1994; Morrison, 1992; Norton and Fox, 1997; Wilson, 1997; Thomas and Gabarro, 1999).
7. Emphasize shared values among employees, customers and stakeholders: the idea that organisations should be conscientious of their culture and strive to create and foster a culture of inclusion of all stakeholder values (Norton and Fox, 1997; Wilson, 1997; Thomas and Gabarro, 1999).

This contribution differs from Cox's model in that it emphasises the importance of using mentoring programmes and establishing advocacy groups and is not content driven.

2.6.2.3 Jane and Dipboye's conditions necessary to maximise diversity management (2004)

Jane and Dipboye (2004) having reviewed theory and empirical research in the literature suggest that certain conditions are necessary in order to maximise organisational benefits regarding the management of diversity. They examine the relationship between workplace diversity and organisational performance and suggest that diversity outcomes depend on how diversity is managed. They argue that 5 steps are critical for management to reap the advantages of a diverse workplace and offer diversity management practices for each step. The 5 steps include:

1. Build senior management commitment and accountability
2. Conduct a thorough needs assessment
3. Develop a well-defined strategy tied to business results
4. Emphasize team-building and group process training
5. Establish metrics and evaluate the effectiveness of diversity initiatives.

The management steps that Jane and Dipboye's research offers are process and content driven and are broadly similar to Cox's original model differing only in emphasis in areas such as the need for multicultural team training and the need for creating measuring metrics to evaluate diversity performance.

2.6.2.4 Diversity Scorecard, Hubbard (2004)

The Diversity Scorecard is a management tool based on the well known Balance Scorecard of Kaplan and Norton. Hubbard's model serves as a method of developing specific

performance measures for evaluating diversity management. He constructed a model that provides a wide range of performance measures beyond financial, and adapted the scorecard system in order to measure an organisation's performance regarding diversity from six viewpoints, including:

- Diverse customer / community partnership: In order to achieve the organisation's vision, there is a need for appropriate delivery of products and services to diverse customers.
- Workforce profile: to meet customer needs, demands an appropriate workforce that reflects the customers, and issues around retention and promotion.
- Diversity leadership commitment: in order to achieve vision, requirement for leadership and accountability for diversity.
- Financial impact: obligation to financially assess returns on investments and a need for the measurement of financial efficiency and effectiveness.
- Workplace climate / culture: need for an inclusive work climate to motivate our workforce and sustain productivity.
- Learning and growth: need to sustain ability to change and improve in the organisation.

The Diversity Scorecard is a tool, which helps an organization to measure and evaluate diversity management initiatives and processes. It measures initiatives rather than a content driven practical oriented model. The model does serve to indicate the relevance and importance of organisations measuring and evaluating their diversity initiatives.

In summary Cox's theoretical model in 1994 is comprehensive and addresses many of the subsequent components from the various models in the diversity management literature and can be used as a reference theoretical model from the diversity literature.

2.6.3 Theoretical frameworks specific to healthcare management

The models and frameworks of diversity management and organisational change in specific to healthcare include Dreachslin's (1996) Organisational Change Model, which was the basis for Weech-Maldonado et al. (2002) research examining diversity management practices in HCOs. Also Gardenswartzs and Rowe's Managing Diversity in Health Care model (1998)

and accompanying 7 step process to implement culture change in the context of managing diversity in health care.

2.6.3.1 Dreachslin's Organisational Change Model (1996)

Dreachslin (1996) offers a five-part diversity management model based on organisational change, where healthcare organisations progress from an initial discovery stage to a position of leveraging diversity. Dreachslin offers corresponding best practices for each stage and the objective is for the organisation to progress to each stage in the model.

Table 2.9 : Dreachslin theoretical models for organisational change in HCOs

Discovery:	Emerging awareness of racial and ethnic diversity as a significant strategic issue
Assessment:	Systematic evaluation of organisational climate and culture vis-à-vis racial and ethnic diversity.
Exploration:	Systematic training initiatives to improve HCOs ability to effectively manage diversity.
Transformation:	Fundamental change in organisational practices resulting in culture and climate in which racial and ethnic diversity is valued.
Revitalisation:	Renewal and expansion of racial and ethnic diversity initiatives to reward change agents and to include additional identity groups among the hospital's diversity initiatives.

Adapted from: Weech-Maldonado et al. (2002)

Based on case study research that documented the strategies and tactics of HCOs as diversity leaders, Dreachslin (1996) proposed a five-part theoretical model for organisational change, from essentially affirmative action to valuing diversity. The five stages in the model as detailed in table 2.9 are: discovery, assessment, exploration, transformation and revitalisation. Each stage is characterized by different diversity management practices or behaviourally based performance indicators. HCOs are expected to be at different stages of Dreachslin's change process and a natural progression is expected from one diversity stage to the next.

2.6.3.2 Weech-Maldonado et al's indicators and diversity management practices (2002)

According to Weech-Maldonado et al. (2002) research examining diversity management practices in HCOs was scarce during the late nineties. Only 3 studies by Muller and Haase (1994), Motwani, Hodge and Crampton (1995), Wallace, Ermer, and Motshabi (1996) had

began to address diversity management in HCOs. However, this prompted Weech-Maldonado et al. (2002) to conduct a comprehensive assessment of diversity management practices covering both human resources and healthcare delivery issues in 234 hospitals in Pennsylvania in the USA. This study provided important insight into the racial/ethnic diversity management practices of hospitals. They surveyed all 234 hospitals using the 5 stages of Dreachslin model and related performance indicators relating to diversity management policies and practices that are characteristic of each phrase. The performance indicators used in the questionnaire were developed through a compilation of best practices in HCOs and in the corporate world. The indicators were organised into 6 categories of indicators consisting of diversity training, human resources, planning, stakeholder satisfaction, healthcare delivery and organisational change indicators.

Their research expanded on Dreachslin's (1996) Organisational Change Model and provided an insight into the management of ethnic/racial diversity in hospitals in Pennsylvania and provided a total of 56 indicators.

However it can be argued that their study was in the context of the American political, social and cultural environment. For example with regard to human resource indicators, Weech Maldonado et al, advise hospital management to ensure that executive search firms are required to present a mix of candidates representative of the racial ethnic diversity of the service area, and that prompt action is to be taken to address variances in the rate of job offers by race or ethnicity or corrective action is to be taken promptly when employee turnover ratios vary by race or when the racial ethnic composition of the workforce varies by organisational level. In addition they suggest that prospective employees are to be interviewed by a team that is diverse in race and ethnicity. Likewise, planning indicators suggest that the strategic plan should emphasize the goal of recruiting and retaining a workforce representative of the service area's racial/ethnic demographics, and that the racial/ethnic demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area.

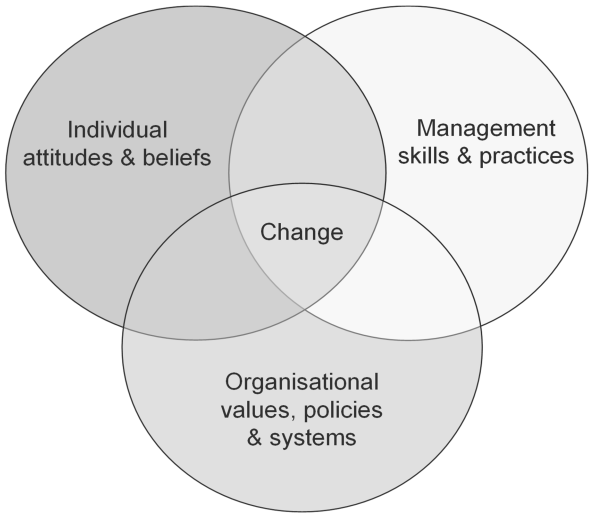
This advice is pertinent only within the USA context where equal opportunity legislation permits such actions. However such advice is less valid in certain European national contexts such as France or Ireland where equality legislation prohibits areas such as recruitment and selection to be based on race or ethnicity.

2.6.4 Gardenswartz and Rowe's Managing Diversity in Health Care Model (1998) and the 7 step process

Gardenswartz and Rowe (1998), in their publication Managing Diversity in Health Care propose a framework and 7 step process for managing diversity to improve organisational performance including provision of health care to diverse populations. They argue that organisations which attempt to manage diversity using a quick fix "check off the box" mentality fail, and that successful diversity management requires longevity, tenacity, determination and initiatives that impact the operational structure of the organisation. The framework focuses on three areas of change that need to be managed simultaneously in order to capitalize on and leverage diversity as an overall strategic asset. These three areas are illustrated in figure 2.7 and are explained as follows:

2.6.4.1 Presentation of the Gardenswartz and Rowe's Model

Figure 2.7: Gardenswartz and Rowe's Managing Diversity in Health Care model (1998)



Individual attitudes and behaviours

This component requires employees in the healthcare industry to examine their feelings and assumptions including accommodating patients with different norms and behaviours, examining their assumptions towards other staff and cultural groups within the hospital community. Training is considered a key element with regard to this component.

Managerial skills and practices

The ideas that one style of management does not fit all and that managerial styles need to be adapted to suit diverse workforces. Relations between managers and staff influence how employees feel about their organisation. Feedback, both positive and negative performance appraisal, meeting participation, conflict resolution, accountability, team cohesion, commitment and performance are culturally relevant among employees and managers need to be aware of culture's impact in these areas. Skills such as team building, coaching, solving problems, at an intercultural level are imperative for effectiveness and none more so, according to Gardenswartz and Rowe, than in the changing healthcare industry.

Organisational values and policies

Organisational values and policies, according to Gardenswartz and Rowe (1998), is the most complex area to manage change in the diversity management process. "Neither the most far reaching enlightened individual nor the most highly developed managerial skills and practices will produce meaningful change in an organisation if its systems and policies do not foster, reward, and hold people accountable for the values, norms and behaviours an organisation is promoting as its way of being in and doing business", p176. Recruitment and selection, promotion, accountability for diversity changes, organisation feedback internally and externally, are examples of systems that need to be adapted to diversity. Organisations need to be committed and follow through on their diversity initiatives by aligning values, policies and systems throughout the organisation.

Gardenswartz's and Rowe maintain that managing diversity is a process that is 'continuous and evolutionary' and that only a "well-thought-out, well-designed strategic change process", p176 will reap the returns. They propose an accompanying 7 step process to implement culture change in the context of managing diversity in health care.

2.6.4.2 Gardenswartz and Rowe's 7 step process to implement culture change in the context of managing diversity in health care

Gardenswartz and Rowe's 7 steps is the theoretical process required to change the mindsets, attitudes and beliefs of healthcare professionals and to develop the necessary management skills to provide appropriate healthcare outcomes. The process enables the cultivation of organisational values through implementation of appropriate policies and systems designed to successfully manage ethno-cultural differences in the healthcare context.

This process involves 7 steps where some steps may be operational at the same time and the authors offer content through actions and suggestions from their experiences of working with healthcare organisations. The process is content driven and the key components of each step are outlined below.

Step 1: Generating executive commitment / Getting commitment from the top

Executives need to lead the way when it comes to diversity management by talking, demonstrating, advocating, writing in newsletters or online, and supporting and attending training. They need to advocate the business case suited to their organisation and ensure employee buy-in as a strategic imperative. Managers need to be held accountable for reporting diversity progress. Employees at every level of the organisation should demonstrate leadership concerning diversity. Concerning budget support, managers should take the time to attend sessions and address staff concerns regarding diversity.

Step 2: Assess and diagnose

The management of diversity is data driven and organisations need to assess their current state regarding diversity, by examining inclusions, exclusions and barriers that are affecting the organisations effectiveness in achieving its goals. Assessing the organisations values, mission and vision and conducting a culture audit are important elements. Data enables management to develop priorities, goals and objectives to formulate a strategic plan. Data can be used as a benchmark to measure progress after strategy implementation and the very fact of assessing diversity serves as a communication vehicle throughout the organisation. Data collection consists of 4 methods of collection, including:

- Reviewing of existing data, (employee opinion surveys, labour force, marketplace, turnover information, grievances and complaints.)
- Interviews with organisation diversity leaders regarding goals, objectives, expectations, perceived challenges and obstacles.)
- Focus groups with all levels of employees to ascertain perceptions of the organisation treatment of staff, and areas of inclusion and exclusion.
- Survey questionnaires leading to statistical information on employees perceptions of how diversity is being managed.

Step 3: Diversity council / Diversity task force

Diversity councils are visible structures that guide the process of change concerning diversity management. They are essential to communicate the importance and relevance of the

diversity agenda and provide feedback and explaining diversity initiatives and policies to employees and executives. They advocate the importance of diversity and explain the how and why of diversity management. They should be diverse in constitution and cross-functional representing various services and professions in the hospital. Diversity councils should undergo training at the initial formation of the council and partake in ongoing training and development initiatives. The main tasks of the diversity council include:

- Defining the challenges and opportunities of diversity management with regard to organisational effectiveness
- Provide recommendations and report to the highest levels of the organisation
- Monitor change process and evaluate outcomes

Step 4: Systems changes / problem solving systemic issues

Organisational systems and policies need to be aligned with diversity management goals and objectives and are the "guts of any long term change", p191. Recruitment; promotion, career development, reward and recognition and mentoring processes need to be aligned to diversity principles of fairness and equity.

Step 5: Training to address awareness, knowledge and skill needs

Training in awareness, knowledge and skills changes individual behaviours, but not necessarily culture change."Training is necessary for change but not sufficient to make it happen", p195. Training should include an organisation's definition of diversity, the appropriate business case, culture's impact at an organisational, team, national, and individual level in the workplace, and understanding stereotypes, biases, prejudices and assumptions. Also, training should include diverse team building, and on management issues related to intercultural dialogue and conflict management, interviewing hiring, coaching, performance reviews. Diversity training should be integrated into existing training in order to reduce resistance and show relevance as opposed to stand alone training. Also measurement and accountability of performance outcomes are recommended.

Step 6: Measurement and evaluation

The idea that "what gets measured gets done, and what gets rewarded gets repeated", p196, is the underpinning idea for the Gardenswartz and Rowe's inclusion of this step. They maintain that measuring diversity change effects and evaluating results and outcomes is "critical" in the change process. The process needs to be monitored in order to see what can

be improved, and the results to establish if diversity efforts have made any difference. Measurement lends credibility to the process and highlights areas to improve. Measurements should be established at the beginning of the diversity management process and concepts such as turnover rates, differences in employee or patient satisfaction surveys linked to ethnicity can be analysed or demographic representation of under-represented groups. Combinations of hard measures such as productivity, customer retention, and demographic representation statistics and soft measures such as customer and employee satisfaction levels should be utilised in order to assess the impact of implementation of the diversity management strategy. Gardenswartz and Rowe observe that "the issue of measurement and evaluation continues to be most problematic", p196.

Step 7: Integration / follow-up

The point where diversity is integrated into all parts of the organisation and is no longer a stand-alone topic. The organisation views diversity management as an on-going process that evolves and changes. Hence organisations at this step of the process need to account for diversity management and continually modify, refine and correct processes and systems and seek ongoing feedback.

In summary the theoretical models do not reflect in the entirety, the social, political, economical or demographic realities in different health sectors and are in some cases limited by their lack of contextual application. The theoretical models are made up of generic components that can apply universally across healthcare settings and jurisdictions e.g. diversity task forces, or education and training initiatives. However certain models or frameworks such as Weech-Maldonado et al's indicators**,** suggest more contextual components including the recruitment of specific ethnic nationalities to mirror image the public, or targeted promotion quotas of certain ethnicities where the application of these components are dependent on equality legislation in each national context. There is perhaps a need for a further contextual debate with regard to the implementation of organisational wide approaches to diversity management, as the theoretical models of reference can lack context as there is no "no one size fits all" model.

Diversity models from the diversity management literature such as Kandola and Fullerton's MOSAIC (1994) and Hubbard's (2004) Diversity Scorecard are general and could be criticised for not being specific enough. The MOSAIC model is too vague, aspirational and not practical or specific to sectors such as the healthcare context. The balance scorecard is

more of a measurement tool than an academic model for organisations to implement organisational change through diversity. Neither are content driven in the healthcare context. However Cox's (1994) organisational change model is content and process driven and while not specific to the healthcare sector, it is frequently referred to across the literature domains in the context of organisational change, diversity management and healthcare. It incorporates a wide range of components that are referred to in subsequent contributions from Kellough and Naff (2004) and Jane and Dipboye (2004). Gardenswart and Rowe's (1998) model and accompanying 7 step process is both content and process driven and overlaps between the research domains of diversity management and organisational change and is suitably applicable and relevant to health care.

2.7 Barriers to the management of diversity

Finally, it would be remiss in any discussion of diversity management not to discuss the barriers that oppose the successful implementation of diversity initiatives. Gardenswartz and Rowe in their analysis of the implementation of diversity management strategies in healthcare organisations summarise eight "stumbling blocks" or barriers that hospitals encounter when attempting to implement diversity management strategies. Table 2.10 highlights these 8 barriers to the management of diversity.

Table 2.10 : Organisational barriers to the management of diversity

1. Cost of implementation Costs such as bilingual software, translation, interpretation, training, replacing staff on training days, in the context of microscopic scrutinisation of health care budgets.
2. Fear of hiring under skilled, undereducated employees Belief that hiring minorities, women and people who can be categorised based on the definition of diversity as defined by legislation, results in reduction in quality and competence due to stereotypes that such people are less educated.
3. Strong belief in a system that favours merit The idea that the current system based on equality can be a barrier to diversity. There is diversity in lower level positions such as house-keeping, cafeteria, nursing, etc and less in higher levels. The idea that the best man for the job is a white male and not a woman or member of an ethnic community.
4. Annoyance at reverse discrimination It does not help to end discrimination of one group at the expense of another and as long as there is a perception that one person's gain is another person's loss, reverse discrimination will be resisted.

5. Perception that there has been a lot of progress
The idea that some people feel that the necessary progress regarding diversity has taken place and that there is no longer any need for advancement.

6. Diversity not seen as a top priority issue
In the context where organisations have many priorities diversity may not be viewed as a priority issue.

7. Need to dismantle the existing systems to accommodate diversity
The idea of changing existing systems to adapt to diversity strategies is of concern to some employees who perceive change as potential loss of opportunity, power and resources.

8. Inertia
Organisations that fear outside intervention and protect themselves from intrusion and thus opt to do nothing.

Adapted from Gardenswartz and Rowe, Managing Diversity in Health Care (1998) p 197-202

These barriers are generic in nature and stem from the American healthcare culture. Different healthcare systems have different strengths and weaknesses and are governed by varying political, legal, economical, social and cultural factors that may enhance or constrain the implementation of a diversity management strategy in a given healthcare environment.

There are many actions ranging from basic initiatives like translation of documentation to more sophisticated efforts such as offering comprehensive intercultural training in attempting to manage diversity in hospitals. However it is evident from the numerous diversity models referred to in the literature that initiatives are not sufficient if they are not part of a coordinated structured approach integrated into a diversity management strategy.

Having examined the theoretical models that support organisational wide approaches in the diversity management and healthcare literature, and potential barriers of implementation, the next step in the research is to explore the international approaches of different healthcare sectors that have confronted the challenges of managing ethno-cultural differences.

2.8 International institutional perspectives and practices (health care related)

A comparison of the different recommendations, standards and guidelines for delivering health care to ethno-cultural diverse communities offered by selected international institutions and organisations from predominantly Europe and North America have been analysed. These continents have experienced the influence of ethno-cultural diversity in their health sector and much of the research in the field of cultural competent health care is documented and originates from these regions. The objective was also to identify patterns and commonalities in national and international institutional approaches. For example, the following international, institutional perspectives all use what can be described as organisation wide approaches in providing culturally appropriate health care to MECs. An overview of firstly the European and then the North American approaches are presented in appropriate chronological order.

2.8.1 Europe, Migrant Friendly Hospital Project (2004): The Amsterdam Declaration towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe

The Amsterdam Declaration of 2004[10] originated from the European Commission funded Migrant Friendly Hospital Project (MFHP) which involved 12 European partner hospitals in different European countries and coordinated by the Ludwig Boltzman Institute for Sociology of Health and Medicine, Vienna. The project took two and half years and was developed to respond to the care needs of culturally diverse patients in hospital settings. Experiences and results of the 12 European hospitals were presented at a final conference entitled, “Hospitals in a Culturally Diverse Europe” in Amsterdam in December 2004. Recommendations for provision of migrant friendly healthcare service and policy from a European perspective were launched as the “Amsterdam Declaration towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe”. The declaration offered 26 recommendations for European hospitals and health settings regarding implementation of migrant friendly health policies based on the MFHP partners, international discussions and the scientific literature. These recommendations are supervised by the Task Force on Migrant-Friendly Hospitals which was established in the framework of the World Health Organisation’s Network on Health

[10] Migrant Friendly Hospital Project, (2004), *The Amsterdam Declaration,* (www.mfh-eu.nethttp://www.mfheu.net/public/files/european_recommendations/mfh_amsterdam_declaration).

Promoting Hospitals. The 26 recommendations cover general and specific advice for healthcare service settings on how to manage diversity. Recommendations are offered to staff and health professions, hospital owners, hospital management including quality managers, service users and representatives of community groups, health policy formulation and health administrators and even offer advice on the importance of health sciences and the need for ethnic diversity to be put on the health research agenda (a list of the 26 recommendations for Migrant Friendly health care is in appendix 1 a).

2.8.2 Migrant-friendliness Quality Questionnaire (2004)

The Migrant-Friendliness Quality Questionnaire (MFQQ)[11] was developed by the European MFHP in cooperation with 12 EU partner hospitals for the European Commission, DG Public Health and Consumer Protection (Sanco), Public Health Programme. It is designed to assess migrant-friendly quality development of hospital services and is a tool to monitor how healthcare organisations are providing services responsive to patients with diverse cultural and ethnic backgrounds and to monitor to what extent support systems are in place to ensure migrant friendliness is a key dimension of service quality. The MFQQ was established after consultation with experts in the field of migrant friendliness and a review of the literature, and the WHO project "Health Promoting Hospitals" and assessment of quality systems. The questionnaire was used as a baseline assessment for the MFHP (2004) of the participating hospitals in each country. The questionnaire identifies 20 areas related to migrant friendliness that healthcare settings can implement (see appendix 1 b).

2.8.3 The Task Force on Migrant-Friendly and Culturally Competent Health Care (2011)

The Task Force on Migrant-Friendly and Culturally Competent Health Care (TFMFCCH)[12] was established in the framework of the World Health Organisation's Network on Health Promoting Hospitals to further develop and continue the impetus of the Migrant Friendly Health project (2004) in promoting health and health literacy of migrants and improving culturally competent healthcare services as recommended in the Amsterdam Declaration (2004). The task force in cooperation with the international network of Health Promoting Hospitals and Health Services aims to develop policies and practices that allow hospitals to

[11] Adapted from Migrant Friendly Hospital Homepage (www.mfh-eu.net).

[12] TF MFCCH Project to Develop Standards for Equity in Health Care for Migrants and other Vulnerable Groups. Self Assessment Tool for Pilot Testing in Health Care Organisations. TF MFCCH Web site (www.ausl.re.it).

provide more equitable and accessible healthcare services to migrants. The initiative is made up of field experts in 11 European countries, who set out to develop standards for equity in health care for migrants in 2010, in order to provide a framework to measure and monitor individual healthcare organisations ability to provide and improve quality of health care for ethnic minorities and migrants. The following standards are preliminary in nature and identify standards to monitor equity in health care. Equity being equal entitlement and fair distribution of services and the removal of barriers to access services and quality of care. These standards are in the process of being pilot tested and finalised in 2012. However they serve for the purposes of this research as indicators towards managing ethno-cultural diversity in service delivery (see appendix 1c).

2.8.4 National standards on Culturally and Linguistically Appropriate Standards in Health Care in the United States of America (2001)

The Office of Minority Health in the USA, Department of Health (2001) established 14 Culturally and Linguistically Appropriate Standards (CLAS)[13], in order to measure the cultural competency of organisations. These standards set out to ensure that service users of ethnic minority communities receive quality based appropriate culturally sensitive health care. In summary the CLAS recommendations suggest 4 standards that deal with language access services, (standards 4-7), 3 standards which focus on culturally competent care (standards 1-3) and 7 standards regarding organisational support for cultural competence (standards 8-14). Standards are divided into three types depending on stringency and can be categorised as follows. Firstly standards 4-7 which are federal requirements for healthcare providers receiving federal funds, secondly standards 1-3, and 8-13 that are guidelines or activities recommended by The Office of Minority Health for voluntary adoption as mandates by federal, state and national accreditation agencies. Finally standard 14 is a suggestion by the Office of Minority Health to be voluntarily adopted by healthcare organisations (the 14 standards are illustrated in appendix 1 d).

2.8.5 Building a Culturally Competent Organisation: The Quest for Equity in Health Care (Health Research and Education Trust 2011)

The Health Research and Educational Trust is a non-profit research and educational affiliate of the American Hospital Association. It was founded in 1944 with the mission to transform

[13] The Office of Minority Health, (2001), *The National Standards for Culturally and Linguistically Appropriate Services in Care (CLAS Standards),* United States Department of Health and Human Services (www.omhrc.gov/clas).

health care through research and education and specialises in healthcare disparity research among other domains. The trust published the guideline "Building a Culturally Competent Organisation: The Quest for Equity in Health Care"[14] consisting of 7 tasks for healthcare leaders to build culturally competent healthcare organisations (see appendix 1e) in order to provide equity in healthcare outcomes. A team of experts set out specific initiatives to promote culturally competent health care and reduce healthcare disparities. By conducting a thorough literature review and using best practices from a selection of high performing hospitals they propose 7 critical steps necessary to construct a culturally competent health care organisation. The objective is that healthcare organisations will improve the quality, efficacy and equity of care to all service users. It can be considered that American discourse concerning provision of culturally competent healthcare has evolved from the CLAS standards by emphasising equity in healthcare outcomes as the key component. An example is that there is more an explicit emphasis on reporting of healthcare disparities in this guideline.

2.8.6 Canadian Council of Refugees

The Canadian publication 'Best Settlement Practices' published by the Canadian Council for Refugees in 1998[15] suggests that healthcare services should follow 12 guidelines for newcomers to the health system (see appendix 1f). These guidelines are broad in nature and focus on similar components found in the American and European approaches. One notable practice emphasised in the Canadian framework is for healthcare organisations to take into account the complex, multifaceted, interrelated dimensions of integration and their impact on the health care of immigrants.

2.8.7 Analysis of international approaches

The American and European approaches offer valuable principles for policy development and for planning and provision of quality healthcare service delivery to diverse patient populations. In analysing the European approach we notice that the Amsterdam Declaration

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[14] Health Research and Educational Trust Institute for Diversity in Health Management, (2011), *Building a Culturally Competent Organisation: The Quest for Equity in Health Care.* Chicago, IL: Health Research& Educational Trust. July 2011 (www.hret.org/cultural-competency).

[15] Gagnon, A. J. (2002). "*Responsiveness of the Canadian Health Care System towards Newcomers."* Commission on the Future of Health Care in Canada, Montreal, McGill University. Extracted from Bischoff (2003), *Report on Caring for Migrant and minority patients in European Hospitals*, A review of effective interventions.

26 standards are comprehensive and broad focusing on hospital management, service providers, service users and health policy. This approach is unique in it's focus on the importance of the need of research in health sciences most notably the suggestion that scientific experts should assist the healthcare sector in planning, monitoring and evaluating the management of ethno-cultural diversity and migrant friendly initiatives, using appropriately designed tools.

It is evident that the TFMFCCH framework addresses the provision of culturally competent health care as an equity issue. The framework, similar to the American Health Research and Education Trust's Building a Culturally Competent Organisation: The Quest for Equity in Health Care (2011), proposes standards of equity in policy, equity in access and utilisation of services, equity in quality of care and emphasises the role of community involvement and the promotion of equity internally and externally within the hospital. There are similarities between the American and European approaches, as both promote the need for education, assessments, evaluation, monitoring, and strategic goals, plans policies etc. However there are differences in the American approach due contextual differences as portrayed through the CLAS.

CLAS are categorised depending on if they are mandatory or voluntary. For example standards relating to the provision of free interpretation services and language assistance, and the issuing of verbal offers and written notices informing patients of their rights to receive language assistance, and the assurance that the language assistance is competent, are mandatory and a federal requirement in the USA. Also, unlike the European approach, American healthcare organisations "must" make available patient related materials and signposting in the languages of commonly encountered groups within the service area. These standards reflect the political and legal context in which the American health sector operates. Another difference involves standards advising healthcare organisations to recruit, retain and promote diverse staff including leadership positions that are representative of the demographic characteristics of the service area.

An overriding conclusion from comparing these varying international institutional guidelines, tools and approaches is that international practices demonstrate the common use of organisation wide approaches in providing and developing culturally appropriate health care to MECs.

Having explored the theoretical approaches and the international institutional approaches to providing cultural competent health care as a means to manage ethno-cultural differences in hospitals, it remains to investigate how the Irish healthcare sector has approached the challenge.

2.9 The Irish experience

Having broadly examined international perspectives, it remains to explore how the Irish health sector has responded to the challenges of providing culturally competent health care to ethnic minority communities. In doing so, it is important to firstly understand the specificities of the Irish health sector, including specific healthcare policies and governmental policy initiatives geared towards improving service to ethnic minorities. Also an appreciation of the national legislative environment in relation to equality and racial discrimination is required.

2.9.1 The Irish context

2.9.1.1 Overview of the Irish healthcare sector

The HSE is the government body responsible for providing health and social services to all those living within the Republic of Ireland. It is the largest employer in the country employing in 65,000 staff in direct employment and a further 35,000 in voluntary hospitals and bodies funded by the state. The HSE was established in 2005 with the aim of delivering health and social services throughout the Republic of Ireland. There are three different types of hospitals in Ireland namely**,** hospitals owned and funded by the HSE, then voluntary public hospitals which are funded by the state but can be owned by private bodies, such as religious orders or are incorporated by charter or statute and are run by boards often appointed by the Minister for Health and Children and finally, private hospitals, which receive no state funding.

2.9.1.2 The EU legislative and policy context

The Irish government as a member of the European Union is influenced by EU international policy and has reacted to legislation such as that proposed by the EU Council Directive 2000/43/EC 2000, regarding equal treatment between persons irrespective of racial or ethnic origin. This directive introduced a binding framework prohibiting racial discrimination in the

EU in various areas including health care. Similarly, the Justice and Home Affairs Council in 2004 adopted 'Common Basic Principles' to underpin a European framework on integration, identifying the need for migrants to have access to institutions, delivered goods and services on an equal basis with national citizens and thus in a non-discriminatory manner (Watt and McGaughey, 2006).

2.9.1.3 The Irish equality and discrimination legislative context

The Irish government introduced key legislation with regard to discrimination and equality through the Employment Equality Acts of 1998 and 2004, and the Equal Status Acts of 2000, and 2004[16]. The Employment Equality Acts legislate against discrimination in the work place and the Equal Status Acts cover the provision of goods and services including health care and both acts cover nine discriminatory grounds including: Gender, Marital status, Family Status, Sexual Orientation, Religious Belief, Age, Disability, Race, and more specifically to the Irish context, Membership of the Traveller Community. The Irish Equality Act amended provisions in the Employment Equality Act of 1998 and the Equal Status Act of 2000 due to new EU Directives (Watt and McGaughey, 2006). Equality legislation is enforced by the Equality Authority and the Director of Equality Investigations who has supported legal compliance by health organisations to equality legislation and on promoting equality initiatives such as training and undertaking equality impact reviews. Discrimination is defined in the Irish Equality Status Acts as "the treatment of a person in a less favourable way than another person is, or has been or would be treated in a comparable situation of any of the nine grounds which exists, existed, may exist in the future or is imputed to the person concerned", Equality Authority Equal Status Acts 2000-2004, p6.

2.9.1.4 Irish government public service policy initiatives

Throughout the 2000s, the Irish government has introduced policies such as "The National Action Plan against Racism" (2005), "The National Anti-Poverty Strategy" (2002) and "The National Action Plan for Social Inclusion" (2007-2016). These national policies had and will continue to have the potential to impact on issues related to providing services to vulnerable members of society including ethno-cultural diverse healthcare service users, and aligned with objectives of endeavouring to provide culturally appropriate health care.

[16] Employment Equality Acts 1998-2004, Equal Status Act 2000-2004 (http://www.Equality.ie)

2.9.1.5 The Irish healthcare policy context

From a healthcare policy perspective, several healthcare related policies that have been published since 2001 refer generally speaking to the need to serve groups or communities that have poorer health status including minority ethnic groups. “The National Health Strategy” (2001) confirmed the need to adapt to a new multiethnic Irish society, by strategically planning for diversity and providing culturally appropriate service delivery. “The Primary Care Strategy” (2001) and the “National Health Promotion Strategy” (2000-2005) both aimed and endeavoured to reduce health inequalities. The initiative “Traveller Health: A National Strategy” (2002) emphasised among many issues that health service providers be trained and educated on traveller lifestyle and culture. “The Regional Health Strategy for Ethnic Minorities” (2004) developed by the Eastern Regional Health Authority considered the healthcare needs of minority ethnic communities and identified the need for local staff to be interculturally trained. This strategy fed into the “Learning, Training and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities” initiative (Thrive Consulting, 2005). The purpose of the report was to set out a framework to address workforce diversity and provision of appropriate service healthcare delivery to MECs**.** Also “A Vision for Change Mental Health Policy” (2006), highlighted the importance of culturally sensitive mental healthcare providers and the “HSE Transformation Programme’” (2007-2010) targeted the improvement of healthcare service provision to socially excluded groups that “everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide” Health Service Executive NIHS (2007) p6.

2.9.1.6 The National Intercultural Health Strategy (2007-2012)

“The National Service Plan” (2006) provided for the introduction and implementation of the HSE’s National Intercultural Health Strategy which was developed following the government’s “National Action Plan against Racism” (2005). The NIHS was launched by the Minister of Health and Children in February 2008 and aims at planning and delivering services that “are provided equally to all and respond appropriately to the specific health and social care needs of new and well established minority communities”, the CEO of the HSE Brendan Drum, NIHS (2007) p2. According to the NIHS, “*the primary objective of the intercultural health strategy is to provide a framework through which service users and providers are supported in addressing the unique care and support needs of people from diverse cultural and ethnic backgrounds”, p28.*

The NIHS has promoted the implementation of initiatives designed to improve healthcare provision to ethno-culturally diverse patients in Irish healthcare settings. For example the strategy has led to the HSE's Social Inclusion department setting up a cross-sector National Advisory Body and a Governance Group for Intercultural Health to implement some of the collaborate principles referred to in the strategy and publishes twice yearly newsletters indicating progress in the implementation of the NIHS. Thus far, the HSE has advanced significantly in the area of translation and has translated health literature such as a *Guide to Health Services* into eight foreign languages and has core health related information on topics such as breast cancer, cervical cancer, drug abuse, translated and available on its website. Also it has pilot tested an *Ethnic Identifier* which establishes accurate data of service users and has been tested in two Dublin hospitals. Furthermore, the HSE has developed an *Emergency Multilingual Aid Box* comprising of 20 translated phrasebooks designed to assist healthcare professionals communicate with patients in acute or emergency situations. In 2009 the HSE published the *Health Services Intercultural Guide* profiling the religious and cultural needs of 25 diverse religions in Ireland and supports Irish healthcare professionals to deliver culturally appropriate care to diverse communities and cultures. The HSE has issued interpreting guidelines for health professionals and organised community interpreting conferences, and it has also developed guidelines to enhance cross-cultural communication in general practice consultations, and supported staff through publishing intercultural mediation training resources. In addition, the HSE has collaborated with Access Ireland[17], which specialises in the area of cultural mediation in respect of the Roma and African communities in Ireland. Cultural mediation is a service provided by a professionally trained third party in assisting a person bridge the gap between his/her culture and the new culture that they find themselves in while using a service such as health care. The goal is to help both the service user and provider reach satisfactory outcomes in service provision and use in health care and other public services (Health Services Executive's HSIG, 2009). Furthermore, the Irish hospital sector including the HSE in the context of the NIHS, have strengthened collaborations with Irish community development organizations such as Cairde[18] who have been working to address health inequalities and access to health services among MECs and the New Communities Partnership[19] launched in 2005, which aims at empowering and representing ethnic minorities to fully participate in economic social,

[17] Access Ireland is a refugee integration organisation, which focused on health issues and social well-being and provided cultural mediation services for immigrant groups.

[18] Cairde is a community development organisation that combats health inequalities among ethnic minority communities by improving ethnic minority access to health services, and encouraging MEC participation in health planning and delivery in Ireland (Cairde http://www.cairde.ie/about/).

[19] New Communities Partnership(http://www.newcommunities.ie/).

political and cultural life in Ireland. At a European level, the HSE has participated on the Health and Social Care for Migrants and Ethnic Minorities in Europe initiative (National Intercultural Health Strategy newsletter 2009, 2010). Hence the NIHS has been the impetus for many changes and the HSE's Corporate Plan (2008-2011), plans for the continued implementation of the strategy throughout the Irish healthcare system.

2.9.2 The WOA to managing cultural diversity in Irish health care

A principal component of the NIHS for hospitals is the development of "a whole organisational approach to working with a diverse population as a means to develop a culture and ethos that supports interculturalism", Health Service Executive's NIHS (2007). A principal aim of the NIHS is to develop a top down national WOA approach to manage diversity and promote equal opportunities in all health agencies. Health agencies should champion a culture and ethos that supports multiculturalism, be multi-stakeholder, embed equality as a principle of planning and delivery of services, cultivate equality of opportunity, manage diversity proactively, address racism and discrimination and respond appropriately to the diverse cultures and religions of service users. In essence the HSE's in proposing the WOA has chosen like its European and North American counterparts "an organisational wide approach" to managing ethno-cultural diversity. The WOA is in fact the HSE's Irish version of an organisation wide approach to managing ethno-cultural differences in health care.

2.9.2.1 Origins of the WOA framework

The framework of the WOA originated from the National Consultative Committee on Racism and Interculturalism (NCCRI), which was an expert body that advised and provided training to statutory and non-statutory Irish agencies (government departments, trade unions, employers and non-profit agencies) on strategies to tackle racism and promote an inclusive intercultural Ireland. The NCCRI introduced a framework for development of a WOA to managing racism and cultivating interculturalism in public service organisations in Ireland.

The NCCRI's definition of a WOA is "a common sense approach to address racism and support inclusive, intercultural strategies within an organisation, with reference to equality policies and equality action plans. It seeks to focus on three key dimensions of an organisation namely organisational ethos, workplace and service provision. Therefore a WOA seeks to take into account: Organisational values, cultural diversity in the workplace

and interaction between staff, and cultural diversity among the customer/service users of an organisation", NCCRI Guidelines for a WOA (2003), p5.

The "Organisational ethos" dimension of the WOA framework is defined as "the dominant value system that underpins the way an organisation works, the way staff relate to each other within the organisation, and the way the organisation relates to its customers/service users", NCCRI Guidelines for a WOA (2003), p6.

It is otherwise referred to as organisational culture in other contexts and the NCCRI propose three forms of organisational ethos. They are an exclusionary ethos, i.e. organisation unreceptive to the needs of MECs, a neutral ethos i.e. organisations that threat everyone the same, despite the fact that some groups have greater needs than others, and an inclusive ethos, i.e. organisations take into account the diverse needs of workforce and customers / service users.

The "Workplace" dimension of the WOA focuses on compliance with legislation, recruitment and selection, work environment, staff retention and awareness, attitudes and behaviour towards cultural diversity.

The "Service delivery" dimension focuses on avoiding inequalities in service provision by adhering to the Irish government's equality and diversity commitments in the Strategic Management Initiative, which aims at modernising public services by implementing 12 Quality Customer service principles including aspects such as, Equality / Diversity, Information, Timeliness and Courtesy, Complaints, Official Languages etc, NCCRI Guidelines for a WOA (2003), p10.

The underpinning objective of a WOA is to support organisations to adapt to a multi-ethnic society by combating racism, providing equality of access to services and outcomes, recruiting and retaining employees and providing equal opportunity working environments to all staff including members of ethnic groups, and to ensure that organisations meet the legal requirements and comply with equality legislation and ensure good practice. The benefits according to the NCCRI for organisations adopting a WOA in public services include improved preparation to meet the needs of new markets through serving MECs, access to a

wider skills, wider experience and talent base, a better public image, increased credibility and reputation, advanced team cohesiveness, improved maximisation of employee potential, reduction in legal proceedings, reduction in absenteeism, reduction in turnover of staff including MECs, and to improve service provision through diverse employees and being better positioned to provide more culturally appropriate and sensitive customer/service user care. According to Watt and McGaughey (2006), the key foundations underpinning a WOA are mainstreaming, targeting, benchmarking and engagement. A brief explanation of each follows:

- Mainstreaming: involves ensuring that diversity and the needs of MECs are embedded in planning, implementation and evaluation of strategies and policies in the organisation. It involves the proofing of policy with regard to the impact on MECs.
- Targeting: concerns providing additional resources in specific areas related to service provision in areas such as health, education and training. If supporting data indicates inequalities experienced by specific groups then targeted actions should be put in place to overcome the discrimination.
- Benchmarking: and the collection of data consisting of baseline information on service providers and customers/service users regarding issues such as their employment, health, education, accommodation depending on the nature of the organisation, should be collected in order to analyse participation, access, and outcomes including MECs. Data facilitates evidence based policy-making and focuses on assessing services and evaluating outcomes. Data collection allows understanding of who is or is not using the services and allow for efficient targeting of resources, assessing discriminatory practices, and tracking inequality.
- Engagement consists of participation of MECs in being able to participate in decision making, advisory committees, and partnership arrangements within the organisation. Consultation with MECs allows for better planning, monitoring and evaluating of organisation strategies and policies (Watt and McGaughey, 2006).

2.9.2.2 The background of the HSE's approach to developing a WOA for the Irish healthcare sector

As previously referred to, the HSE and Thrive consulting published a report entitled "Learning, Training, and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities" in 2005. The purpose of the report was to set

out a framework of learning and development initiatives to address workforce diversity and the challenge of provision of appropriate healthcare services to MECs**.**

The HSE undertook an extensive scientific research and scoping exercise identifying best practices, training and educational needs of service providers and gaps in the Irish health sector regarding the provision of appropriate health care to MECs. A comprehensive review of the literature was undertaken focusing on anti-racism and interculturalism in the provision and receiving of health services. This included an analysis of models of good practice, emerging from other jurisdictions and a comparison of international health policies concerning the engagement of minority ethnic communities was also carried out. Furthermore, a study of the international debates and practices entitled "Anti-Racism and Intercultural health: A guide to best practice", by Fanning et al. (2005), were commissioned by the HSE in collaboration with scholars from the University College Dublin.

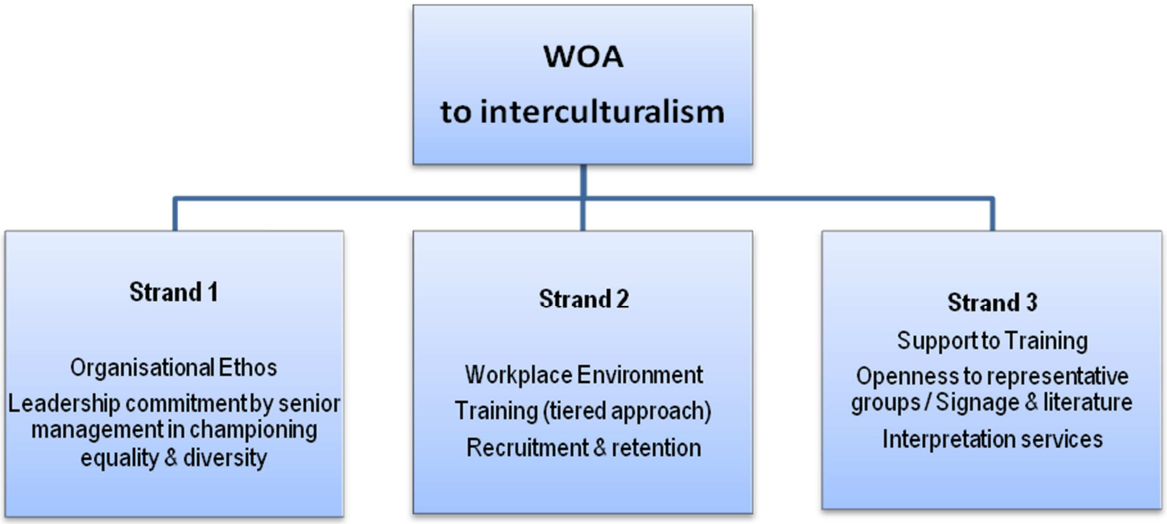
The HSE utilised the generic framework of the WOA as proposed by the National Consultative Committee for Racism and Interculturalism including the three strands**,** Organisational Ethos, Workplace Environment and Service Delivery (Support to Training) and adapted it as the model to address workforce diversity and provision of appropriate service healthcare delivery to MECs in the Irish healthcare sector.

Studies of relevant guidelines and policies from England, Scotland, Wales, Northern Ireland, Australia, Canada and the United States and the work of the Migrant Friendly Hospital Project were compared and the HSE visited Bradford teaching hospitals in the UK (part of the NHS Foundation Trust), which had long established intercultural health policies in place. In addition, consultations between the HSE and health related organisations which had experience in intercultural training to staff and service providers in New York, USA and Queensland, Australia were conducted.

2.9.2.3 Description of the HSE's WOA in the Irish health sector

The WOA focuses on developing three main strands of an organisation namely, Organisational Ethos, Workplace Environment and Service Elements necessary to Support Intercultural Training which will be referred to as support to intercultural training. Figure 2.8 outlines figuratively the three key dimensions.

Figure 2.8: Three strands of the WOA



Within each of the three strands of the WOA there are 4 corresponding sub-elements. The following table illustrates the sub-elements for each strand of the WOA.

Table 2.11: Key elements of the WOA proposed by the HSE

Strand 1: Organisational Ethos Leadership and commitment from senior management in championing a culture that promotes equality and values diversity. Developed informed policies and ensuring they are applied consistently. • Specific initiatives that demonstrate the commitment and support of managers • Up to date Intercultural policy for the health services • Equality framework including culture proofing of documentation and a template for Equality proofing service planning and delivery • Ethnic monitoring system including an agreed framework for data collection and data usage
Strand 2: Workplace environment Proactively promoting diversity in the profile of the workforce through attraction and retention initiatives. Educating and embracing the involvement of all staff through learning, training and development initiatives. • A tiered approach to intercultural training • Workplace support structures to support staff to manage issues relating to cultural diversity • Development of initiatives to integrate and manage multicultural teams • Training methodology to include co-facilitation by members of minority ethnic communities

Strand 3: Service elements necessary to support intercultural training

Embracing openness to partnership between health services agencies and representative groups. Developing services that are appropriate to the needs of a diverse and multi-ethnic society.

- Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system.
- Signage, particularly in reception and public areas in the key languages of service users
- Literature in the key languages of service users
- A comprehensive interpretation service

Adapted from Learning, training and development needs of health services staff in delivering services to members of minority ethnic communities. Thrive Consulting for the HSE (2005).

The HSE, in its publication *Learning, Training and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities* (Thrive Consulting 2005), introduced the WOA framework and reported on various common practices and recommendations from national and international research which aligns with the strands and sub-elements of the WOA.

2.9.2.4 Intercultural training in the WOA

A key element of the Irish WOA is a tiered approach to intercultural training. This multi-levelled framework for cultural competence capacity training is a sub-element of the work place environment strand of the WOA. Due to the importance of intercultural training for cultural competency skills obtainment (Gilbert, 2001), this framework represents a key driving factor of the WOA model in providing culturally sensitive health care. Table 2.12 illustrates the 6 levels of training included in the framework, consisting of level 1 induction and orientation training, level 2 understanding cultural diversity, level 3 specialist training for professional groups, level 4 intercultural dialogue training, level 5 managing multicultural teams and level 6 training for managers in legislative and ethical responsibilities of diversity management.

The following table illustrates the 6 levels of training, including the purpose of the training, target group and the potential content as recommended by the Irish WOA.

Table 2.12 : Tiered and incremental approach to intercultural training

Training level	Purpose of training	Target Group	Content
Level 1 Induction / Orientation	Introduce the individual to the organisation approach to interculturalism and anti-racism. Increase individual's awareness of diversity.	All staff	Organisation's code of practice on interculturalism and anti racism. Relevant legislation. Respecting equality and diversity in delivering services.
Level 2 Understanding cultural diversity	Develop understanding of one's own culture, other cultures and develop self-awareness.	Managers and all staff, who have direct contact with service users.	Exploring the norms of Irish culture. Understanding Traveller culture, and the cultures of other main service user groups including their experiences, history and beliefs. Personal beliefs and attitudes, including stereotyping, prejudice, racism, and developing self awareness basic skills in interacting in situations involving diversity. Basic skills with working with interpreters.
Level 3 Specialist training for professional groups	Develop improved knowledge, skill and competence in working therapeutically with service users from a different culture as well as developing self awareness.	Clinical staff e.g. Medical staff, Nursing staff, and health and social care professionals	Knowledge about cultural and spiritual beliefs regarding health related matters (e.g. illness, pain, birth and death) specific to the area of care (e.g. midwifery). Assessment tools/intervention strategies for specific service users groups specific to the area of care (e.g. mental health). Working with therapeutic groups in an intercultural context. Managing the relationship between cultural norms and the Irish Health care model. Ethical issues. Advanced Skills with working with interpreters.
Level 4 Intercultural dialogue	To enable staff to acquire the skills to interact, facilitate and negotiate the professional challenges of intercultural situations.	All staff, who have direct contact with service users.	Intercultural Communication. Facilitation in intercultural situations. Negotiation in intercultural situations. Managing conflict in intercultural situations.

Level 5 Managing multicultural teams	To enable managers to effectively manage the dynamics of multicultural teams and to increase retention levels.	All frontline managers	Understanding the necessity for this type of training. Different learning styles and communication styles. Interpersonal issues and prejudice managing conflict. Systems issues. Leadership skills in relation to this issue. Conducting effective multicultural staff meetings. Using a diversity management model. Understanding one's own limit and seeking information / help.
Level 6 Training for managers	To enable managers to effectively discharge their responsibilities for Equality and Diversity in the health sector	All senior personnel in service planning and service management roles (e.g. Care Group Managers at all levels and service planners at all levels).	Understanding the business case for diversity. Legislative and ethical responsibilities. Knowledge of cultural patterns relevant to service planning. Planning for a WOA to interculturalism. Ethnic equality monitoring data systems. Equality proofing tools and implementing equality proofing systems. Service user involvement. Influencing change in relation to intercultural issues. Skills for Line Managers and Professional Supervisors in enabling staff manage cultural diversity issues.

Adapted from Learning, training and development needs of health services staff in delivering services to members of minority ethnic communities. Thrive Consulting for the HSE (2005).

This comprehensive multi-level approach is tiered as it is designed to meet the varying needs of staff members as their cultural competence needs may vary depending on each staff member's contact and exposure to ethnic minority communities. This incremental approach to training is theoretically supported by Lister's Taxonomy for Developing Cultural Competence (1999) and Gilbert (2001).

2.9.3 Critique of the Irish approach

A review of the literature suggests that the HSE's development of the WOA as a model of reference for managing ethno-cultural diversity in the Irish health sector is well researched having followed scientific research standards involving empirical research and testing. This approach encompasses the recommendations of improving healthcare delivery to diverse patient groups as referred to by international institutional practices and recommendations. However it can be argued that the WOA is synthetic in nature and the 3 strands and

subsequent 12 sub-elements offer broad directions that do not specify within the framework enough details or practical instructions for healthcare settings to implement. The framework is a good basis but needs to evolve by issuing more specific indications for each sub-element. For example, the WOA framework suggests in the organisational ethos strand that healthcare managers should provide up to date intercultural health policies for health services but is limited in prescription of specific policies. Similarly in the workplace environment strand, workplace support structures to support staff to manage issues relating to cultural diversity are suggested with limited reference to particular support structures. There is an opportunity to develop a more complete framework consisting of a more detailed and comprehensive set of indicators that healthcare organisations can use to manage ethno-cultural differences in the Irish healthcare context.

2.9.4 Theoretical support for the WOA

Cox's "Framework for guiding organisational change" (1994, 2001) and Gardenswartz and Rowe's "Managing diversity in healthcare model" (1998) can serve as theoretical conceptual models which support the Irish WOA to managing ethno-cultural diversity. Cox's model is tried and tested and well established as a reference model in the broader business context, and is widely referred to in the fields of diversity management and organisational change. This five component model incorporates the three strands and sub-elements of the WOA. However Gardenswartz and Rowe's "Managing diversity in healthcare model" is perhaps more relevant with regard to this study, as it originates directly from the healthcare context and outlines the process and content for organisations in health care to manage and reap the performance rewards of managing diversity. Similarly the three core elements of the model necessary for change, namely, individual attitudes and beliefs, management skills and practices and organisational values, policies and systems and the accompanying 7 step process incorporate the essential components and philosophy of the Irish WOA.

2.10 Chapter summary

This chapter has investigated the challenges of managing ethno-cultural differences in healthcare service delivery and addressed the need for the provision of culturally competent healthcare in order to meet the changing demographic and ethno-cultural profiles of patient populations. The necessity of an "organisational wide approach" incorporating vital

intercultural training for frontline healthcare professionals, combined with appropriate systems, policies and services as the means to cultivating cultural competence in healthcare settings was discussed. The theoretical and conceptual models of organisational wide approaches originating predominately from the diversity management field were compared and international institutional approaches to providing migrant friendly and culturally competent healthcare were contrasted. This was followed by a thorough examination of the Irish experience in managing rapid ethno-cultural differences in service user populations was undertaken. This involved a comprehensive discussion and critical analysis of the origins and objectives of the HSE's top down policy consisting of an adapted variation of an organisational wide approach namely the WOA. Finally the research of Gardenswartz and Rowe's "Managing diversity in healthcare" was discussed in the context of theoretical and conceptual comparison to the WOA framework.

However as so often seen in the international arena, the existence of national policies does not necessarily guarantee implementation. There is scope to explore to what extent Irish hospitals are complying with the WOA framework and understand how it is being implemented in an effort to manage ethno-cultural differences. Furthermore questions relating to whether WOA meets the reality of the needs and constraints of Irish hospitals and what are the limitations regarding the implementation of this national top down approach in Irish hospitals need to be investigated.

Chapter 3

Research methodology

3. Research methodology

This chapter describes the qualitative research methodology that was employed in this study. In-depth informant interviews were conducted with key personnel and healthcare professionals involved with the provision of services to ethno-culturally diverse service users. The research process commenced in May 2009, with a preliminary research involving interviews in 9 health related agencies/organisations to establish the problematic (referred to in Chapter 1) followed by an exploratory research in September 2009 involving interviews with senior and middle management in 5 voluntary hospitals in Ireland.

The principal empirical research consisted of a series of semi-structured interviews with 93 hospital employees in 6 Irish hospitals. No previous published analysis has taken place concerning the implementation of national policies and initiatives to manage ethno-cultural differences in Irish hospitals and there is a deficit in literature on the provision of culturally competent health care in Irish hospitals. It is with this regard that a qualitative approach to investigating these ideas by interviewing a wide range of hospital employees was deemed to most likely yield the richest data.

This chapter is intended to provide a clear background for the reasons for choosing the study, the research question, the justification of the choice of methodology and explanation of the research design and ethical issues.

The chapter is divided into four sections in order to outline the logic and process of the research. Firstly, the problem statement, research objective, research question including sub-research questions are outlined. Secondly, a discussion of the varying approaches to scientific research follows, highlighting the differences in ontological and epistemological approaches to conducting research and providing a foundation for the rationale of choosing the appropriate method for this research project. Thirdly the rationale for a qualitative approach is provided including the choice of methodology and research process and design. Finally data collection and data treatment methods are addressed concerning codification and ethical issues of the research are outlined in the final section.

3.1 Problem statement

How do hospitals manage ethno-cultural differences in providing healthcare service delivery to service users?

3.1.1 Research objective

The research objective and focus is on acute hospital settings in the form of Irish voluntary and public hospitals.

3.1.2 Research question

The thesis aims at examining ***how healthcare service providers (hospitals) manage ethno-cultural differences in providing healthcare service delivery to (ethnic minority) service users in the Irish healthcare system?***

To answer this question a more refined analysis is performed by answering three sub-research questions (SRQ).

- **Sub-research question 1 (SRQ1)**: *What are the approaches and practices that Irish hospitals can utilise in managing ethno-cultural diversity in providing culturally appropriate healthcare service delivery and is there an overriding framework that can be used?*

The study thus far thanks to the preliminary research, exploratory research and literature review answers this question by identifying the WOA as the Irish health system's overriding framework to managing ethno-cultural differences in health care. This top down, national strategy is part of the Health Service Executive's NIHS.

By using this framework as the basis of analysis this thesis investigates how Irish hospitals are managing ethno-cultural differences in healthcare service delivery. An analysis is carried out at two levels, firstly a vertical analysis to investigate how individual hospitals were implementing the WOA framework (see RQ2). Secondly a horizontal analysis to investigate how each of the three strands of the WOA, were being implemented across hospitals (see RQ 3).

- **Sub-research question 2 (SRQ2)**: *What are the experiences of individual Irish hospitals in implementing the WOA?* (Vertical analysis)

This question seeks to understand what the experiences and reactions of individual Irish hospitals are in applying the selected approach.

- **Sub-research question 3 (SRQ3)**: *To what extent are the three strands of the WOA framework applied and implemented across Irish hospitals?* (Horizontal analysis)

This question seeks to understand to what extent the key contents of the selected approach are implemented across Irish hospitals**.**

3.2 General approaches to scientific research

In explaining the choice of methodology selected for this study, a discussion of the general approaches to scientific research is carried out in order to understand the rationale and reasons for choosing the methods employed to conduct this research. A researcher's decision to choose the appropriate methods to employ depends on several factors including the research process and the ontological and epistemological stances of the researcher. Furthermore the type of research employed depends on the purpose, process, logic and outcomes envisaged and can range from exploratory, descriptive, analytical to predictive research, or quantitative or qualitative, or deductive or inductive research, or applied or basic research. Initially a discussion of the critical elements of these factors are outlined in order to distinguish the differences in approaches to scientific research. This provides the necessary background information and context of research and assists to rationalize and defend the research methodology selected for this study.

Research functions at two levels, the abstract level of concepts and propositions and the empirical level of variables and hypotheses, Zikmund (2003). The purpose of science and research is to expand knowledge and discover the "truth", Zikmund (2003). This is usually undertaken by the careful selection of appropriate research methodology and following a research process.

3.2.1 Research process

It is widely accepted in the scientific community that scientific academic researchers need to follow a research process in order to produce research findings and conclusions that are reliable and valid. Brannick (1997) proposes the following research process which outlines a step by step approach and is illustrated in the following figure.

Figure 3.1: The elements of a research process

Adapted from Brannick (1997)

3.2.2 Ontological and epistemological stances

How researchers decide to undertake their research depends on a variety of factors including their ontological and epistemological philosophical stances. Ontology refers to “the nature of the social world and what can be known about it”, and Epistemology asks about the “nature of knowledge and how it can be acquired” and refers to the relationship between the inquirer and the known (Snape and Spencer 2003). Both concepts can be analyzed using a continuum ranging from objectivist, realist perspective to a subjectivist relativist perspective as portrayed in the following figure (Coghlan and Brannick, 2005).

Figure 3.2 : Two opposing perspectives: objectivist to realist (Coghlan and Brannick, 2005)

Adapted from Coghlan and Brannick, 2005

The essential ontological question confronting management researchers is whether reality is of an objective nature and external to the individual (independent of mind) or the product of individual cognition and mind (Babbie 1992, taken from Zalan and Lewis 2005).

An important ontological question is if there is a captive social reality and how to position the construction of a social reality namely by three separate positions, realism, materialism and idealism. "Realism claims that there is an external reality which exists independently of peoples beliefs or understanding about it; materialism claims that there is a real world but that only material features of that world hold reality; idealism holds that reality is only knowable through human mind and socially constructed meanings" (Snape and Spencer, 2003).

The main epistemological debate includes the opposing positions of positivism and interpretivism. "Positivism claims that methods of natural sciences are appropriate for social inquiry because human behaviour is governed by law like regularities; and that it is possible to carry out independent, objective and value free social research. Interpretivism maintains that natural science methods are not appropriate for social investigation because the social world is not governed by regularities that hold law like properties, and thus the researcher has to conduct the research through the perspectives of the participants and their own perspectives and explanations can only be offered at the level of meaning rather than cause" (Snape and Spencer 2003).

3.2.3 Types of research

According to Hussey and Hussey (1997, 2009)There are a several types of research that can be classified or categorized according to the purpose, process, logic and the outcome of the study. Table 3.1 demonstrates the different types of research and their relevant categorization.

Table 3.1 : Types of research by categorization

Types of Research	Basis of Categorization
A. Exploratory, descriptive, analytical or predictive research	Purpose of the research
B. Quantitative and qualitative research	Process of the research
C. Deductive or inductive	Logic of the research
D. Applied or basic research	Outcome of the research

Adapted from Hussey and Hussey (1997, 2009)

3.2.3.1 Exploratory, descriptive, analytical or predictive research

These can be described as follows:

Exploratory research is common when there is not a significant amount of information available regarding a specific subject and the objective is to uncover patterns, associations, ideas and looks for hypotheses as oppose to testing hypotheses.

Descriptive research "describes the form and nature of what exists", Ritchie (2003) p 27, and is useful to obtain information on a particular phenomena or problem.

Analytical research explains and analyses why and how and is an extension of the descriptive research, "examining the reasons for what exists", Ritchie (2003) p.27.

Predictive research is an extension of descriptive research which aims to predict certain outcomes and results depending on different relationships and hypotheses.

3.2.3.2 Quantitative and qualitative research

According to Guba and Lincoln (1994), the question of the paradigm which guides the researcher is more important than the question of method. McGuckian (2000) proposes that the paradigm through which the research question is being posed will influence the overall approach of the research. In referring to the term paradigm Kuhn (1970) explains it as a philosophical and conceptual framework made up of interrelated assumptions to help organize the study of the world. Creswell (1994) maintains that paradigms influence our questions, assumptions towards a topic and how we collect and interpret data.

Objectivity and subjectivity are two different perspectives which differentiate between paradigms, (Anderson 1995). Both perspectives relate to the relationship between the

researcher and the researched. In the natural science model of research, the researched is seen as being unaffected by the researcher's behaviour and hence the researcher is considered objective and value free. However in the social world the researched party (social phenomena) is considered to be affected by the process of the research and the relationship between the researcher and the researched is interactive or subjective.

The concept of objectivity supports the school of thought or paradigm known as Positivism which was a principal method of research in the twentieth century and dates back to esteemed philosophers such as Descartes (1637) and his publication "Discourse in Methodology" or Hume (1711-76) or Auguste Compte (1798-1857), (Snape and Spencer 2003) According to Bryman (1998), the beliefs and practices of social researchers concerning positivism usually include that the methods of the natural sciences are appropriate for the study of social phenomenon, only those phenomena which are observable can be counted as knowledge, knowledge is developed inductively through the accumulation of verified facts, hypotheses are derived deductively from scientific theories to be tested empirically (the scientific method), observations are the final arbiter in theoretical disputes, and facts and values are distinct, thus making it possible to conduct objective enquiry.

Positivism is an approach to social research that applies the social science model to study social phenomena and the social world (Denscombe 2002). Generally positivism is associated with idea that in order to understand events, measurable, empirical, quantifiable data is required and researchers who subscribe to positivism will have a preference to study observable social reality and produce law-like generalizations (Remenyi et al., 1998).

The concept of subjectivity supports the school of thought or paradigm known as Interpretivism which claims that qualitative data is of greater use to the researcher, (Guba and Lincoln 1994). Interpretivism originates from the writings of Immanuel Kant and his publication of the "Critique of Pure Reason" in 1781. Kant proposes that perception relates not only to the senses but to human interpretations of what our senses tell us, our knowledge of our world is based on 'understanding' which arises from thinking about what happens to us, not just simply from having had particular experiences, knowing and knowledge transcend basic empirical enquiry, distinctions exist between 'scientific reason' based strictly on casual determinism and "practical reason", based on moral freedom and decision-making which involve less certainty (Snape and Spencer 2003).

It is important to note that interpretivism is integrally linked to qualitative research traditions and qualitative researchers stress the importance of the human interpretative dynamics of knowledge related to the social world and emphasis the importance of the inquirers own interpretations and understanding of the social phenomena being studied.

Researchers who are in favour of Interpretivism or phenomenology reject some of the basic tenets of positivism and claim that it is impossible to gather objective knowledge regarding social phenomena and suggest that social reality is subjective to allowing humans to interact when being researched (Denscombe 2002). Interpretivism is a school of thought that emphasizes the important role of interpretation in addition to observation in comprehending the social world (Snape and Spencer 2003). Researchers critical of positivism argue that research of the social world can not be limited to the production of law-like generalizations, but rather there is a need to uncover rich complex insights through the interpretation of subjectively meaningful experiences.

Snape and Spencer (2003) highlight concerns of the positive approach and refer to criticisms and doubts concerning the possibility of the positive approach to “control” variables in experimental research involving human “subjects”. They also refer to the argument that the elimination of contextual variables in controlled experimental conditions is an inappropriate way to study human behavior. Furthermore they highlight the question if “overarching theories” of the world and ‘aggregated data’ are relevant and applicable to the lives of individuals, and maintain that the positivist emphasis on hypothesis testing neglects the importance of discovery through alternative methods (p9).

In terms of research philosophy and the production of knowledge, the literature is predominately divided into two paradigms namely positivism and phenomenology or interpretivism (Saunders et al., (2000). Table 3.2 adapted from Hussey and Hussey (1997) highlights the features of the two research paradigms and serves as a comparative overview of the differences in the approach to research.

Table 3.2 : Features of the two main research paradigms

Positivism paradigm	Phenomenological paradigm
Tends to produce quantitative data	Tends to produce qualitative data
Uses large samples	Use small samples
Concerned with hypothesis testing	Concerned with generating theories
Data is highly specific and precise	Data is rich and subjective
The location is artificial	The location is natural
Reliability is high	Reliability is low
Validity is low	Validity is high
Generalizes from sample to population	Generalizes from one setting to another

Adapted by Hussey and Hussey, (1997)

The terms qualitative and quantitative methods are often used to differentiate the different research methods associated with the two main paradigms namely Positivism and Interpretivism (Creswell 1994). It must be noted that these terms are not to be minimized as data collection techniques but can in fact stand alone as conceptualized paradigms.

Quantitative research is traditionally described as a positive approach and according to Chapman et al., (2005) in addition to being positivist, is objective in nature and is based on numbers, and focuses on measuring phenomena in an exact manner and is concerned with the quantity and extent of the outcome (Zikmund 2003). It emulates the scientific method as employed in the natural sciences and collects and analyses statistical data, and emphasizes hypothesis testing, causal explanations, generalizations and predictions (Snape and Spencer 2003). Typically quantitative research techniques involve methods such as randomized experiments, quasi-experiments, paper and pencil objective tests, multivariate statistical analysis and sample surveys etc. (Cook and Reinhardt 1979).

A qualitative, phenomenological or interpretivist research approach is subjective in nature and based more on a rejection of the natural science model and focuses more on understanding, description, meaning and on emerging concepts and theories, rather than on measurement of quantity and extent of outcome, Snape and Spencer (2003). The measurement approach is left more to the discretion of the inquirer and generally is not associated with statistical mathematical analysis, (Zikmund 2003). Likewise Strauss and

Corbin (1998), refer to qualitative research as “research that is not arrived at by statistical procedures or other means of quantification” (taken from Snape and Spencer 2003, p3).

Qualitative research studies a phenomena in its environment by usually asking how and why questions which tend to necessitate more in depth explanations regarding context, attitudes and behaviours (Patton 1990). According to Bryman (1998), “the way in which the people being studied understand and interpret their social reality is one of the central motifs of qualitative research”, p8. Typically, qualitative techniques consist of methods including ethnography, case studies, in-depth interviews, participation observation, focus groups, observational methods, narratives, and documentary analysis etc.

Denzin and Lincoln (2000) define qualitative research as “a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices turn the world into a series of representations including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them” (taken from Snape Spencer 2003 p3).

Table 3.3 demonstrates Creswell’s (1994) analysis of quantitative and qualitative paradigms based on ontological, epistemological, axiological, rhetorical and methodological assumptions and the table illustrates the core differences between each paradigm for the corresponding assumption.

Table 3.3 : Assumption of the two main paradigms (Hussey and Hussey, 1997 adapted from Creswell, 1994)

Assumption	Question	Quantitative	Qualitative
Ontological	What is the nature of reality?	Reality is objective and singular, apart from the researcher.	Reality is subjective and multiple as seen by participants in a study.
Epistemological	What is the relationship of the researcher to that researched?	Researcher is independent from that being researched.	Researcher interacts with that being researched.
Axiological	What is the role of values?	Value-free and unbiased.	Value-laden and biased.

Rhetorical	What is the language of research?	Formal based on set definitions. Impersonal voice. Use of accepted quantitative words.	Personal voice. Use of accepted qualitative words.
Methodological	What is the process of research?	Deductive process. Cause and effect. Static design-categories isolated before study. Context-free. Generalizations leading to prediction, explanation and understanding. Accurate and reliable through validity and reliability.	Inductive process. Mutual simulations shaping of factors. Emerging design categories identified during research process. Context-bound. Patterns, theories developed for understanding. Accurate and reliable through verification.

Hussey and Hussey, 1997 p48 adapted from Creswell, 1994, p5

According to Zalan and Lewis (2005) the quantitative research methods have been the dominant methodological approach in social sciences including management research focusing on the positivistic, hypothetico-deductive model and human resource management research in the British Isles, including the Republic of Ireland which has employed quantitative research methods (Conway 2003). Peterson (2005) maintains that quantitative methods have been the prevailing method employed in international management studies over the last 30 years and argues that both methods can be complementary to one another.

3.2.3.3 Deductive and inductive research

A researcher in ascertaining to acquire knowledge in research can utilize two different options or logics in undertaking the research depending on his/her epistemological positioning. These are the deductive approach or the inductive approach.

A *deductive approach* is broadly referred to as moving from the general to the specific, and consists of the development of theoretical and conceptual positioning involving hypotheses building and then testing the hypotheses through empirical observation (Hussey and Hussey 1997). Snap and Spencer (2003), maintain that deductive processes use evidence in support of a conclusion and Martin (2002) describes the typical scientific process as theory, hypothesis, methods, results and conclusions which align with a deductive logic.

Inductive research is broadly referred to as moving from the specific to the general where inferences are induced from specific instances. Theory emerges or is developed from observation (Hussey and Hussey 1997). Inductive research involves “using evidence as the

genesis of a conclusion" by looking at "patterns and associations derived from observations", Snape and Spencer (2003), p14. Inductive logic, while often associated with qualitative inductive approach, should not be seen as a defining characteristic of qualitative research.

An emic perspective is usually associated with inductive research while an epic focus is associated with deductive approach. An emic approach is an "analysis that reflects the viewpoint of the native informants", Nattiez (1990), p61. Hence, an emic approach will focus on what is in the mindset of the people being researched rather than an epic approach which is more focused on the mindset of the researcher including theories and hypotheses (Martin 2002). Thus emic research is frequently associated with grounded theory which concerns hypotheses emerging from data rather than theory (Glaser and Strauss 1967).

3.2.3.4 Applied or basic research

Research can be classified into two categories regarding the outcome of the study. Applied research has the objective to fulfill the purpose of addressing a specific problem by the discovery or application of its findings. Thus it is research applied to a specific problematic. The objective of basic research or pure research is to produce and contribute to a body of knowledge for general consumption and not necessarily to solve a particular problem.

3.3 Selected research methodology for this research

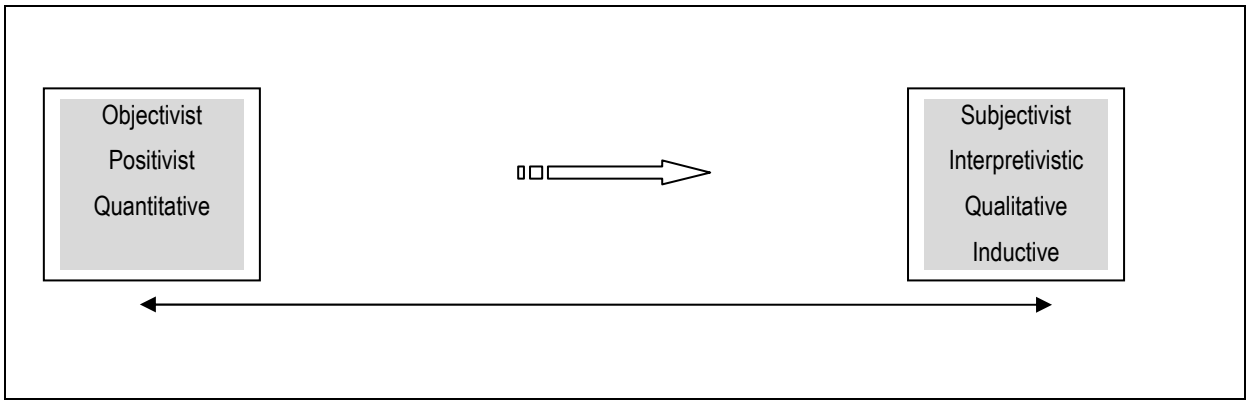
Having examined the relevant theoretical and philosophical approaches and types of research, an explanation of the selected research methodology employed is presented. This includes the ontological and epistemological positioning for this study and the type of research methodology based on the purpose, process, and logic and envisaged outcome of the research.

3.3.1 Ontological and epistemological positioning for this research

From an ontological perspective, the research is based on the subjectivist stance that reality of the social world, or in this case how hospitals are managing ethno-cultural differences is based on the individual's subjective cognitive view point and that the reality is not independent of the individual's beliefs. The research aligns with the epistemological positioning of interpretivism as the research relies on knowledge being acquired and

interpreted through the opinions and perspectives of individuals. Figure 3.3 portrays the ontological, epistemological and methodological positioning of this research project

Figure 3.3 : Ontological, epistemological and methodological positioning of this research project



Based on Hussey and Hussey's (1997, 2009) classification of research types, the methodological positioning of this research is descriptive, analytical, qualitative, (phenomenological), inductive and applied in nature. The research methodology was selected taking into account the following considerations in the context of Hussey and Hussey's categorization.

3.3.2 Purpose of the research: descriptive and analytical research

The purpose of this research project is descriptive (and analytical) since its purpose is to describe how hospitals are managing ethno-cultural differences but also analyses how and explains why something is happening i.e. the implementation of the WOA.

3.3.3 Process of the research: qualitative research / paradigm phenomenological

The process of this research is phenomenological or qualitative in nature as it consisted of 93 in-depth interviews in 6 hospitals where the researcher interacted with the participants and the reality was investigated from the subjective viewpoint of the interviewee. Each hospital has its own contextual environment and has different functions and traditions. Quantitative methodology focuses on measurement and is limited to law like generalizations which was deemed less appropriate**.** A subjective interpretive approach allows for interpretation and interaction between the respondent and inquirer providing rich complex information that can be interpreted in the context of each individual hospital.

There is a deficit of appropriate literature on the provision of culturally competent health care (Donohue 2010) and particularly concerning a whole organization approach to managing ethno-cultural differences in provision of healthcare services in Ireland. It was therefore considered that a qualitative approach to investigating this problematic would yield the most appropriate data.

3.3.4 Logic of the research: inductive

This research project is inductive as it moves from the specific to the general and draws conclusions from the evidence emerging from interviewing healthcare professionals in their hospital environment. The process of interviewing 93 healthcare professionals provides an opportunity to induce inferences from specific circumstances and allows for observation and identification of patterns and associations. An emic perspective was employed focusing on the viewpoint of the interviewees.

3.3.5 Outcome of the research: applied

The outcome of this research is applied as it aims to serve hospital management in better managing ethno-cultural differences in healthcare settings by examining how policy is being implemented; highlighting reasons for poor implementation and recommending improved implementation strategies.

3.4 Presentation of the research design

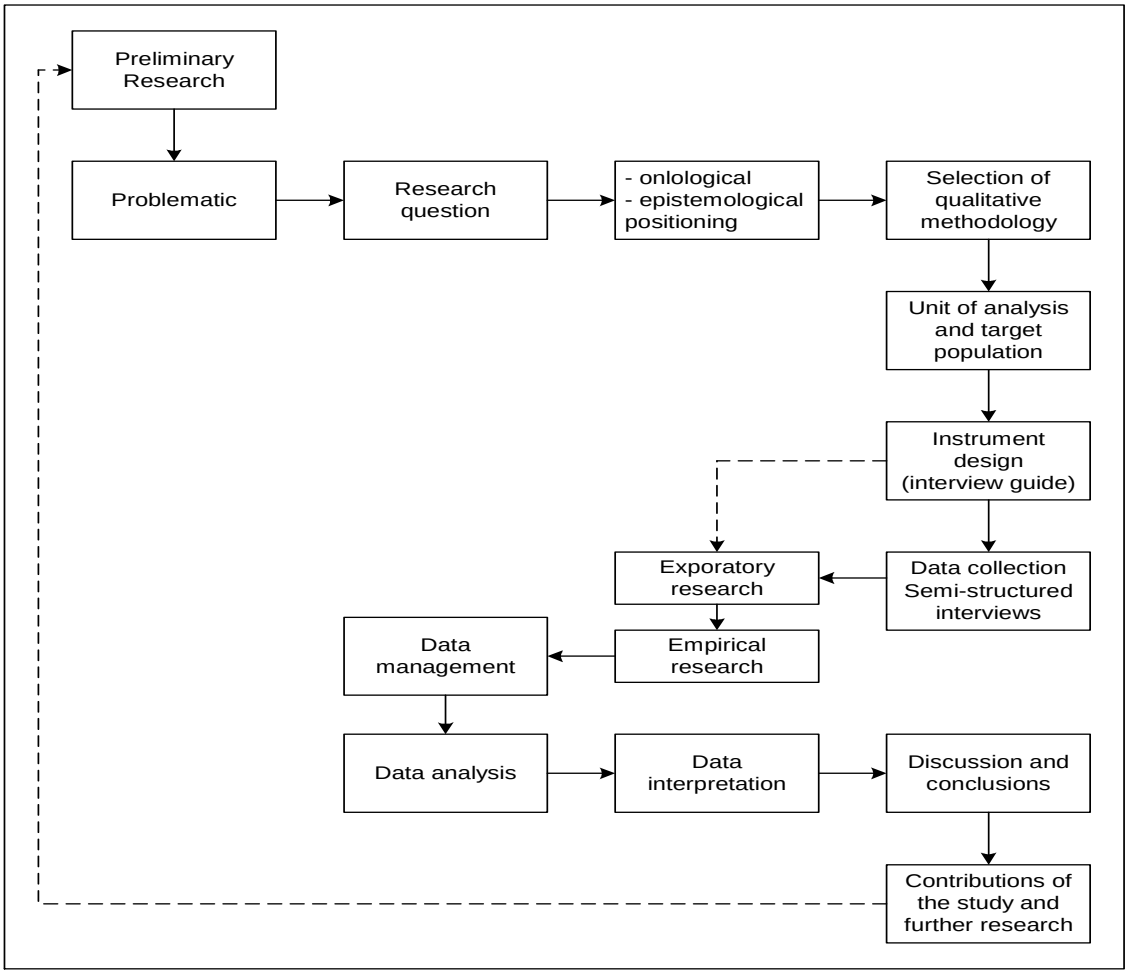
The logical sequence and design employed for this study is illustrated in figure 3.4.The process started with preliminary research to explore how ethno-cultural diversity impacted the Irish health sector and establishing the problem. The research question was thus constructed and the ontological and epistemological position selected. A review of the literature exploring cultural competence in health care, diversity management and international approaches including the Irish experience and the emergence of the WOA framework was carried out. Then a qualitative methodology involving semi-directed interviews in hospitals setting using the WOA as the interview guide were selected. An exploratory research preluded the principal empirical research allowing for pilot testing of the interview guide and data collection instrument. The management of data including data

analysis, and interpretation followed using parameters, a Likert scale and a codification system. Finally, the results and conclusions were analyzed and documented**.**

3.4.1 Presentation of the global design of research

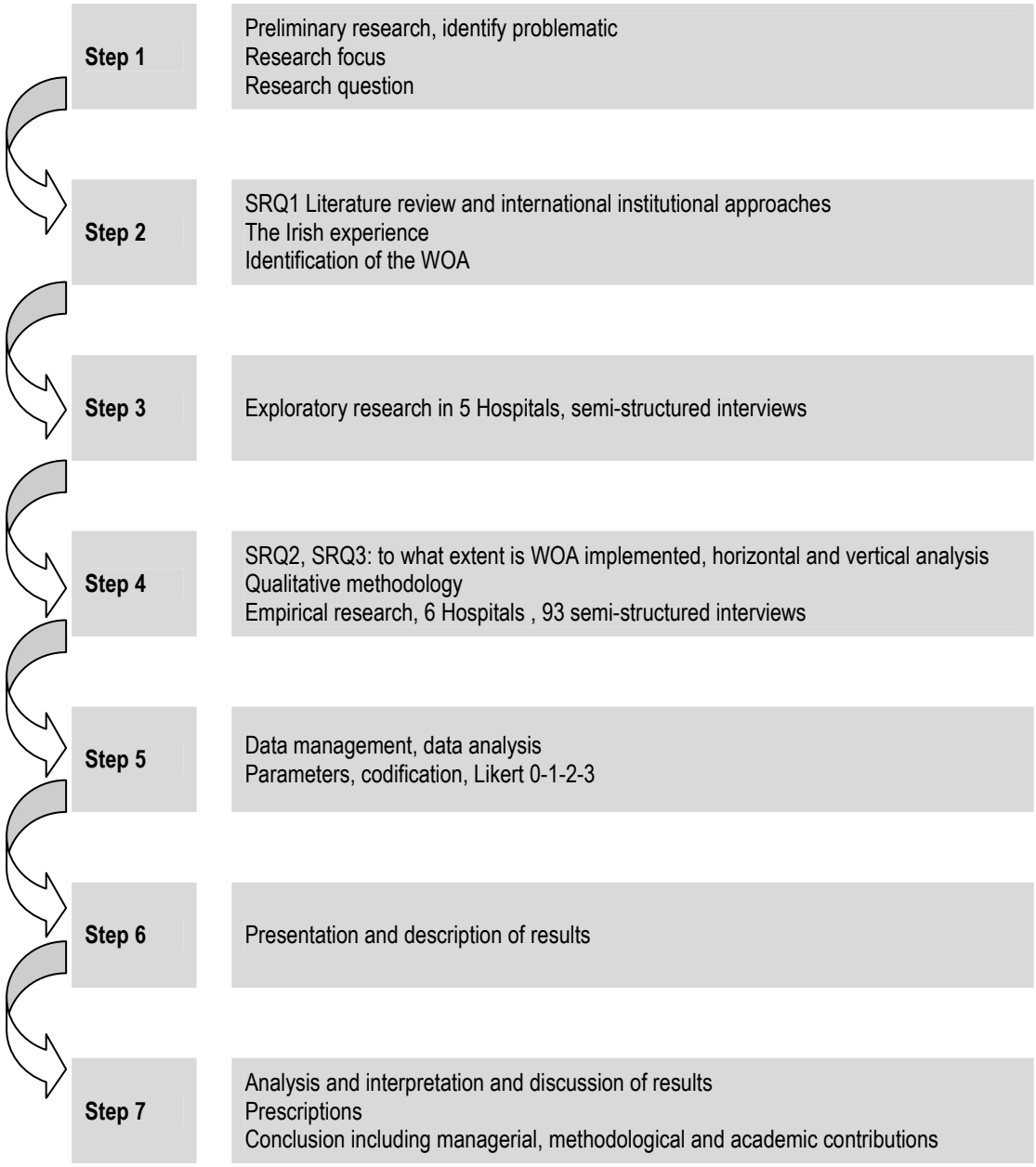
Figure 3.4 illustrates the starting point and finality of the research**.**

Figure 3.4: Design of research



The research process for this study can be described as a series of 7 logical steps that were followed. Figure 3.5 illustrates these 7 principal steps of the research process.

Figure 3.5: Principal 7 steps of the research process



3.4.2 Step 1

The process began with preliminary research in May 2009 which identified the problematic and research questions.

3.4.3 Step 2

This step consisted of a review of the appropriate literature and examined how hospitals manage ethno-cultural diversity in providing health care service delivery and addressed SRQ1 by identifying the Irish WOA as a legitimate framework with scientific background, for managing ethno-cultural diversity in patient populations in Ireland.

3.4.4 Step 3

Step 3 concerned the organisation of exploratory research conducted in 5 hospitals indicated that hospitals were implementing the WOA at different speeds and provoked further inquiry to understand why.

3.4.4.1 Description of exploratory research (Ireland, 2009)

Having established that the Irish government had reacted to managing ethno-cultural diversity by introducing an intercultural health strategy consisting of a WOA framework, an exploratory study of 5 voluntary hospitals was organised in September 2009. The aim of the research was firstly to explore to what extent the three strands of the WOA had been implemented, and secondly to investigate how each of the five individual institutions had implemented the WOA framework as recommended in the NIHS (2007) and in the Learning, Training and Development Needs of Health Services Staff in Delivering services to members of Minority Ethnic Communities guideline (Thrive Consulting 2005). The research methodology involved semi-directed personal interviews with 6 high ranking employees in a sample of five voluntary hospitals of varying sizes and functions located in Ireland.

Table 3.4: Hospital type and profile of interviewees for exploratory research 2009

Hospitals	Interviewee profile	Hospital status
H2	HR Manager	Elderly and disabled adults care
H5	HR Manager	General - multi specialized
H6	HR Manager	General – multi specialized
H4	Training and Diversity Officer	Maternity Care
H3	HR Manager / Director of Nursing	Children's care

Table 3.4 illustrates the profile of the interviewees and a broad description of the type of care offered by each hospital. Contact with 4 of the 5 hospitals had already been established for

the preliminary research referred to in chapter 1 that established the challenge of managing ethno-cultural differences in service users as the priority concern for Irish hospitals in the context of new Irish multiculturalism.

3.4.4.2 The results of the exploratory research

This research has served as a preliminary indication of the extent to which the WOA has been implemented on the ground in Irish hospitals. The research indicated that 4 out of 5 of the hospitals which have experienced increasing ethnic diversity in their service user profiles, had advanced in implementing the WOA, all be it at different degrees of implementation. The research illustrates that while advancement has been made, there are considerable efforts remaining to be made in areas of intercultural training, cultural competency skills obtainment, and initiatives to support training. Different hospitals are implementing the WOA at different speeds and this research identified key variable factors that influence the implementation of the WOA in each hospital. These variables include factors such as function, size, location, ethno-cultural differences in service users, ethno-cultural differences in service providers, existence of diversity champions, or the hospital's background in MF healthcare. As previously mentioned the exploratory research revealed the need to broaden the sample to public hospitals and provided an opportunity for the author to cultivate relationships of trust with the management of each hospital for the purposes of conducting the more comprehensive empirical research. The exploratory research also provided an opportunity to test the interview guide. It emerged that contextual considerations had to be taken into account with regard to best practices relating to recruitment, retention and promotion policies of ethno-culturally diverse staff. Irish equality legislation does not allow deliberate targeting of employment candidates that are representative of the demographic characteristics of the service user population. Therefore recommendations by the American health sector to healthcare managers to intentionally recruit and mirror image healthcare employees with service users is not appropriate in the Irish context (Weech-Maldonado et al 2002).

3.4.5 Step 4 to 7

Step 4 addressed the remaining two sub-research questions (SRQ2, SRQ3) and focused on the empirical research involving qualitative research methodology and 93 semi-directed interviews in 6 hospitals.

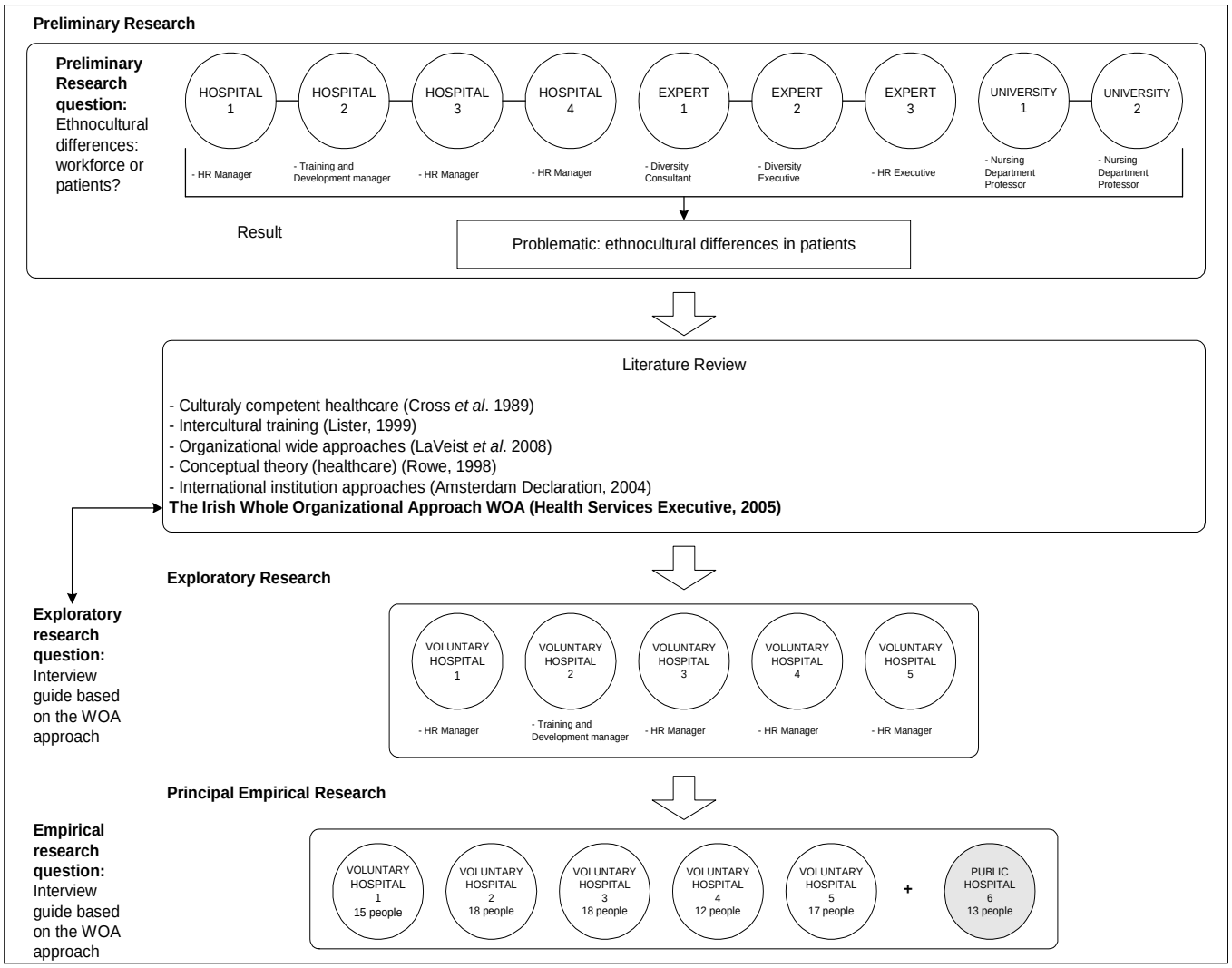
Step 5 was concerned with the data management and the data analysis process. This consisted of the data being manipulated, treated and coded using parameters and a Lickert scale from 0-1-2-3.

Step 6 represented the presentation and analysis of the results.

Step 7 incorporated an analysis, interpretation and discussion of the results including prescriptions for each hospital. Finally conclusions were drawn from the research and the managerial, methodological and academic contributions summarised.

Figure 3.6 outlines graphically the process of the research highlighting the objective of each step of the research beginning with preliminary research and establishing the problematic, followed by a review of the literature, then exploratory research in 5 hospitals and finally the principal empirical research in 6 hospitals. The nature of the type of establishment contacted and the position or number of respondents interviewed is illustrated.

Figure 3.6 : Illustration of the research process



Appendix 2 shows a chronological list of contacts and meetings during the research process.

3.4.6 Target population

The unit of analysis in this thesis are healthcare personnel who are responsible for implementing strategies or are in the frontline regarding delivery of health care to service users in voluntary or public hospitals in Ireland.

3.4.7 Number of cases to study and generalisation of results

The objective was to focus on an adequate number of hospital cases to provide sufficient information and allow for in-depth and credible analysis of the topic. A target list of hospitals was constructed with guidance from the IBEC in Dublin, Ireland and the HSE employer's agency.

Hospitals that had been contacted during the original preliminary research were re-contacted. The author had previously worked for the IBEC as a HR Executive and utilized contacts from a portfolio of hospitals that he had previously consulted while living and working in Ireland. These included 3 hospitals where the author had formerly worked in a consulting or advising capacity in 1998 and 2000 and hence had prior contacts with the management. 2 other hospitals were recommended for the study by the Director of Diversity at the Irish Business Employers Confederation and finally a 6th hospital was proposed by the Health Service Executive employer's agency.

Ghauri (2005) considers that a single case study is appropriate for a study that reflects a unique accomplishment, out of the ordinary or alternatively a critical or unique example. If the research involves posing similar questions to different actors in order to compare the results between them, then multiple case studies are pertinent. Mintzberg (1979) proposes that the size of the fieldwork, i.e. number of cases is of less importance than a well defined research study and a systematic research method.

3.4.8 Sample and size

The sample consisted of 5 voluntary and 1 public hospital of varying sizes and functions located in Dublin, Ireland. Each hospital had its own range of specialization care ranging broadly from elderly care; general care, maternity care, and children's care (see table 3.5). Using 6 different hospitals, each with its own organizational culture and separate function, allowed for a more comprehensive and comparative investigation.

Hospitals were selected in Dublin city and the greater Dublin area. This was because ethno-cultural differences and cultural diversity are more prevalent in the capital city which has a population of 1.2 million, Census (2006). Dublin has experienced rapid immigration from countries such as Poland, Lithuania, China and Nigeria. The capital city plays host to more new arrivals than other cities and towns in the country with 60% of Ireland's Asian population living there (McDonald 2006).

3.4.9 Profile of respondents and interview protocol

A total of 93 healthcare professionals were interviewed in the empirical research ranging from between 12 and 18 interviewees with an average of 15 respondents in each hospital. The sample of participants in each hospital was selected to represent a wide variety of personnel and allow for a triangulation of sources (see appendix 3). Personnel were selected from management; medical and non-medical positions in order to get a comprehensive and varied perspective of how the hospital managed ethno-cultural differences in healthcare service provision.

Examples of management participants interviewed include, the Director of Mission Effectiveness, members of the Board of Directors, HR Directors, HR Managers, Training and Development Managers, Directors of Quality and Risk, Quality and Accreditation Managers, Clinical & Patient Services Managers and a Nursing Support Services Manager. Examples of medical interviewees include Directors Midwfe nursing, Directors of Nursing, Assistant Directors of Nursing, Clinical Nurse Managers, Staff Nurses and Neo-natal / Midwife Nurses. Examples of non-medical interviewees include Social Workers, Dietician Managers, Catering Managers, Porter/General Service Managers, a Health Promotion Coordinator, an Assistant in the administration for Cardiology, an Allied Services Manager and a Healthcare Records Manager.

For the purposes of this study it was considered imperative to secure interviews with HR and training management to understand the organisational aspects of managing ethno-cultural differences and those personnel in the frontline of service provision notably nursing managers and nurses. Hospital chaplains, HR management, nurses and nurse managers are the 4 common grade/positions that were secured in each of the six sampled hospitals.

Given the nature of the study efforts were made to invite non-Irish national participants from different ethnic backgrounds, this included respondents from Asian, Filipino, Indian, African, Eastern European and Pakistani backgrounds.

3.4.10 Protection of identities

Participants were informed that protection of the anonymity of all participants and hospitals would be respected. Consequently names of participants, gender, age, and specific addresses and names of hospitals have not been cited in this study. Participant's anonymity has been protected irrespective of positive or negative comments about critiques regarding hospital services. Any quotations from participant interviews have been protected by using the professional identity or job title. The names of the 6 hospitals surveyed in this study have been replaced and are referred to as H1 to H6 (H1=Hospital 1).

3.4.11 Selection of cases

The choice of the case to study depends on what it can add to the knowledge of the phenomena that is positioned in the heart of the research, Ghauri (2005). 5 voluntary hospitals and 1 public hospital were selected for the purposes of this research. The exploratory research indicated that the implementation of HSE policies may be influenced by the relationship that the individual hospital has with the HSE. It emerged from exploratory interviews that voluntary hospitals being privately owned, even though funded by the HSE were traditionally more independent than public hospitals which were totally under the governance of the HSE and less autonomous. Therefore it was decided to add a public hospital to be targeted for the purposes of this research.

Private hospitals were not included in the research as they are not funded by the state and thus exercise more autonomy in their management of their establishments and are not obliged to implement the elements of the WOA. A wide variety of different hospitals varying in size, function, catchment, location and service user diversity were targeted. This allowed for a more comprehensive view of how hospitals were managing ethno-cultural differences in healthcare service provision.

Table 3.5 illustrates the profile of each of the hospitals selected for this study including size, function, if the service user population is diverse, the number of interviews conducted, the time period when the research was carried out and the title of the hospital contact gatekeeper.

Table 3.5 : Profile of hospitals surveyed

Hospital	Size In terms of beds	Function	Public ethno-cultural differences	Interviews 2010	Period 2010	Contact Gate keeper
H1	Medium	General/Public	Diverse	13	Sept	Health Promotion Coordinator
H2	Small	Elderly	Mono	12	Sept	HR Manager
H3	Medium	Children	Diverse	15	Sept	CEO/HR Manager
H4	Medium	Maternity	Diverse	18	Nov	Training & Development Manager
H5	Large	General	Diverse	17	Nov	HR Manager
H6	Large	General	Diverse	18	Nov	HR Manager

The following is a brief description of the profile of each hospital and the source by whom the hospital was recommended by for the purpose of this study: Determining the size of a hospital is a complicated process due to the function and nature of the hospital services and catchment area population. The sizes of the hospitals have been described for the purposes of this study based on the amount of beds offered by each hospital. A small size hospital has less than 150 beds. A medium sized hospital has between 150 and 300 beds and a large has above 300.

- **H1:** A medium sized public general hospital (approx 167 acute beds), located in North Dublin in a noted ethno-culturally diverse area identified by the HSE employer's agency and HSE literature.
- **H2:** A small sized voluntary hospital (approx 78 beds), located in South Dublin, specialised in elderly service user healthcare provision and identified by IBEC.
- **H3:** A medium sized voluntary hospital (approx 155 beds), centrally located specialised in children's health care that has a strong association with managing

ethno-cultural differences in health care and the author had consulted with the hospital previously and thus aware of the hospital's research potential.

- **H4:** A long established medium sized voluntary hospital (approx 193 beds), centrally located, specialised in maternity services with a strong ethno-culturally diverse service user population identified for the purposes of this study by IBEC.
- **H5:** A large voluntary general hospital (approx 570 beds), centrally located, identified by IBEC.
- **H6:** A large voluntary general hospital (approx 500 beds), located in South Dublin and identified by IBEC.

3.4.12 Access to research: chronological time frames and ethics committees

Each hospital visit was planned and undertaken separately. The author spent between two and three days on each site of the six hospitals in order to conduct interviews. Each interview was prepared individually and chronologically so as information from each interviewee could be noted before conducting the next interview.

Hospitals are important institutions that provide essential services for the health of individuals and communities and receive many requests to provide access for research. Therefore, certain hospitals required a certain number of formalities before agreeing to provide access for the research. Two hospitals required applications to an ethics committee, which included submitting comprehensive documentation on the nature and background of the research, letters of application and an oral presentation and questions and answers session to ethics committee members. Other hospitals required board of director approval without application to the hospital's ethics committee. One hospital required that all participants in the research be given the opportunity to meet the researcher and be given an explanation in person of the nature of the research.

The principal empirical research involving 93 interviews took place in September and November 2010. Table 3.6 illustrates the total visits to each hospital from the beginning of this research project in chronological order. Also this table indicates the number of visits and the nature of the visit timeframe of the principal empirical research and the preliminary and exploratory research visits where appropriate.

Table 3.6 : Chronological time frame and nature of visits to each hospital

Hospital	1st visit	2nd visit	3rd visit	4th visit
H1	Sept 2010 Principal Empirical Interviews			
H2	May 2009 Preliminary Research	Sept 2009 Exploratory Research	August 2010 Met participants	Sept 2010 Principal Empirical Interviews
H3	May 2009 Preliminary Research	Sept 2009 Exploratory Research	July 2010 Met Director	Sept 2010 Principal Empirical Interviews
H4	May 2009 Preliminary Research	Sept 2009 Exploratory Research	July 2010 Ethics committee	Nov 2010 Principal Empirical Interviews
H5	Sept 2009 Exploratory Research	July 2010 Ethics committee	Nov 2010 Principal Empirical Interviews	
H6	May 2009 Preliminary Research	Sept 2009 Exploratory Research	July 2010 HR Manager	Nov 2010 Principal Empirical Interviews

3.4.13 Preparation of research visit

In each of the 6 hospitals a selected member of staff in each hospital was targeted as the gatekeeper and contact person to organise the research. All the gatekeepers were management level and were selected based on relationships cultivated throughout the research process. The gatekeeper assisted in the selection of interviewees, the distribution of information and the organisation of the interview schedule.

3.5 Data collection

3.5.1 Interview guide

The interview guide consisted of 13 questions (see appendix 4) constructed to solicit information relating to the implementation of the 3 strands and sub-elements of the WOA. 12 questions were open which allowed the interviewee to speak openly and construct his/her answer liberally.

A sample of the open nature of the questioning is portrayed in the following example from the interview guide: “In what ways does leadership and commitment from service management cultivate a culture that promotes equality and values diversity?”

Questions 2, 3, 4 and 5 relate to Strand 1, Organisation Ethos, in the WOA. Questions 6, 7, 8, 9 and 10 were associated with Strand 2, workplace environment, and question 11, 12, and 13 relate to Strand 3, service elements necessary to support intercultural training. Question 1a was a closed question seeking to know if the interviewee had experienced problems due to cultural diversity in his or her career at the hospital. If the question was answered affirmatively, the respondent was instructed to describe some examples of such difficulties in question 1b. This provided information regarding the problems that each hospital was encountering in managing ethno-cultural differences. At the beginning of each interview respondents were requested to provide general information including title, function, length of service working in the hospital and the health sector.

The interview guide was piloted and tested in the exploratory research in September, 2009 and further tested by hospital and diversity specialists in the field in Ireland and the USA. These included 6 healthcare professionals, 3 from the Irish healthcare context and 3 from the USA context. The author wished to solicit the advice of practitioners and specialists from Ireland and the USA who were specialists in the field of cultural diversity and health care and who worked in health systems that had been proactive in managing ethno-cultural differences in health care. The Irish representatives included the head of the HSE project which instigated the creation of the WOA and the publication of the guideline entitled *Learning, Training and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities* (Thrive Consulting 2005), which preluded the Intercultural Health Strategy in 2007. Also a member of the HSE Intercultural Health Strategy Committee and leading nurse practitioner and trainer in transcultural health care in Ireland and an Equality Authority of Ireland representative and specialist in intercultural health care. The American representatives included a leading author, academic and consultant on diversity in healthcare based out of Los Angles, the HR manager from Oregon Health and Science University, Portland and the Director of Diversity at Roswell Park Cancer Institute, Buffalo, New York.

3.5.2 Interview protocol

Data collection took place in September and November in 2010, in Ireland. All interviews in this study took place on site in the interviewee’s workplace i.e. hospital setting. Four

hospitals arranged for an interview room where each interviewee came to be interviewed. Two hospitals organised the interview schedule so that the researcher went to the interviewees working area of the hospital and conducted the interview in a nearby office. In all cases privacy was assured in a quiet and calm environment. The majority of the interviews were one to one but on a few but rare occasions due to time constraints, two interviewees were interviewed at the same time if they worked in the same area e.g. catering staff. Interviews were digitally or tape recorded to ensure validity. The interview process involved semi-directed interviews which lasted on average 45 minutes and permitted conversational two-way communication and in depth discussion.

Permission to be recorded was granted by the interviewee. Notes were rigorously taken during the interview and re-read after the interview was completed. Interviews were transcribed and recordings were listened to, to check accuracy of transcription. Recordings and transcripts were re-listened to and re-read for accuracy and again a second time for coding purposes. Interviews were analysed in the same order as the interview took place.

The interviewer was candid in his approach and attempted to conduct the interview in the same manner with all interviewees irrespective of their rank or grade and equally to promote the interviewee to be clear and explicit in answering questions. The same questions were asked to a variety of personnel working in different areas and functions of the hospital and who had different service records in the establishment and in the healthcare sector and in some cases different nationalities, origins and country of birth. Some of the international nurses from India and the Philippines had different points of view, perceptions and assumptions on how the hospital was managing ethno-cultural differences. Interviews were conducted over an average of three days in order to respect the availably of personnel and their work schedules and to minimize interruptions to the functioning of the hospital.

3.6 Classification and treatment of data

When the data from the semi-conducted interviews was recorded, replayed, transcribed, then the interview guide was completed. A chart for each hospital was constructed listing the 13 questions from the interview guide and the corresponding responses of the respondents for each question.

12 of the 13 questions contained in the interview guide were directly related to the 12 sub-elements of the WOA. The Irish WOA is synthetic in nature and is a broad framework concerning the management of diversity and provision of culturally competent health care. For the purposes of measuring individual hospital efforts regarding the management of ethno-cultural diversity in service users, and establishing to what extent the WOA was implemented in each hospital, a set of parameters for each of the sub-elements of the WOA framework was constructed. These parameters originate from the WOA and from other international institutional approaches and research as discussed in chapter 2.

3.6.1 Description of parameters

These international approaches originally included the work of Thrive Consulting (2005) in establishing the WOA, and recommendations to the Irish health sector including practices from the UK and Australia included in the HSE's commissioned publication "Learning, Training and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities" (Thrive Consulting 2005). Then contributions from The EU Amsterdam Declaration (2004), The Migrant Friendliness Quality Questionnaire (2004), the American CLAS (2001), and the Canadian' Best practice Guidelines for Health Service Delivery for Newcomers'(1998) were cross examined and added.

Appendix 5 entitled "Comparison of key elements of 5 international institutional approaches categorised into the WOA framework", is designed to outline each institutional approach categorised into the strands of the WOA.

The author, having been invited to present this research to the 2nd European Transcultural Nursing Association International Conference at University of Limerick, Ireland 30th, June - 1st July 2011, was made aware of two recently published bodies of relevant research. These included firstly, European research published in 2011 by the HPH TF MFCCH, a project to develop standards for equity in health care for migrants and other vulnerable groups which was a task force set up to follow up and continue the work and momentum of the Migrant Friendly Project, 2005 as previously referred to in chapter 2. Secondly the most recent research regarding the subject from the USA entitled *Building a Culturally Competent Organisation: the Quest for Equity in Health Care* from the Health Research & Educational Trust, Institute for Diversity in Health Management, Chicago, and published in 2011, by the Health Research and Education Trust. Both these approaches constituted organisational

wide approaches to managing ethno-cultural differences in health care and were thus both considered pertinent or the purpose of building parameters for the sub-elements of the WOA.

Appendix 6 entitled “Comparison of the building of a culturally competent Organisation, The Quest for Equity in Health Care 2011, the HPH TF MFCCH Project to develop standards for equity in Health Care for Migrants and other vulnerable groups 2011, and a summary of the Irish WOA, including the Amsterdam Declaration, MFQQ, CLAS and the Canadian approaches, categorised into the WOA framework”, illustrates and compares the two new approaches with the previously constructed summary of original 5 approaches in the context of the WOA (an explanation of each these approaches is detailed in the literature review).

From a comparison of all the institutional and international approaches associated with managing ethno-cultural differences of service users in health care dating from 1998 to 2011 and incorporating 7 different approaches, a final set of parameters were drawn up for each strand and sub-element as outlined in the framework of the WOA.

Table 3.7 illustrates the final set of parameters for each of the strands and sub-elements of the WOA based on a conglomeration and synthesis of the 7 approaches mentioned above and used as the final parameters for the purposes of coding and measuring organisational efforts in this thesis. The table indicates the 3 strands of the WOA and the 4 sub-elements in each strand. In addition, each sub-element is illustrated with the corresponding question from the interview guide.

Table 3.7 : Final summary of 7 international institutional approaches used to construct parameters

STRAND 1: ORGANISATIONAL ETHOS	
Question 2: **Specific initiatives that demonstrate the commitment and support of managers**	
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality
P 3	Diversity committees (that include members of MECs and are multidisciplinary)
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training
P 5	Project leader or responsible for Diversity & Equality / Champion at management level
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour

P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities (absenteeism, productivity, litigation, morale).
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)
Question 3 and 6: **Up-to-date intercultural policy for the health services**	
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies).
P2	Bereavement policies and guidelines, adapted mortuary with appropriate alters & symbols etc.
P3	Adapted diet and revision of menus (e.g. halal)
P4	Interfaith policy e.g. multi denominational chaplain service, prayer rooms
P5	Culture days and celebrations, or diversity celebration weeks
P6	Interpretation policy or translation policy
P7	Newsletter (referring to diversity & equality topics or research)
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff
P9	Diversity & Equality policy
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)
P11	Use of cultural mediators
Question 4: **Equality framework including culture proof of document templates for equality proofing, service planning and delivery**	
P1	Culture proofing of documentation
P2	Equality auditing / Review (equality impact assessments)
P3	Equality / cultural proofing of service provision
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)
P5	Diversity benchmarking
P6	Seek advice externally from organisations such as IBEC or Cairde
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality
Question 5: **Ethnic monitoring systems including an agreed framework for date collection and usage**	
P1	Ethnicity: country of origin / nationality
P2	Language
P3	Beliefs (Religion)
P4	Race (skin colour)
P5	Use information to inform services, diversity training and active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?

STRAND 2: WORKPLACE ENVIRONMENT	
Question 7 and 10 : **A tiered approach to intercultural training (systematic and ongoing)**	
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training
P2	Level 2: cultural awareness training e.g. diversity committee
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or training on specific ethnic groups such as the travelling community
P5	Level 5: multicultural team training
P6	Level 6: legal & business case training
P7	Cultural awareness developed in consultation with stakeholders including members of MECs
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers
P9	Train the trainer programmes
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)
P11	Training on major ethnic groups e.g. travelling community
P12	Multidisciplinary training
P13	Online options for intercultural training
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference
Question 8: **Workplace support structures to support staff to manage issues relating to cultural diversity**	
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff
P2	Bereavement and care for the dying guides
P3	Multi-denominational chaplaincy services
P4	Language guides & multilingual aids
P5	Point to picture cards / pictograms
P6	Website or links specific to diversity or cultural competence in health care
P7	Interpretation & translation policy and guidelines
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards
P9	List of MF staff contact lists regarding cultural issues
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see racism, dignity at work policies and trust in care policies
P12	Cultural mediators
Question 9: **Development of initiatives to integrate and manage multicultural teams**	
P1	Multicultural team training for all staff
P2	Career development programmes for overseas staff
P3	Buddy and mentor system for all incoming staff including non-Irish
P4	Overseas nurse coordinator
P5	Preparation work with existing staff

Question 10: **Training method to include co-facilitation by members of MECs**	
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point [20] traveller community trainers
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING	
Question 11 and 12: **Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system**	
P1	Links with MEC advocacy groups
P2	MECs on patient involvement committees e.g. patient forums or diversity committees
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc
P4	Use cultural mediators or support worker from MECs, to explain hospital procedures to patients
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)
P7	Website explaining the processes and practices of the hospital and Irish health system
Question 13a: **Signage particularly in reception and public areas in key languages of service users**	
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information
P3	Visual orientation system / Sign-post pictograms
Question 13b: **Literature in the key languages of service users**	
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc
P2	Culturally appropriate documentation that has been culturally proof read
P3	Website translated
Question 13c: **A comprehensive interpretation service**	
P1	Accessible to all staff
P2	Publish the right to language & interpretation service / Access to interpretation indicated
P3	Access to interpretation service by telephone
P4	Access to face to face interpretation service
P5	24 hours, 7 days a week service
P6	Ensure all staff is aware of service
P7	Ensure all staff trained to use interpreters
P8	Ensure a written interpretation policy
P9	Guidelines for staff on how to access and use interpretation services
P10	Use of hospital staff who speak more than one language as first contact interpreters

[20] Pavee Point is a voluntary, non-governmental organisation that aims to support the human rights for Irish Travellers (http://paveepoint.ie/about-2/values-and-vision)

3.6.2 Codification

An approach to code the information was chosen using the methods of Miles and Huberman. Miles and Huberman (1994) propose several techniques for analysing qualitative data such as tables, graphs and using a codification system to separate the information and introduce clarity. A thematic codification system was established using the constructed parameters for each sub-element of the WOA. With these parameters, the data was analysed for each sub-element using a Likert scale ranging from 0-1-2-3 and a matrix table was created for each hospital.

Table 3.8 is matrix table entitled *coded results demonstrating the implementation of the WOA for H1,* which is a sample of how the results of the findings will be presented for each of the 6 hospitals (see Chapter 4). The table highlights the three strands of the WOA and illustrates the four main sub-elements of each strand. The column on the left indicates the question numbers in the interview guide corresponding to each sub-element of the WOA. The column entitled "*Strand 1 Organisational Ethos"* shows the strand and its subsequent sub-element components. The column "*number of parameters obtained"* indicates the amount of parameters that the hospital has implemented for each sub-element of the WOA. The right side of the table contains a separate column entitled *codification* showing coded Likert scale scores ranging from 0 to 3 for a given hospital.

For each of the four sub-elements of each strand, there is a corresponding score based on a Likert scale. Scores range from 0 to 3. A 0 score indicating that the sub-element is not installed, a 1 score signifying that the sub-element is installed up to 33 %, a 2 score signifying that the sub-element is between 34 % and 66 % implemented, and a 3 score indicating between 67% and 100% implementation. Each strand has a sub-total indicating the combined score of each sub-element scored out of a maximum of 12 for each hospital with corresponding codification of:

- 0 = not installed
- 1-4 = up to 33% installed
- 5-8= 34% - 66%
- 9-12 = 67%-100%

Also each hospital has a cumulative total score combining the total of each of the three strands scored out of a maximum of 36 with:

- 0 = not installed
- 1-12 = up to 33% installed
- 13-24 = 34%-66% installed
- 25-36 =67%-100% installed

Table 3.8 serves to demonstrate numerically to what extent the three strands of the WOA have been implemented in each hospital.

Table 3.8: Coded results demonstrating the implementation of the WOA in H 1

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	8/9	3
3&6	Up-to-date intercultural policy for the health services	10/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	8/12	2
5	Ethnic monitoring system including an agreed framework for date collection and data usage	3/5	2
	Sub-total	*29/37*	*10/12*
	Strand 2: Workplace Environment		
7&10	A tiered approach to intercultural training	8/14	2
8	Workplace support structures to support staff to manage issues relating to cultural diversity	10/12	3
9	Development of initiatives to integrate and manage multicultural teams	3/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	1/2	2
	Sub-total	*22/33*	*9/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	6/7	3
13 a	Signage, particularly in reception and public areas in the key languages of service users	1/3	1
13 b	Literature in the key languages of service users	2/3	2
13 c	A comprehensive interpretation service	9/10	3
	Sub- total	*18/23*	*9/12*
	TOTAL	**69/93**	**28/36**

Explanation of codification:

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

The study of a particular case may involve several different methods of collection of data such as interviews, archive documents, questionnaires and observations in order to have an overall vision. Eisenhardt (1989) and Ghauri (2005) propose that the study of a case study is not limited to discourse analysis and study of transcripts of the targeted population but also may include multiple sources such as meeting documents, institutional archive documents and observation reports etc.

In this thesis secondary data was collected wherever possible through hospital newsletters, or reports related to ethno-cultural management initiatives or minutes from meetings, annual reports or service user literature translated into different languages, web sites or patient healthcare documentation. The interviews confirmed much of the information obtained in written documentation but secondary data sources complimented the information and in some cases gave a complete picture of the circumstances.H3 for example issued a report from the Chairman of the Diversity committee detailing a summary of the hospital wide initiatives that had been implemented with regard to managing cultural diversity. This report confirmed and complemented the information obtained from the interview process.

3.6.3 Treatment of data

Analysis was carried out manually and without the use of software. Software assists in analysis but does not actually carry out the analysis. 93 interviews although large still allowed for manual analysis. The researchers belief that given the nature of the study that manual analysis would allow for a stronger connection and understanding of the richness of the data and a better exploitation and abstraction of information. The researchers need to train and up-skill in specific software and the cost considerations of utilising such software were also considered. Table 3.9 incorporates the steps of the process of treatment of data concerning this study.

Table 3.9: Process of treatment of data

Step	Action	Commentary
Compile and gather data	Semi-directed interviews interview guide	On site interviews allowing personal contact and validation of data and complementary information
Process data	Re-listen, transcribe and complete	Allowed proximity to richness of data
Codification	Relevant data selected and coded based on constructed parameters	Codes established to ensure coherent organisation of data
Matrix	Constructed matrix for each hospital	Score 1-3 distributed identifying high and low implementation levels of WOA
Secondary data	Assessed secondary data	Confirm and complement primary data
Comparison of strands	Comparison of strand Implementation between hospitals	Identify the similarities and differences between strand implementation between hospitals
Comparisons of hospitals	Comparison of WOA implementation in each hospital	Identify the similarities and differences between the overall implementation of WOA between hospitals

3.6.4 Validation

A research design must factor in all ways possible to minimize the inaccuracy and maximise the accuracy of the data. Therefore, two important elements of the research design which must be focused on are validity and reliability.

3.6.5 Reliability

The findings of the research must be credible and valid (Hussey and Hussey 1997). Reliability is concerned with stability over a period of time and internal consistency (Kline 2000). Reliability essentially is concerned with the consistency of the data collection methods and that there is minimum potential for distortion of the findings. The research endeavoured to maximise reliability of the data collection by firstly undertaking an exploratory research process using a similar interview guide allowing for learning and adaptation of the instrument. Secondly by conducting semi-directed interviews to a variety of respondents in the same manner, tone, appearance and under the same circumstances, in an effort to minimize the variations from interview to interview. Thirdly, the semi-directed interview guide was piloted and tested by healthcare professionals specialised in the field of ethno-cultural diversity in healthcare. The piloting process provided identification of errors in the design of the questions, choice and use of terms and words and ensured an open framework allowing for focused, conversational, two-way communication.

Fourthly, the selection of the respondents took into consideration demographic information such as length of employment service in the hospital, thus identifying if the respondent had sufficient experience to be able to comment on how the hospital was managing ethno-cultural differences. All respondents had completed at least 1 year of employment and the professional experience of working in healthcare ranged from 1 to 40 years. Fifthly, respondents were invited to participate in the study based on their experiences, function and responsibilities in the hospital and their frontline contact with service-users and were selected from various functions and working areas in the hospital to ensure a comprehensive investigation into hospital policies, practices and procedures with regard to ethno-cultural heath care.

3.6.6 Validity

If the findings represent the reality or what is actually happening on the ground, then they can be considered valid according to Saunders et al., (2000) and Hussey and Hussey (1997). Kline (2000) refers to research being valid if it measures what it claims to measure. Validity is concerned with the idea that the data, findings and explanations correspond to what is real and true (Denscombe 2002).

The following initiatives were undertaken in an attempt to ensure that the findings of this research project are valid. Firstly, the relevance and accuracy of the questions in the interview guide were piloted and tested by healthcare professionals or those associated with diversity in healthcare contexts. Secondly semi-directed interviews were deemed suitable as they allowed for conversational, two-way communication, which provide ample opportunity for the interviewer and the interviewee to exercise flexibility and probe for details and discuss in depth related issues. Thirdly, the data collection method was applied to all interviews in the same rigorous manner and notes were taken contemporaneously. Fourthly, respondent answers and explanations were compared by a triangulation process whereby a variety of respondents from different areas of the hospital were asked the same questions in order to minimize the risk of misinformation, ignorance or lack of knowledge. The objective in using this triangulation approach was to increase validity and credibility by cross checking data from different sources within each hospital. Altrichter et al. (1996) contend that triangulation allows for a more detailed and balanced picture of the situation.

3.6.6.1 Internal validity

Internal validity refers to the idea that one should eliminate the effects of variables within the research environment that are irrelevant or of little interest to the researcher. The selection of

relevant respondents who had relevant experience and service length to participate in the study were solicited to increase internal validity.

3.6.6.2 External validity

The results of each of the six hospitals can be compared and similarities and differences can be analysed. This can be a process of verification by comparative analysis. The results of the research have been presented to members of the HSE. Furthermore, the final parameters selected for the purpose of measurement of the implementation of the WOA can be utilised in other environments other than hospital settings.

3.7 Ethical issues of the research

3.7.1 Confidentiality and publication rules

A request to conduct empirical research involving hospital employees required board approval in each hospital. Ethical approval was granted by all 6 hospitals while 2 hospitals requested a formal approval from their respective ethics committees. The remaining 4 hospitals approved the study through their Board of Directors and did not request application for approval to an ethics committee. Generally, it was deemed by hospital administration that the nature of this research was not harmful to hospital personnel or patients.

Each hospital gatekeeper was officially sent a formal letter by post explaining the nature and purpose of the study and requesting access to interview personnel in each hospital. This letter gave full details of the researcher and addressed confidentiality and ethical concerns. The gatekeeper informed his/her hierarchy and requested approval. H4 and H5 required that an application was made to the ethics committee for approval. The application process was lengthy and involved the preparation of a substantial application file for each member of each hospital's ethics committee. The application process also required a visit to the 2 hospitals to present the research proposal to the ethics committees consisting of 18 hospital members in H5 and 8 in H4, on specific pre-fixed dates where the respective committees were meeting. Applications and oral presentations were made, and in the case of one hospital, in the company of the gatekeeper, to the respective ethics committees, in July 2010. After rigorous questioning the applications to access the hospitals were granted. However H4's ethic's committee required changes to the application and a second appearance before the ethics committee approved the request. Each ethics committee application included a letter of application including details about the researcher (see appendix 7), director of research,

credentials, a lay summary, a detailed study proposal and protocol study design, participant information sheet, respondent consent form (see appendix 8) questions, discussions headings in qualitative research, recruitment advertisement letter for respondents, permissions from other hospitals to do research, financial information, indemnification and a list of hospital departments involved.

A letter of information designed to invite and inform potential participants was sent to each gatekeeper who in turn sent the letter to medical, non-medical and administrative staff. This letter gave details of the background of the research study, the research aims, the description of the area of interest, the procedures and aims of what is going to be studied, why the respondent/participant has been asked to take part in the study, the duration and nature of the participation, contact details, confidentiality and ethical issues (see appendix 9). The gate keeper organised a schedule of interviews based over two or three days on site in each hospital. A third hospital requested that the researcher meet each of the targeted participants who showed interest in being interviewed individually to explain the project and answer any questions. Participants were all given a document of consent whereby each potential respondent could choose to fill it in, and give their consent to participating in the research. The access to hospitals for research purposes in Ireland is a complex and much sought after domain and hospitals are very selective due to the nature of health care, privacy and safety. The reason that only 2 of the 6 hospitals required that an application be submitted to an ethics committee was that relationships had been cultivated with the hospitals involving several on site visits over a period of 18 months and trust and credibility had been established.

In the interest of confidentiality interview tapes were stored in a locked drawer in a locked office and digital recordings were stored on the researcher's computer and were password protected. A commitment was made to one hospital to delete the recordings and decrypt the data as per their request. Transcript documents were stored in a secure and protected location in the researcher's home office.

The research aimed to collect information to ascertain to what extent each hospital has implemented policies and procedures to promote interculturalism and manage ethno-cultural differences across the organisation in the context of the WOA. Participating hospitals were informed that the research aimed to contribute to the wider research in the hospital sector and were made aware that the researcher would report findings back to the health sector and

relevant audiences for the purposes of learning and progress in the field of hospital management in the 21st century.

In-depth interviews were undertaken to meet the needs and objectives of this thesis and inform the broader community on the management of ethno-cultural differences in Irish hospitals. Hospital and participants were informed that their anonymity would be maintained and respected with regard to publication of this thesis. Only one hospital requested formally, anonymity in any published document or report. The majority of interviewees indicated their satisfaction with the nature of this study and its potential contribution to research and the management of ethno-cultural differences in hospitals.

3.8 Chapter summary

The purpose of this chapter was to justify and explain the selected methodology in relation to the research question and nature of the study. A summary of the existing general approaches to scientific research was discussed in order to defend and give meaning to the selected methodology. This included the discussion of the process of research, the ontological and epistemological stances, and an examination of the different types of research based on the purpose of the research (exploratory, descriptive, analytical etc), the process of the research (quantitative versus qualitative), or the logic of the research (deductive versus inductive), or the outcome of the research (applied or basic). A section was devoted to the research design based on the chosen qualitative approach for this study. Subsequent sections present a description of the configuration of the target population, sample collection, profile of respondents, and explain the protection of identities, and the selection of cases. The data collection method including the interview guide and interview protocol is discussed and the classification and treatment of data is explained including the construction of parameters and selected codification system. Finally a section on the validity and reliability of the study including ethical issues concerning confidentiality and publication are considered.

Chapter 4

Results

4. Results

The aim of this chapter is to present the results of the empirical research in the 6 surveyed hospitals. This chapter is divided into two sections. The first section focuses on describing the results of a vertical analysis (SRQ2) of how each hospital has implemented the 12 sub-elements of the WOA framework. The second section describes the results of a horizontal analysis (SRQ3) of how each of the 3 strands of the framework has been implemented across the 6 hospitals.

The first section is organised by providing a brief portrait of each hospital regarding the nature, type, function and services of the hospital, including its location and historical origins. Also an overview of each hospital's background in managing ethno-cultural differences is discussed and any links that a hospital has to national or international migrant friendly healthcare networks, or intercultural health initiatives, policies, systems or key players focussing on the improvement of health services to members of minority ethnic groups are identified. Moreover, the profile and number of respondents that were interviewed in each hospital is indicated, including the time schedule for the hospital visit. A table of the results of the implementation of the WOA framework presenting the extent to which each sub-element of the framework is implemented and highlighting the total number of parameters that have been implemented for each sub-element is illustrated for each hospital. This is followed by a second table that specifically signals which parameters for each sub-element were or were not implemented, by the hospital. This section is concluded by a brief commentary on the implementation of the parameters in each hospital.

The second section of the chapter refers to each of the 3 strands of the WOA. A separate table for each strand focusing on the results of implementation of the strand's associated sub-elements, is presented and briefly discussed. This includes a brief description and comparison of the implementation scores for each strand across the 6 hospitals.

4.1 Presentation of the results of the implementation of the WOA in each hospital (SRQ2)

4.1.1 Hospital 1 (H1)

4.1.1.1 Portrait of H1

This is a teaching hospital which provides a wide range of healthcare services including a 24 hour emergency department, acute medical and surgical service including a 167 acute bed capacity, acute psychiatric services, long stay care, day care, outpatient, diagnostic and support services to a population of 290,000 living in the catchment area. The hospital is situated in the Northwest of Dublin, which until recently was identified as one of the fastest growing regions in Europe. H1 was founded in 1955 and is a general hospital with an accident and emergency service for North County Dublin. The hospital also is an important training facility for medical, nursing and allied health professionals, collaborating with healthcare training faculties in local third level educational institutions.

4.1.1.2 Background with managing ethno-cultural diversity

The catchment area for the hospital includes West Dublin, Meath and Kildare and emergency services are provided 365 days a year 24 hours per day. 80% of admissions to H1 are accessed through the emergency department and in 2010, 19% of admissions to the emergency department were patients from countries other than Ireland. Nationality composition of staff as of October 2007 included 78% Irish and 22% non-Irish. The five most representative nationalities from countries other than Ireland includes, Filipino 42%, Indian 22%, Nigerian 8%, British 6% and South African 4%. This information does not include contracted staff. The composition of patients includes 81% of Irish and 19% non-Irish.

In 2002, research in H1 identified that 17% of admissions to the emergency department were from countries other than Ireland or Britain. This led to the hospital successfully applying to be the Irish representative and pilot hospital for Ireland, in the European Migrant Friendly Hospital Project (EMFHP). This initiative of the HPHN focused on promoting the health and health-related knowledge and competence of migrants and minority ethnic groups, on improving hospital services for these patient groups. The specific purpose of this project was to improve the health and literacy of minority ethnic groups as well as to improve hospital services for these patient groups. Outcomes from this participation included (1) improving interpretation in clinical communication such as point to picture cards and questions in a

range of languages, (2) developing guidelines for accessing interpreting agency and (3) developing cultural competency training.

H1 participated in the Equal at Work[21] project from September 2005 to December 2007 to address integration and intercultural working needs of staff which led to initiatives such as cultural competency training for staff and managers, English ESOL (English for speakers of other languages) language courses and introduction of the Development and Cultural Diversity Induction Programme.

In addition, H1 was a member of the HSE NIHP 2006-2007 which was a HSE led project led by the HSE's department of Social Inclusion, focusing on implementing intercultural care in acute hospitals and primary care settings. H1's purpose in participating in this project was to provide strategic leadership and expertise across service directorates to support the HSE in the delivery of health and social services to meet the needs of MECs. Outcomes included training to staff and managers, translation of patient information booklets, the development of translated posters advising patients on the provision of interpreting services for all wards and departments.

H1 has been a member of the National Intercultural Hospitals Initiative (NIHI) since 2004, which is a national project established as a result of the Migrant Friendly Hospitals Project (MFHP). The purpose of the project is to manage and advise the dissemination and further development of the EMFHP in the Irish healthcare setting through the NIHI. Activities included piloting the multilingual aid to support interpreting projects and H1 is a member of the NIHI Management Group and a member of the project group to expand the multilingual aid project. Outcomes included piloting the multilingual aid in 2006-2007 and national development of the Emergency Multilingual Aid. The main contact person in the hospital who is responsible for migrant health is the Health Promotion Co-ordinator who falls under the authority of the Health Promotion Office.

[21] Equal at Work project operated under the EU EQUAL programme and designed by the EU Commission to address discrimination and inequalities in the labour market. The Dublin Employment Pact promoted the project in 50 organisations across different sector in Dublin including the health service sector. The programme was designed in 2005 to pilot actions in relation to equality and diversity by guiding organisations to adapt and change their HR systems (Dublin Employment Pact 2007).

4.1.1.3 Profile of respondents in H1

Interviews were conducted on the 13th, 14th and 15th of September, 2010. Table 4 shows a profile of the respondents indicating the titles of each interviewee and the classification of their position. In H1, 4 members of the management team, 3 medical employees, 5 non-clinical employees and a member of the chaplaincy service were interviewed.

Table 4.1: Profile of respondents in H1

HOSPITAL 1 : Total number of people interviewed	**13**
Management	***4***
HR Director / Manager	1
Training & Development Manager	1
Risk Manager	1
Nursing Support Services Manager	1
Medical	***3***
Director of Nursing	1
Clinical Nurse Manager	2
Non Clinical Administrative	***5***
Catering Manager	1
Patient Service Manager	1
Health Promotion Coordinator	1
Clerical Officer	1
Health Care Assistant	1
Other	***1***
Chaplain	1

4.1.1.4 Results demonstrating the implementation of WOA in H1

Table 4.2 demonstrates a synthesis of the results of the 13 respondents for each of the 12 questions related to the WOA posed, during the semi-directed interviews. The table illustrates the three strands of the WOA and associated sub-elements and indicates the question each sub-element refers to in the semi-directed questionnaire. Furthermore, the two columns on the left of the table indicate a summary of the number of parameters implemented for each sub-element and the corresponding coded score.

Table 4.2 : Coded results demonstrating implementation of WOA in H 1

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	8/9	3
3-6	Up-to-date intercultural policy for the health services	9/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	8/12	2
5	Ethnic monitoring system including an agreed framework for data collection and data usage	3/5	2
	Sub-total	*28/37*	*10/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	8/14	2
8	Workplace support structures to support staff to manage issues relating to cultural diversity	10/12	3
9	Development of initiatives to integrate and manage multicultural teams	3/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	1/2	2
	Sub-total	*22/33*	*9/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	6/7	3
13a	Signage, particularly in reception and public areas in the key languages of service users	1/3	1
13b	Literature in the key languages of service users	2/3	2
13c	A comprehensive interpretation service	9/10	3
	Sub- total	*18/23*	*9/12*
	TOTAL	**68/93**	**28/36**

Table 4.3 explains the codification for three variations of results. Firstly, there is a codification from 0-3 indicating the score with regard to the implementation of the individual sub-element of the WOA. Secondly, there is a score from 0-12 indicating the implementation of each individual strand and thirdly, a total score from 0-36 indicating the overall extent of the implementation of the three strands of the WOA. The column entitled “Number of Parameters Obtained” serves to justify the score of 0-3 regarding implementation.

Table 4.3: Explanation of codification

Question & Sub-element results /3	Individual Strand total /12	Totals /36
0 = not installed	0 = not installed	0 = not installed
1 = up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5 – 8 = between 34% - 66%	13 - 24 = between 34 – 66% installed
3 = between 67% - 100%	9 - 12 = between 67% - 100%	25 - 36 = between 67-100% installed

4.1.1.5 Overview of results

H1 scores a total score of 28/36 with regard to the implementation of the WOA and ranks 2nd amongst the 6 hospitals studied. The hospital's highest scores correspond to 5 sub-element categories scoring a maximum 3 points in each. These include specific initiatives that demonstrate the commitment and support of managers, up-to-date intercultural policy for the health services, workplace support structures to support staff to manage issues relating to cultural diversity, information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system and a comprehensive interpretation service. However the hospital's lowest scoring category was signage in reception and public areas in key languages of service users, with a score of 1. Strand 1 organisational ethos is the most implemented with a score of 10/12 while Strand 2 workplace environment and Strand 3 support to intercultural training, are equal in score with 9/12.

Table 4.2 also summarises how many parameters were implemented for each sub-element and strand of the WOA in the hospital. A total of 68 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.4.

Table 4.4: The implementation of the parameters in H1

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: Specific initiatives that demonstrate the commitment and support of managers		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	
P 5	Project leader or responsible for Diversity & Equality / Champion at management level	1	
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching	1	
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and to provide provision equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities(absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	

Question 3 and 6: Up-to-date intercultural policy for the health services		Installed	Not installed
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	
P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)	1	
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy		0
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)	1	
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation	1	
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision		0
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination))	1	
P5	Diversity benchmarking	1	
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)		0
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards		0
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	
P4	Race (skin colour)		0
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?		0

STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10: **A tiered approach to intercultural training (systematic and ongoing)**		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee		0
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community	1	
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training	1	
P7	Cultural awareness developed in consultation with stakeholders including members of MECs	1	
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes		0
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)	1	
P11	Training on major ethnic groups e.g. travelling community	1	
P12	Multidisciplinary training	1	
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference		0
Question 8: **Workplace support structures to support staff to manage issues relating to cultural diversity**		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care		0
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards	1	
P9	List of MF staff contact lists regarding cultural issues	1	
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see or experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: **Development of initiatives to integrate and manage multicultural teams**		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0

P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator	1	
P5	Preparation work with existing staff		0
Question 10: Training method to include co-facilitation by members of MECs		**Installed**	**Not installed**
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers	1	
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training		0
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups	1	
P2	MECs on patient involvement committees e.g. patient forums or diversity committees	1	
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc	1	
P4	Use cultural mediators or support worker MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in the community or hospital information geared towards MF care or diversity issues available in community	1	
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)	1	
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	
Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information		0
P3	Visual orientation system / Sign-post pictograms	1	
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc	1	
P2	Culturally appropriate documentation that has been culturally proof read	1	
P3	Website translated		0
Question 13c : A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	

P7	Ensure all staff trained to use interpreters		0
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services	1	
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	

Table 4.4 illustrates the parameters for each sub-element of the three strands of the WOA and indicates if the parameter has been installed in the hospital by the presence of a "1" in the installed column. Alternatively parameters that have not been installed are indicated with the presence of a "0" in the not installed column. This table explains the rationale behind the allocating of coded scores for implementation of the sub-elements of the WOA in table 4.2

Table 4.4 illustrates the specific 25 parameters that H1 has not implemented. These include 9 parameters not implemented in strand 1, 11 in strand 2 and the 5 in strand 3.

4.1.2 Hospital 2 (H2)

4.1.2.1 Portrait of H2

H2 is a long established hospital that caters for the disabled and the elderly of Dublin. Founded in 1743 the hospital has been providing healthcare services for over two and half centuries. Throughout this time the hospital has built up expertise in providing healthcare services to the elderly and special needs for chronically ill and disabled adults. The hospital today offers care for people requiring rehabilitation, respite and complex continual care and day hospital services. The service provision includes medical, nursing, therapy, physiotherapy, occupational therapy, speech and language therapy, clinical psychology, nutrition and medical social work. The hospital provides day-care, continuing care, respite and rehabilitation services to over 200 people. There are 78 residential care places for people over 65 years.

4.1.2.2 Background with managing ethno-cultural diversity

H2 provides services to a population of approximately 324,308 (Census 1996) living in the catchment area and is located in the South of Dublin. It is noted that given the nature of the hospital service provision to elderly seniors over 65 years of age, there is little ethno-cultural differences in patient population. The composition of patients consists of approximately all Irish nationals with few exceptions. Nationality composition of staff (as of October 2010) included 46% of employed hospital staff are Irish and 54% non-Irish. The principle 5 nationalities from countries other than Ireland are Filipino 37%, Polish 4.5%, Indian 3.5%,

British 2.4% and Czech 1.7%. This information does not include contracted staff. The hospital was in the process of drafting an equality and diversity policy and complies with the dignity at work and other policies proposed by the HSE. There is no designated Diversity Officer but relevant responsibilities lie with the Human Resource manager.

4.1.2.3 Profile of respondents

Interviews were conducted on the 23rd and 24th of September 2010. Table 4.5 illustrates that interviews were conducted with 12 employees consisting of 1 member of the management team, 5 medical employees, 4 of which were clinical managers, 5 non-clinical employees and a member of the chaplain service.

Table 4.5: Profile of respondents in H 2

HOSPITAL 2: Total number of people interviewed	**12**
Management	***1***
HR Director/Manager	1
Medical	***5***
Medical Director / Doctor	1
Director Mid-wife Nursing/ Director of Nursing	1
Clinical Nurse Manager	2
Education Coordinator Student, & Nurse/Quality	1
Non Clinical / Administrative	***5***
Social Worker / Medical	1
Senior Speech and Language Therapist	1
Dietician / Manager	1
Allied Health Services Manager	1
Porter / Head Porter / General Services Manager	1
Other	***1***
Chaplain / Pastoral care	1

4.1.2.4 Results demonstrating the implementation of the WOA in H2

Table 4.6.demonstrates a synthesis of the answers of the 12 respondents for each of the 12 questions related to the WOA posed during the semi-directed interviews and table 4.7 explains the codification.

Table 4.6: Coded results demonstrating implementation of WOA in H2

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	2/9	1
3-6	Up-to-date intercultural policy for the health services	8/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	7/12	2
5	Ethnic monitoring system including an agreed framework for data collection and data usage	3/5	2
	Sub-total	*20/37*	*8/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	2/14	1
8	Workplace support structures to support staff to manage issues relating to cultural diversity	8/12	2
9	Development of initiatives to integrate and manage multicultural teams	2/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	0/2	0
	Sub-total	*12/33*	*5/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	1/7	1
13a	Signage, particularly in reception and public areas in the key languages of service users	1/3	1
13b	Literature in the key languages of service users	0/3	0
13c	A comprehensive interpretation service	7/10	3
	Sub- total	*9/23*	*5/12*
	TOTAL	**41/93**	**18/36**

Table 4.7: Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1 = up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

4.1.2.5 Overview of results

Scores are low in all three strands and consequently, this hospital has the lowest total score of 18/36 and ranks 5th among the hospitals surveyed. This may indicate that the WOA is at the beginning stages of implementation. The hospital's highest scores reflect the sub-elements related to up-to-date, intercultural policy for the health services and interpretation services. However, the hospital's lowest scores are in intercultural training and translation of signage and literature for service users. Strand 1 is the most implemented strand scoring 8/12 and Strand 2 and Strand 3 are less implemented both sharing the score of 5/12. These low scores reflect the fact that the service user profile of this hospital is elderly populations with limited ethnic diversity.

Table 4.6 indicates a total of 41 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.8.

Table 4.8 : The implementation of the parameters in H2

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: Specific initiatives that demonstrate the commitment and support of managers		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality		0
P 3	Diversity committees (that include members of MECs and are multidisciplinary)		0
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training		0
P 5	Project leader or responsible for Diversity & Equality / Champion at management level		0
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching		0
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities (absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)		0
Question 3 and 6: Up-to-date intercultural policy for the health services		**Installed**	**Not installed**
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	

P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	
P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)		0
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy	1	
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)		0
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation		0
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision		0
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)	1	
P5	Diversity benchmarking		0
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)		0
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	1	
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	
P4	Race (skin colour)		0
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?		0
STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10 : A tiered approach to intercultural training (systematic and ongoing)		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee		0
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community		0
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training		0

P7	Cultural awareness developed in consultation with stakeholders including members of MECs		0
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes		0
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)		0
P11	Training on major ethnic groups e.g. travelling community		0
P12	Multidisciplinary training		0
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference		0
Question 8: Workplace support structures to support staff to manage issues relating to cultural diversity		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care		0
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards		0
P9	List of MF staff contact lists regarding cultural issues		0
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see or experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: Development of initiatives to integrate and manage multicultural teams		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0
P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator		0
P5	Preparation work with existing staff		0
Question 10: Training method to include co-facilitation by members of MECs		**Installed**	**Not installed**
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers		0
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training		0
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups		0
P2	MECs on patient involvement committees e.g. patient forums or diversity committees		0
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc		0
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community		0

P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)		0
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	
Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information		0
P3	Visual orientation system / Sign-post pictograms	1	
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc		0
P2	Culturally appropriate documentation that has been culturally proof read		0
P3	Website translated		0
Question 13c: A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated		0
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	
P7	Ensure all staff trained to use interpreters		0
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services	1	
P10	Use of hospital staff who speak more than one language as first contact interpreters		0

Table 4.8 illustrates the specific 52 parameters that H2 has not implemented. These include 17 parameters not implemented in strand 1, 21 in strand 2 and 14 in strand 3.

4.1.3 Hospital 3 (H3)

4.1.3.1 Portrait of H3

H3 is a charitable, non-profit making, acute paediatric hospital in Dublin's north inner city. It provides a secondary and tertiary referral care service regionally and nationally for children up to the age of 16 years old. The emergency department is one of the largest in the country with approximately 45,000 attendances per annum and represents the biggest paediatric casualty department in Ireland. The hospital also is the National Centre for inherited Metabolic Disorders, and operates the National Screening Laboratory for newborn children for inherited conditions. H3 is the National Centre for Paediatric Ophthalmology, the National Craniofacial Centre, the National Airway Management Centre and the National Meningococcal Reference Laboratory and the National Sudden Infant Death Register is located in the hospital. H3 offers a wide range of in-patient and out-patient services, including

paediatric critical/intensive care and a range of clinical health and social services such as physiotherapy, medical social work, occupational therapy, clinical nutrition/dietetics, psychiatric social work, neuropsychology, chaplaincy, laboratory, radiology services, child and adolescent mental health, psychology, speech audiology and child sexual abuse assessment. The hospital is a training facility and is linked to educational training facilities in local universities at both undergraduate and post-graduate levels. The hospital was founded under the trusteeship of a religious order of charity approximately 150 years ago and is now under the trusteeship of the order of the Sisters of Mercy, as a voluntary public hospital.

4.1.3.2 H3 background with managing ethno-cultural diversity

H3 is the only inner city children's hospital and its catchment area includes both north and south inner city servicing approximately 60 ethnic groupings. The catchment area has the highest percentage of minority ethnic groups such as asylum seekers and refugees. In 2003 25% of accident and emergency attendances were patients with ethnic minority backgrounds.

There are over 1,000 full-time and part-time nursing, paramedical and other staff working in the hospital made up of management/administration, nursing, consultants, health and social care professionals, support staff and other patient/client care. The composition of nationalities of staff includes approximately 14 different nationalities and the hospital bed capacity is 155.

This establishment has worked in close collaboration with the HSE in piloting programs such as the ethnic identifier which allows hospital staff to collect personal data and ethnic related information from patients that is used to inform policies and strategies within the hospital. The hospital is widely regarded as being proactive in the field of diversity management and has been recognised nationally regarding management of diversity.

The hospital has an active diversity committee that focuses on the development of cross-cultural and intercultural dialogue throughout the organisation. The HR manager is the main contact person who is responsible for migrant friendly healthcare and who founded the diversity committee. She is considered a champion of the diversity agenda and the provision of culturally appropriate healthcare in H3 and across the national healthcare landscape.

4.1.3.3 Profile of respondents

Interviews were conducted on the 20th, 21st and 22nd of September, 2010. Table 4.9 illustrates that interviews were conducted with 15 employees of the hospital consisting of 3 members of the management team, 3 medical employees, 8 non-clinical employees and a member of the chaplaincy service.

Table 4.9: Profile of respondents in H3

HOSPITAL 3: Total number of people interviewed	**15**
Management	***3***
HR Director / CEO	1
Quality & Accreditation Manager	1
Clinical & Patient Services Manager	1
Medical	***3***
Paediatrician Dr	1
Clinical Nurse Manager	1
Post Graduate Education Coordinator Nurse	1
Non Clinical /Administrative	***8***
Head/Senior Social Worker	1
Social Worker/Medical	1
Psychiatric Social Worker	1
Healthcare records/Manager	1
Porter/Head Porter/General Services Manager	1
Health Promotion Coordinator	1
CHIC (Children Hospital Information Coordinator)	1
Emergency Support Officer	1
Other	***1***
Chaplain	1

Table 4.10 demonstrates a synthesis of the answers of the 15 respondents for each of the 12 related questions of the WOA posed during the semi-directed interviews and table 4.11 explains the codification.

Table 4.10: Coded results demonstrating implementation of WOA in H 3

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	8/9	3
3-6	Up-to-date intercultural policy for the health services	10/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	10/12	3
5	Ethnic monitoring system including an agreed framework for data collection and data usage	5/5	3
	Sub-total	*33/37*	*12/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	10/14	3
8	Workplace support structures to support staff to manage issues relating to cultural diversity	11/12	3
9	Development of initiatives to integrate and manage multicultural teams	2/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	2/2	3
	Sub-total	*25/33*	*11/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	6/7	3
13a	Signage, particularly in reception and public areas in the key languages of service users	2/3	2
13b	Literature in the key languages of service users	2/3	2
13c	A comprehensive interpretation service	9/10	3
	Sub- total	*19/23*	*10/12*
	TOTAL	**77/93**	**33/36**

Table 4.11 : Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

4.1.3.4 Overview of results in H3

This hospital shares the highest scores of the 6 hospitals in all three strands with a total score of 33/36. It scores a maximum 12/12 in Strand 1, organisational ethos with strong top down commitment from management and is one of the few hospitals that has implemented fully an ethnic monitoring system and is advanced in the provision of intercultural health policies. Strand 2 shows an equally advanced scoring 11/12 with a strong tradition of training

co-facilitated by members of ethnic minorities, and a full arsenal of workplace support structures for frontline service providers. There is a margin to improve in developing initiatives to integrate and manage multicultural teams which represents the weakest sub-element in strand 2 of the WOA framework in terms of implementation. Strand 3, support to intercultural training, scores 10/12, reflecting strong information and awareness for minority ethnic service users and the implementation of a comprehensive interpretation policy. This strand, while scoring strong in comparison to other hospitals represents H3's weakest strand mirroring room for development in the translation of literature and signage into in key language of service users. H3 broadly speaking, has a strong tradition in attempting to provide culturally appropriate service provision and in implementing the WOA framework approach to managing ethno-cultural differences in Irish hospitals.

Table 4.10 above indicates a total of 77 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.12.

Table 4.12: The implementation of the parameters in H3

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: Specific initiatives that demonstrate the commitment and support of managers		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	
P 5	Project leader or responsible for Diversity & Equality / Champion at management level	1	
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching	1	
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities (absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	
Question 3 and 6: Up-to-date intercultural policy for the health services		**Installed**	**Not installed**
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	

P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)	1	
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy	1	
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)	1	
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation	1	
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision		0
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)	1	
P5	Diversity benchmarking	1	
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)	1	
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	1	
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	
P4	Race (skin colour)	1	
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?	1	
STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10 : A tiered approach to intercultural training (systematic and ongoing)		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee	1	
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community	1	
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training		0
P7	Cultural awareness developed in consultation with stakeholders including members of MECs	1	

P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes	1	
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)	1	
P11	Training on major ethnic groups e.g. travelling community	1	
P12	Multidisciplinary training	1	
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference	1	
Question 8: Workplace support structures to support staff to manage issues relating to cultural diversity		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care	1	
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards	1	
P9	List of MF staff contact lists regarding cultural issues	1	
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see or experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: Development of initiatives to integrate and manage multicultural teams		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0
P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator		0
P5	Preparation work with existing staff		0
Question 10: Training method to include co-facilitation by members of MECs		**Installed**	**Not installed**
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers	1	
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training	1	
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups	1	
P2	MECs on patient involvement committees e.g. patient forums or diversity committees	1	
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc	1	
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community	1	
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)	1	

P7	Website explaining the processes and practices of the hospital and the Irish health system	1	
Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information	1	
P3	Visual orientation system / Sign-post pictograms	1	
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc	1	
P2	Culturally appropriate documentation that has been culturally proof read	1	
P3	Website translated		0
Question 13c: A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	
P7	Ensure all staff trained to use interpreters		0
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services	1	
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	

Table 4.12 illustrates the specific 16 parameters that H3 has not implemented. These include 4 parameters not implemented in strand 1, 8 in strand 2 and 4 in strand 3.

4.1.4 Hospital 4 (H4)

4.1.4.1 Portrait of H4

The hospital is a charitable voluntary maternity hospital that has been providing maternity services and healthcare to women and their families for over two centuries. It is one of three maternity hospitals located in the city of Dublin. The hospital cares for pregnant women and their children and services include a comprehensive gynaecology service, including infertility services, a menopause clinic, a coloscopy clinic and an early pregnancy loss clinic. H4 is one of the first hospitals in Europe to offer midwifery education programmes in collaboration with a local university at both undergraduate and postgraduate levels. H4 employs 855 employees and the hospital had approximately 9000 women who chose the hospital to deliver their child in 2010. The hospital has recruited extensively non-Irish nationals over the past decade and there are 39 different nationalities represented in the workforce according to the Training & Development manager.

4.1.4.2 H4 background with managing ethno-cultural diversity

The hospital participates in the NIHP and works in collaboration with the Department of Social Inclusion of the HSE and has co-piloted national projects including the ethnic identifier data collection programme. H4 was a demonstration site under the National Social Inclusion Steering Committee of the HSE to create an ethos in healthcare settings that supports the delivery of care in a culturally appropriate manner.

The hospital participates on inter-hospital committees between the maternity and children's hospitals and benchmarks migrant friendly and diversity initiatives with leading local maternity hospitals and networking through the NIHP.

4.1.4.3 Profile of respondents

Interviews were conducted on the 4th, 5th and 8th of November, 2010. Table 4.13 illustrates that interviews were conducted with 18 employees consisting of 3 members of the management team, 3 medical employees, 8 non-clinical employees and a member of the chaplaincy service.

Table 4.13 : Profile of respondents in H4

HOSPITAL 4 : Total number of people interviewed	**18**
Management	***2***
HR Director/Manager	1
Training & Development Manager	1
Medical	***6***
Obstetric Gynaecologist Dr	1
Director Mid Wife Nursing/ Director of Nursing	1
Staff Nurse/ neo-natal/midwife	3
Bereavement Midwife nurse	1
Non Clinical /Administrative	***9***
Head/Senior Social Worker	1
Catering Manager/officer	1
Assistant Catering Manager	1
Catering employee supervisor	1
Patient Service /officer/Manager	1
Team Leader Admin/out patient	3

Health Care Assistant	1
Other	***1***
Chaplain	1

Table 4.14 demonstrates a synthesis of the answers of the 18 respondents for each of the 12 questions related to the WOA posed during the semi-directed interviews and table 4.15 explains the codification.

Table 4.14 : Coded results demonstrating the implementation of WOA in H4

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	7/9	3
3-6	Up-to-date intercultural policy for the health services	10/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	11/12	3
5	Ethnic monitoring system including an agreed framework for data collection and data usage	5/5	3
	Sub-total	*33/37*	*12/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	10/14	3
8	Workplace support structures to support staff to manage issues relating to cultural diversity	11/12	3
9	Development of initiatives to integrate and manage multicultural teams	2/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	2/2	3
	Sub-total	*25/33*	*11/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	5/7	3
13a	Signage, particularly in reception and public areas in the key languages of service users	2/3	2
13b	Literature in the key languages of service users	2/3	2
13c	A comprehensive interpretation service	8/10	3
	Sub- total	*17/23*	*10/12*
	TOTAL	**75/93**	**33/36**

Table 4.15: Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

4.1.4.4 Overview of results

H4 has the same total score of 33/36 and shares with H3 the highest scores of implementation of the WOA among the 6 hospitals surveyed. 9 sub-elements of the WOA framework score 3/3. Strand 1 is the most implemented with 12/12 indicating a strong ethos from the top down towards equality and diversity issues in the hospital. Strand 2 scores 11/12 with 3 sub-elements scoring a maximum of 3, and indicating that the hospital has improvements to make in formal multicultural team training. Strand 3 scores a 10/12 and areas relating to the translation of signs in key areas, literature and the hospital website, are areas that the hospital can develop.

Table 4.14 above indicates a total of 77 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.16.

Table 4.16: The implementation of the parameters in H4

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: **Specific initiatives that demonstrate the commitment and support of managers**		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	
P 5	Project leader or responsible for Diversity & Equality / Champion at management level		0
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching	1	
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory	1	

	manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour		
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities. (absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	
Question 3 and 6: Up-to-date intercultural policy for the health services		**Installed**	**Not installed**
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	
P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)	1	
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy	1	
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)	1	
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation	1	
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision	1	
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)	1	
P5	Diversity benchmarking	1	
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)	1	
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	1	
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	
P4	Race (skin colour)	1	
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?	1	

STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10 : A tiered approach to intercultural training (systematic and ongoing)		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee		0
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community	1	
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training	1	
P7	Cultural awareness developed in consultation with stakeholders including members of MECs	1	
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes	1	
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)	1	
P11	Training on major ethnic groups e.g. travelling community	1	
P12	Multidisciplinary training	1	
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference	1	
Question 8: Workplace support structures to support staff to manage issues relating to cultural diversity		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care	1	
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards	1	
P9	List of MF staff contact lists regarding cultural issues	1	
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see or experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: Development of initiatives to integrate and manage multicultural teams		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0
P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator		0
P5	Preparation work with existing staff		0
Question 10: Training method to include co-facilitation by members of MECs		**Installed**	**Not installed**
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers	1	

P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training	1	
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups	1	
P2	MECs on patient involvement committees e.g. patient forums or diversity committees	1	
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc	1	
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community	1	
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)		0
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	
Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information	1	
P3	Visual orientation system / Sign-post pictograms	1	
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc	1	
P2	Culturally appropriate documentation that has been culturally proof read	1	
P3	Website translated		0
Question 13c: A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	
P7	Ensure all staff trained to use interpreters		0
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services		0
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	

Table 4.15 illustrates the specific 17 parameters that H4 has not implemented. These include 4 parameters not implemented in strand 1, 8 in strand 2 and 5 in strand 3.

4.1.5 Hospital 5 (H5)

4.1.5.1 Portrait of H5

Hospital 5 is a charitable voluntary hospital established in 1861 under the guidance of the religious order of the Sisters of Mercy. H5 is located in the city centre in Dublin and provides services to both North county Dublin and also the entire country through its tertiary services. The hospital has two national specialities namely, cardiothoracic surgery and spinal injuries. Regional specialities include ophthalmology, dermatology, breast cancer screening, oncology and surgical medical speciality services such as cardiology, renal services, urology, orthopaedics and general and vascular surgery.

The hospital is a teaching hospital and hosts on site, a medical school, which is affiliated with a local university and a college for training surgeons. The hospital hosts a Centre of Nurse Education linked with the School of Nursing at the local university, an Institute of Radiological Science, offering postgraduate and PhD programmes, an institute of Ophthalmology, a college for postgraduate education and research, a department of Child and Family Psychiatry offering postgraduate programmes in Child and Family Psychotherapy and an independent private hospital.

4.1.5.2 Background with implementing of ethno-cultural diversity in H5

The hospital has 570 beds and employs approximately 3,000 employees in 120 departments. According to one of the chaplains the hospital has “staff from 50” cultures and approximately 40% of the staff is non-Irish according to the HR Director. H5 participated in the NIHI at a European project level with the HPHN to help improve the quality of the service provided to migrant patients. The hospital’s participation in HPHN assisted in the design of an assessment tool to help participant hospitals to identify cultural issues in hospital settings. A needs assessment of staff and patients in the hospital was undertaken in 2006 and an action plan was developed following the recommendations of staff and patients in the area of clinical communication and training in cultural competency (H5’s NIHI Needs Assessment Report 2006)[22].

The mission and ethos of the hospital towards sick and elderly, patients, staff and relatives is cultivated and led through the Office of the Director of Mission Effectiveness. The Director of Mission Effectiveness is responsible for a Mission Effectiveness Programme which according

[22] H5 NIHI needs assessment report 2006 internal documentation.

to the annual report 2009[23], *"has the objective to integrate the vision, mission and ethos beliefs and values as outlined in the hospitals mission statement into the hospital structures and activities of the hospital to keep the mission alive and to hold the values in trust for the future".* Diversity is a value enshrined in the mission statement and according to the mission effectiveness values programme 2009, *"respect for diversity builds community and unity. It fosters an atmosphere that is open and welcoming to people of diverse cultures, diverse ideas and perspectives."* The main contact person in the hospital who is responsible for the management of cultural diversity issues is the Director of Mission Effectiveness.

4.1.5.3 Profile of respondents

Interviews were conducted on the 1st, 2nd and 3rd of November 2010. Table 4.17 illustrates that interviews were carried out with 17 employees consisting of 3 members of the management team, 3 medical employees, 8 non-clinical employees and 3 members of the chaplaincy service.

Table 4.17: Profile of respondents in H5

HOSPITAL 5 : Total number of people interviewed	**17**
Management	***3***
Director of Mission Effectiveness, Board of Directors	1
HR Director/Manager	1
Quality & Accreditation Manager	1
Medical	***3***
Staff Nurse/ neo-natal/midwife	1
Clinical Placement Overseas Coordinator/nurse	1
Nursing Practitioner Development Facilitator	1
Non-Clinical/Administrative	***8***
Social Worker/Medical	1
Catering Manager/officer	1
Patient Service /officer/Manager	1
Healthcare records/Manager	1
Porter/Head Porter/General Services Manager	1
Contract Cleaning Manager	1
Health Promotion Coordinator	1
Training & Development Coordinator	1
0ther	***3***
Chaplain	3

[23] H5 annual report published by H5's Corporate Publications 2009.

Table 4.18 demonstrates a synthesis of the answers of the 17 respondents for each of the 12 questions related to the WOA posed during the semi-directed interviews and table 4.19 explains the codification method.

Table 4.18: Coded results demonstrating the implementation of the WOA in H 5

Question Number	Strand 1: Organisation Ethos	Number of parameters obtained	Codification
2	Specific initiatives that demonstrate the commitment and support of managers	8/9	3
3-6	Up-to-date intercultural policy for the health services	10/11	3
4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	10/12	3
5	Ethnic monitoring system including an agreed framework for data collection and data usage	3/5	2
	Sub-total	*31/37*	*11/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	8/14	2
8	Workplace support structures to support staff to manage issues relating to cultural diversity	9/12	3
9	Development of initiatives to integrate and manage multicultural teams	3/5	2
10	Training methodology to include co-facilitation by members of minority ethnic communities	0/2	0
	Sub-total	*20/33*	*7/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	6/7	3
13a	Signage, particularly in the reception and public areas in the key languages of service users	0/3	0
13b	Literature in the key languages of service users	2/3	2
13c	A comprehensive interpretation service	10/10	3
	Sub- total	*18/23*	*8/12*
	TOTAL	**69/93**	**26/36**

Table 4.19: Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

4.1.5.4 Overview of results

H5 has a total score of 26/36 and ranks 3rd regarding the overall implementation of the WOA amongst the 6 hospitals surveyed. H5's highest scores are in the implementation of Strand 1 organisational ethos, with an 11/12 score which indicates a strong top down commitment from management and results in the implementation of a variety of intercultural health policies and a significant commitment to equality in the organisational culture. The hospital has room to improve regarding monitoring of ethnic diversity in patients and particularly the usage of such data to be fed into hospital services provision. Strand 2 workplace environment scores 7/12 and the hospital scores highest in this category by offering a host of workplace support structures for staff to manage issues relating to cultural diversity. A tiered approach to intercultural training scores a 2/3 and reflects the need for a more systematic and on-going approach to intercultural training and similarly, the hospital needs to improve the integration of multicultural teams by more multicultural staff team training. Training with co-facilitation by members of MECs needs to be developed, despite efforts being made to incoming overseas nurse training regarding cultural competence. Strand 3 support to intercultural training, scores 8/12 and mainly reflects the strong implementation of the sub-elements related to information and awareness for minority ethnic service users on the processes and practices of the Irish health care system and a comprehensive interpretation service which both score 3/3. However, translation of literature and signage into the key languages of service users needs to be developed.

Table 4.18 indicates a total of 69 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.20.

Table 4.20 : The implementation of the parameters in H5

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: Specific initiatives that demonstrate the commitment and support of managers		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	
P 5	Project leader or responsible for Diversity & Equality / Champion at management level	1	

P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching	1	
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities (absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	
Question 3 and 6: Up-to-date intercultural policy for the health services		**Installed**	**Not installed**
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	
P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)	1	
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy	1	
P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)	1	
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation	1	
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision	1	
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)	1	
P5	Diversity benchmarking	1	
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)	1	
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	1	
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality		0
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	

P4	Race (skin colour)		0
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?		0
STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10 : A tiered approach to intercultural training (systematic and ongoing)		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee	1	
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community	1	
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training		0
P7	Cultural awareness developed in consultation with stakeholders including members of MECs		0
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes	1	
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)	1	
P11	Training on major ethnic groups e.g. travelling community		0
P12	Multidisciplinary training	1	
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference	1	
Question 8: Workplace support structures to support staff to manage issues relating to cultural diversity		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care		0
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards	1	
P9	List of MF staff contact lists regarding cultural issues		0
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see and experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: Development of initiatives to integrate and manage multicultural teams		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0
P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator	1	
P5	Preparation work with existing staff		0

Question 10: Training method to include co-facilitation by members of MECs		Installed	Not installed
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers		0
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training		0
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups	1	
P2	MECs on patient involvement committees e.g. patient forums or diversity committees	1	
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc	1	
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community	1	
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)	1	
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	
Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information		0
P3	Visual orientation system / Sign-post pictograms		0
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc	1	
P2	Culturally appropriate documentation that has been culturally proof read	1	
P3	Website translated		0
Question 13c: A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	
P7	Ensure all staff trained to use interpreters	1	
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services	1	
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	

Table 4.19 illustrates the specific 24 parameters that H5 has not implemented. These include 6 parameters not implemented in strand 1, 13 in strand 2 and 5 in strand 3.

4.1.6 Hospital 6 (H6)

4.1.6.1 Portrait of H6

Hospital 6 was founded by the Religious Sisters of Charity in 1834 and since 2003 has been part of a wider 3 hospital healthcare group, incorporating a private hospital and an acute general hospital. The hospital is owned by the Religious Sisters of Charity and is an academic teaching hospital working in collaboration with a local university at undergraduate and postgraduate levels. Research and educational facilities are provided for academic and clinical training of medical students, nurses, laboratory technicians, research scientists, physiotherapists, occupational therapists, radiographers, medical social workers, dieticians and speech and language therapists.

H6 provides emergency services and national/regional medical care at in-patient and out-patient levels and provides over 40 medical specialities. There are 500 in-patient beds with 7-day, 5-day and day care options, including intensive care, coronary care, medical care, surgical care, orthopaedic care, elderly care and psychiatry care. H6 provides services to people living in south Dublin and Wicklow, serving a population of approximately 350,000 people.

4.1.6.2 Background with implementing ethno-cultural diversity in H6

There is an Intercultural Working Group acting as an advisory resource on issues related to intercultural working with the aim to "proactively develop diverse cultural relations amongst employees and patients and identify projects to continuously develop positive intercultural working" (H6 Employee handbook[24] p 59).

The hospital has approximately 1025 nurses and Health Care Assistants consisting of 60 nationalities. The hospital is the only public hospital accredited by the JCI Quality accreditation system which measures include reference to provision of appropriate cultural care: *"all private hospitals have JCI but we are the only public hospital accredited",* Director of Nursing.

4.1.6.3 Profile of respondents

Interviews were conducted on the 10th, 11th and 12th November, 2010. Table 4.21 illustrates that interviews were conducted with 18 employees, consisting of 3 members of the

[24] H6's Employee handbook 2010, internal documentation.

management team, 3 medical employees, 8 non-clinical employees and a member of the chaplaincy service.

Table 4.21: Profile of respondents in H6

HOSPITAL 6 : Total number of people interviewed	**18**
Management	***4***
HR Director/Manager	1
HR Managing Nursing	1
Training & Development Manager	1
Director Quality & Risk	1
Medical	***5***
Head of Physiologist Ontology Dr	1
Director Mid Wife Nursing/ Director of Nursing	1
Assistant Director Nursing	1
Staff Nurse/ neo-natal/midwife	1
Nursing Practitioner Development Facilitator	1
Non Clinical /Administrative	***7***
Dietician /Manager	1
Porter/Head Porter/General Services Manager	2
Clerical Officer Ambulance Dept/Supervisor A&E	1
Assistant Administrator in Cardiology department	1
Health Care Assistant	2
Other	***2***
Chaplain	1
Chaplain Educator Coordinator	1

Table 4.22 demonstrates a synthesis of the answers of the 18 respondents for each of the 12 questions related to the WOA posed during the semi-directed interviews and table 4.23 explains the codification.

Table 4.22: Coded results demonstrating implementation of WOA in H 6

Question Number	**Strand 1: Organisation Ethos**	**Number of parameters obtained**	**Codification**
2	Specific initiatives that demonstrate the commitment and support of managers	7/9	3
3-6	Up-to-date intercultural policy for the health services	9/11	3

4	Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	8/12	2
5	Ethnic monitoring system including an agreed framework for data collection and data usage	3/5	2
	Sub-total	*27/37*	*10/12*
	Strand 2: Workplace Environment		
7-10	A tiered approach to intercultural training	8/14	2
8	Workplace support structures to support staff to manage issues relating to cultural diversity	9/12	3
9	Development of initiatives to integrate and manage multicultural teams	4/5	3
10	Training methodology to include co-facilitation by members of minority ethnic communities	0/2	0
	Sub-total	*21/33*	*8/12*
	Strand 3: Support to Intercultural Training		
11-12	Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	3/7	2
13a	Signage, particularly in reception and public areas in the key languages of service users	0/3	0
13b	Literature in the key languages of service users	0/3	0
13c	A comprehensive interpretation service	9/10	3
	Sub- total	*12/23*	*5/12*
	TOTAL	**60/93**	**23/36**

Table 4.23: Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

4.1.6.4 Overview of results

H6 has a total score of 23/36 and ranks 4th out of the 6 hospitals in the study. 5 sub-elements score a maximum of 3/3 but alternatively there are sub-elements of the framework that no efforts have been made to implement. Strand 1 is the highest score and the most advanced strand of the WOA framework indicating strong enthusiasm for equality and awareness of cultural diversity by management and good implementation of intercultural health policies. Strand 2 is approximately 66% implemented and the sub-element, training methodology to include co-facilitation by members of minority ethnic communities is one area that H6 needs

to improve. Strand 3 has the weakest scores of 5/12 and the hospital has not taken initiatives in sub-elements areas such as the translation of signage and literature into the key languages of service users.

Table 4.22 above indicates a total of 60 out of 93 parameters have been implemented. A more detailed analysis of the implementation of the individual parameters for each sub-element of each strand of the WOA is demonstrated in table 4.24.

Table 4.24 : The implementation of the parameters in H6

STRAND 1: ORGANISATIONAL ETHOS			
Question 2: Specific initiatives that demonstrate the commitment and support of managers		**Installed**	**Not installed**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	
P 5	Project leader or responsible for Diversity & Equality / Champion at management level		0
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges & teaching	1	
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non- discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes. Examples of outcomes include: patient satisfaction levels, access services in a timely fashion, improvement in assessment of patients, reduction in need for unnecessary and risky diagnostic tests, elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities (absenteeism, productivity, litigation, morale)		0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	
Question 3 and 6: Up-to-date intercultural policy for the health services		**Installed**	**Not installed**
P1	Clarify the expectations of staff regarding diversity & equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bullying & harassment policies)	1	
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	
P3	Adapted diet and revision of menus (e.g. halal)	1	
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	
P5	Culture days and celebrations, or diversity celebration weeks	1	
P6	Interpretation policy or translation policy	1	
P7	Newsletter (referring to diversity & equality topics or research)	1	
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	
P9	Diversity & Equality policy		0

P10	Consultation with staff & patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC Advocacy groups)	1	
P11	Use of cultural mediators		0
Question 4: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**Installed**	**Not installed**
P1	Culture proofing of documentation		0
P2	Equality auditing / Review (equality impact assessments)		0
P3	Equality / cultural proofing of service provision		0
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on 9 grounds of discrimination)	1	
P5	Diversity benchmarking	1	
P6	Seek advice externally from organisations such as IBEC or Cairde	1	
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	
P8	Need to evaluate patient and community outcomes (e.g. patient satisfaction, MECs on committees and patient involvement)		0
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	1	
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	
P11	Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies	1	
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	
Question 5: Ethnic monitoring systems including an agreed framework for date collection and usage		**Installed**	**Not installed**
P1	Ethnicity: country of origin / nationality	1	
P2	Language	1	
P3	Beliefs (Religion)	1	
P4	Race (skin colour)		0
P5	Use information to inform services, diversity training and the active use of real data for strategic and outreach planning. Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?		0
STRAND 2: WORKPLACE ENVIRONMENT			
Question 7 and 10 : A tiered approach to intercultural training (systematic and ongoing)		**Installed**	**Not installed**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	
P2	Level 2: cultural awareness training e.g. diversity committee	1	
P3	Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment & selection training related to equality and diversity	1	
P4	Level 4: intercultural dialogue training e.g. customer service, crisis intervention or on specific ethnic groups such as the travelling community	1	
P5	Level 5: multicultural team training		0
P6	Level 6: legal & business case training	1	
P7	Cultural awareness developed in consultation with stakeholders including members of MECs		0
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers		0
P9	Train the trainer programmes	1	
P10	3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas)	1	

P11	Training on major ethnic groups e.g. travelling community		0
P12	Multidisciplinary training	1	
P13	Online options for intercultural training		0
P14	Staff attend conferences related to diversity e.g. European Transcultural Nursing Association conference		0
Question 8: Workplace support structures to support staff to manage issues relating to cultural diversity		**Installed**	**Not installed**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	
P2	Bereavement and care for the dying guides	1	
P3	Multi-denominational chaplaincy services	1	
P4	Language guides & multilingual aids	1	
P5	Point to picture cards / pictograms	1	
P6	Website or links specific to diversity or cultural competence in health care		0
P7	Interpretation & translation policy and guidelines	1	
P8	Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings, regular staff meetings on wards	1	
P9	List of MF staff contact lists regarding cultural issues		0
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies	1	
P11	Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see or experience racism, dignity at work policies and trust in care policies	1	
P12	Cultural mediators		0
Question 9: Development of initiatives to integrate and manage multicultural teams		**Installed**	**Not installed**
P1	Multicultural team training for all staff		0
P2	Career development programmes for overseas staff	1	
P3	Buddy and mentor system for all incoming staff including non-Irish	1	
P4	Overseas nurse coordinator	1	
P5	Preparation work with existing staff	1	
Question 10: Training method to include co-facilitation by members of MECs		**Installed**	**Not installed**
P1	Use MECs to co-facilitate and conduct intercultural training e.g. Pavee Point traveller community trainers		0
P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training		0
STRAND 3: SUPPORT TO INTERCULTURAL TRAINING			
Question 11 and 12: Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system		**Installed**	**Not installed**
P1	Links with MEC advocacy groups	1	
P2	MECs on patient involvement committees e.g. patient forums or diversity committees		0
P3	Outreach information health education programmes to MEC associations, community organisations, churches and schools etc		0
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients		0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community	1	
P6	MF Open House (inviting MECs or MEC advocacy groups on site to hospital)		0
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	

Question 13a: Signage particularly in reception and public areas in key languages of service users			
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area		0
P2	Posters to promote intercultural health care & diversity related healthcare issues e.g. ethnic identification monitoring information or translated healthcare information		0
P3	Visual orientation system / Sign-post pictograms		0
Question 13b: Literature in the key languages of service users		**Installed**	**Not installed**
P1	Relevant literature in key languages e.g. patient information book, provision or discharge or post discharge care translated, interpretation services information etc		0
P2	Culturally appropriate documentation that has been culturally proof read		0
P3	Website translated		0
Question 13c: A comprehensive interpretation service		**Installed**	**Not installed**
P1	Accessible to all staff	1	
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	
P3	Access to interpretation service by telephone	1	
P4	Access to face to face interpretation service	1	
P5	24 hours, 7 days a week service	1	
P6	Ensure all staff is aware of service	1	
P7	Ensure all staff trained to use interpreters		0
P8	Ensure a written interpretation policy	1	
P9	Guidelines for staff on how to access and use interpretation services	1	
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	

Table 4.24 illustrates the specific 33 parameters that H6 has not implemented. These include 10 parameters not implemented in strand 1, 12 in strand 2 and 11 in strand 3.

4.2 Presentation of the results of the implementation of the 3 Strands of the WOA across the 6 hospitals (SRQ3)

This section of the chapter presents a description of a strand analysis of the findings concerning the extent to which the 3 strands of the WOA have been implemented across the 6 hospitals.

A separate table for each strand is presented indicating by a score out of 3, the extent that each sub-element of the strand has been implemented for each hospital, including an average score for the 6 hospitals. Furthermore the table provides a sub-total score out of 12 indicating the extent to which the overall strand has been implemented in each hospital, including an average score across the 6 hospitals. A brief description and comparative analysis of the implementation scores for each strand across the 6 hospitals is discussed.

4.2.1 Description of results of Strand 1

Strand 1, organisational ethos, is the most implemented strand in the 6 hospitals surveyed as illustrated in table 4.25. Sub-total scores for each hospital range from 8/12 to 12/12 with an average implementation of 10.5/12. Two hospitals H3 and H4 score a maximum 12/12. The sub-element referring to *up to date intercultural policy for the health services* was the most advanced with all 6 hospitals scoring 3/3 indicating that hospitals have reacted well in implementing relevant intercultural policies. The sub-element *specific initiatives that demonstrate the commitment and support of the manager,* has an average implementation score of 2.67/3 and reflects that the hospital management have made significant efforts towards creating an organisational ethos of managing equality and ethno-cultural differences in health care. Equality and equality frameworks are recognised and embedded in the ethos of each hospital. However *ethnic monitoring system including agreed frameworks for data collection and data usage* are operational in all the hospitals with margins for improvement in 4 hospitals.

Table 4.25 : Strand 1 "Organisation Ethos": scores for the 6 hospitals

Strand 1 : Organisation Ethos	H1	H2	H3	H4	H5	H6	Avg
Specific initiatives that demonstrate the commitment and support of managers	3	1	3	3	3	3	2.67
Up to date intercultural policy for the health services	3	3	3	3	3	3	3
Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	2	2	3	3	3	2	2.5
Ethnic monitoring system including an agreed framework for data collection and data usage	2	2	3	3	2	2	2.33
Sub-total	10/12	8/12	12/12	12/12	11/12	10/12	10.5/12

4.2.2 Description of results of Strand 2

Strand 2 workplace environment is the second most implemented strand of the WOA framework with a total average implementation of 8.5/12 and individual hospital scores ranging from 5/12 to 11/12 (see table 4.26). H3 and H4 score the highest with 11/12 respectively followed by H1 scoring 9/12, H6 8/12, H5 7/12 and H2 has the least implemented elements of this strand with 5/12. The sub-element, *workplace support structures to support staff to manage issues relating to cultural diversity,* is the most implemented with an average of 2.83/3 with 5 of the 6 hospitals scoring a 3/3. *A tiered approach to training* is the second most implemented sub-element with an average score of

2.17 with H3 and H4 being the most advanced regarding intercultural training initiatives while H2 has progress to make in this regard. *Development of initiatives to integrate and manage multicultural teams* scores a constant 2/3 in 5 out of 6 of the hospitals with H6 scoring a 3/3. H2 and H6 are the only two hospitals that have not advanced regarding co-facilitating training sessions with members of MECs while contrastingly, H3 and H4 are proactive and fully operative.

Table 4.26 : Strand 2 "Workplace Environment": scores for the 6 hospitals

Strand 2 : Workplace Environment	H1	H2	H3	H4	H5	H6	Avg
A tiered approach to intercultural training	2	1	3	3	2	2	2.17
Workplace support structures to support staff to manage issues relating to cultural diversity	3	2	3	3	3	3	2.83
Development of initiatives to integrate and manage multicultural teams	2	2	2	2	2	3	2.16
Training methodology to include co-facilitation by members of minority ethnic communities	2	0	3	3	0	0	1.33
Sub-total	9/12	5/12	11/12	11/12	7/12	8/12	8.5/12

4.2.3 Description of results of Strand 3

Strand 3, support to intercultural training, is the least implemented strand of the WOA framework with a total average implementation of 7.83/12 and individual hospital scores ranging from 5/12 to 10/12 (see table 4.27). H3 and H4 are the most advanced hospitals regarding this strand, scoring 10/12, followed by H1 9/12, and H5 8/12. H2 and H6 are the least advanced scoring 5/12 respectively. The sub-element concerning *a comprehensive interpretation service* is the most implemented in this strand with an average score of 3/3 for each hospital indicating the importance of interpretation services in Irish hospitals in providing culturally appropriate health care. Also the sub-element concerning *information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system* is well developed in the majority of the hospitals surveyed. However, the most striking feature is the need for the provision of signage in public areas and the distribution of literature in the key languages of service users where scores are the lowest, not only in Strand 3 but in the entire WOA framework. H2 and H6 are the hospitals that have the weakest implementation of initiatives in translation of literature and signage.

Table 4.27: Strand 3

Strand 3 : Support to Intercultural Training	H1	H2	H3	H4	H5	H6	Avg
Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	3	1	3	3	3	2	2.5
Signage , particularly in reception and public areas in the key languages of service users	1	1	2	2	0	0	1
Literature in the key languages of service users	2	0	2	2	2	0	1.33
A comprehensive interpretation service	3	3	3	3	3	3	3
Sub-total	9/12	5/12	10/12	10/12	8/12	5/12	7.83/12

4.3 Chapter summary

The WOA to managing ethno-cultural differences in Ireland is a top down, national approach that in theory applies to all healthcare settings in the country. The results portrayed in this chapter clearly indicate that different hospitals are implementing the framework at different speeds and some are more advanced than others. The reality on the ground is that hospitals such as H3 and H4, both score an admirable 33/36 with regard to implementation of the WOA while H2 in contrast, obtained a score considerably lower at 18/36. Hence, there are disparities in the speed and progress that the WOA is being introduced in different hospitals. Furthermore, Strand 1 organisational ethos, is the most implemented strand followed by Strand 2 workplace environment and Strand 3 support to intercultural training. The question poses itself as to why Strand 1 leads the way in strand implementation. Is it a reflection of reactive equality driven culture that has been led in hospitals due to national equality legislation emanating from Europe? There is a need to examine these results more closely and interpret the rationale as to why different hospitals are implementing the WOA differently and why certain strands seem to be more of a priority than others. A full analysis, interpretation and discussion of these results will follow in chapter 5.

Chapter 5

Analysis and interpretation of results

5. Analysis and interpretation of results

This chapter's main aims are to firstly address SRQ2 by analysing and explaining the results of the implementation of the WOA in each hospital as presented in chapter 4 and to prescribe suggestions for improvement. Secondly the chapter aims to address SRQ3 by analysing and explaining the results of the implementation of the three strands of the WOA across the 6 hospitals and prescribes recommendations that will lead to improvement.

With this in mind the chapter begins with a brief synthesis of the results of each hospital's advancement of the implementation of the WOA, followed by a classification of the 6 hospitals in terms of their advancement and progress.

Then 7 key characteristics are identified that influence the implementation of the WOA framework in each hospital. These characteristics include *(function, size/resources, location, ethno-cultural differences of service users, ethno-cultural differences of service providers, existence of a champion/diversity committee and history of MF care initiatives).*The impact of the new Irish economic reality of economic recession and its impact on the allocation of resources in healthcare in Ireland is addressed. A comparative assessment of the influence of the 7 characteristics on each individual hospital's implementation of the WOA is discussed.

This is followed by a closer individual examination and analysis of the results of each hospital to explain why certain sub-elements of the WOA are more implemented and prioritised than others. Interpretations for the success or failure of implementing the WOA are discussed and compared across the 6 hospitals. Suggested prescriptions for the improvement of the implementation of specific parameters are provided for each hospital.

Then an analysis of the implementation of the 3 strands of the WOA across the 6 hospitals is presented and explains why certain strands are more implemented than others. This includes an explanation of those sub-elements and parameters that are well implemented followed by prescriptions for each strand explaining weaknesses and highlighting strand areas that need improvement.

In addition the chapter draws observations from the research findings in the context of the future application of the WOA. This includes an interpretation of the research findings which

permit the repositioning of the WOA parameters depending on whether they are relative to the management of ethno-cultural differences in service providers or service users. This analysis will allow future nation states that experience rapid demographic changes in their healthcare systems to provide a WOA framework that can be more tailored to the contextual needs of individual hospitals. Two categories of parameters or actions are suggested, one category is relevant to putting in place initiatives to manage ethno-cultural difference in service providers and the second category is geared toward initiatives for service users.

The results of the implementation of the WOA are compared and contrasted with the theoretical framework of Gardenswartz and Rowe (1998) in order to assess their theoretical relevance.

In conclusion arbitrary non-scientific interpretations are drawn regarding the overall implementation results and efforts of the 6 Irish hospitals against several academic models emanating from the literature review. These include an arbitrary assessment and interpretation of whether each hospital's overall efforts to managing diversity is reactive or proactive, using Kandola and Fullerton's (1998) distinction. Moreover the Irish approach to managing diversity in hospitals through the analysis and interpretation of the 6 hospitals is characterised and positioned arbitrarily into the academic frameworks of Cox (1993), Baytos (1995), and Dass and Parker (1999).

5.1 Classification of the results in the 6 hospitals

In order to elaborate and discuss, the explanation of the results concerning the implementation of the WOA framework in each hospital, a synthesis of the results of the 6 hospitals described individually in chapter 4 and displayed in table 5.1, permits a comparative review of individual hospital efforts. Table 5.2 explains the codification method.

Table 5.1 : Coded results demonstrating a synthesis of the implementation of WOA in the 6 Irish hospitals

Strand 1: Organisation Ethos	H1	H2	H3	H4	H5	H6
Specific initiatives that demonstrate the commitment and support of managers	3	1	3	3	3	3
Up to date intercultural policy for the health services	3	3	3	3	3	3

Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	2	2	3	3	3	2
Ethnic monitoring system including an agreed framework for data collection and data usage	2	2	3	3	2	2
Sub-total	10/12	8/12	12/12	12/12	11/12	10/12
Strand 2: Workplace Environment						
A tiered approach to intercultural training	2	1	3	3	2	2
Workplace support structures to support staff to manage issues relating to cultural diversity	3	2	3	3	3	3
Development of initiatives to integrate and manage multicultural teams	2	2	2	2	2	3
Training methodology to include co-facilitation by members of minority ethnic communities	2	0	3	3	0	0
Sub-total	9/12	5/12	11/12	11/12	7/12	8/12
Strand 3: Support to Intercultural Training						
Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	3	1	3	3	3	2
Signage , particularly in reception and public areas in the key languages of service users	1	1	2	2	0	0
Literature in the key languages of service users	2	0	2	2	2	0
A comprehensive interpretation service	3	3	3	3	3	3
Sub-total	9/12	5/12	10/12	10/12	8/12	5/12
Total	**28/36**	**18/36**	**33/36**	**33/36**	**26/36**	**23/36**

Table 5.2 : Explanation of codification

Questions results	Strands results	Totals
0 = not installed	0 = not installed	0= not installed
1= up to 33% installed	1 – 4 = up to 33% installed	1 – 12 = up to 33% installed
2 = between 34% - 66%	5-8 = between 34% - 66%	13- 24 = between 34 – 66% installed
3 = between 67% - 100%	9-12 = between 67% - 100%	25-36 = between 67-100% installed

The hospitals can be classified with H3 and H4 ranking joint first. Then H1 second, H5 third, H6 fourth and finally H2 finishing in fifth place. This classification is temporal in nature and represents the efforts made by each hospital at the time of the research only. It reflects the status of each hospital with regard to the implementation of the WOA at a specific point in time and is not a definitive reflection of the subsequent efforts made. It is reasonable to assume that the classification will change. The research was conducted in organisations at the time when each hospital may have had different priorities and pressures due to changing economic circumstances in the Irish economy. For example, the new reality of an Irish

economic crisis which began in 2008 and resulted in the Irish Department of Health and the HSE being forced to take measures to drastically reduce costs across the Irish health sector. An explanation of the Irish economic crisis and its impact on the health sector is discussed later in the chapter in relation to factors that have influenced the implementation of the WOA in hospitals.

The findings in table 5.1 can be a basis to provide a classification of each of the 6 hospitals with regard to their implementation of the WOA framework.

Table 5.3 : Classification of Irish hospitals

Hospital	Score	Description
H3	33/36	'The Trailblazer' (has led the way in Irish healthcare) Children's hospital, has a strong diversity committee led by a champion at senior level.
H4	33/36	'The Good student and Diligent Implementer' Has been inspired by H3, Maternity hospital which is demand driven.
H1	28/36	'The Old Timer' was the first and only Irish representation in the European Migrant Friendly Health Project in early 2000s representing the HSE.
H5	26/36	'The Mission Queen and Adequate Applier' (A senior level, champion) The patriarch, Godmother figure who leads the mission of the hospital. The Largest hospital
H6	23/36	'The Quality Driven Outsider' Staff diversity. Strong ethos "check the boxes" culture. No champion. Patients not as diverse. Large hospital which is quality driven.
H2	18/36	'The Head in the Sand, Awakening to the issues of Diversity.' Little ethno-cultural differences in patients

The hospitals have been re-identified and each hospital has been given an identification based on the characteristics of their efforts in implementing the WOA and managing ethno-cultural differences. H3 has been identified as the "Trailblazer" as it has led the way in managing ethno-cultural differences in the Irish healthcare. H4 is the "Good Student and Diligent Implementer" as it has learnt from the experiences of its neighbour H3 and implemented policies accordingly. H1 is an "Old Timer" as it was the first and only hospital to participate in the EMFHP in the years leading up to 2004. H5 is the "Mission Queen, Adequate Applier" reflecting the strong influence of the patriarch figure and godmother like influence of a long serving member of the Board of Directors, who was an Ex-CEO and is current leader of the Mission Effectiveness committee in the hospital. H6 is considered "The Quality-driven Outsider" as it appears to be more autonomous and independent in its approach to managing ethno-cultural differences in healthcare. Finally H2 efforts are classified as "The Head in the Sand, Awakening to the Issues of Diversity", reflecting the idea

that the hospital is only awakening to the realities of diversity management in healthcare delivery. A more elaborated analysis and interpretation of each hospital is detailed later in this chapter.

5.2 Key characteristics of hospital that influence the implementation of the WOA

The findings of this research show that the WOA is being implemented to different extents and varying degrees in the hospitals. The advancement of the implementation process can be determined by the function of the hospital, its size and resources, its location, the ethno-cultural differences of the service users, the cultural diversity of the employees, the existence of champions and diversity committees, and the hospitals background and history of being involved in MF networks, programmes and policies through links with the HSE**.** To illustrate the point, we remark that H3 and H4 are the most advanced in implementing the WOA in part due to the function of the hospitals being related to child care and maternity care. Also, both hospitals are medium sized, located in the culturally diverse centre of the capital city, and have significant ethno-cultural differences in both employees and patients. In addition, both hospitals have active diversity committees and project leaders at middle or senior level. H3 has a champion of cultural diversity issues who is a CEO and an active member of the diversity committee. Contrastingly H2 provides services to elderly service users, is small, located in a less diverse catchment area, has no diversity committee or champion, and no background of working on MF healthcare and is the least advanced in the implementation of the WOA framework. Table 5.4 defines the 7 characteristics in the context of this research project.

Table 5.4 : Table of 7 key characteristics of a hospital that influence the implementation of the WOA

Characteristic	Description
Function	The function of the hospital (maternity, elderly, children etc) can determine the need to manage ethno-cultural diversity. A maternity hospital may have more need to provide culturally appropriate care to younger non-Irish national mothers than a hospital that caters for the elderly.
Size & Resources	The size of the hospital may determine the resources. Smaller and medium size specialised hospitals may have less resources than larger multi-functional hospitals. Also resources may depend on specific links with the HSE regarding cultural diversity initiatives. Resources are provided by the HSE for intercultural training, ethnic identifier or pilot projects in multilingual aids in certain hospitals (see H1, H3 & H4). Resources also depend on the economic welfare of the nation and the annual budget allocation to the health sector from the government.

Location	The extent of the ethno-cultural diversity of the service users is determined by the location of the hospital. Locations that are centrally located in the inner-city, or associated with urban expansion, or industry can have more need for management of ethno-cultural diversity than hospitals in the suburbs or periphery of the city.
Ethno-cultural diversity of service users	Proportion of ethno-cultural diversity among the service users of the hospitals.
Ethno-cultural diversity of service providers	The hospitals history of recruiting non-Irish nationals in the hospital.
Champion and Divsersity Committee	A champion is a member of the hospital staff who is a lynchpin and leads the ethno-cultural diversity agenda in the hospital and is usually involved in the establishment of a diversity committee or diversity task group.
History of managing (MF care)	The hospital's history in participating in migrant friendly health care initiatives through association with the HSE and migrant friendly health care networks at a national or European level.

5.2.1 The impact of the new Irish economic reality on the allocation of resources in health care

In analysing the implementation of the WOA from a resource perspective, undoubtedly the most constraining factor has been the radical change that has taken place in the Irish economic context since 2008. This change has led to a new more restrictive Irish economic reality which has constrained hospital managers and limited resources concerning the implementation of the WOA in Irish hospitals.

This new Irish economic reality emerged when Ireland experienced a major economical crisis in 2008 that resulted in the country becoming one of the first Euro zone members to enter into a recession, and exposed the Irish economy to hardships it had not experienced since the 1980s. Ireland as previously mentioned in chapter 1, had expanded considerably due to low corporate tax rates, low European central bank interest rates and shrewd government investment in education and technology which led to the "Celtic Tiger" economic period. Unfortunately, this expansion led to a property bonanza and the over pricing or bubbling of properties throughout the country. As a consequence banks became over exposed with borrowings increasing from 15 billion euro in 2004 to 115 billion in 2008 (Ahearne 2012).This led to the Irish banking sector being particularly vulnerable to the global financial crisis of 2007-2010. Within a short period of time, the property market crashed, the Irish stock index fell and Ireland went into recession in 2008 and sped further into economic depression in 2009 (Slattery 2009). Unemployment rose rampantly from 4.2% in 2007 to 14.3% in 2012,

(Kinsella 2012). This resulted in a return to emigration with an estimated 34,500 people who left the country from April 2009-2010, the largest net emigration since 1989 according to the Central Statistics Office 2010[25].

This economic crisis resulted in financial cut backs throughout the public and private sectors in the Irish economy. The Irish Department of Health as acting paymaster to the HSE slashed the Irish healthcare budget by 1.2 billion euros in 2010 which had negative knock on effects in hospital budgets throughout the country.

In March 27th 2009, the Irish government introduced a moratorium[26] as a measure to reduce costs in the public service. This included a moratorium on recruitment, promotions for all grades in the health sector including all management and administrative grades. Some areas were exempted from the measures such as Medical Consultants, Speech and Language Therapists, Physiotherapists, Occupational Therapists etc.

In 2010 the Health Ministry in an effort to promote departures from the sector introduced a voluntary early retirement and redundancy scheme throughout the health sector. The number of whole time positions in the HSE fell from 107,972 to 104,500 in the year leading to December 2011. The consistent lack of funding led to amended recruitment restrictions being introduced prohibiting the recruitment of even those posts that were previously deemed exempt (Cahill 2012). Despite these reductions the HSE had a 100 million euro budget deficit at the end of 2010 sparking a further wave of cuts and additional austerity measures in 2011 (O' Regan 2010). As the HSE budgets are scaled back, the entire health system is subject in the future to meet the challenges of further aggressive financial targets to reduce overall expenditure. This is confirmed by the comments of the CEO of the HSE, Mr. Cathal Magee, on the 5thMay 2011, when he stated at a key note address at the IMNO Annual Delegate Conference *"Ireland is facing economic challenges that are unprecedented in the history of our state. The healthcare system has been experiencing the reduced funding impact of this over the past eighteen months. Following significant funding reductions in 2010 and once again this year - the HSE is targeting total cuts in spending of approximately 1 billion euro. Implementing this level of expenditure reduction in this timescale is a hugely challenging agenda."*[27]

[25] Central Statistics Office, 2010, April, Population and Migration Estimates,(http:/www.cso.ie/pop).

[26] HSE Website (http://www.hse.ie/eng/staff/jobs/Moratorium.htlm)

[27] Keynote Address by the CEO of the HSE, Mr. Cathal Magee ,INMO Annual Delegate Conference 5thMay, 2011 (http://www.hse.ie/eng/services/News/newsarchive/2011archive/may2011/keynoteaddress.htm).

Bearing in mind this difficult economical context, it is interesting for the purposes of this research to investigate how this constraint and the other key characteristics have influenced the implementation of the WOA and ultimately the management of ethno-cultural differences in healthcare delivery in each hospital.

5.3 Analysis, interpretation and prescription of the implementation of the WOA in individual hospitals (SRQ2)

The analysis for the characteristics is presented in table format and follows the order of the classification of each hospital's performance with regard to the implementation of the WOA (Table 5.1). In addition, an interpretation and explanation of the efforts employed by each hospital is explained. This followed by a set of prescriptions for each hospital on measures that they should put in place.

5.3.1 Analysis and interpretation of Hospital 3 (H3): "The Trailblazer"

H3 can be considered the "Trailblazer" with a score of 33/36 and ranks joint 1st with regard to the implementation of the WOA. The hospital has won awards for its work in diversity management in the Irish hospital sector and has inspired other hospitals into action regarding the management of ethno-cultural difference. A testimony to the hospitals success is that management are frequently requested to give presentations at HSE level and national levels on the management of cultural diversity in the context of hospital management.

Table 5.5: Impact of H3's characteristics on the implementation of the WOA

Characteristic	Description
Function	Acute emergency service, paediatric hospital that provides care regionally and nationally for children up to the age of 16 years old. It was founded in 1872 and is managed by the trusteeship of the Sisters of Mercy as a voluntary public hospital.
Size & Resources	The emergency department is one of the largest in the country with approximately 45,000 attendances per annum and represents the biggest paediatric casualty department in Ireland. There are over 1,000 full-time and part-time nursing, paramedical and other staff working. The hospital bed capacity is 155. The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector.
Location	The hospital is located in the inner city and serves the north and south of the capital city.

Diversity of service users	H3's catchment area includes both north and south inner city servicing approximately 60 ethnic groupings. The catchment area has the highest percentage of minority ethnic groups such as asylum seekers and refugees. In 2003, 25% of accident and emergency attendances were patients with ethnic minority backgrounds**.**
Diversity of service providers	The composition of staff in terms of nationalities is approximately 14 different nationalities.
Champion and Diversity Committee	The HR manager is a champion of promoting diversity issues in the hospital and has given presentations at HSE level and national levels on the management of cultural diversity. She is a member of the training sub-group of Regional Ethnic Minorities Strategic Working Group and led the establishment of a diversity committee in 2000.
History of managing (MF care)	The establishment of a diversity committee in 2000 comprising of a multidisciplinary team with the aim of exploring and developing effective methods of cross-cultural and intercultural dialogue has researched cultural diversity issues within the hospital and has carried out a research project entitled "*Discuss best practice in the delivery of cultural appropriate care of children and families taking into account their clinical needs while respecting their cultural and health beliefs."* Collaboration with the HSE in piloting programmes such as the ethnic identifier, being proactive in the field of diversity management and has been the recipient of national awards.

A principal reason for this success is the nature or function of the hospital. The hospital is a children's hospital and its emergency department is the largest paediatric casualty department in Ireland, located in the heart of Dublin city. The provision of healthcare to sick children is perhaps more prone to the need for sensitive provision of culturally appropriate care to the children and parents as opposed to adult or elderly care.

The location of the hospital in an ethno-culturally diverse catchment area, leads to the hospital servicing families from different ethnic backgrounds. H3 has been one of the first hospitals to be affected by immigration and rapid change of demographics. Consequently H3 is recognised as being one of the original hospitals in Ireland to have established a diversity committee to promote the delivery of cultural appropriate care of children and families by respecting their cultural and health beliefs.

In analysing the success of the hospital in implementing the WOA, one of the critical factors of the hospital's success is the role of the HR manager who has been a linchpin in leading the diversity agenda. The HR manager is a long-serving experienced employee who is a member of senior management and acting CEO. She is responsible for setting up the diversity committee, which is the only committee among the hospitals surveyed that is based on a voluntary basis. The meetings are held at lunchtime and outside normal working hours. This speaks volumes for the ethos and commitment of the employees towards the respect

and importance of managing ethno-cultural differences. This is even more remarkable considering the success of the diversity committee and the distinguished work that it has accomplished.

Since its inception, the committee has initiated translation projects, interpretation services, cultural mediation, signage, intercultural training, ethnic identifier and diversity theme weeks. Furthermore, H3 is the only hospital that has established a minority health forum, which is an ongoing consultation with community groups representing different ethnic groups in order to inform them about work on diversity within the hospital and to obtain feedback about their services. The committee conducts internal research assessing the needs a staff in the context of managing diversity. An example is the hospital's published report entitled "*Best practice in the delivery of cultural appropriate care of children and families taking into account their clinical needs while respecting their cultural and health beliefs"*. This report was produced by the Health Promotion Coordinator who was also the Chairwoman of the diversity committee in 2010. It is evident that the diversity committee has a strong influence in the hospital. It can be inferred that contrary to other hospitals, the success of the diversity committee can be attributed to the fact that its founder and leader is the HR manager, who has the knowledge and expertise to cultivate and implement diversity management strategies more easily, as diversity management fits into human resource management functions and is according to (Gilbert et al., 1999), a principle of management used in making HR decisions. This coupled with the fact that the HR manager is a member of senior management has perhaps rendered the diversity committee more influential and operationally effective in the organisation.

Given the voluntary status of the hospital and the initiatives of the diversity committee the hospital has cultivated strong links with the HSE. Consequently the hospital has received specific HSE funding for interpretation and intercultural training initiatives. This collaborative relationship with the HSE has led to the hospital being chosen to be one of two hospitals to pilot migrant friendly policy initiatives such as the 'ethnic identifier', which included staff training on collecting data from patients who are members of MECs. In addition H3 is the only hospital in the country, which has a HSE funded Children's Hospital Information Centre (CHIC) with an appointed coordinator. The CHIC translates hospital information and produces health literacy information in local community languages, and sends booklets out in advance to patients before hospital entry to explain hospital procedures. The CHIC coordinator also gathers translated information from within the Irish health system and acts as a central collection point for healthcare literacy including translated documentation.

It can be argued that the hospital has a top down, bottoms up approach to managing ethno-cultural diversity. Management apply directions from the HSE but also cultivate a culture which encourages staff to be implicated through for example, voluntary participation in the diversity committee. There is a sense that the subject of cultural diversity is alive at every level of the hospital. This is evident from the comments of the Clinical and Patient Services manager who maintains *"that there is a top down, bottoms up approach led from the top through our diversity committee which reports to the executive committee with senior management and bottoms up initiatives from the ground up from people".* This is an indication of a strong organisational culture, which cultivates an ethos of respecting ethno-cultural difference throughout the hospital. Therefore it is no surprise that the hospital has been ranked as one of the best places in Ireland to work in the "*best workplaces in Ireland survey*"[28] in association with the Irish Independent Newspapers, for the 6 years prior to 2010 despite the difficult economic climate in the latter years.

The hospital can be considered proactive regarding the management of ethno-cultural differences and is the only hospital to have trained members of the diversity committee to conduct intercultural training to the rest of the employees in the hospital and have introduced shorter training sessions, which take place on the wards to combat time and resource deficiencies. Furthermore, in the Accident and Emergency department, the hospital has recently piloted a multi-racial incident form to capture the ethnicities, to flag diversity related incidents and to report disparities, should they arise. The hospital is the only hospital that was surveyed to provide leaflets to staff and patients entitled "What if you see racism?" informing the hospital community on the appropriate procedures to follow. In addition the hospital has cultivated strong networks and is a member of the training sub-group of Regional Ethnic Minorities Strategic Working Group and participates on the inter-hospital networks at local and national level.

Generally speaking H3 has been a "Trailblazer" in the Irish hospital sector on account of it being the first to implement successful hospital-wide migrant friendly initiatives and having successfully used the WOA to ensure inclusive, culturally sensitive strategies are the norm for meeting the healthcare needs of MECs. Despite being considered a "Trailblazer" the hospital needs to continue to further develop certain sub-elements of the WOA framework most notably in training and support to training initiatives. Also given the substantial resources that the hospital and HSE have invested in managing ethno-cultural differences

[28] Best workplaces in Ireland lists the best organisations to work for in Ireland based on confidential inputs from employees of the organisation (www.greatplacestowork.ie/best/index.php).

there are surprisingly no explicit performance evaluation systems linked to diversity. There is no systematic measurement of outcomes related to investments in diversity and equality inputs.

5.3.1.1 Prescriptions for H3 “The Trailblazer”

The following section is designed to offer suggestions and guide hospital management in improving the management of ethno-cultural differences in H3. Prescriptions for the hospital will be made by reviewing each sub-element of the three strands of the WOA and by analysing those parameters that are judged to need development in each sub-element.

- ***Specific initiatives that demonstrate the commitment and support of managers***

H3 should introduce explicit performance management systems linked to equality and diversity and staff should be evaluated directly related to equality or diversity indicators. The hospital should consider the introduction of systematic measurement of outcomes related to investments in diversity and equality inputs such as training or correlations between migrant friendliness to patient satisfaction surveys and rely less on anecdotal evidence.

- ***Up to date intercultural policy for the health services***

Cultural mediation did take place with cultural brokering for the Roma populations through Access Ireland but this service provider no longer exists due to financial restrictions. The hospital should therefore seek alternative cultural mediation services and solutions through its established network with MEC advocacy groups.

- ***Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery***

The hospital should introduce formal equality auditing reviews and equality/culture proofing of service provision. H3 could go beyond the current consultation feedback methods with MECs and community groups through a minority health forum, by soliciting the views of more patients who are members of MECs directly trough patient satisfaction surveys linked to cultural competent healthcare.

- ***Training and development initiatives in the field of diversity management***

H3 should consider introducing Level 5 multicultural team training, given the cultural diversity of the 14 nationalities in the workforce. Also, with regard to a tiered approach to intercultural training Level 6, concerning legal and business case training, which took place for service department heads and senior managers in 2006 and 2007; this should be systematic for all

manager levels in the hospital. Moreover, all levels of intercultural training should be mandatory for all senior leadership management and staff in the hospital. Finally, it is recommended that the hospital introduces online training options in intercultural training to combat time and budget constraints in the context of the current economic cutbacks in health care.

- ***Workplace support structures to support staff to manage issues relating to cultural diversity***

The hospital could consider alternative ways to use cultural mediators through contacts within the long established MF healthcare networks.

- ***Development of initiatives to integrate and manage multicultural teams***

H3 needs to introduce formal multicultural team training, which is an area of training that the hospital acknowledges needs to developed. Also, in the event of future recruitment of overseas nurses, the hospital should consider creating an overseas nursing coordinator post and ensure that that existing Irish staff be prepared to work on multicultural teams.

- ***Signage, particularly in reception and public areas in the key languages of service users***

Despite the hospital's efforts to translate the welcome signs in the entrance area, H3 needs to have more signs directly translated in key service areas.

- ***Literature in the key languages of service users***

H3 is advised to translate the hospital website into the main foreign languages represented in the community.

- ***A comprehensive interpretation service***

Interpretation services costs are monitored and evaluated for quality and the hospital provides translation services on a need by need basis. However the hospital needs to modify its policy and ensure that staff are trained to use interpreters.

5.3.2 Hospital 4 (H4): "The Good Student and Diligent Implementer"

H4 is a maternity hospital located in Dublin city centre that has been providing maternity services and healthcare to women and their families for over 250 years. The hospital has a total score of 33/36 and ranks joint 1st for the implementation of the WOA. It has been in the frontline of delivering health care to ethno-culturally diverse service users having

experienced an increase in activity of 50% from 2000 to 2010 according to the Deputy Patient Services manager. The hospital has overseen an increase of births from 6,000 babies in 2000 to approximately 9,000 in 2010. This in part has been the result of immigrants arriving in Ireland to deliver their babies and profiting from the then right of the Irish constitution that entitled the newborn child to receive Irish citizenship automatically, and the right for the parents to stay for 18 years to care for the child. This new entitlement was introduced in the Irish constitution, following the signing of "The Good Friday Agreement" in 1998. The Patient Service's Manager describes a typical daily scenario during this time when she states *"around the time of "The Good Friday Agreement", 20 to 40 African women would present themselves (in the hospital) each day, without any reservation, (pre-booking) and being around 38 weeks pregnant".* Management have responded by setting up out-reach programmes such as the Balseskin centre which is a holding centre for in-coming, non-Irish national asylum seekers and refugees coming to Ireland. This centre, located close to the national airport, screens and caters for the incoming pregnant immigrants.

Table 5.6: Impact of H4's characteristics on the implementation of the WOA

Characteristic	Description
Function	H4 is a maternity hospital, with emergency services and is a charitable voluntary institution.
Size & Resources	The hospital is medium sized and hosts medical education programmes at both undergraduate and postgraduate levels. There are 855 employees. H4 registered approximately 9,000 births in 2010. The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector.
Location	It is located in the centre of Dublin, in a culturally diverse catchment area.
Diversity of service users	H4 serves the same catchment area as H3 and includes both north and south inner city servicing approximately 60 ethnic groupings. The catchment area has the highest percentage of minority ethnic groups such as asylum seekers and refugees.
Diversity of service providers	39 different nationalities are represented in the workforce according to the Training & Development manager.
Champion and Diversity Committee	The strong influence of the Training and Development manager and the Head Social Worker who are responsible for establishing the diversity committee and act as key participants. H4 has a multiethnic diversity committee with members from different departments and chaired by the Training and Development Manager. It has been operational and active since 2007.

History of managing (MF care)	H4 was a member of the Intercultural Healthcare Pilot project, and was a demonstration site under the National Social Inclusion Steering Committee of the HSE, to create an ethos in healthcare settings that supports the delivery of care in a culturally appropriate manner. H4 also participates in the NIHP and has piloted national projects including the ethnic identifier data collection programme.

H4 was particularly influenced by demographic changes of its patients, i.e. non-Irish national pregnant women. This forced the hospital to focus on delivering culturally appropriate care to mothers and newborns in order to respect their cultural beliefs while attending to their clinical health needs. The nature of maternity health care is particularly relevant as the MFHP findings in 2004 noted the urgency to provide culturally appropriate healthcare particularly in maternity services. Consequently, the hospital has put in place a strong patient focus to the hospitals strategic plan taking advice and input from MEC patient advocacy groups such as Cairde and Pavee Point so as to adapt to the needs of those service users who are members of MECs.

The hospital has been inspired by the efforts made by H3 to manage ethno-cultural differences in service delivery and has diligently followed similar policies and initiatives. This has been encouraged by the close proximity between the two hospitals who are neighbours in Dublin city centre. Also the maternity and children services provided by each hospital are linked as H3 offers follow-on services for sick infants and children. Managers from both hospitals sit on inter-hospital network committees and benchmark service provision with other children and maternity hospitals. Thus there has been the opportunity for a strong exchange of information regarding managing ethno-cultural differences in service delivery between the two organisations. This has permitted H4 to learn from H3's efforts and diligently put in place similar WOA initiatives. This "reliance and dependence" on following the diversity management policies of H3 is portrayed in the following quote by the Head Social Worker and co-founder of the diversity committee: *"We have a draft intercultural policy based on HSE policy and we work in conjunction with (H3), and other maternities. We have an internal diversity committee and work at local hospital committee level with other hospitals and at national committee level. As a social worker I would meet heads of other social work departments and we meet as a multidisciplinary group around issues and we take a lot of direction from (H3). We see them as being further down the road, they got started before us."* H4 has put in place similar policies as H3 and established a diversity committee in 2007 with 12 members from different departments. This multiethnic and multidisciplinary committee is chaired by the Training and Development manager and collaborates with patient advocacy

groups representing MECs (Cairde, Pavee Point). The hospital has most likely benefited from the 7 years of experience that H3 had in introducing a diversity committee.

While there is no senior management directly participating in the committee, senior management are represented through heads of departments such as social work, chaplaincy, catering, training and development, and the committee reports to partnership committee which in turn reports to senior management. The driving influence of the diversity committee is the Training and Development manager and the Head Social Worker who were responsible for establishing the diversity committee. The diversity committee is as active as H3 and organises cultural days celebrating religious and international holidays, international arts and crafts exhibitions, music, dance, international movie nights, publish a recipe book and hanging national flags among other initiatives.

A testimony to the hospital's commitment to the diversity agenda and the diversity committee is that unlike H3, members of the diversity committee meet during working time and are essentially paid to attend meetings. Also, the Board of Directors officially launched a new patient information booklet translated into key languages represented in the hospital community.

The hospital has strong links with the HSE, most likely due to the sensitive function and nature of the hospital from the perspective of providing culturally appropriate healthcare to pregnant women and women after childbirth. The increase in activity levels in the hospital of a 34% cumulative increase over the 7 years leading up to 2009, brings an inherent risk which explains the hospital's motivation for putting in place initiatives to manage ethno-cultural differences and the support of the HSE in funding certain actions. This has led to funding of the establishment of the diversity committee by the HSE. Equally, costs of interpretation services and translation of patient information and intercultural training are partly financed by HSE funding. Furthermore, the hospital has an established record of participating in the NIHP and works in collaboration with the Department of Social Inclusion of the HSE. H4 has also piloted national projects, including the ethnic identifier data collection programme. This may be a result of the nature of the hospital's services as a leading maternity hospital located in a culturally diverse catchment area in the inner city of the capital. In addition, the hospital is particularly strong in providing training in death and dying rites and traditions and has bereavement information documentation available to staff. The Chaplain provides training on care for the dying from a cultural perspective, through the HSE to midwives in 3 maternity hospitals.

The overall results depict a hospital that is fully aware of the multifaceted issues of managing diversity in hospitals. The hospital can be described as having a top down, bottoms up approach where staff have the opportunity, through the Diversity Committee, to contribute towards the management of ethno-cultural differences. Management have shown strong commitment and staff have been encouraged to be aware and conscientious of providing culturally appropriate care. The Diversity Committee is made up of local managers who promote the importance of the issue at operational level. Also, the nature of the maternity service, where cultural and religious beliefs impact the provision of clinical care explicitly, means that staff are more likely to be more aware of the significance and importance of providing culturally appropriate healthcare at childbirth. The hospital acknowledges room for improvement in the training and development initiatives in the field of diversity management.

5.3.2.1 Prescriptions for H4 "The Good Student and Diligent Implementer"

- ***Specific initiatives that demonstrate the commitment and support of managers***

H4 could consider creating an official post of a diversity officer or equality officer instead of solely relying on the diversity committee to lead in the area of management of ethno-cultural issues. There is an argument that despite middle management and heads of departments involved in the diversity committee that senior management could be more visible. The hospital should consider introducing performance management systems linked to equality and diversity for management and staff. H4 should consider introducing appraisals linked to cultural competence and MF care. Co-correlating MF and the patient satisfaction survey would allow the hospital to measure progress. Systematic measurement of outcomes related to investments in diversity and equality inputs such as training must be measured. The Training and Development manager summarises the hospital's weakness regarding measurement by stating that with regard to *"cost analysis we are aware of what we are spending but not aware of measuring the impact or the return on investment."*

- ***Up to date intercultural policy for the health services***

The hospital could consider the use of cultural mediators by using volunteer networks or contacts with MEC advocacy groups.

- ***Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery***

H4 undertook a one-off external audit of patients regarding services, through Prospectus Consultant Management Service with executives from health services, who tested services

and proposals with regard to alignment with hospital values. H4 should introduce equality auditing and more impact assessments systematically. H4 could consider the introduction of formal risk management occurrence, specific to flagging diversity incidents and reporting disparities.

- ***Training and development initiatives in the field of diversity management***

H4 should introduce a systematic approach to all levels of the tiered approach to intercultural training and most noticeably introduce Level 5 multicultural team training and Level 2 cultural diversity training. Intercultural training should be mandatory for all management and staff. One medical Doctor responded that she was not aware of any intercultural training outside of the induction training. This suggests a need for the hospital to investigate if medical doctors need intercultural training. *"I live here 12 years and I have seen nothing like this (referring to a tiered approach to training)",* Medical Doctor*.*

Like most hospitals surveyed H4 experiences human resource restraints due to the moratorium in the health sector which has resulted in difficulties for staff to attend training as attested by the Bereavement Support Midwife Nurse who states *"I am sure there are programmes but I have not had the time to get out to train".* In this context H4 should develop online intercultural training facilities on culturally competent care which would create time and financial cost efficiencies.

- ***Development of initiatives to integrate and manage multicultural teams***

H4 should consider the introduction of formal multicultural team training to staff especially in the context of having a culturally diverse workforce. Also, in the event of future recruitment of overseas nurses the hospital like other healthcare organisations should consider creating an overseas nursing coordinator post and ensure that that existing Irish staff would be better prepared to work on multicultural teams. There is evidence that suggest possible problems with career planning and promotion of non-nationals employed at the hospital. This lack of succession according to the Director of Nursing may be linked to the fact that some non-Irish national nurses do not wish to be promoted as they may lose out on overtime work opportunities and some staff are sending *"80% of their salary back home".* One social worker states that she has *"seen promotion and has seen no promotion"* with regard to non-Irish nationals and proposes that some non-Irish national staff probably feel that *"I will not get the promotion if I am not Irish"*, but further states that "*there are midwife nurses that have moved up".* The hospital would be advised to further investigate to what extent non-Irish nationals are evolving professionally in the view of future succession planning strategies.

- ***Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system***

The hospital should endeavour to increase multi-ethnic patient involvement in the development of processes, procedures and practices in the hospital. This is underlined by the Director of Nursing who states that *"we are developing a patient forum with multi-ethnic representation, we have one focus group to help create a strategy so as service users are involved in service planning, we don't do it as well as we should, we need to develop it."*

- ***Signage, particularly in reception and public areas in the key languages of service users***

The hospital also needs to introduce signage translated into languages of service users in key areas in the hospital and ensure the implementation of the recommendations of an access audit executed by the University of Birmingham which include an assessment of signage and visual displays.

- ***Literature in the key languages of service users***

The hospital needs to translate its website into the language of its commonly encountered ethnic service users.

- ***A comprehensive interpretation service***

The hospital should consider putting in place training structures to formally train staff on how to use interpreters and introduce guidelines to the same effect.

5.3.3 Hospital 1 (H1): the "Old Timer"

H1 ranks 2nd and is relatively advanced in managing ethno-cultural differences. It has a total score of 28/36 regarding the implementation of the WOA approach. The hospital at the beginning of the influx of non-Irish nationals was reactive toward the problematic involving the provision of culturally competent care especially since the hospital's catchment area was one of the most diverse in Ireland. H1 could be considered an "Old Timer" in the context of putting into place provisions for managing ethno-cultural differences.

Table 5.7 : Impact of H1's characteristics on the implementation of the WOA

Characteristic	Description
Function	General emergency services, 80% of admissions to H1 are accessed through the emergency department, leading to more urgent needs for culturally appropriate healthcare. H1 is a public hospital, entirely controlled by the HSE.
Size & Resources	The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector.
Location	H1 is a medium sized hospital located in the North West of Dublin. This area was identified as one of the fastest growing regions in Europe (Census 2006).
Diversity of service users	In 2010, 19% of admissions to the emergency department were patients from countries other than Ireland.
Diversity of service providers	The nationality composition of staff (2007) included 78% Irish and 22% non-Irish.
Champion And Diversity Committee	H1 has a Health Promotion Coordinator, who is the leader of the diversity agenda and drives the Diversity Committee.
History of managing (MF care)	H1 was Ireland's first and only representative hospital in the MFHP. It participated in the Equal at Work project in 2005, the HSE's NIHP and has been a member of the National Intercultural Hospitals Initiative since 2004. It has also piloted a national project concerning the 'Emergency Multilingual Aid'(2006-2007).

Historically, management showed strong commitment and pioneered Irish participation at an international level with its involvement in the MFHP in 2004. In collaboration with the HSE the hospital applied to participate in the MFHP in 2004 and was accepted. This led to funding at a European level for migrant friendly initiatives and assessment tools involving training and focused research assessing the needs of staff from a cultural diversity perspective. Participation in this project led to the implementation of migrant friendly services such as the introduction of interpretation and translation services, guidelines for accessing interpreting services and the implementation of a wave of cultural competency training, funded by the HSE directly. The hospital has also participated in the NIHI assisting in the follow through of initiatives in the Irish hospital sector emanating from the MFHP. For example the hospital was the pilot site for the testing of the multilingual aid and supported the project group to develop the Emergency Multilingual Aid nationally. This project is a language aid available to

healthcare professionals to assist them when communicating with members of MECs. In addition, H1 has participated in the NIHP and the national Equal at Work project.

Consequently the hospital's strong links with the HSE ensures that the use of HSE produced initiatives such as the Emergency Multilingual Aid and Intercultural Health guides are rolled out and made available to staff. Unlike all the other hospitals surveyed in this study, H1 is governed entirely by the HSE and therefore, according to certain senior managers in voluntary hospitals, it has less scope to act independently. Hence, it has a history of following the HSE corporate policies and implementing national top down policies such as the National Intercultural Health Strategy and the WOA in a routine order. H1 was one of the first hospitals to have established a diversity committee structure as a direct result of its involvement in the MFHP. The committee is led by the Health Promotion Coordinator, who is also responsible for cultural diversity issues in the hospital. The Health Promotion Coordinator's role is key to support diversity structures in the hospital. She acts as a champion for promoting culturally appropriate healthcare. This is acknowledged by the comments of the Nursing Support Services manager who states that *"the Health Promotion Coordinator is our cultural diversity contact who drives the cultural diversity committee."*

The hospital is proactive and has a tradition of having strong links with MEC advocacy groups as well as with the broader minority ethnic communities. We can consider that the hospital has made strong efforts in the past to ensure that cultural diversity in the provision of healthcare is embedded in the organisational culture. This is portrayed by a senior Mental Health Nurse who commented *"I have worked for 4 different hospitals and this hospital is the best regarding cultural diversity, the topic is alive here. The hospital does well in recognising different cultures."* However, while strong commitment seems evident at the outset of the influx of non-nationals, it is debatable as to whether there is still the same momentum. For example there are no managers currently sitting directly on the cultural diversity committee as they were replaced by other staff acting as representatives for management as indicated by the Health Promotion Coordinator who states that *"management are not on the cultural diversity committee now but were represented, in past years".* Following its participation in the MFHP, H1 implemented systematic and ongoing intercultural training programmes, which was funded by the HSE. However in recent years H1's participation in intercultural training initiatives has progressively decreased. When asked about the commitment from management to cultivate a culture that promotes equality and diversity one Clinical Nurse manager replied that "*in the beginning yes, there was commitment but now priorities have changed."* This trend is due to the current economic crisis in the Irish health sector, whereby

funding for training has been drastically reduced leading to a lack of resources available for intercultural training. This is confirmed by the Chaplain who states "*these things do not seem priority and our budget is cut"*. Likewise the Clinical Nurse manager maintains *"we were certainly offered training but it seems of less importance these days".* In conclusion H1 can be considered as an "Old Timer" in terms of managing ethno-cultural differences in service delivery. However, like most "Old Timers", H1 needs a fresh approach and search for new innovative ways to improve the implementation of the WOA and ensure that the management of ethno-cultural diversity stays a priority of the hospital.

5.3.3.1 Prescriptions for H1, "The Old Timer"

The following section aims to guide hospital management in improving the management of ethno-cultural differences in H1. Prescriptions are suggested by reviewing each sub-element of the three strands of the WOA and by analysing those parameters that are deemed to require development in the future.

- ***Specific initiatives that demonstrate commitment and support of managers***

The hospital should implement performance management systems and evaluate directly staff performance with relation to diversity and equality or MF measures. The hospital needs to introduce measurements of cultural competence and develop correlations to MF care in patient satisfaction surveys. The hospital should introduce outcome based evaluations such as access to services in a timely fashion, or evaluate the elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay or potential legal liabilities.

Furthermore, systematic measurement of outcomes related to investments in diversity and equality inputs such as training should be introduced. The hospital must refrain from relying on anecdotal evidence and introduce correlations between MF and the patient satisfaction survey. The hospital has to be more explicit in its accountability for providing culturally competent health care by ensuring that performance management for managers or staff is linked to diversity or MF measures. Also H1 has to ensure that cultural competence is linked to quality standards or accreditation by introducing measurements of healthcare outcomes concerning culturally competence. An example is that the patient satisfaction questionnaire surveys could be referenced to culturally appropriate healthcare service delivery.

- ***Up to date intercultural policy for the health services***

There is a need for management to introduce an explicit equality or diversity policy. Also, despite the budgetary constraints the hospital should endeavour to cultivate links or introduce a voluntary network with cultural mediators to assist with building bridges between the hospital and members of MECs.

- ***Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery***

The equality framework should include equality audits and equality proofing of service provision, as a measure to ensure effective management of the ethno-cultural differences of both service users and service providers. Equality audits, which seem limited to complaints systems and reporting of incidents, could be expanded to include the expert services of the equality authority. Furthermore, the hospital should introduce measurement and assessment of equality by introducing specific related questions in the context of ethno-cultural differences and culturally competent care, to patient satisfaction surveys, or staff competence assessments or community outcomes assessments. Also, it is recommended that the hospital explicitly links culturally competent care to quality and accreditation standards at local and national levels.

- ***Ethnic monitoring system including an agreed framework for data collection and data usage***

There is a need for the hospital to register race, in the process of monitoring patients in order to reflect accurately the ethno-cultural diversity of the patient. In addition, the hospital can implement best practices by using ethnic data to inform its services, such as diversity training needs, strategic planning, and development of outreach programs or develop culturally competent disease management programs.

- ***Training and development initiatives in the field of diversity management***

The hospital should invest in more systematic and ongoing intercultural training. Intercultural training needs to be mandatory for all staff and particularly frontline staff. Level 2, cultural awareness training was prominent from 2004 to 2007 but is not as active today due to resource constraints. Level 5, multicultural team training needs to be introduced especially taking into consideration the workforce diversity in the hospital. The Director of Nursing stated that Level 5 will be "*coming down the line"* and the hospital should ensure that it does. The hospital may consider a 'train the trainer' programme in the intercultural field and this would be cost effective as it would avoid the use of costly external intercultural training. One

area that the hospital could focus on is training for working with interpreters as staff seem to have never been trained in this area. The hospital may examine the feasibility of introducing online options for intercultural training. This would be effective for combating the current dilemma of budget restraints on training and unavailability of staff to attend trainings sessions due to time pressures and lack of substitute staff to replace while attending training sessions. Staff members should be encouraged to attend and present research in conferences on intercultural health care. The hospital could introduce training in short 20 minute sessions that take place during shift changes on wards or lunch times to counteract time and budget constraints and overloaded work schedules.

- ***Workplace support structures to support staff to manage issues relating to cultural diversity***

The hospital's website needs to be developed by adding links to culturally competent health care and diversity issues specific to staff. The introduction of a policy for the use of cultural mediators with particular MECs such as the Roma is suggested.

- ***Development of initiatives to integrate and manage multicultural teams***

The hospital lacks formal multicultural team training given the proportionately large workforce diversity in the hospital. There is evidence from this research that there can be tensions between national and non-Irish national staff. While promotion and career planning opportunities are open to all, certain areas of the hospital are experiencing promotion of non-Irish national staff at lower levels than others. For example the catering department has examples of non-Irish nationals being promoted. *"Yes non-Irish move up in catering to chef",* Catering manager*.* However a Clinical Nurse manager disagrees stating *"I don't see non-Irish nationals moving up".* This may suggest that succession planning may be a problem in the future in certain areas of the hospital.

- ***Training methodology to include co-facilitation by members of minority ethnic communities***

The hospital should provide resources to staff who are members of MECs to build their capacity to design, deliver and evaluate training, through for example, train the trainer initiatives. Also H1 could specialise in specific training to major ethnic groups such as the Polish or other Eastern Europeans using staff members who are from these MECs.

- ***Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system***

The hospital makes efforts to build bridges with MECs but should endeavour to increase participation of members from MECs on the patient council or patient involvement committees.

- ***Signage, particularly in reception and public areas in the key languages of service users***

Signage translated in the main languages and posters promoting diversity in healthcare issues especially in the main reception areas in the hospital could be introduced.

- ***Literature in the key languages of service users***

Translated versions of the hospital website in local community languages are recommended to ameliorate external communication services.

- ***A comprehensive interpretation service***

The hospital needs to ensure that staff are formally trained to use interpreters; especially in complex services areas such as mental healthcare provision.

5.3.4 Hospital 5 (H5): "The Mission Queen and Adequate Applier"

H5 ranks 3rd highest in overall implementation of the WOA and this may reflect the fact that the hospital is the largest of the six hospitals surveyed, with approximately 3,000 employees. H1 has a total score of 26/36 with regard to the implementation rate of the WOA approach. In this sense this voluntary hospital could be described as an "Adequate Applier" but more interestingly as 'The Mission Queen' as the hospital strongly emphasises the application of the values of its mission statement throughout the hospital. In doing so, H5 relies heavily on the Director of the Mission Effectiveness Committee who is a long established mission champion and a widely respected matriarch-like figure across the hospital.

Table 5.8: Impact of H5's characteristics on the implementation of the WOA

Characteristic	Description
Function	H5 is a charitable voluntary general hospital with emergency services. The mission and ethos of the hospital towards the sick and elderly, patients, staff and relatives is affected through the Office of the Director of Mission Effectiveness.

Size & Resources	The hospital is a large hospital for Irish standards. It has 570 beds and employs approximately 3,000 employees in 120 departments. The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector.
Location	Located in the city centre in North County Dublin, it provides services to North county Dublin and the rest of the country, through its specialised services.
Diversity of service users	The hospital provides services to an ethno-culturally diverse service user population because of its central location and the variety of it's services.
Diversity of service providers	The hospital employs 3,000 employees and approximately 40% of staff are non-Irish nationals.
Champion and Diversity Committee	The Director of Mission Effectiveness, who is a religious nun, a former CEO as well as a current member of the Board of Directors, has been a champion for the cause of mission effectiveness which includes the concepts of equality and diversity.
History of managing (MF care)	H5 participated in the NIHI and published a document on Religious and Cultural Issues in health care.

H5 has a strong commitment to the management of ethno-cultural differences emanating from the work of the Mission Effectiveness Committee chaired by a long serving religious nun (Sister X) who is a former CEO, a long-standing senior executive and a member of the Board of Directors of the hospital. Historically, she has been a champion defending and promoting the values of the mission statement which includes the values of diversity, respect and equality and can be considered as 'The Mission Queen". (Sister X) was referred to by all the hospital personnel interviewed in this study, as testified by the Nursing Practice Development Coordinator who declared *"we have a mission effectiveness committee led by (Sister X) to ensure an ethos of respect and diversity in the hospital", and the Chaplain who stated that, "Sister X is a strong example of leadership and management commitment and she gets people involved".*

While the hospital can be considered to have a committee that partly focuses on diversity issues, it does not have a typical structure referred to as a Diversity Committee, as in H3 or H4. Instead, it has chosen to promote the values and ethos of diversity through a similar structure entitled the Mission Effectiveness Committee, which substitutes for a stand alone Diversity Committee. The hospital maintains that the role of a Diversity Committee is encompassed in the Mission Effectiveness Committee. It can consequently be debated to what extent the theme of diversity has been implemented on the ground, at operational level throughout the hospital. The Mission Effectiveness committee does not deal exclusively with

diversity, but promotes other issues related to the hospital mission statement. This can be inferred through the comments of the Chaplain in his statement: *"Each year we take a value from the mission statement and heighten awareness through mission awareness week, and we develop posters on each ward in 80 departments. This year's (2010) mission awareness week was the 24th September and the theme was cultural diversity".*

Also the Patient Services manager describes the efforts made during the mission awareness week as: *"all the department heads do posters on how cultural diversity exists in their department".* This type of approach is open to criticism as it is descriptive and is not operations based. The hospital has a top down approach to managing ethno-cultural differences and demonstrates leadership through the Mission Effectiveness committee. This approach reflects the role of (Sister X) who leads from a strategic 'Queen' or matriarch-like perspective. In the absence of a focused stand alone diversity committee consisting of heads of departments, there is not the sense of staff engagement and awareness for diversity issues as witnessed in H3 and H4. This may constrain a bottoms up approach where staff are participating, innovating and are strongly implicated at an operational level as in H3 and H4. This argument can be construed from the comments of a Medical Social worker who states*, "Apart from her (Sister X) who promotes it at every turn (diversity and mission effectiveness) and the legislation, there is not really a lot of leadership at local level"* and adds that "there has not been *a huge emphasis from a management point of view".*

Another factor that may restrict a bottom up approach is the size of H5, which is significantly larger than H3 and H4, and thus makes it more difficult to cultivate the same drive and application at an operational level. The hospital has adequately applied initiatives to manage ethno-cultural diversity. It has also had in place several intercultural initiatives since 2005. These include guidelines to staff on how to access an interpreter, provision of halal foods for patients and staff, the publication of two documents, one on Religious and Cultural issues by a member of staff in collaboration with a variety of community religious leaders from the community, and a resource manual entitled "Point to Talk" devised by the Speech and Language Therapy Department which aids staff with basic communication with any patients who have communication difficulties. Furthermore, nursing staff have a Cultural Awareness Day with input from different nationalities from the nursing context. There was also orientation training for overseas nurses and annual ecumenical services are available for patients and relatives of deceased patients. The catering department celebrates cultural events with specific food choices such as the Chinese New Year among others.

The hospital piloted the national HFHP for care for the end of life in 2005 incorporating migrant friendly care provision for members of ethnic communities. The management benchmark service provision regarding diversity and equality, through membership in the HPHN and the NIHI. They also seek advice from IBEC and the Equality Authority of Ireland. Furthermore MEC patient advocacy groups such as Cairde, are consulted to exchange information and to obtain feedback and input from a minority ethnic perspective on hospital services. Certain hospital services have been culture proofed by involving Cairde and other MEC advocacy groups in the development of the service. An example is that the hospital collaborated with Cairde and the Dublin Jehova Witness community in piloting the HFHP for care of end of life.

Despite a cultivated ethos, there are gaps to be filled regarding the implementation of the WOA and the hospital could increase resources in the area of workplace environment and support to training. The hospital is an "Adequate Applier" of the WOA but could go further in selected areas as suggested in the following comments from the Training and Development Coordinator who is positioned at the heart of the training and development needs of hospital employees in regard to this subject: "*We have no equality officer, we need a focused diversity committee" and "we don't check how cultural competent our staff are".*

5.3.4.1 Prescriptions for H5 "The Mission Queen and Adequate Applier"

Despite a well cultivated ethos there are gaps to be filled regarding the implementation of the WOA and the hospital must decide to increase resources in the area of workplace environment and support to training. The hospital could be described as an "Adequate Applier' of the WOA but could advance further in the implementation of certain initiatives of the WOA.

- ***Specific initiatives that demonstrate the commitment and support of managers***

It is recommended that H5 implement performance management systems linked to equality and diversity and intercultural healthcare provision. Staff are not evaluated directly related to equality or diversity. It is advisable that H5 introduces measurements of cultural competence and develop correlations to MF care in patient satisfaction surveys. The hospital should introduce outcome based evaluations such as patient satisfaction surveys linked to intercultural care, or assess access to services in a timely fashion, or evaluate the elimination of unwarranted variations in care such as readmissions, medical errors, extended length of stay, or potential legal liabilities. There is no systematic measurement of outcomes related to investments in diversity however the HR Director confirms that *"we don't have the systems in*

place to monitor the implementation of the WOA, we are in transition and we are building benchmarks through the staff evaluation exercise".

- ***Up to date intercultural policy for the health services***

The hospital should consider the use of cultural mediators in the provision of health care.

- ***Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery***

The hospital should be prepared to undertake equality auditing (equality impact assessments) throughout the hospital. The hospital may wish to consider introducing a risk management procedure specifically and explicitly linked to flagging diversity incidents, by staff being required to report incidents, staff supervisors required to investigate, identify and report disparities. Also, the hospital would be advised to establish explicit links between diversity and equality to quality and accreditation standards.

- ***Ethnic monitoring system including an agreed framework for data collection and data usage***

The hospital should introduce a system that captures race and the collected data should inform strategic service planning. *"Our data collection does not allow us to do that but we will change this in the future", Patient Services manager.*

- ***Training and development initiatives in the field of diversity management***

The hospital should introduce a more systematic tiered approach to intercultural training including all levels of training and most notably Level 5 multicultural team and Level 6 legal and business case training. Also cultural awareness training needs to be revised and be developed to include co-facilitation and consultation with stakeholders including members of MECs. Intercultural training must become mandatory for all senior leadership, management, staff and volunteers in the organisation and specific training should be made available on major ethnic groups such as the travelling community. Given budget restraints for training and a lack of availability of staff, online intercultural training options may be introduced which are more cost and time effective.

- **Workplace support structures to support staff to manage issues relating to cultural diversity**

The hospital has the possibility to introduce further workplace support structures such as website links on diversity or cultural competence in health care, construct staff contact lists

regarding cultural issues and expertise in cultural fields available to all staff members and consider using cultural mediators to explain hospital procedures and medical information.

- ***Development of initiatives to integrate and manage multicultural teams***

Surprisingly the hospital has never prepared existing staff or provided formal multicultural team training to staff to work on multicultural teams. *"Irish nurses have no training to deal with multicultural staff and patients",* Nursing Practice Development Coordinator*.* This is alarming given the fact that there is relatively large work force diversity. Even in areas of the hospital where there are traditionally large numbers of non-Irish national working such as the catering department, there has been no multicultural team training. There is however a basis to believe that such training is needed for both existing and new incoming nationals and non-Irish nationals as portrayed by these employee comments *"there can be a lack of cultural understanding between Irish and non-Irish staff",* Training and Development Coordinator*.*

The hospital may need to think about the introduction of formal multicultural training given the diversity of the workforce to complement informal socialisation team building methods.

A primary method of team building seems to be through socialisation and "social nights" which is acknowledged by the Health and Records manager's response saying that management of multicultural teams is *"through socialisation, cooking and having food together",* and the Nursing Practice Development Coordinator saying "I *do it myself through social nights in my house".* Furthermore, a medical social worker, in referring to initiatives in management and integration of multicultural teams in the social work department concurs, that *"its organic and natural, we have no specific initiatives taken"* but *"we do a lot socially out of work".* The absence of formal multicultural training may be a result of over dependence on socialisation as the principal means of integrating multicultural teams.

- ***Training methodology to include co-facilitation by members of minority ethnic communities***

The hospital is recommended to develop intercultural training by making resources available to MEC staff or patient advocate groups to build their capacity to design and deliver and evaluate intercultural training and use members of MECs to co-facilitate training.

- ***Signage, particularly in reception and public areas in the key languages of service users***

This is an area where the hospital should initiate actions as it the one area of the WOA that has not been implemented. The hospital needs to introduce translated signs in the key languages of service users and have posters and public displays indicating culturally

appropriate services or promoting intercultural healthcare or cultural diversity. There are some universal pictorial signs but there is a general acknowledgement that the signage is not adapted to ethnically diverse service users.

- ***Literature in the key languages of service users***

The hospital should make available a website translated in different languages representing the local service user community.

5.3.5 Hospital 6 (H6): 'The Quality Driven Outsider"

H6 ranks 4th in overall implementation of the WOA with a total score of 23/36 and the hospital could be described as a "Quality Driven Outsider". Generally speaking the management of ethno-cultural diversity is driven by ethno-cultural differences in service providers and H6 classifies diversity and migrant friendliness as a quality driven issue.

Table 5.9: Impact of H6's characteristics on the implementation of the WOA

Characteristic	Description
Function	H6 is a general hospital, which provides emergency service and national/regional medical care and provides over 40 medical specialities.
Size & Resources	H6 is currently part of a wider 3 hospital healthcare group incorporating a private hospital and an acute general hospital. There are 500 in-patient beds with 7-day, 5-day and day care options, including intensive care, high dependency care, coronary care beds and medical, surgical, orthopaedic and psychiatry beds and care of the elderly. The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector
Location	H6 provides its services to people living south Dublin and Wicklow, serving a population of approximately 350,000 people.
Diversity of service users	There is little information on the public, however given its location, this is not as culturally diverse an environment as inner city Dublin. In addition, the hospital serves the region with the most aged 80 and over people in the country.
Diversity of service providers	The hospital has staff from 60 nationalities and employs 1025 nurses and Healthcare Assistants.
Champion and Diversity Committee	There is no real champion or project leader for intercultural health care. The subject of diversity is primarily considered as a quality and risk issue. The main driver is quality and responsibility lies with the HR department. HR is responsible for equality and diversity .There is no outright diversity champion at senior level. However, there is strong leadership from a quality and safety perspective.
History of managing (MF care)	The hospital has not participated in the HIHP or national or European initiatives concerning MF health care and has limited participation in networks, specific to migrant friendly care.

These results of the implementation of the WOA may reflect a service user public that is not as diverse as other hospitals. This is because it is located in the south of Dublin in a more affluent area, with high rentals, substantial home costs and little industry as suggested by the Nursing Practice Development Facilitator when she says "*in this hospital you wouldn't see as many MECs as other hospitals as there is not a lot of industry around here*." A second factor, according to the Director of Nursing, is that the hospital serves the highest profile of 80 year olds and older people in the country, of whom "*the vast majority are Irish nationals*". Consequently, the hospital does not have established outreach programmes, or translated patient information or significant exchanges and links with MEC advocacy groups like H3 and H4.

Hence concerning the management of ethno-cultural differences, H6 has been led by rapid workforce diversity, as it has a higher ratio of staff diversity than patient diversity. The Director of Nursling's remarks illustrate the extent of workforce diversity and highlight the initiatives that the hospital took to adapt: *"Leadership is very important, as 43-46% of the workforce is from overseas here in Dublin, more than the rest of the country. Six years ago I had 100 vacancies and in my first year I hired 108 from India and the Philippines. This was a huge change for us and we had to learn. Our nursing board set up an overseas nursing programme and framework, which gave us resources and we had a lead nurse who managed the programme of integrating new employees. This dedicated person actually managed the (non-Irish nationals) induction programme, their registration and adaptation programmes. New employees' work was assessed and signed off by me. Leadership is the key and I need to make sure that leadership applies and that structures are adhered to as it all leads to safety."*

The hospital classifies equality and diversity and migrant friendliness as a quality issue, which aligns with the value of quality in the mission statement. Thus the hospital's motivation to provide appropriate quality healthcare services is very much "Quality Driven". This is supported by the fact that the hospital is an 'Outsider' in comparison to the other hospitals surveyed as it is the only non-private hospital in Ireland that was quality accredited by the Joint Commission International (JCI). The JCI accreditation is an obligation for private hospitals and is an internationally renowned accreditation system that takes into account culturally appropriate health standards through measuring specific standards. These standards relate to interpreting services, communicating in means that are understood by everyone in everyday situations, and having opportunities to practice one's own faith and eat

one's own food among other issues. The following quote by the Director of Quality and Risk explains the motivation behind the hospital's decision to apply for JCI accreditation: *"One significant area of our mission is quality and within our company's strategic plan, quality and patient safety are one of 14 objectives of the hospital and that falls to me to put strategies in place. So over the last 6 years there hasn't been an Irish quality system, so about 3 years ago we made a decision to use the Joint Commission International. It seemed appropriate as it is an international system that has benchmarking opportunities, and most particularly there is independence in the evaluation process."*

The hospital has been successful at raising awareness of diversity issues in the workforce environment. This is confirmed by the comments of non-Irish Admission Assistant who states *"the hospital has been proactive and very good at promoting diversity",* and a non-Irish staff nurse who says *"they do make an effort to promote diversity and culture."* H6 shows commitment by providing cultural diversity education to all staff through mandatory induction and orientation training and by making available resources, such as the intercultural health guide on cultural norms relating to healthcare provision and bereavement and care for the dying documentation.

There is a Mission Effectiveness Committee responsible for ensuring that the mission and values are integral in the running of the hospital although diversity or equality are not explicitly mentioned in the mission statement or core values of the hospital. Thus, there is an absence of a stand-alone focused Diversity Committee. It is incorporated in the Mission Effectiveness Committee like H5. However to the hospital's credit, H6 has an Intercultural Working Group, which endeavours to promote intercultural relations and diversity issues between employees and patients. The Intercultural Working Group is multiethnic, multi-disciplinary and is chaired by the Training and Development manager. The group meets every six weeks and according to its chairperson, it *"focuses on communication and awareness"* and promotes good relations and understanding of cultural differences among the 60 nationalities that work in the hospital. The group tends to focus on highlighting national and international holidays from around the world and organises music, dances and creates posters to educate other members of the hospital community about cultural issues in the hospital. It is not evident that the group leads diversity policy initiatives or as in the case of H4 replaces the role of Diversity and Equality Officer.

Hence the impact of the Mission Effectiveness Committee and the Intercultural Group is debatable in terms of driving diversity management strategies. These structures, while

worthwhile, do not have the same “teeth” as the diversity committees of H3 and H4. The hospital may rely too heavily on the JCI accreditation as its measure of progress to managing ethno-cultural diversity. A noticeable difference between H6 and H3, H4, H1 and H5 is the absence of a champion or linchpin figure who drives the agenda with passion across the organisation.

On the contrary H6 is somewhat of a “Quality Driven Outsider”, in that it is the only hospital that has steered the issue of ethno-cultural differences through a ‘quality accreditation’ perspective. H6 being committed to its convictions for health and safety has applied and succeeded in obtaining international quality accreditation. Also the hospital, unlike the majority of the other hospitals surveyed, is an ‘Outsider’ in the sense that it has a limited history of collaborating with the HSE on migrant friendly healthcare initiatives and policies and unlike H3, H4 and H1 there is no evidence of special HSE funding for migrant friendly initiatives or piloting programmes at local level. This is particularly surprising considering the size of the hospital and may reflect that the hospital is part of a healthcare group consisting of three hospitals including a private entity. H6 seems to have a tradition of independence and autonomy as a voluntary hospital, as shown through its initiative to be the first public hospital to have applied for JCI accreditation. The hospital needs to continue to develop its tiered approach to intercultural training but at the time of research, management were already in the process of expanding their multicultural team training. Moreover, the hospital will need to address weak scores in literature in the key languages of service users, among other issues.

5.3.5.1 Prescriptions for H6 “The Quality Driven Outsider”

The following section offers suggestions for hospital management to improve the management of ethno-cultural differences. Prescriptions for the hospital are made for those sub-elements of the three strands of the WOA that have been interpreted to need further development.

- ***Specific initiatives that demonstrate the commitment and support of managers***

The hospital seems to be legally driven and views ethno-cultural differences through the lens of quality and risk, and equality legislation. However the hospital management should consider delegating responsibility to a project leader, preferably at senior level, who is responsible and who champions equality and diversity issues in the hospital. H6 would be advised to introduce explicit performance management systems for staff related to equality or

diversity. There is no systematic measurement of outcomes related to investments in diversity. The hospital should endeavour to evaluate staff using competence measured in patient satisfaction surveys or by assessing access to services, assessment of patients, evaluating readmissions, medical errors, length of visit or stay of patients in the hospital and potential legal liabilities among others.

It could be of benefit if the hospital increased its participation in policy networks, such as membership to NIHI or to subscribe to think thanks and policy networks that focus on and specialise in migrant friendly health care. Like most hospitals surveyed, H6 has committed human and financial resources to the management of ethno-cultural differences through its intercultural group or the costs of running an interpretation service. It is acknowledged that due to economic constraints, reduced budgets and a recruitment moratorium that resources are limited. However, the hospital should in the current times of tight resources to look at alternative ways to reduce costs by for example, training staff in intercultural training through innovative online options.

- ***Up to date intercultural policy for the health services***

The hospital, in order to expand its intercultural policies, could introduce the use of cultural mediators. Despite the hospital's consultation with the Jehovah Witnesses and the Irish travelling community there is scope for more consultation with MECs in the future, by ensuring their representation on patient involvement committees, patient councils or patient forums or the intercultural group.

- ***Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery***

The hospital is recommended to improve the culture proofing of documentation, and equality auditing /review (equality impact assessments).Moreover, although the hospital does make efforts to review staff policies from an equality perspective such as the annual leave and compassionate leave policies, it needs to expand equality and culture proofing with regard to service provision from a service user perspective. It is recommendable that the hospital introduces evaluations of patient and community outcomes related to migrant friendliness by improving links between culturally appropriate healthcare provision and patient satisfaction surveys and increasing the involvement of members of MECs and MEC advocacy groups on committees providing feedback to hospital services.

- ***Ethnic monitoring system including an agreed framework for data collection and data usage***

The hospital should monitor and collect data concerning race and ensure that it collects data on the profiles of minority ethnic patients. Also H6 must determine how to put in the necessary systems to use the data to inform hospital services and strategic planning.

- ***Training and development initiatives in the field of diversity management***

It is recommended that the hospital introduces a systematic tiered approach to intercultural training. H6 has experience of offering elements of 5 of the 6 levels of the tiered approach to intercultural training through the provision of training sessions that are not solely linked to intercultural training. Given the availability difficulties experienced by the hospital of freeing staff to attend intercultural training, the Training and Development manager offers one solution when he stated *"the best way is to add a cultural piece into existing training due to release of staff problems"*.

The hospital does not provide Level 5 multicultural team training. This is necessary as the hospital has a large staff consisting of approximately 60 nationalities employed. Management consideration for expanding mandatory diversity awareness and cultural competency training for all senior leadership, management, staff and volunteers beyond Level 1 induction training is required. The hospital should endeavour to plan, provide and facilitate intercultural training in consultation with MECs or MECs advocacy groups. Also intercultural training should include specific sessions on major ethnic groups such as the Irish travelling community. The introduction of online intercultural training options is an opportunity for the hospital to overcome staff shortages, and combat the unavailability of staff to attend intercultural training. Finally, the hospital should ensure that staff attends conferences related to diversity and culturally competent healthcare.

- ***Workplace support structures to support staff to manage issues relating to cultural diversity***

H6 should envisage developing website links or a website on diversity or cultural competence in health care and considering the use of cultural mediators in the future. Given the hospital's significant workforce diversity, the development of staff contact lists regarding cultural issues and staff that have specialised information in specific cultures and languages should be considered.

- ***Development of initiatives to integrate and manage multicultural teams***

It is recommended that taking into consideration the large ethno-cultural diversity in the workforce and the recognised challenges of multicultural working teams, that formal multi-cultural team training be put in place for all staff. Despite an equal opportunities approach the hospital may wish to assess its career planning and promotion trend for future succession planning in the context of significant workforce diversity in the hospital.

- ***Training methodology to include co-facilitation by members of minority ethnic communities***

Management needs to consult with MEC advocacy groups regarding intercultural training and to ensure training is co-facilitated by members of MECs in the future. Furthermore, it is advisable that H6 make resources available to staff who are members of MECs to build their capacity to design, deliver and evaluate training.

- ***Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system***

The hospital should increase members of MECs on patient involvement committees as suggested by the Assistant Director of Nursing who states, *"we are not advanced at getting patients involved, it's up and coming through consumer affairs",* It is evident that H6 could develop more outreach information health education programmes to MEC associations and further build bridges with MECs through organising migrant friendly open days on site and using more opportunities to invite MECs on site in the hospital.

- ***Signage, particularly in reception and public areas in the key languages of service users***

H6 needs to examine the feasibility to introduce the provision of signage in the language of the commonly encountered groups and representatives in the service area and introduce relevant posters to promote diversity and intercultural health care. Equally, the provision of a visual orientation system or sign posts pictograms could be considered beyond the utilisation of toilet signs.

- ***Literature in the key languages of service users***

H6 should equally consider the feasibility of introducing relevant literature translated into key languages and ensure that such literature is proof read and culturally appropriate. Also, a relatively straightforward initiative to improve communication is to translate the hospital website into key languages represented in the community. *"People get confused, if the*

website was translated, it would be easier and we need more leaflets translated and more training in the frontline", Clerical Officer.

- ***A comprehensive interpretation service***

The hospital would be advised to consider the introduction of training staff on the use of interpreters. H6 is strong on quality and equality, as portrayed through a strong Strand 1, organisational ethos scores e.g. parameters related to mission statement, strategic plan, an intercultural group, recruitment, intercultural policies, dignity at work and trust in care policies, and successful accreditation from the JCI. However, H6 can be more proactive regarding ethno-cultural diversity of service users by implementing more of Strand 2, workplace environment, particularly a systematic approach to intercultural training, online options, and using MECs to conduct training. Finally H6 by implementing a more proactive Strand 3 support to training initiatives such as translated signage, literature websites and posters, the hospital would be in a better position to maximise overall organisational performance.

5.3.6 Hospital 2 (H2): "The Head in the Sand, awakening to ethno-cultural diversity"

H2 has a total score of 18/36 and ranks 5th in the implementation of the WOA approach. The hospital is the least advanced in managing ethno-cultural differences and implementing a WOA approach. The reasons for this can be explained by the fact that H2 provides healthcare services to elderly seniors over 65 years of age, and thus the composition of patients consists of practically all Irish nationals with very few exceptions. There are very little ethno-cultural differences in the patient population.

Table 5.10: Impact of H2's characteristics on the implementation of the WOA

Characteristic	Situation
Function	H2 is an old hospital catering for the disabled and the elderly.
Size & Resources	A relatively small healthcare provider offering services to approximately 200 people. The hospital has been affected by the Irish economic crisis in terms of budget reductions and an employment moratorium in the health sector.
Location	It provides services to a population living in the South of Dublin, in a region that is not ethno-culturally diverse.
Diversity of service users	Patients are all Irish nationals with few exceptions.

Diversity of service providers	As of October 2010, the nationality composition of employees included 46% Irish and 54% non-Irish nationals.
Champion and Diversity Committee	There is no project leader, linchpin or champion leading an agenda or diversity committee.
History of managing (MF care)	There is no real history of the hospital managing ethno-cultural differences in service users.

The hospital is awakening to the need to focus on intercultural issues, not by ethno-cultural differences in service users but rather by workforce diversity issues as a result of significant recruiting of non-Irish national nurses due to tight labour markets during the economic boom period. The majority of the staff in the hospital were non-Irish nationals representing 54% of the workforce in 2010. Despite this overwhelming majority, there has been no multicultural team training offered to staff and thus the hospital has had its "Head in the Sand" with regard to the intercultural training of employees. Management did state their plans to begin such training for nursing teams in the near future. It can be argued that while there are currently little or no ethno-cultural differences in the service user population, that this scenario will change in the forthcoming years as members of migrant communities age and access elderly service provider hospitals. This would indeed suggest that the future will necessitate proactive initiatives by the hospital to meet the needs of a more ethno-culturally diverse service user population as confirmed by the Director of Nursing who forecasts the future of the hospital by stating *"we have not had many MECs service users to date, we will in the future".*

5.3.6.1 Prescriptions for H2 "The Head in the Sand, awakening to ethno-cultural diversity"

Findings revealed that H2 is the only hospital surveyed that does not have significant ethno-cultural differences in its service user population due to the nature and function of the hospital. However it is envisaged that this situation will change in time as suggested by the HR manager who confirms that *"ethno-cultural diversity will undoubtedly be coming down the line in the future".* Thus the following suggestions for hospital management in H2 are in the context of service users becoming more culturally diverse in the future. In reviewing the issues related to managing ethno-cultural differences in the context of H2 some elements such as succession planning, a tiered approach to intercultural training and particularly multi-cultural team training for a diverse staff are relevant now, as the workforce is considerably diverse.

- ***Specific initiatives that demonstrate the commitment and support of managers***

It is advisable that the hospital refers to migrant friendly care in its strategic plan or, introduces a policy action plan referring to MF care. Similarly, the hospital needs to commit resources and form a multi-disciplinary and multiethnic diversity committee and encourage the evolution of a diversity champion or a diversity officer. A budget for intercultural training should be considered. Also H2 should cultivate links with think tanks and research initiatives which promote equitable approaches with, MEC advocacy groups, other health organisations, community groups and advice organisations. Performance management systems to evaluate staff, linked to diversity and equality such as competence measured in patient satisfaction and outcome based evaluations could be envisaged in the future. Also management should highlight the rich cultural diversity in the hospital workforce by publishing information about diversity issues and events in the hospital newsletters, or annual reports.

- ***Up to date intercultural policy for the health services***

H2 in the future may consider publishing articles and reports on diversity research and cultural diversity issues in the hospital newsletter. In time the hospital may wish to consult with staff and patients on intercultural healthcare through patient involvement, patient councils, forums, diversity committees and MEC advocacy groups in the context that ethno-cultural diversity will certainly increase in Ireland and in the hospital sector. Also, in the future the use of cultural mediators may be introduced especially for specific MEC groups should the need arise.

- ***Equality framework including culture proof of documents template for equality proofing, service planning and delivery***

It is recommended that H2 introduces equality auditing /review (equality impact assessments) and equality/cultural proofing of service provision. Furthermore, the hospital could profit from diversity benchmarking in other similar institutions and introduce a culture of evaluating staff, patient and community outcomes through patient satisfaction surveys linked to cultural competence. Areas such as cultural proofing of documentation or obtaining feedback from members of MECs on committees are certainly premature to be put in place currently, but may be considered in the future.

- ***Ethnic monitoring system including an agreed framework for data collection and data usage***

A revision of the monitoring and identifying of the ethnicity of patients is advised in the future. This should include race and monitored data needs to be used for strategic planning purposes and to adapt services accordingly.

- ***Training and development initiatives in the field of diversity management***

H2 should provide a full tiered approach to intercultural training offering all 6 levels of training in a systematic and on-going manner. The hospital has only offered Level 1 and Level 3, consistently and needs to add a cultural diversity element to induction training. However Level 2 has been offered in a sporadic and ad-hoc manner and H2 has never offered Level 4 to Level 6. The absence of Level 5, multicultural team training is of particular relevance given the levels of ethno-cultural diversity in the workforce. The main non-Irish nationalities in the composition of the staff include Filipino 37%, Polish 4.5%, Indian 3.5%, British 2.4% and Czech 1.7%.

There is a reason to believe that such workforce diversity may cause problems amongst staff and interfere with workforce morale on the ground. In a meeting during the preliminary research stage with an Irish Head Nurse manager, who had 25 years experience in health care, the subject of tensions between Irish and non-Irish nurses was evoked through the following comments, *"they sit together in the canteen and speak in their own language" or "they spend too much time in relationship building with the patient, or they don't take the imitative like an Irish nurse".* This particular interviewee resigned from the hospital before the principal research took place in September 2010.

In the context of an ever increasing multi-ethnic patient population, the hospital should anticipate that cultural awareness training is developed in consultation with stakeholders including members of MECs. Also, diversity awareness and cultural competency training should become mandatory for all senior leadership, management, staff and volunteers associated with hospital. In the context of an economic crisis and moratorium on recruitment in the health sector and new budget constraints on training, the hospital could develop a 'train the trainer' structure in the field of intercultural training and maximise the rich ethno-cultural diversity within the staff. Furthermore, the introduction of cost and time effective training options such as online intercultural training is advisable. Also ensuring that members of staff have the opportunity to further develop their qualifications by taking classes including cultural competency skills in health care at third level, and staff should be encouraged to

attend conferences related to diversity and health care. Training should target major ethnic groups in the community, and be as multi-disciplinary as possible to cultivate transfers and exchanges of learning and a cross-pollination of ideas and experiences.

- ***Workplace support structures to support staff to manage issues relating to cultural diversity***

The introduction of website links or a website on diversity or cultural competence in health care would be of benefit to healthcare employees and in the future, H2 could organise staff meetings referring to cultural issues or introduce lunch time talks on diversity or issues in health care such as culture and bereavement. Given the rich diversity currently in the staff rank and file, contact lists of staff, knowledgeable in cultural issues and who have MF care experience could be drawn up. Also the idea of using cultural mediators and building up appropriate mediator networks in the future could be considered.

- ***Development of initiatives to integrate and manage multicultural teams***

The hospital should encourage the use of multicultural team training. Given the workforce diversity, it follows that formal team building training should be put in place with a multicultural aspect. Moreover in the event of future recruitment of non-Irish nurses, the hospital could introduce an overseas nurse coordinator post to assist and help integrate overseas nursing staff. Likewise, preparation work with existing staff on working in multi-cultural environments should be introduced through cultural awareness training. An issue of immediate relevance for hospital management to take into account is the potential of succession planning and career development issues arising due to the trend of non-Irish nationals not presenting themselves for promotion and upgrading. This could result in gaps in the systems and shortages of managerial staff through succession planning in the future.

- ***Training methodology to include co-facilitation by members of minority ethnic communities***

In the event that the hospital introduces intercultural training, then management should endeavour to use members of MECs to conduct or co-facilitate the training and make resources available to staff who are members of MECs to build their capacity to design and deliver training.

- ***Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system***

In the event that the hospital encounters ethno-cultural differences in its service users in the future the hospital should attempt to build links with MECs and include members of MECs on patient involvement committees, develop outreach information health education programmes to MEC associations, community organisations, churches, schools etc. Moreover, the hospital could develop a newsletter that refers to diversity and MF healthcare issues and make hospital information available to the ethnic communities. Finally, H2 in the future could consider organising open house events inviting MECs on site to the hospital to learn about the hospital services.

- ***Signage particularly in reception and public areas in the key languages of service users***

While by no means being a current priority, the hospital may consider in the future translating signage in the main areas of the hospital in the language of the commonly encountered groups and representatives in the service area. Also, the issuing of posters to promote intercultural health care and diversity should be introduced and which aid developing an organisational culture associated with cultural diversity.

- ***Literature in the key languages of service users***

Similarly relevant literature in key languages such as the patient information book, or provision or discharge or post discharge care documentation will need to be translated in the future event of increased patient ethno-cultural diversity. Hospital literature should be proof read by members of MECs or advocate groups to ensure culturally appropriate documentation. Also the website translation into the key languages represented in the community would meet the needs of a changing demographic profile of service users.

- ***A comprehensive interpretation service***

The hospital has an interpretation service and management should endeavour to ensure that the right to language service and access to interpretation services is published and appropriately indicated to in-coming patients. Likewise, areas such as the training of staff to use interpreters in efficient and effective ways and the establishment of a hospital staff contact list of staff who speak more than one language is recommended.

This hospital has the lowest total score among the six hospitals. Scores are low or below average in all three strands compared to the other 5 hospitals. This would indicate that the WOA is at the beginning stages of implementation. In summary the hospital has to an extent awoken to the importance of managing ethno-cultural differences due to an influx of non-Irish national staff, but will need to concentrate on further workforce diversity management initiatives such as multicultural team training. Also H2 will have to raise its head from the sand and prepare for the future by providing more healthcare services in more culturally appropriate ways as its service users become more ethno-culturally diverse in time.

5.4 Summary of the comparison of the hospitals

To summarise the results of the hospitals, the two most advanced hospitals (H3 & H4) have a function linked to children or maternity services, are medium sized, have diverse patient and workforce populations, are located in North or North-central Dublin, have champions at middle or senior management who lead active diversity committees, and have strong links and history working with the HSE in migrant friendly health care. The hospitals with least advancement of the WOA (H2 & H6) are located in South Dublin, have less patient diversity, have no champions leading the diversity agenda and have no history of explicitly collaborating with the HSE on migrant friendly healthcare issues. This information serves to indicate the factors that will influence a WOA being implemented in healthcare organisations.

Table 5.11 : Summary of characteristics for each of the surveyed hospitals

Characteristic	H1	H2	H3	H4	H5	H6
Function	Emergency General	Elderly	Emergency Children's	Emergency Maternity	Emergency General	Emergency General
Size & Resources	Medium Sponsored by the HSE	Small	Medium Sponsored by the HSE	Medium Sponsored by the HSE	Large	Large
Location	North Dublin Diverse	South Dublin Less Diverse	North-Central Dublin Diverse	North-Central Dublin Diverse	North-Central Dublin Diverse	South Dublin Less diverse
Diversity of service users	Diverse	Not diverse	Diverse	Diverse	Diverse	Less diverse
Diversity of service providers	Diverse	Diverse	Diverse	Diverse	Diverse	Diverse

Champion And diversity committee	Yes middle mgm	No	Yes Senior Mgm	Yes Middle Mgm	Yes Senior Mgm	No
History of managing (MF care)	Yes	No	Yes	Yes	Yes	No

5.4.1 A comparison of the impact of the characteristics on the extent to which the WOA is implemented in the 6 hospitals

The impact that the characteristics have had on the implementation of the WOA by comparing and contrasting the 6 hospitals merits discussion.

5.4.1.1 Function

The function of the hospital has an impact to what extent the WOA is implemented. H3 and H4 which are the most advanced, are children's and maternity hospitals respectively and the most urgent with regarding to safety and risk in the context of culturally competent care. Also H1, H5 and H6 are general hospitals with emergency services and care is administered in urgent and sometimes life threatening circumstances where culturally competent care is vital. Contrastingly H2's principal function is to provide services to elderly patients over 65 and consequently there is no significant ethno-cultural diversity in the patient cohort and thus is the least advanced.

5.4.1.2 Location

H5, H3 and H4 are all located in the inner city of the capital city of Ireland and serve catchment areas that are culturally diverse. H1 is located in one of the fastest and most diverse parts of Ireland. H2 and H6 are in the south side of Dublin and have less culturally diverse locals and thus lower implementation scores.

5.4.1.3 Size and resources

It is not definitive to say that the size of the hospital may determine the resources. There is a logic that smaller and medium size specialised hospitals may have less resources than larger multi-functional hospitals for training and professional development in culturally competent health care. For example, for a smaller sized hospital, diversity management resources may depend on specific links between the hospital and the HSE where resources are provided by

the HSE for intercultural training, ethnic identifier or pilot projects in multilingual aids in certain hospitals. This has been the case for H1, H3 & H4.

Also it could be argued that cultivating a hospital wide ethos is influenced by the size of the establishment. The findings indicate that the top three scoring hospitals with regard to the implementation of the WOA are all medium sized. H5 and H6 are much larger structures where it may be more difficult to cultivate an organisational ethos geared toward interculturalism, diversity management or culturally competent healthcare provision. All the hospitals have been influenced by the economic crisis through reduced financial resources and the moratorium on recruitment.

5.4.1.4 Service user ethno-cultural diversity

All the hospitals with exception of H2 cater to ethno-culturally diverse service users and score well in intercultural policies such as interpretation, adapted diets, interfaith religious services and culturally appropriate bereavement services. H2 however has practically no ethno-culturally diverse patients and many of its intercultural policies are driven by strong workforce diversity.

5.4.1.5 Service provider ethno-cultural diversity

All six hospitals throughout the late 90s and early 2000s recruited non-Irish medical and non-medical staff due to the then fast growing Irish economy. Hence, there is significant ethno-cultural diversity in the workforce in each hospital. An ethos of equality and anti-discrimination and respect for diversity in hospitals reflect compliance to national equality legislation and anti-racism guidelines set out by the Irish government and reflect high Strand 1 implementation scores. The following comments from Training and Development Manager, in H6 illustrate the point*. "An equal opportunities approach applies to all areas of the hospital including recruitment and selection, training and work experience, promotion and re-grading, and conditions of employment and our policies are legally driven, based on Irish legislation governing equality/diversity e.g. Employment Equality Act 1998 and 2004 and Equal Status Act 2000 and 2004".*

5.4.1.6 Champions and diversity committees

Managers, especially at senior level, championing the cause of cultural diversity including active diversity committees are another reason for strong strand implementation. H3 and H4 are advanced in creating an organisational ethos of interculturalism and both have active

diversity committees involving middle and senior management, and in the case of H3, the acting CEO. These figureheads champion the diversity cause in the hospital by participating on committees and driving the agenda. Similarly, H1 has a diversity champion in health promotion and H5 has a champion who is a former CEO and member of the board of directors. H2 and H6 who were the only hospitals who did not have champions of diversity are the least advanced in the implementation of this strand. The Porter Services manager in H3 confirms the importance of diversity champions by stating *"senior management have taken on board the issue and our HR manager (acting CEO) champions the cause and is the lead figure in the formation of actions"*. A social worker from the same hospital argues that champions are even more important than committee structures by claiming that *"it really depends on the individuals not so much the structure; we are blessed to have one or two utterly committed managers".*

5.4.1.7 History of managing migrant friendly care

Hospitals such as H3 and H4 have strong links to the HSE and have participated in the NIHI working closely with the department of Social Inclusion of the HSE. H1, a public hospital controlled entirely by the HSE was Ireland's only representative for the MFHP. Also H3 and H4 have piloted national initiatives in ethnic monitoring and emergency multilingual aids and have benefited from intercultural training funded by the HSE. H5 has participated in HSE initiatives but contrastingly H2 and H6 are the only 2 hospitals surveyed that have limited history of working with HSE networks on MF healthcare initiatives.

5.5 Analysis, interpretation and prescriptions for the implementation of the 3 Strands of the WOA across the 6 hospitals (SRQ3)

We shall now examine to what extent each strand of the WOA has been implemented across the 6 surveyed hospitals and analyse why some strands are more advanced in implementation than others. An overview table of the implementation of the WOA is initially illustrated for each strand. This is followed by an overview of the strand results and an analysis, interpretation and discussion of prescriptions for each sub-element of the relevant strands. The discussion is complemented by selected examples and quotations from the research data in the 6 hospitals. This analysis serves to explain the implementation of the WOA framework from a strand perspective and prescribes areas to improve in each strand.

5.5.1 Analysis, interpretation and prescriptions for the implementation of Strand 1

The implementation of Strand 1 across the 6 hospitals is illustrated in table 5.12. It highlights the implementation of the specific parameters in each sub-element of the WOA in each hospital. This is followed by an analysis and interpretation of the implementation of the 4 sub–elements in each strand and their corresponding parameters using data from interviews. Prescriptions are provided for each sub-element of the strand.

Table 5.12 : Strand 1 implementation of WOA

STRAND 1: ORGANISATIONAL ETHOS								
Sub-element 1:Specific initiatives that demonstrate the commitment and support of managers		**H1**	**H 2**	**H 3**	**H 4**	**H 5**	**H 6**	**Total**
P 1	Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care	1	1	1	1	1	1	6
P 2	Strategic plan, policy action plan referring to MF care, diversity or equality	1	0	1	1	1	1	5
P 3	Diversity committees (that include members of MECs and are multidisciplinary)	1	0	1	1	1	1	5
P 4	Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training	1	0	1	1	1	1	5
P 5	Project leader or responsible for Diversity & Equality / Champion at management level	1	0	1	1	1	0	4
P 6	The organisation is an active participant in policy networks / think tanks / research initiatives	1	0	1	1	1	1	5
P 7	Accountability for all staff to behave appropriately and provide provision of care in a non-discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour	1	1	1	1	1	1	6
P 8	Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes.	0	0	0	0	0	0	0
P 9	Encouraged to publish information about diversity progress or MF care (newsletters, annual report)	1	0	1	1	1	1	5
	Total number of implemented parameters per hospital	*8*	*2*	*8*	*7*	*8*	*7*	
Sub-element 2: Up-to-date intercultural policy for the health services		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Clarify the expectations of staff regarding diversity & equality issues	1	1	1	1	1	1	6
P2	Bereavement policies and guidelines and an adapted mortuary with appropriate alters & symbols etc.	1	1	1	1	1	1	6
P3	Adapted diet and revision of menus (e.g. halal)	1	1	1	1	1	1	6
P4	Interfaith policy e.g. multi-denominational chaplain service & prayer rooms	1	1	1	1	1	1	6
P5	Culture days and celebrations, or diversity celebration weeks	1	1	1	1	1	1	6

P6	Interpretation policy or translation policy	1	1	1	1	1	1	6
P7	Newsletters (referring to diversity & equality topics or research)	1	0	1	1	1	1	5
P8	Policy of recruitment, retention and promotion of ethno-culturally diverse staff	1	1	1	1	1	1	6
P9	Diversity & Equality policy	0	1	1	1	1	0	4
P10	Consultation with staff & patients on intercultural health care	1	0	1	1	1	1	5
	Total number of implemented parameters per hospital	*9*	*8*	*10*	*10*	*10*	*9*	
P11	Use of cultural mediators	0	0	0	0	0	0	0
Sub-element 3: Equality framework including culture proof of document templates for equality proofing, service planning and delivery		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Culture proofing of documentation	1	0	1	1	1	0	4
P2	Equality auditing / Review (equality impact assessments)	0	0	0	0	0	0	0
P3	Equality / cultural proofing of service provision	0	0	0	1	1	0	2
P4	Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on the 9 grounds of discrimination)	1	1	1	1	1	1	6
P5	Diversity benchmarking	1	0	1	1	1	1	5
P6	Seek advice externally from organisations such as IBEC or Cairde	1	1	1	1	1	1	6
P7	Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality	1	1	1	1	1	1	6
P8	Need to evaluate patient and community outcomes	0	0	1	1	1	0	3
P9	MF efforts, diversity and equality linked explicitly to quality or accreditation standards	0	1	1	1	1	1	5
P10	Code of practice for anti-discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies	1	1	1	1	1	1	6
P11	Grievance & complaints procedures for staff and patients	1	1	1	1	1	1	6
P12	Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality	1	1	1	1	0	1	5
	Total number of implemented parameters per hospital	*8*	*7*	*10*	*11*	*10*	*8*	
Sub-element 4: Ethnic monitoring systems including an agreed framework for date collection and usage		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Ethnicity: country of origin / nationality	1	1	1	1	1	1	6
P2	Language	1	1	1	1	1	1	6
P3	Beliefs (Religion)	1	1	1	1	1	1	6
P4	Race (skin colour)	0	0	1	1	0	0	2
P5	Use information to inform services, diversity training and active use of real data for strategic and outreach planning	0	0	1	1	0	0	2
	Total number of implemented parameters per hospital	*3*	*3*	*5*	*5*	*3*	*3*	

5.5.1.1 Overview of Strand 1 "Organisational Ethos"

Strand 1 is the most implemented of the 3 strands of the WOA framework. This may reflect that Ireland at the time of the introduction of the NIHS and the WOA framework was experiencing a new inward migration and the effects of a new multicultural society. Migrant friendly health care, equality and integration of non-nationals were issues on the national agenda. The Irish government led numerous equality and cultural diversity initiatives in the public and private sector, such as "The National Action Plan Against Racism 2005" or "The National Action Plan for Social Inclusion 2007" (see chapter 2) and introduced equality legislation (Employment Equality Acts 1998, 2004 and the Equal Status Acts 2000, 2004) in order to advance equality and anti-discrimination practices in the Irish workplace. The healthcare sector, being a major employer and positioned in the frontline of providing services to non-Irish nationals, was proactive in creating top down national approaches such as the NIHS, which in turn may have strengthened the commitment and support of management towards managing ethno-cultural differences at local level. Thus in summary the results signify a strong commitment to the ethos of diversity and leadership and reflect compliance with national equality legislation and anti-racism initiatives promoted by the Irish government in the late 1990s early 2000s.

5.5.1.2 Specific initiatives that demonstrate the commitment and support of managers

This sub-element is the 2nd most implemented sub-element in Strand 1 and the 3rd in the WOA framework. Hospital management have shown strong commitment for managing ethno-cultural differences and the majority of hospitals have mission statements and strategic plans that incorporate the needs of providing excellence in service delivery to all members of the community. An example is shown of the commitment to diversity in H5 when the HR Director states *"our mission statement includes values such as diversity, dignity, respect, equality and they are part of our strategic plan regarding all healthcare service provision".*

This strong commitment reflects the fact that the majority of the hospitals are voluntary hospitals with charitable, not for profit philosophies and were founded on traditions of religious orders whose aim is to serve the sick and needy irrespective of their political, social, economical and cultural backgrounds. Furthermore, the majority of hospitals commit resources towards the management of ethno-cultural differences and publish information about diversity initiatives such as the work of the diversity committee or equivalent structures in hospital publications. Five hospitals have a multi-disciplinary and multiethnic diversity

committee or task force that endeavour to promote diversity issues throughout the hospital. These committees play an integral role in managing ethno-cultural differences in hopsitals and need to be active and motivated. This is certainly the case in H3 where according to the Porter Services manager*, "the diversity committee is one of the most successful committees".* Four of the hospitals have designated project leaders who are champions for leading the diversity agenda and are given time to assume responsibilities around migrant friendly issues. This is particularly relevant for the successful management of ethno-cultural differences in organisations as illustrated in the comments of the Clinical Nurse manager in H1, who claims, "*our Health Promotion Coordinator is our unofficial director/responsible for cultural diversity, our linchpin, our cultural diversity contact".* Most hospitals have been active participants in policy networks, think tanks and research initiatives at national levels and such participation demonstrates management commitment to managing ethno-cultural differences. H1's participation in the MFHP is according to the Health Promotion Officer *"an example of the management's commitment to cultural diversity issues in service users".* There is accountability for staff in all the hospitals to behave appropriately and provide provision of care in a non-discriminatory manner through the "dignity at work" policy and codes of practice around anti-discrimination, with explicit disciplinary procedures established.

The universal weak point in this sub-element is that all 6 hospitals do not implement performance management systems to evaluate staff and organisational outcomes that are linked to the provision of culturally competent health care, diversity or equality i.e. competence measured in patient satisfaction and outcome based evaluations.

The scope of evaluating outcomes of employee or organisational performance regarding diversity inputs could be expanded. The following observations are noted from the research:

- All 6 hospitals do not measure outcomes or change effects of their efforts in managing ethno-cultural differences in services users.
- There is no hard data to indicate if the WOA has made hospitals more efficient or effective.
- There is little evidence of cost efficiencies. There is no scientific evidence to see if hospitals are managing members of MECs more efficiently and are a more responsive health system.
- There are no correlations to the reduction of discrimination practices or minimizing health care disparities.

- There is an absence of measurement of changes in production, innovation, morale, strategy for new markets, or business case.
- There are no correlations of cultural competence to patient satisfaction surveys or patient safety.
- Managing ethno-cultural differences and culturally competent care is not linked explicitly to quality standards with the exception of H6 with the JCI standards and H2 because of specific standards associated with residential care centres.
- Culturally competent care is not explicitly linked to accreditation.
- There is no cost analysis with the exception of interpretation services in some hospitals.

The following quotes reflect the absence of adequate performance and evaluation procedures concerning the provision of culturally appropriate healthcare in each of the 6 hospitals studied in this research project.

- *"We monitor complaints; there is no cultural competence piece in performance evaluation."* Risk Manager H1
- *"You are accountable for the care that you deliver to patients but cultural competence is not measured in terms of care."* Director of Nursing H2
- "*There are no key performance indicators to measure change effects."* HR Manager Acting CEO H3
- *"We are all accountable for our actions."* Quality Manager H4
- *"It's a pity that with the effort we put in that's its not quantified."* Training and Development Manager H4
- *"We measure turnover, absenteeism, bullying cases, we are strong on this, but the softer measures we are in development embryonic stages."* HR Director H5
- "*No one is responsible for monitoring the implementation of the WOA."* HR Nursing Manager H6

The findings suggest that the Irish hospitals sampled are weak in quantifying and monitoring the outcomes of their diversity initiatives at an individual and organisational level. In reality hospitals are not measuring the effects and outcomes of their implementation of the WOA. Hospitals are relying on anecdotal and testimonial evidence to determine if the WOA has increased capacity to be a more responsive healthcare service provider. The following comments testify to the reliance that each of the 6 hospitals have on anecdotal evidence, as

the principal method to assess and measure outcomes related to the provision of culturally competent health care to ethno-culturally diverse service users.

- *"Our efforts have made us more efficient anecdotally."* Clinical Nurse Manager H1
- *"Outcomes related to staff are anecdotal."* Clinical and Patient Services Manager H3
- *"There are only anecdotal measurements of efficiency or to see if we are more responsive to MECs."* HR Manager, Acting CEO H3
- *"There are no real measurements of outcomes or satisfaction." Quality and* Accreditation Manager H5
- *"Measuring outcomes is a real challenge; there is lots of anecdotal evidence but no hard data."* Director of Nursing H6

Gardenswartz and Rowe (1998) warn that "testimonial data while much easier to get, carries less weight with CFOs (Chief Financial Officers)" p197. Irish hospital management are weak in quantifying their efforts and measuring the returns on investment regarding provision of migrant friendly care or culturally competent care. This weakness is confirmed by the HR Manager of H5 who says that with regard to return on investment for diversity inputs, *"we have no cost analysis of where we get the best bang for our buck*", HR Manager H5. Also the Director of Quality and Risk in H6 states *"It's (measurement of return on investment) not linked to patient satisfaction, we have no direct links or correlations from the patient side, we have no hard data."*

In the context of scare resources in the current economic crisis in the Irish health sector, this will create a dilemma for hospital management by making it all the more difficult to obtain funding for diversity management initiatives and intercultural policies at local and national level, as most finance directors will rely on hard data to prove economic justification of future investment in the provision of culturally appropriate care.

It can be argued that the reason for the weakness in the evaluation and measurement of organisation and performance outcomes with regard to diversity and culturally competent care is due to the fact that such care is not a mandatory legal requirement as is the case in the American health sector (see CLAS). There is for example no requirement for cultural competent training in Ireland which is a requirement for accreditation of institutions in countries such as the USA and Sweden (Donohue 2010). Specific CLAS standards are mandatory in the USA obliging healthcare settings to put measures in place. For example CLAS standard number 7 requires healthcare organisations to make available easily

understood patient related materials and signposting in the languages of the commonly encountered groups and/or groups represented in the service area.

Moreover, provision of culturally competent care is not explicitly linked to quality accreditation of healthcare organisations in Irish health care. The HR Director in H5 states that, *"diversity is not a separate standard in accreditation"* and claims that *"much of the monitoring, evaluation and measurement is implicit and quality and accreditation here-to-fore is not explicit".* Similarly the Training and Development manager in H4 in referring to the relationship between culturally competent care and accreditation says simply that *"accreditation is not linked".* The Quality manager in H3 confirms this by stating that it is *"not part of accreditation".*

At the time of research the hospital sector was waiting for an accreditation system to be re-introduced after original accreditation systems were suspended in order to be upgraded. Hospitals were waiting on the publication of accreditation standards from HIQA[29]. This is portrayed by the comments of the Quality Manager in H3 who stated that there is *"no accreditation system at the moment, we are waiting for new one from HIQA".* Some hospitals such as H6 in the absence of HIQA standards took it upon themselves to get accredited internationally from the JCI. Others such as H1 were waiting for HIQA to announce accreditation guidelines before progressing. It can be assumed that in the suspended position of waiting for new quality accreditation guidelines, Irish hospitals may not yet have been as astringent for putting in place measuring and evaluating machinery into their management systems. Thus, the culture of accreditation may not have been as strong at the time of the research as other national health systems like in the USA, where culturally competent care is explicitly linked to the American based JCI accreditation. While all the hospitals had experience of accreditation in the past, and accreditation was according to some respondents implicitly linked to equality efforts, there is an absence of explicit links to diversity measures or culturally competent healthcare provision. If such links were mandatory it would most likely result in cultural competence being evaluated for accreditation purposes. Gardenswart and Rowe (1998) proclaim that diversity initiatives that are "measured will get done". Thus there is a need for mandatory measuring and evaluating of initiatives related to provision of culturally competent health care.

[29] Health Information and Quality Authority is an independent body established in 2007 and reports to the Minister of Health. The objective is to drive continuous improvement in Ireland's health and social services by setting safety standards and monitoring healthcare quality.

The Irish efforts of evaluating performance outcomes in this area can be interpreted by borrowing Gardenswart and Rowe's (1998) observations of the American healthcare system prior to the introduction of the (CLAS) in 2001, when they refer to *"the area of measurement is still ripe for more work", p197.* The research findings would suggest that with regard to the measurement and evaluation of the management of ethno-cultural differences in the provision of health care, that now the time is right and the Irish health sector is sufficiently experienced and mature enough, for accreditation standards to be explicitly linked to the provision of culturally appropriate health care.

5.5.1.3 Up to date intercultural health policies

This sub-element is the most implemented sub-element in Strand 1 and the joint 1st in the WOA framework. Hospitals have put in place a variety of intercultural policies for health services and clarify expectations for staff, regarding diversity and equality issues through induction training, employee handbooks and policies such as "dignity at work" and "trust in care". All the hospitals have implemented initiatives such as bereavement policies, adapted diets, interfaith services, culture days and celebrations and interpretation policies. Also, 5 hospitals publish information about diversity issues in their newsletters and internal communications. This strong implication is partly due to individual hospital participation in MF care initiatives, benchmarking and implementation of proactive HSE national policies relating to bereavement and interpretation.

In relation to recruitment and retention, all the hospitals had policies in place promoting diversity in the profile of the workforce through attraction and retention initiatives. During the economic boom period, all 6 hospitals had actively recruited health sector professionals from around the world to fill the gap resulting from the lack of Irish recruits due to a highly competitive labour market. Thus each hospital had significant experience and tradition in the recruitment of non-Irish nationals and has complied with subsequent national equality legislation with regard to recruitment and equality.

With regard to retention and promotion, one area that emerged as problematic for hospital managers is a lack of succession planning and promotion of non-Irish national employees. This can be a direct consequence that non-Irish national nurses decline from promotion opportunities due to the potential loss of earnings as a result of the withdrawal of overtime earning opportunities when promoted. Also some managers referred to the concept of peer pressures from fellow non-Irish national employees who sometimes do not look admirably on fellow nationals distinguishing themselves through promotion.

Equality and diversity policies are embedded in the recruitment process in adherence to national equality legislation. Recruitment, retention and promotion are not based on race, gender or ethnicity and all hospitals are equal opportunity employers as confirmed by the HR Manager in H1 when she commented "*We have an equality at work policy and we are an equal opportunity employer".*

The majority of hospitals consult patients and staff on intercultural health care through diversity committees, which have staff participants who are members of MECs. They also frequently consult with MEC advocacy groups such as Cairde and Pavee Point among others. The HSE and individual hospitals have, on the whole, constructed good working relationships with MEC advocacy groups, which is indicative of the importance of these not for profit organisations in the management of ethno-cultural differences in the Irish healthcare sector. Furthermore, the hospitals acquire information through clinical incident reports, social workers and rely on the chaplaincy service to acquire knowledge about representative ethnic groups in order to provide services that are appropriate to the needs of a diverse and multi-ethnic society. The Director of Nursing in H1 refers to the proactive approach of her organisation when she states *"our health promotion office go out and meet the Muslim and travelling community and we ask them how best can we serve them".* None of the hospitals use cultural mediators, to explain hospital processes and healthcare procedures to members of MECs. Cultural mediators increase the capacity of healthcare professionals to diagnose problems specific to ethnic populations and facilitate the interpretation of medical information by assisting patients to understand the diagnosis and treatment (Perez Carratalà et al., 2010). The lack of use of cultural mediators may be reflected by the fact that agencies such as Access Ireland, which train and provide cultural mediators, have been forced to close down due to economic hardship and lack of government funding and sponsorship. Hospitals such as H3 did state that they used the services when they were available. A Social Worker stated that "*we used cultural mediators to explain Roma the nuances of diabetes healthcare, injections and blood transfusions and as social workers we valued this service"*. Hospitals should however investigate alternative methods attempting to develop MEC advocacy group volunteer networks or developing internal staff members who are trained and experts in major culture groups.

5.5.1.4 Equality framework including culture proofing of documentation and a template for equality proofing service planning and delivery

This sub-element is the 3rd most implemented sub-element in Strand 1 and the 4th in the WOA framework. The relatively strong implementation of equality frameworks consisting of equality based initiatives in healthcare management is due to the strong Irish legal context. The Employment Equality Acts and the Equal Status Acts that were enacted by the Irish government between 1998 and 2004 and were timely with regard to the unprecedented influx of non-Irish nationals into the health sector and wider economy. The government established the Equality Authority to administer advice and govern the implementation of the legislation in organisations across every sector in Ireland. Thus there was a motivation for all organisations to uphold the law by ensuring that equality was embedded in the systems and policies in their workplaces. Hospital staff for example, are made aware of their legal entitlements and requirements regarding equality in the workplace through human resource policies, induction training and human resource literature etc. The HR Director of H4 states quite categorically that *"HR is bound by equality legislations which are embedded in all our policies".* Similarly, the Health Records manager in H5 says *"I think staff are aware of expectations of equality and diversity with policies through induction training and staff handbooks".* Hospitals seek advice on equality issues externally from employer agencies or the Equality Authority and benchmark through their participation in MF networks and participation in the MFHP. H6 illustrates this through the comments of the HR Nursing manager who states *"we are linked in with the HSE, IBEC and from time to time, the Equality Authority if issues come up".*

Furthermore, Irish hospital management promote equal opportunities and endeavour to minimise discrimination by ensuring that hospitals have equality legislation embedded in and adhered to in all HR policies. These include recruitment and retention, as portrayed by the Quality and Accreditation manager in H5 when he says, *"we follow the rules and laws of the land and we are an equal opportunities employer".* Equally, hospitals have grievance and complaints procedures for both staff and patients that follow HSE proposals and initiatives such is the case in H5 where the Patient Service manager states *"trust in care policy for patients and dignity at work policy including grievances, bullying and harassment which are all national policies adapted locally".* Hospitals have put in place procedures based on code of practices on anti-discrimination to instruct employees how to handle inequality in the workplace. For example, according to the Dietician manager, H6 has policies such as *"dignity at work and trust in care, and any allegations of racism go through this".* The majority of hospitals systematically have risk management procedures in place requiring employees to

flag and investigate incidents related to inequalities or disparities in workplace activities or service provision. One example is in H3 where according to the HR Manager and acting CEO, *"in the Accidents and Emergency department, the hospital has recently piloted a multi-racial incident form to capture the ethnicities involved should incidents arise and to flag diversity related incidents and report disparities should they arise".*

While there are no explicit links to diversity or culturally competent care in Irish accreditation standards there is however evidence that equality standards for hospitals referring to anti-discrimination on the specific grounds referred to the Irish equality legislation are incorporated in accreditation. This is indicated through the comments of the HR Director in H4, who states *"from an accreditation point of view we were the first maternity hospital to be accredited and we are working towards HIQA licensing. Quality is driving the committee (accreditation) we tick the boxes and equality is linked".*

The majority of the hospitals culture proof documentation for distribution to the different MEC groups in the hospital community. This can be a lengthy process and the Deputy Patient Services manager in H4 commented that *"it took 2 to 3 years to culture proof our patient information book".* Hospitals use local MEC advocacy groups to contribute to the proofing process of healthcare related literature. The Patient Service manager of H5 confirms the important role that advocacy groups have when he states "we culture proof using Cairde for the Hospice Friendly Hospital Programme, death and dying and anti-bullying leaflets". Assessing or auditing techniques such as equality auditing/equality impact assessments, and equality/cultural proofing of service provision are operational in very few hospitals. The HR manager in H2 frankly states that *"we don't do equality audits"* and the Director of Quality and Risk confirms that *"culture proofing and equality audits can be considered as a probable weak point."*

The absence of using equality audits or equality impact assessing may be explained due to the relative weak culture of measurement and evaluation regarding performance outcomes related to the diversity and culturally competent care area. Also, while certain equality measures are linked to accreditation in healthcare, there may not go so far as to require such initiatives. Hence these equality related evaluation techniques while being 'nice' procedures to do are not necessarily mandatory and are thus not strongly implemented.

5.5.1.5 Ethnic monitoring system including an agreed framework for data collection and data usage

This sub-element is the 4th most implemented sub-element in Strand 1 and the 6th in the WOA framework. The HSE and the individual hospitals realise the importance of collecting ethnic related data in order to accurately serve the hospital community. All the hospitals have the necessary mechanisms in place to monitor country of origin, language and religious beliefs. However the majority of the hospitals do not solicit race data or most importantly use the ethnic monitored data collected, to inform services and strategy planning etc. The Director of Nursing in H6 testifies to this when she commented "*the data collected does not feed into service planning".* Only H3 and H4 have complete ethnic monitoring systems that collect all the relevant data including race and inform hospital services. This is because these 2 hospitals were selected by the HSE to pilot the national ethnic identifier programme and tested new data collection systems in the view of rolling out the system to all Irish hospitals in the future. The findings suggest that those Irish hospitals sampled are weak in quantifying and monitoring the outcomes of their diversity initiatives at an individual and organisational level. In reality hospitals are not measuring the effects and outcomes of their implementation of the WOA. Hospitals are relying on anecdotal and testimonial evidence to determine if the WOA has increased capacity to be a more responsive health care service provider.

5.5.2 Analysis, interpretation and prescriptions for the implementation of Strand 2

The implementation of Strand 2 across the 6 hospitals is illustrated in table 5.13. It highlights the implementation of the specific parameters in each sub-element of the WOA in each hospital. Table 5.13 illustrates the implementation of Strand 2 across the 6 hospitals, indicating the implementation score for each sub-element in each hospital.

Table 5.13 : Strand 2 implementation of the WOA

STRAND 2: WORKPLACE ENVIRONMENT								
Sub-element 5: A tiered approach to intercultural training (systematic and ongoing)		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training	1	1	1	1	1	1	6
P2	Level 2: cultural awareness training	0	0	1	0	1	1	3
P3	Level 3: training for specific professionals	1	1	1	1	1	1	6
P4	Level 4: intercultural dialogue training	1	0	1	1	1	1	5
P5	Level 5: multicultural team training	0	0	0	0	0	0	0
P6	Level 6: legal & business case training	1	0	0	1	0	1	3

P7	Cultural awareness developed in consultation with stakeholders including members of MECs	1	0	1	1	0	0	3
P8	Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers	0	0	0	0	0	0	0
P9	Train the trainer programmes	0	0	1	1	1	1	4
P10	3rd level schooling with intercultural modules integrated	1	0	1	1	1	1	5
P11	Training on major ethnic groups e.g. travelling community	1	0	1	1	0	0	3
P12	Multidisciplinary training	1	0	1	1	1	1	5
P13	Online options for intercultural training	0	0	0	0	0	0	0
P14	Staff attend conferences related to diversity, e.g. European Transcultural Nursing Association conference	0	0	1	1	1	0	3
	Total number of implemented parameters per hospital	*8*	*2*	*10*	*10*	*8*	*8*	
Sub-element 6: Workplace support structures to support staff to manage issues relating to cultural diversity		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Intercultural Health Guide on cultural norms of MECs readily available to staff	1	1	1	1	1	1	6
P2	Bereavement and care for the dying guidelines	1	1	1	1	1	1	6
P3	Multi-denominational chaplaincy services	1	1	1	1	1	1	6
P4	Language guides & multilingual aids	1	1	1	1	1	1	6
P5	Point to picture cards / pictograms	1	1	1	1	1	1	6
P6	Website or links specific to diversity or cultural competence in health care	0	0	1	1	0	0	2
P7	Interpretation & translation policy and guidelines	1	1	1	1	1	1	6
P8	Staff meetings referring to cultural issues	1	0	1	1	1	1	5
P9	List of MF staff contact lists regarding cultural issues	1	0	1	1	0	0	3
P10	Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference	1	1	1	1	1	1	6
P11	Anti-discrimination guides, policies & practices	1	1	1	1	1	1	6
P12	Cultural mediators	0	0	0	0	0	0	0
	Total number of implemented parameters per hospital	*10*	*8*	*11*	*11*	*9*	*9*	
Sub-element 7: Development of initiatives to integrate and manage multicultural teams		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Multicultural team training for all staff	0	0	0	0	0	0	0
P2	Career development programmes for overseas staff	1	1	1	1	1	1	6
P3	Buddy and mentor system for all incoming staff including non-Irish	1	1	1	1	1	1	6
P4	Overseas nurse coordinator	1	0	0	0	1	1	3
P5	Preparation work with existing staff	0	0	0	0	0	1	1
Sub-element 8: Training method to include co-facilitation by members of MECs		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Use members of MECs to co-facilitate and conduct intercultural training	1	0	1	1	0	0	3

P2	Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training?	0	0	1	1	0	0	2
	Total number of implemented parameters per hospital	*1*	*0*	*2*	*2*	*0*	*0*	

5.5.2.1 Overview of Strand 2 "Workplace Environment"

Strand 2 is the 2nd most implemented strand in the WOA. Irish hospitals are advanced in implementing policies and systems in the workplace that support staff. However despite having made efforts to implement a tiered approach to intercultural training, critical areas such as multicultural team training to enable managers to effectively manage the dynamics of multicultural teams have not been developed. Also, more consultation with members of MECs is required in implementing appropriate training. Considering the importance of intercultural training and cultural competency in the delivery of quality healthcare services to MECs, the results clearly indicate that majority of the hospitals are not undertaking adequate systematic intercultural training. This is predominantly a result of the negative impact of the economic crisis on the management of healthcare organisations.

An explanation of the results for each of the 4 sub-elements of Strand 2 as illustrated in table 5.13 is supported by data from interviewees form the different hospitals.

5.5.2.2 A tiered approach to intercultural training

A tiered approach to intercultural training is the 2nd most implemented sub-element in Strand 2 and the 7th in the WOA framework. Despite the importance of intercultural training, which is a key element in the pursuit of cultural competence care as illustrated in the literature review (see Gilbert, 2001 and Lister, 1999) it is apparent that intercultural training is not ongoing or systematic in the 6 hospitals. Level 1 orientation and induction training, Level 3 training for specific healthcare professionals and Level 4 intercultural dialogue training are the only levels of training that have been conducted in the all of the hospitals. Level 2, cultural awareness training and Level 6 legal and business case training are implemented in only half of the hospitals surveyed. Most alarmingly Level 5 multicultural team training is not conducted in any of the hospitals surveyed, even though all hospitals share significant numbers of non-Irish nationals as members of their workforces. In summary a tiered approach to intercultural training is not systematic or mandatory for all employees in Irish hospitals.

A principal reason for this is that training and development budgets in hospitals have been reduced or frozen in the context of the Irish economic crisis. This has had a negative impact on the financing of intercultural training programmes across the healthcare sector. This is evident by the comments made by the Clinical and Patient Service manager in H3, who said *"we don't have enough resources; money is getting tighter and tighter".* Likewise the HR Director in H5 stated that *"the training budget has been constrained since 2008",* while the hospital's Quality and Accreditation manager reported that *"we lost the Training and Development post due to cut backs".*

Lack of financial resources for intercultural training has also led HR departments to prioritise technical and medical training ahead of the obtainment of what is often perceived as the softer skills of intercultural or cultural competency training. This is illustrated by the HR Manager in H5 who states that *"The training priority is technical and medical skills",* and continues by declaring that *"investment in soft skills is at an all time low".* H1's Chaplain confirms that priorities in training are changing across hospitals when he states, *"these things do not seem priority and our budget is cut".*

Two further knock-on effects of the impact of the economic crisis in the health sector and its critical impact on intercultural training is the moratorium on recruitment of new employees imposed by the Minister of Health on the HSE in 2009, and indeed the redundancies introduced throughout the health sector in 2010. These constraints have effectively reduced staff numbers in hospitals, which has resulted in frontline staff such as ward nurses being unable to leave wards and departments to attend training sessions. The Chaplain in H4 describes the dilemma as *"a struggle to get people together, the will is there but impossible to get frontline staff on diversity issues".* His colleague the Deputy Patient Service manager supports this view when she states *"the impetus is there, getting time off is the problem in the current context".* Understaffing is not just limited to nursing grades and frontline staff as reflected in the comments of one Clerical Officer in H6, who states from an administrative employee perspective that *"it's difficult for me to get into training because of understaffing".*

Such is the dilemma that in H4 even when there was a sufficient training budget to conduct a hospital wide intercultural training workshop, the training had to be abandoned due to lack of staff available to attend. The Training and Development manager summarised the situation by stating *"we had the money to provide training but we had to cancel training because no staff showed up due to the current situation".*

H2 is the least advanced with regard to intercultural training which is indirectly linked to the function and nature of the hospital i.e. providing health care to elderly patients, which by and large are not culturally diverse. Hence according to a Medical Doctor *"there is no need for intercultural training at the* moment". However, H3 and H4, in their functions as a Children's and Maternity hospital respectively, score highest in the implementation of a tiered approach to intercultural training indicating possible correlations to the function of the hospital, the location relative to the ethno-cultural diversity of the service users, and the extent of intercultural training being implemented. Also, both of these hospitals have worked closely in collaboration with the HSE intercultural health projects and associated MF health care networks and have benefited from funding for intercultural training as confirmed by the HR manager and Acting CEO of H3 who stated *"diversity was funded by the HSE up to 2008-2009".*

In order for a tiered approach to intercultural training to be more comprehensively implemented into the Irish health system, provisions should be made to ensure that cultural competency and diversity awareness training are mandatory for all senior leadership, management, staff and volunteers in the hospital. Also, due to the large influx of non-Irish nationals into the Irish health system as is the case for the 6 hospitals surveyed, hospitals should undertake Level 5 Multicultural team training. Cross-cultural mis-communication problems, misunderstandings, perceptions and assumptions can lead to breakdowns in intercultural working environments (Adler 91). Asking Indian, Filipino, Irish and other nationalities to work together in high pressure work environments can lead to conflicts and be problematic as reflected in the following comments from a Medical Doctor in H2 who is of the opinion that *"Filipinos don't take the initiative, don't take control, don't take leadership, are placid and caring while an Irish nurse will rattle you",* and the Training and Development Coordinator in H5 maintains that *"there is a lack of cultural understanding between Irish and non-Irish staff".*

None of the hospitals use online options for intercultural training. This is particularly noteworthy given that one solution to combat the time and financial constraints restricting the implementation of a tiered approach of intercultural training could be the introduction of online cultural competence healthcare training (Kutob, Senf and Harris 2009).

5.5.2.3 Workplace support structures to support staff to manage issues relating to cultural diversity

This sub-element is the most implemented sub-element in Strand 2 and the 2nd in the WOA framework. Workplace support structures to support staff to manage issues relating to cultural diversity are strongly implemented in the majority of the hospitals. The reasons for the strong implementation can be attributed to the fact that all hospitals surveyed have ethno-culturally diverse employees and 5 hospitals provide health care to ethno-culturally diverse service users. This creates a need for hospital systems to be put in place to support staff to manage issues relating to cultural diversity. For example, all the hospitals providing interpretation policies, adapted diets, inter-faith religious services, may be driven by ethno-cultural differences in service users while strong implementation of conflict resolution, bullying and harassment, grievance procedures, anti-discrimination guides and policies may be led through workforce cultural diversity and Irish equality legislation. Strong performance in this sub-element may also be influenced by HSE national initiatives such as those relating to equality, interpretation or the distribution of intercultural health guides or multilingual aid guides designed to support frontline staff to manage ethno-cultural differences in the provision of care at the point of contact. All hospitals surveyed had an intercultural health guide on cultural norms of MECs and multilingual language aids issued by the HSE and provided interpretation services. Surprisingly, hospitals in the context of the multitude of support structures that they have been successful in implementing for staff do not have web links or a website on ethno-cultural diversity and cultural competency in health care. It is worth repeating that this is a relatively low cost initiative that hospitals can use to provide support to healthcare professionals particularly in the absence of systematic intercultural training programmes.

5.5.2.4 Development of initiatives to integrate and manage multicultural teams

This sub-element is the 3rd most implemented sub-element in Strand 2 and the 8th in the WOA framework. With regard to development of initiatives to integrate and manage multicultural teams, all the hospitals recruited non-Irish nationals during the Irish economic boom period, when there was a shortage of Irish staff in areas such as nursing. During the influx of non-Irish nationals into the health system (Lyons et al., 2008) most of the hospitals put in place strategies to integrate non-Irish employees particularly in nursing grades. Initiatives included areas related to career development and introducing mentor programmes and creating an overseas nurse coordinator post. These strategies were implemented in individual hospitals in alignment with national HSE policies. The majority of hospitals did not provide any intercultural preparation work for Irish national staff who were already employed

in the health system and who had to adapt to the different working and cultural behaviours of non-Irish healthcare professionals coming from all over the world. The scores in the parameter relating to 'preparation work with existing staff' are understandably low in the current climate where there are no new overseas staff being recruited into the health system. Hospitals need to pay attention to integrating multicultural teams in the workplace (Adler 1991). The absence of multicultural team training in all 6 hospitals may be due to an under-estimation of the consequences or a minimization of the problem of international working environments. Several respondents from different hospitals referred to problems due to ethno-cultural differences in the workforce. The Director of Quality and Risk in H6 claimed that *"multicultural teams are very challenging at times between Indian and Filipinos and there can be some unpleasantries".* Likewise the HR Director in H5 confirms that *"it's a challenge to integrate staff from different backgrounds"* and his colleague a Nursing Practice Development Coordinator identified some of the challenges and consequences associated with multicultural teams as being when *"nurses talk in their own language and this is frustrating at times". A* Clinical Nurse manager in Mental Health in H1 raises the tensions related to the planning of working time and annual leave between Irish nationals and non-Irish national nurses when she comments *"we (nurses) are like swans from the outside, but there are myths, that non-Irish nurses come here for the money, they need 6 weeks holidays to go home, but what about the nurse from Kerry (South of Ireland). Also there are conflicts over working time, for example women staff whose kids and family are back home in the Philippines, it impacts their work, their entire work is based on their next annual leave."*

The introduction of multicultural team training including Irish nationals and non-Irish nationals would prepare all the relevant staff members to work efficiently and effectively in international teams. This would enable non-Irish nationals to better integrate into the hospital which in turn may have knock-on effects in critical areas such as promotion and succession planning. Certain respondents mentioned that non-Irish nationals were slower to present themselves for promotion. H2 has a staff composition consisting of 54% of non-Irish nationals and the importance this cohort presenting themselves for career advancement is critical for the future management of the hospital. A Medical Doctor confirms the problem by stating that *"MECs are not moving up the ladder".* The HR Manager acknowledges the dilemma in H2 by stating "w*e have promotion problems as they (non-Irish nationals) don't aspire to being managers, due to financial resource issues but also cultural aspects".* The problem exists in H4 as the HR Manager is of the opinion that *"they (non-Irish nationals) are working every hour of the day and are not interested in promotion".* When investigated from the perspective of non-Irish nationals working in H5, one staff nurse feels that *"some of the minority nurses have felt left*

out" and a Clerical Officer put forward the following possible reasons for non-promotion by suggesting that *"non-Irish seem to be at the same grades, maybe due to the language barriers. In my department there is no overtime and I do think local people are promoted due to the recession. The system needs to be developed."*

While the subject of succession planning is not the focus of this research it is nonetheless noteworthy and relevant to hospital managers in the Irish context. This phenomenon could impact human resource strategy and lead to shortages of managerial staff in the short to medium term. There is a lack of qualitative or quantitative data analysing succession planning with regard to non-Irish nationals working in the Irish health system and given its potential impact on human resources, this problem merits future research.

5.5.2.5 Training methodology to include co-facilitation by members of minority ethnic communities

This sub-element is the 4th most implemented sub-element in Strand 2 and the 9th in the WOA framework. H2, H5 and H6 do not initiate training methodologies involving co-facilitation by members of MECs, which may reflect lower levels of ethno-cultural differences in the service providers particularly in H2 and H6. Intercultural training is limited in H2 and the service users are not as diverse as in the other hospitals. H1, H3 and H4 use local MEC advocate groups to design and deliver intercultural training. This may be linked to the function of these hospitals and to the fact that all three hospitals serve the most culturally diverse service user populations, have cultivated strong links with MEC advocacy groups through diversity committees, intercultural healthcare forums or information exchange programmes.

5.5.3 Analysis, interpretation and prescriptions for the implementation of Strand 3

An explanation of the results for each of the 4 sub-elements of Strand 3 as illustrated in table 5.14 follows, supported by data from interviewees from selected hospitals.

Table 5.14: Strand 3 implementation of the WOA

STRAND 3: SUPPORT TO INTERCULTURAL TRAINING								
Sub-element 9: Information and awareness for minority ethnic service users on the processes and practices of the Irishhealth care system		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Links with MEC advocacy groups	1	0	1	1	1	1	5
P2	Members of MECs on patient involvement committees	1	0	1	1	1	0	4

P3	Outreach information health education programmes to MEC associations, community organisations etc.	1	0	1	1	1	0	4
P4	Use cultural mediators or support workers from MECs, to explain hospital procedures to patients	0	0	0	0	0	0	0
P5	External marketing, newsletters, flyers in community or hospital information geared towards MF care or diversity issues available in community.	1	0	1	1	1	1	5
P6	MF Open House	1	0	1	0	1	0	3
P7	Website explaining the processes and practices of the hospital and the Irish health system	1	1	1	1	1	1	6
	Total number of implemented parameters per hospital	*6*	*1*	*6*	*5*	*6*	*3*	
Sub-element 10: Signage particularly in reception and public areas in key languages of service users		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area.	0	0	0	0	0	0	0
P2	Posters to promote intercultural healthcare & diversity related healthcare issues.	0	0	1	1	0	0	2
P3	Visual orientation system / Sign-post pictograms	1	1	1	1	0	0	4
	Total number of implemented parameters per hospital	*1*	*1*	*2*	*2*	*0*	*0*	
Sub-element 11: Literature in the key languages of service users		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Relevant literature in key languages	1	0	1	1	1	0	4
P2	Culturally appropriate documentation that has been culturally proof read	1	0	1	1	1	0	4
P3	Website translated	0	0	0	0	0	0	0
	Total number of implemented parameters per hospital	*2*	*0*	*2*	*2*	*2*	*0*	
Sub-element 12: A comprehensive interpretation service		**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**
P1	Accessible to all staff	1	1	1	1	1	1	6
P2	Publish the right to language & interpretation service / Access to interpretation indicated	1	0	1	1	1	1	5
P3	Access to interpretation service by telephone	1	1	1	1	1	1	6
P4	Access to face to face interpretation service	1	1	1	1	1	1	6
P5	24 hours, 7 days a week service	1	1	1	1	1	1	6
P6	Ensure all staff is aware of service	1	1	1	1	1	1	6
P7	Ensure all staff trained to use interpreters	0	0	0	0	1	0	1
P8	Ensure a written interpretation policy	1	1	1	1	1	1	6
P9	Guidelines for staff on how to access and use interpretation services	1	1	1	0	1	1	5
P10	Use of hospital staff who speak more than one language as first contact interpreters	1	0	1	1	1	1	5
	Total number of implemented parameters per hospital	*9*	*7*	*9*	*8*	*10*	*9*	

5.5.3.1 Overview of Strand 3 "Support to intercultural training"

With limited financial and human resources across the health sector, Strand 3 seems to be the least priority of the three strands of the WOA. Hospitals having secured the provision of

interpretation services and having endeavoured to build contacts for information, awareness and exchange with MECs, seem to be less inclined, for different reasons, towards the implementation of translated signage and literature initiatives. Findings suggest that in order for this strand to be more comprehensively implemented, these two areas should be improved and in some cases initiated. An analysis of the results for each sub-element of the strand is outlined using interview data to support the analysis.

5.5.3.2 Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system

This sub-element is the 2nd most implemented sub-element in Strand 3 and the 5th in the WOA framework. Results indicate that this sub-element is relatively well implemented and the 4 highest scoring hospitals are all located in ethno-culturally diverse catchment areas with culturally diverse service users. Equally the 4 hospitals have consequently cultivated strong links with MEC advocacy groups, have outreach MEC initiatives and have involved patients who are members of MECs on patient involvement committees. H2, on the contrary, has practically no ethno-cultural diversity in service users and thus is not developed in this area. H6 has multiethnic service users, but according to the Nursing Practice Development Facilitator*, "there is not a large cohort of a particular ethnic group".* This explains why there is a lesser emphasis on implementing this sub-element in the hospital.

5.5.3.3 Signage, particularly in reception and public areas in the key languages of service users

This sub-element is the 4th most implemented sub-element in Strand 3 and the 11th in the WOA framework. None of the hospitals provide adequate translated signage in key reception areas and public areas. This may reflect the costs of providing such signage, or may reflect poor use of information gathered through ethnic monitoring and data collection in particular information regarding the languages of service users not being fed back into hospital services. Another reason may be that the hospitals consider that there is not enough demand due to low levels of ethno-cultural diversity in service user populations as is the case for H2 or H6. The Nursing Practice Development Facilitator in H6 testifies to this by stating that *"there are no translated signs probably because there is not a large cohort of a particular group".* Other hospitals such as H3 debate the justification of the cost of translating in relation to the extent of service user diversity. For example one Paediatric Consultant in the same hospital poses the question "*"how far do we push it, if patient diversity is 20%, does this mean we change all the signs?"*

The majority of the hospitals recognise signage as a problem in the context of migrant friendly care and H3 and H4 have taken initiatives to have their signage externally audited. All the hospitals with the exception of H2 should consider translating signage in the language of the commonly encountered groups and representatives in the service area. This is to ensure clarity to members of MECs in what can be already complex and intimidating environments for persons unfamiliar with hospitals and the Irish health system. Posters communicating services appropriate to MECs and intercultural care issues, such as the usage of an ethnic identifier programme, the availability of translated literature, the availability of translation and interpretation services, or multi-faith religious services, or simply posters promoting and valuing cultural diversity, should be posted in main public areas of the hospital.

5.5.3.4 Literature in the key languages of service users

This sub-element is the 3rd most implemented sub-element in Strand 3 and the 10th in the WOA framework. The financial cost of translating healthcare literature is a principal constraint regarding this sub-element. The Nursing Practice Development Facilitator justifies that the literature is not translated in H6, "*as we have to think of the cost effectiveness".* Likewise the Director of Mission Effectiveness refers to the lack of translation of healthcare leaflets and brochures in H6 as a problem of *"huge cost".* H2 has not a need for literature to be translated which explains why the Director of Nursing states "*we have not thought about it".* Even hospitals that have made efforts concerning this sub-element concede that there is more progress to make in adapting signage and visual communication in relation to migrant friendly health care provision. This is alluded to by the comments of the Team Leader in Patient Services in H4 who refers to it as *"a problem we are not really adapted to"* and the Director of Mission Effectiveness in H5, who summarises the hospitals approach by stating *"we still need to work on this".* H2 and H6, which both score *0* in this category, are the hospitals with the least ethno-cultural differences in their service user populations. This explains the lack of emphasis on this sub-element.

5.5.3.5 A comprehensive interpretation service

This sub-element is the most implemented sub-element in Strand 3 and joint 1st in the WOA framework. Strong implementation may be linked to the top down approach through the issuing of national guidelines and draft policies on the subject to the hospital sector by the HSE. Also, the subject of interpretation as a critical means for communicating and providing health services is widely recognised as an important factor in the culturally competent

healthcare literature (see CLAS 2001, Amsterdam Declaration 2004). Studies show that people who are unable to speak and understand English to an appropriate level will not make the best use of health services (Gill et al. 2010). The importance of language capacity and the need for interpretation and translation services are well documented in areas such as primary care (Lakha et al. 2010). Thus the HSE have encouraged the use of professional interpretation services by telephone and face to face across the hospital sector. The issue of training staff to use interpreters in complex areas such as mental health nursing needs to be developed as no hospital implements it except for H5.

5.5.4 Summary of parameter implementation

In analysing the implementation of the 3 strands of the WOA framework, approximately 39% of the parameters of the WOA are implemented across the 6 hospitals. A total of 59% of the parameters have been implemented in those hospitals that provide services to ethno-culturally different service users i.e. all hospitals except H2. Approximately 10% of parameters have not been implemented in any of the 6 hospitals. The results indicate that Strand 1 has a total of 17 parameters implemented out of 37, Strand 2 has 12 parameters out of 33, and Strand 3 has 7 parameters out of 23 implemented in all the hospitals.

5.5.4.1 Principal parameters of the WOA not being implemented

It can be noted that out of the 93 parameters assembled and included in this research, there are 11 that have not been implemented by any of the 6 hospitals. 3 of these refer to the same practice of using cultural mediators as this parameter is associated with three different sub-elements of the WOA. Similarly 2 parameters are related to multicultural team training. Research findings demonstrate among the 11 parameters which are not implemented by the 6 hospitals, 3 constitute parameters from Strand 1 Organisational Ethos, 5 from the Strand 2 Workplace Environment and 3 from Strand 3 Support to Training.

Table 5.15 : List of top 11 parameters that are absent in all hospitals

Strand 1: Organisation Ethos	Missing parameters
Specific initiatives that demonstrate the commitment and support of managers.	(P8) Performance management systems to evaluate staff competence and organisational outcomes with regard to diversity and equality.
Up to date intercultural policy for the health services.	(P11) Use of Cultural mediators.
Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery.	(P2) Equality auditing impact assessment.

Strand 2: Workplace Environment	Missing parameters
A tiered approach to intercultural training.	(P8) Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers. (P5) Multicultural team training. (P13) Online options for intercultural training.
Workplace support structures to support staff to manage issues relating to cultural diversity.	(P12) Use of Cultural Mediators.
Development of initiatives to integrate and manage multicultural teams.	(P1) Multicultural team training to all staff.
Strand 3: Support to Intercultural Training	**Missing parameters**
Signage, particularly in reception and public areas in the key languages of service users.	**(**P1) Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area.
Literature in the key languages of service users.	(P3) Website translated.

The non-implemented parameters illustrated in table 5.15 can be categorised into 3 areas. These include Measurement and Evaluation, Intercultural training and Other (Signage and website translation, cultural mediators). A discussion of each category follows which refer to additional parameters that at least 4 out of the 6 hospitals have not implemented.

- ***Measurement and evaluation***

The research findings indicate few initiatives undertaken by Irish hospitals with regard to measurement and evaluation of performance in the context of managing ethno-cultural differences. Findings suggest that management, staff and hospital performance is not evaluated regarding diversity or culturally competent care. There is no measurement of implementation, outcomes or change effects and no hard data to say if the WOA has made hospitals more efficient or is making a difference. There are no quantities or few qualitative data or measurements to evaluate returns or improvements that are a result of implementing the WOA approach. The only area of measurement that surfaced in the research was H6 who referred to a reduction in legal liabilities and court cases taken against the hospital.

Equality auditing and impact assessments are not implemented in the hospitals and there are only 2 hospitals that conduct culture proofing in service provision. There is evidence of auditing staff needs and patient needs in terms of equality and diversity in H3, H5 and H6. Also only 2 hospitals have complete ethnic monitoring systems that audit and assess the ethnic profile of the patients and use the data to adapt hospital services.

- ***Intercultural training***

Diversity awareness and cultural competency training is not mandatory for all senior leadership, management, staff and volunteers. Also given the significant multicultural workforces in each hospital there is no multicultural team training. Equally in the context of limited budgets and reduced healthcare workforces, there is an absence of using online cultural competence training methods. Only 1 hospital prepared existing staff for the integration of non-Irish nationals during the influx of immigrant workers into the health system. Also a minority of 2 hospitals have made resources available to staff who are members of MECs or MEC advocacy groups to build their capacity to design, deliver and evaluate training.

There is a concern regarding the provision of adequate resources for training in the current economic context. The moratorium on recruitment has crippled the hospital's ability of getting staff out of the wards and into training. There are no replacement staff to fill the gap. Time shortages due to understaffing and training budgets being reduced have had negative impacts. Hospitals will need to explore new cost effective and time effective ways of providing intercultural training by using e-learning and delivering training in short session's deliverable between work shifts or at lunch time. Also there is an alarming minimization of the challenges of integrating multicultural teams in hospitals which is posing problems on the floor in hospitals but which is not been recognised or acted upon by hospital management.

- ***Other: signage and website translation, cultural mediators***

There is no use of cultural mediators in explaining practices and procedures of the hospitals to members of MECs. This is mainly due to the cost factor and the fact that Access Ireland was closed down due to budget constraints. Hospitals have not translated their signage or website into representative languages in the local community and the majority of hospitals do not have a website or website links to diversity issues or cultural competent health care. Furthermore only 2 hospitals have posters promoting health care and diversity related health care issues in different languages. Finally the majority of hospitals have not trained staff how to use interpreters properly. These areas are seen as less priority in the current economic context.

5.6 Observations of the findings in the context of the future application of the WOA framework

The findings of the research indicate that the strands are implemented to different extents, which may indicate different priorities. It is in this context that upon examining the findings that the following 3 observations can be made with regard to future applications of the WOA framework.

5.6.1 Observation 1

The first observation can be extrapolated from the findings, that Strand 1 and Strand 2 are implemented when the hospital accommodates both ethno-culturally different service providers and service users. This is due to the fact that parameters in both Strand 1 and Strand 2, are not reliant on the hospital serving only a diverse service user population, but are also related to the management of ethno-culturally diverse service providers. For example, sub-element 1 "specific initiatives that demonstrate the commitment and support of managers", and sub-element 3 "equality frameworks" both in Strand 1, contain parameters relating to both service provider and service user ethno-cultural diversity. However, the implementation of the sub-elements in Strand 3 are more dependent on whether the hospital serves ethno-culturally different service users and are not conditional on the ethno-cultural differences of service providers. Table 5.16 illustrates that the implementation of Strand 1 and Strand 2 relates to managing both service provider and service user ethno-cultural differences. However, Strand 3, irrespective of whether the hospital has service provider ethno-cultural diversity, will be less implemented if there is less ethno-cultural diversity in the service user population.

Table 5.16 : Service Provider / Service User dependents of strand implementation of WOA

Strand	Ethno-culturally different Service Providers	Ethno-culturally different Service Users
Strand 1: Organisational Ethos	✓	✓
Strand 2: Workplace Environment	✓	✓
Strand 3: Support to Intercultural Training	✘	✓

5.6.2 Observation 2

A second observation to emerge is that from the 93 parameters of the WOA, 53 (see table 5.17) are related directly to the provision of care to ethno-culturally different service users and 40 (see table 5.18) are more concerned with the management of service provider diversity. Thus the implementation of these parameters is contingent to the contextual circumstances of the hospital.

This division can be of interest in the future context of implementing frameworks such as the WOA to manage ethno-cultural diversity in healthcare depending on the priority. (This is particular to the context of rapid demographic changes in a nation state or region as a result of dramatic economic or political environmental changes). It is understood that healthcare organisations need to engage human resources and manage more diverse workforces in order to enhance customer satisfaction and improve organisational performance through the provision of culturally appropriate systems of care (Weech-Maldonado 2002). The contention that healthcare organisations need to respond to the demographic changes and attitudes of both the patients and the workforce is well established (Dreachslin 1999 and Cox 1994). The Irish hospitals in the Irish healthcare systems were confronted with both rapid service provider diversity and service user diversity at the same time and thus utilised both categories of parameters as a matter of priority.

However, different hospitals may have different needs depending on their contexts. Hospitals that have traditions of strong workforce diversity and have already diversity management systems in place, but are rapidly confronted with a need to focus on provision of care to ethno-culturally diverse service users, (due to a rapid demographic change context) can prioritise the 53 parameters identified to directly manage service user diversity. Contrastingly, a hospital that has traditionally little service provider ethno-cultural diversity but requires the recruitment and management of ethno-culturally diverse service providers due to labour shortages may focus on the other 40 parameters.

5.6.3 Observation 3

A third observation is that 53 parameters identified as being service user oriented can be further distinguished into 2 categories of parameters based on the extent or size of the ethno-culturally diverse service user community. Category 1 consists of 21 parameters that can be considered fundamental for every hospital that serves ethno-culturally diverse service users. These 21 parameters are less dependent on the size and quantity of the MEC groups

in the community. They can be considered as fundamentals or 'first step' measures to put in place to manage directly members of MECs. Research findings in the Irish hospitals indicate that for example parameters related to interpretation services, or adapted diets or culturally appropriate bereavement policies are implemented in all 6 hospitals irrespective of the size of the minority ethnic communities. These parameters are important and are less sensitive to the consideration of the size of the ethnic groups in the community.

Category 2 consists of 32 parameters that are important but more sensitive to the extent and size of the service user community that a hospital serves. In other words these parameters should be implemented depending on the context of each hospital, with regard to the amount or size of ethno-culturally diverse service user communities that the hospital serves. For example with regard to the sub-element of *Signage particularly in reception and public areas in the key languages of the service users* it is unlikely that a hospital will invest resources to provide signage in the language of the commonly encountered groups and representatives in the service area if there are low amounts service users in that group. Likewise, if there are few Chinese nationals for example, living in the community the hospital will have to review a cost benefit analysis before investing in translation healthcare literature into Chinese. While these parameters are important for the management of ethno-cultural difference in the provision of healthcare, they may be secondary to parameters described in Category 1.

Thus this categorisation based on the findings of the research can serve future hospitals or healthcare settings to discriminate as to which parameters should be implemented as a matter of priority depending on the extent of the demand from the service user community.

Table 5.17: Category 1 and Category 2 (53) parameters focused on the ethno-cultural differences of service users

Category 1 (21 parameters): Priority measures to manage service user diversity
Up-to-date intercultural policy for the health services: Bereavement policies and guidelines, and adapted mortuary with appropriate alters & symbols etc. Adapted diet and revision of menus (e.g. halal) Interfaith policy e.g. multi-denominational chaplain service, & prayer rooms Interpretation policy or translation policy **Ethnic monitoring systems including an agreed framework for date collection and usage:** Ethnicity: country of origin / nationality Language Beliefs (Religion) Race (skin colour) Use information to inform services, diversity training and active use of real data for strategic and outreach planning? Does the hospital gather information to determine conditions of high prevalence within the community's minority populations?

Workplace support structures to support staff to manage issues relating to cultural diversity:
Bereavement and care for the dying guides

Interpretation and translation policy and guidelines

A comprehensive interpretation service :
Accessible to all staff
Publish the right to language & interpretation service / Access to interpretation indicated
Access to interpretation service by telephone
Access to face to face interpretation service,
24 hours, 7 days a week service
Ensure all staff is aware of the service
Ensure all staff are trained to use interpreters
Ensure a written interpretation policy
Guidelines for staff on how to access and use interpretation services
Use of hospital staff who speak more than one language as first contact interpreters

Category 2 (32 parameters): Measures depending on extent of ethno-culturally diverse community

Specific initiatives that demonstrate the commitment and support of managers:
Encouraged to publish information about diversity progress or MF care , through newsletters, annual report
The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches with MEC advocacy groups, other health organisations, community groups, advice organisations or 3rd level research, educational exchanges and teaching

Up-to-date intercultural policy for the health services:
Newsletters (referring to diversity & equality topics or research)
Use of cultural mediators

Equality framework including culture proof of document templates for equality proofing, service planning and delivery:
Culture proofing of documentation
Equality / cultural proofing of service provision
Need to evaluate patient and community

A tiered approach to intercultural training (systematic and ongoing):
Level 4: intercultural dialogue training
Cultural awareness developed in consultation with stakeholders including members of MECs
Training on major ethnic groups
Staff attend conferences related to diversity

Workplace support structures to support staff to manage issues relating to cultural diversity:
Intercultural Health Guide on cultural norms of MECs readily available to staff
Multi-denominational chaplaincy services
Language guides & multilingual aids
Point to picture cards / pictograms
Staff meetings referring to cultural issues , e.g. lunch time talks on diversity, culture, bereavement information meetings etc.
List of MF staff contact lists regarding cultural issues
Cultural mediators

Training method to include co-facilitation by MEC:
Use MECs to co-facilitate and conduct intercultural training

Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system:
Links with MEC advocacy groups
Members of MECs on patient involvement committees e.g. patient forums or diversity committees
Outreach information health education programmes to MEC associations, community organisations, churches and schools etc
Cultural mediators
External marketing, newsletters, flyers in the community or hospital information geared towards MF care

MF Open House (inviting MECs or MEC advocacy groups on site to hospital)
Website explaining the processes and practices of the hospital and the Irish health system

Signage particularly in reception and public areas in key languages of service users:
Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area
Posters to promote intercultural health care & diversity related healthcare issues
Visual orientation system / Sign-post pictograms

Literature in the key languages of service users:
Relevant literature in key languages
Culturally appropriate documentation that has been culturally proof read
Website translated

Table 5.18: 40 Parameters focused on workforce diversity

Specific initiatives that demonstrate the commitment and support of managers
Mission statement, vision or value statement or equality statement that refers to diversity equality or MF care Strategic plan, policy action plan referring to MF care, diversity or equality Diversity committees (that include members of MECs and are multi-disciplinary) Committed resources including financial resources, e.g. interpretation, time off for diversity committee and training Project leader or responsible for Diversity & Equality / Champion at management level Accountability for all staff to behave appropriately and provide provision of care in a non discriminatory manner and equally to all patients e.g. dignity at work, trust in care, discipline & grievance for inappropriate behaviour Performance management systems to evaluate staff competence and outcomes with regard to diversity and equality outcomes
Up-to-date intercultural policy for the health services
Clarify the expectations of staff regarding diversity and equality issues (e.g. induction training referring to diversity & equality, handbook, talks, dignity at work, trust in care policies, bully & harassment policies) Culture days and celebrations, or diversity celebration weeks Policy of recruitment, retention and promotion of ethno-culturally diverse staff Diversity and Equality policy Consultation with staff and patients on intercultural health care (Patient involvement, patient councils, forums, diversity committees, MEC advocacy groups)
Equality framework including culture proof of document templates for equality proofing, service planning and delivery
Equality auditing / Review (equality impact assessments) Staff aware of legal entitlements and requirements regarding equality (handbook or circulars on the 9 grounds of discrimination) Diversity benchmarking Seek advice externally from organisations such as IBEC or Cairde Recruiters trained to eliminate discrimination & recruit in a manner that eliminates discrimination and promotes equality MF efforts, diversity and equality linked explicitly to quality or accreditation standards Code of practice for anti discrimination practices and policies for how to handle discrimination e.g. trust in care, dignity at work, bullying and harassment policies Grievance & complaints procedures for staff and patients e.g. trust in care, dignity at work, bullying and harassment policies Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate, identify and report disparities related to diversity or equality

A tiered approach to intercultural training (systematic and ongoing)
Level 1: orientation training (with equality and cultural diversity element) or included in induction training or dignity at work training Level 2: cultural awareness training e.g. diversity committee Level 3: training for specific professionals e.g. ethnic identifier monitoring training for administrative staff, bereavement training for midwifes or recruitment and selection training related to equality and diversity Level 5: multicultural team training Level 6: legal & business case training Diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers Train the trainer programmes 3rd level schooling with intercultural modules integrated (e.g. student nurses and social workers undertaking 3rd level diplomas) Multidisciplinary training Online options for intercultural training
Workplace support structures to support staff to manage issues relating to cultural diversity
Website or links specific to diversity or cultural competence in health care Conflict resolution procedures for patients and staff including bullying and harassment, grievance procedures with anti-racism / equality reference e.g. dignity at work policies and trust in care policies Anti-discrimination guides, policies & practices e.g. leaflets on what to do if staff or patients see racism, dignity at work policies and trust in care policies
Development of initiatives to integrate and manage multicultural teams
Multicultural team training for all staff Career development programmes for overseas staff Buddy and mentor system for all incoming staff including non-Irish Overseas nurse coordinator Preparation work with existing staff
Training method to include co-facilitation by members of MECs
Does the hospital make resources available to MECs (staff members or advocacy groups) to build their capacity to design, deliver and evaluate training

5.7 Comparison of the results with the theoretical framework of Gardenswartz and Rowe (1998)

In assessing the added value that this research may contribute from a theoretical perspective, we must first compare the results of the implementation of the WOA approach in the 6 Irish hospitals to a chosen theoretical framework related to managing cultural diversity in organisations. For the purposes of this research, Gardenswartz and Rowe's (1998), theoretical framework was selected as it supports the WOA framework and is specific to the healthcare sector. This framework will be analysed in relation to the results of the empirical research in Irish hospitals using the WOA framework. In doing so, the objective is to compare the theory as proposed by Gardenswartz and Rowe to the reality of the Irish health sector in the context of hospital settings. By comparing the theory in use against the reality in practice

in the Irish experience, this research conforms with the theory and highlights which elements and practices are most emphasised in reality and which are not.

Gardenswart's and Rowe's framework propose 7 steps in the process of capitalising on diversity as part of an overall strategy in health care. These steps are referred to in table 5.19 numbered 1 to 7 and are explained in chapter 3. The 93 parameters of the WOA were positioned in the 7 steps of Gardenswart and Rowe's framework, according to their pertinence to each of the 7 steps. Table 5.19 illustrates the parameters chosen for each step and indicates their origins with regard to the WOA framework. For example, step 1 in Gardenswart's and Rowe's framework namely "Get commitment from the Top" corresponds to a selection of 8 parameters from 3 sub-elements of the WOA.

Table 5.19 : Gardenswartz and Rowe (1998) : 7 step strategic change process to capitalize on diversity

Gardenswartz & Rowe's 7 Steps	WOA Parameters (P)
Step 1 **Get commitment from the top**	**Specific initiatives that demonstrate the commitment and support of managers (1 strand 1):** - Mission statement (P1) - Strategic plan (P2) - Financial resources (P4) - MF networks and think tanks (P6) - Accountability for all staff to behave in line with equality policy (P7) - Publications about diversity (P9) **Up-to-date intercultural policy for health services (2 strand 1):** - Writing about diversity issues in newsletters (P7) **Equality framework including cultural proof of document templates for equality proofing, service planning and delivery (3 stand 1)** - Staff aware of legal equality entitlements and requirements (P4)
Step 2 **Assess and diagnose**	**Equality framework including cultural proof of document templates for equality proofing, service planning and delivery (3 strand 1):** - Cultural proofing of documentation (P1) - Equality / cultural proofing of service provision (P3) - Diversity benchmarking (P5) - Seek advice externally from organisations (P6) **Ethnic monitoring systems including an agreed framework for data collection and usage (4 strand 1):** - Ethnicity (P1) - Language (P2) - Beliefs (P3) - Race (P4)

Step 3 **Create a diversity task force**	**Specific initiatives that demonstrate the commitment and support of managers (1 strand 1):** - Diversity committees (P3) - Project leader diversity champion (P5)
Step 4 **Systems changes & Problem solve systemic issues**	**Up-to-date intercultural policy for health services (2 strand 1)** - Clarify expectations of staff (P1) - Bereavement policy (P2) - Adapted diets (P3) - Interfaith policies (P4) - Culture days (P5) - Interpretation policy (P6) - Recruitment and retention (P8) - Diversity and equality policy (P9) - Consultation with staff and patients (P10) - Use of cultural mediators (P11) **Equality framework including cultural proof of document templates for equality proofing, service planning and delivery (3 stand 1)** - Code of practice for anti discrimination (P10) - Grievance and complaint procedures (P11) - Risk management for diversity incidents (P12) **Workplace support structures to support staff to manage issues relating to cultural diversity (6 strand 2)** - Intercultural health guide (P1) - Bereavement guide (P2) - Multi-denominational chaplaincy services (P3) - Language guides (P4) - Picture cards (P5) - Website links to diversity (P6) - Interpretation policy (P7) - MF staff contact list (P9) - Conflict resolution procedures for patients and staff (P10) - Anti-discrimination guides and policies (P11) **Development of initiatives to integrate and manage multicultural teams (7 strand 2)** - Career development programmes for overseas staff (P2) - Overseas nurse coordinator (P4) **Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system (9 strand 3)** - Cultural mediators (P4) - External marketing (P5) - Website explaining practices of national hospital/health system (P7) **Signage particularly in reception and public areas in key languages of service users (10 strand 3)** - Signage in key areas translated (P1) - Posters to promote intercultural health care (P2) - Visual orientation systems (P3) **Literature in key languages of service users (11 strand 3)** - Health literature in key languages (P1)

	- Culturally appropriate documentation (P2) - Websites translated (P3) **Comprehensive interpretation service (12 strand 3)** - Accessible to all staff (P1) - Publish right to access to interpretation service (P2) - Access to interpretation service by telephone (P3) - Access to face to face interpretation service (P4) - 24/7 interpretation service (P5) - Ensure all staff is aware of the service (P6) - Ensure all staff is trained to use interpreters (P7) - Ensure a written interpretation policy (P8) - Guidelines for staff on how to access and use interpretation service (P9) - Use of hospital staff who speak more than one language (P10)
Step 5 **Train to address awareness knowledge and skill needs**	**Equality framework including cultural proof of document templates for equality proofing, service planning and delivery (3 stand 1)** - Recruiters trained to eliminate discrimination (P7) **A tiered approach to intercultural training (5 strand 2)** - Level 1: Orientation training (P1) - Level 2: Cultural awareness training (P2) - Level 3: Training for specific professionals (P3) - Level 4: Intercultural dialogue training (P4) - Level 5: Multicultural team training (P5) - Level 6: Legal and business case training (P6) - Cultural awareness developed in consultation with members of MECs (P7) - Mandatory diversity training for all staff (P8) - 3rd level schooling with intercultural models (P10) - Training on major ethnic groups (P11) - Multidisciplinary training (P12) - Online options for intercultural training (P13) **Development of initiatives to integrate and manage multicultural teams (7 strand 2)** - Multicultural team training for all staff (P1) - Intercultural preparation work with existing staff (P5) **Training method to include co-facilitation by members of MECs (8 strand 2)** - Use members of MECs to co-facilitate intercultural training (P1) - Resources made available to members of MECs to design training (P2)
Step 6 **Measure and evaluate**	**Specific initiatives that demonstrate the commitment and support of managers (1 strand 1)** - Performance management systems (P8) **Equality framework including cultural proof of document templates for equality proofing, service planning and delivery (3 stand 1)** - Need to evaluate patient and community outcomes (P8) - MF efforts diversity and equality linked to quality or accreditation standards (P9) - Equality auditing and impact assessments (P2)

Step 7 **Follow up / Integration**	**Ethnic monitoring systems including an agreed framework for data collection and usage (4 strand 1):** - Use information to inform services (P5) **A tiered approach to intercultural training (5 strand 2)** - Train the trainer programmes (P9) - Staff attend conferences related to diversity (P14) **Workplace support structures to support staff to manage issues relating to cultural diversity (6 strand 2)** - Staff meetings referring to cultural issues (P8) - Cultural mediators (P12) **Development of initiatives to integrate and manage multicultural teams (7 strand 2)** - Buddy and mentor systems (P3) **Information and awareness for minority ethnic service users on the processes and practices of the Irish healthcare system (9 strand 3)** - Links with MEC advocacy groups (P1) - Members of MECs on patient involvement committees (P2) - Outreach information programmes (P3) - MF open house (P6)

The results obtained in the empirical study were transferred into the 7 step framework. Evaluations for each step were calculated by multiplying the number of parameters for the step by the number of hospitals to establish a total amount of points to evaluate against. (E.g. step 1 has 8 parameters multiplied by 6 hospitals = 48 points).This provided a total score to evaluate the overall scores of the 6 hospitals for each step of Gardenswartz and Rowe's process. Table 5.20 illustrates the results.

Table 5.20: Results of transfer of data into Gardenswartz and Rowe's 7 step process

Gardenswartz and Rowe's 7 steps	Score for 6 hospitals	% implementation
Step 1: Get commitment from the top	43/48	89.5%
Step 2: Assess and diagnose	37/48	77%
Step 3: Create a diversity task force	9/12	75%
Step 4: Systems changes / Problem solve systemic issues	207/264	78%

Step 5: Train to address awareness, knowledge and skill needs	51/102	50%
Step 6: Measure and evaluate	8/24	33%
Step 7: Follow up / Integration	36/60	60%

The results convey that the 7 steps of the process are implemented to different variations in the Irish hospitals sampled. Step 1, “Get commitment from top” is the most implemented, step 4, “Systems Changes problem solve systematic issues” and step 3 “Create a diversity task force” are the most implemented. These are followed by step 2, “Assess and diagnose”, and step 7 “Follow up / integration”. However, step 5 “Train to address awareness knowledge and skill” and step 6, “Measure and evaluate” are considerably less implemented. The result highlights lower scores of 50% for step 5 (Train to address awareness, knowledge and skill needs) and 33% for step 6 (Measure and evaluate) and conforms to the Irish WOA results. The Irish approach to managing ethno-cultural differences in healthcare delivery seems to have overlooked the importance of step 6 in the 7 step process.

Thus it is apparent that the areas of intercultural training and the measurement and evaluation of diversity inputs require improvement across the hospitals. These important domains are the least implemented in Irish hospitals in the context of Gardenswartz and Rowe’s process framework. The analysis of the 6 hospitals using the WOA showed the same trend and lead to the same conclusion. For example results show that Irish hospitals are less advanced in measuring and evaluating individual and organisational performances with regard to diversity initiatives. All 6 hospitals scored negatively in relation to parameter regarding performance appraisal systems from an individual and organisational perspective. Also evaluating patient and community outcomes is not well implemented with only 3 hospitals taking initiatives in feedback exercises with MEC patients. Practically none of the 6 hospitals link patient satisfaction surveys to cultural competence, diversity or migrant friendliness and none conduct equality auditing or equality impact assessments. From a training perspective the research findings indicate that a tiered approach to intercultural training is not systematic, ongoing or mandatory for staff and that none of the hospitals have conducted multicultural team training.

As an aside, it is of managerial interest that by merging the 93 parameters of the WOA into Gardenswartz and Rowe’s framework, this provides a step by step process with an enlarged

inventory of accompanying indicators to help hospital management in the future, implement appropriate (step by step) policies to manage ethno-cultural differences in health care.

5.8 The Irish approach to managing diversity in hospitals

This study has examined the Irish experience of how hospitals have managed ethno-cultural differences in healthcare service delivery. While not the central focus of this study it is of interest to describe the Irish approach to managing diversity in hospitals from the broader perspective of noted scholars in the field of diversity management in organisations.

5.8.1 Irish hospitals: reactive or proactive in managing ethno-cultural differences

Kandola and Fullerton's (1998) defined the differences between equality reactive and diversity proactive organisations (see chapter 2). In this context we can arbitrarily assess the 6 hospitals' overall efforts to managing diversity by positioning each hospital based on whether they are reactive to equal opportunity legislation or proactive being more internally driven in the management of diversity. If we generalise by assuming that Strand 1 of the WOA is linked to equality frameworks including adhering to equality legislation, and Strand 2 and Strand 3 represent initiatives that go beyond adherence to externally driven moral and legal arguments, such as intercultural training, translation of literature or interpretation services, we can arbitrarily assess the 6 Irish hospitals efforts. It can be argued arbitrarily that all the Irish hospitals have reacted to equality driven legislation scoring their highest scores in Strand 1. However H1, H3, H4, H5, could be described as being more proactive and going beyond equality and managing diversity based on their strand scores for Strand 2 and Strand 3.

5.8.2 Characterising diversity management organisational approaches in Irish hospitals

The approaches to diversity management of the 6 hospitals can be arbitrarily and summarily assessed using the classification frameworks proposed by Cox (1993), Baytos (1995) and Dass and Parker (1999) to characterise diversity management organisational approaches. These frameworks are discussed in detail in chapter 2.

With regard to Cox's 3 category typology, table 5.21 illustrates that all the hospitals could be arbitrarily categorised as having an inclusive multicultural approach, which values inclusion and fairness and views diversity as an asset.

Table 5.21 : Cox's typology 1993

Cox's typology 1993	Monolithic	Plural	Inclusive multicultural
Position of hospital			H1, H2, H3, H4, H5, H6

Likewise, table 5.22 indicates that the majority of hospitals are action oriented according to Bathos's classification having developed initiatives such as diversity committees, or diversity celebration days etc. H3 and H4 could be described as seeking leadership position with the former, being widely referred to as a benchmark hospital in managing ethno-cultural diversity in the Irish sector. H2 could be arbitrarily classified as timid in its approach.

Table 5.22 : Baytos 1995 classification

Baytos 1995 classification	Unaware	Timid or preoccupied	Action Oriented	Seeking a leadership position
Position of hospital		H2	H1, H5, H6	H3, H4

Finally table 5.23 demonstrates that the majority of the sampled hospitals have introduced responsibilities for diversity to management, and are strategic oriented in responding to diversity issues and can be thus arbitrarily classified as having made systemic efforts according to Dass and Parker's (1999) contribution.

Table 5.23: Dass & Parker 1999

Dass & Parker 1999	Episodic	Freestanding	Systemic
Position of hospital		H2	H1, H3, H4, H5, H6

5.9 Chapter summary

The goal of this chapter was to interpret the results of the implementation of the WOA from both an individual hospital perspective (vertical analysis) and from a strand perspective (horizontal analysis) and understand what are the factors that have facilitated or constrained the implementation of the WOA within the Irish health sector.

With regard to the vertical strand analysis, we have classified the 6 hospitals and established 7 characteristics that influence the implementation of the WOA. Moreover, an analysis of the influence of each characteristic is discussed in each hospital and a subsequent comparative analysis of the hospitals is considered. The horizontal strand analysis explains the reasons why the strands are implemented to different extents and demonstrates where the priority lies with regard to strand implementation. This section also served to explain why certain parameters have been more implemented than others. However, those common parameters across the 6 hospitals that have not been implemented are discussed and reasons for their non-implementation have been highlighted.

A section was set aside to discuss observations of the findings with regard to the future implementation of the WOA in new contexts. The parameters were positioned into a hierarchy of importance based on the contextual needs of individual hospitals and depending on the size of the minority ethnic communities being served.

This chapter is beneficial in that it serves hospital management in the 6 hospitals by offering suggestions for each hospital on what initiatives need to be introduced and developed with regard to a more comprehensive implementation of the WOA. The results of the implementation of the WOA framework are compared against the theoretical framework of Gardenswartz and Rowe (1998). The findings conform to their framework and confirm those areas that the Irish hospitals need to ameliorate in terms of implementation of actions and initiatives.

Finally the Irish health sector's responses to diversity management and cultural competent care are broadly and non-scientifically described in the context of the academic research in these subject areas. They indicate a generally progressive reaction from the Irish health sector to providing culturally appropriate healthcare.

Chapter 6

Conclusion

6. Conclusion

This chapter presents the general conclusions of the research and begins with an overview of the goals and key steps of the study. It then summarises the key findings of the research with regard to the implementation of the WOA in individual hospitals and from a strand analysis and proceeds to organise the main contributions of the research into three categories. The first category outlines the managerial implications and recommendations that can be drawn from the study. The second category highlights the methodological contributions of this research and its implications for future research in this area and aligns with the third category which summarises the theoretical implications of the study. In addition, this chapter reserves a space to address the limitation factors of the research which constrained and restricted the scope of the research. Finally, a section is reserved to address and recommend those areas related to the subject matter that merit subsequent future investigation and would further contribute to the field of healthcare management.

6.1 Overview

This research has explained the Irish experience of managing ethno-cultural differences in healthcare service delivery in hospital settings. The objective of this study was to provide a deeper understanding of how service providers (hospitals) manage ethno-cultural differences when providing healthcare service delivery to ethno-culturally different service users in an Irish context of rapid demographic change. To answer this question we examined the various models in the literature and those proposed by international institutions to find that the principal solution for organisations is to implement an organisational wide approach, as proposed by scholars such as Cross et al. (1989) and LaVeist et al. (2008). In examining how the Irish health system has, in a comparatively short period of time, had to manage ethno-cultural differences in healthcare service delivery, the Irish WOA approach was identified and explained.

This research identified that the WOA is an appropriate framework and has endeavoured to investigate to what extent it has been implemented in Irish hospitals. By using this framework as the basis of analysis it was decided to investigate how Irish hospitals were managing ethno-cultural differences in healthcare service delivery and to what extent the WOA was being implemented. An analysis was carried out at two levels, firstly, to see how selected

individual hospitals were implementing the WOA framework, and secondly, how each of the three strands of the WOA were being implemented across these hospitals. The research findings have identified the system changes and development initiatives that have taken place in Irish hospitals with regard to managing ethno-cultural differences in patient care.

6.2 Summary of the implementation of the WOA in individual hospitals

The research indicated that hospitals are implementing the WOA at different speeds depending on the contextual needs of the hospital including a series of specific factors. These factors include critical variables such as the levels of ethno-cultural differences in service user population, the function of the hospital, the role of diversity champions and the existence of proactive diversity task forces which are fundamental drivers for successful policy implementation. It is noteworthy that the two hospitals with the highest scores for implementing the WOA were a maternity and a children's hospital that provided healthcare delivery to multiethnic communities and were led by diversity champions and effective diversity committees. However, most notably, it is the reduction in financial and human resources as a direct result of the negative impact of the Irish economic crisis on the health sector that has had the greatest influence on the application of the WOA. These are some of the variables that have all been found to influence the extent to which the WOA has been implemented in Irish hospitals. Thus it is evident that an imposed WOA framework does not necessarily meet the reality of different hospitals and is limited to the often complex realities of individual hospitals and indeed the wider economic context.

6.3 Summary of the implementation of the WOA across the 3 strands of the WOA

The research findings regarding the implementation of the 3 strands of the WOA across the 6 hospitals indicate clearly that Strand 1, Organisational Ethos is the most implemented with approximately 87% of the strand implemented followed by Strand 2, Workplace Environment 69% and finally Strand 3, Support to Intercultural Training at 65%. Therefore, the findings indicate to us that even though the NIHS consisting of the WOA approach is a top down imposed national approach, that compliance has been implemented differently. Different

strands of the framework are more advanced than others and that top down does not necessarily mean an equal implementation of each strand.

6.3.1 Strand 1: Organizational Ethos

The 6 hospitals were relatively advanced in all aspects which may reflect compliance to national equality legislation and anti-racism guidelines. It can be inferred that Strand 1 is considered the highest priority strand as it involves parameters such as recruitment policies, which led to a push-pull policy of recruiting international healthcare professionals during the labour shortage in the “Celtic Tiger” economy. Also this strand relates to equality frameworks which are heavily influenced by hospital management following their statutory responsibilities vis-à-vis, Irish equality and anti-discrimination legislation in 2000 and 2004. It is feasible that the topic of immigration in the context of a new multicultural Ireland and recruiting internationally was the hot topic at the time and creating an appropriate culture and ethos was the management trend of the day. There is a critical absence of measuring and evaluating machinery in place to evaluate individual and organisational performance outputs with regard to provision of culturally competent care.

6.3.2 Strand 2: Workplace Environment

Strand 2 and Strand 3 are less implemented primarily due to current inadequate budgets and financial resources. The WOA approach and indeed the NIHS were developed when Ireland was still experiencing an economic boom and there was adequate funding, locally and nationally, in health care. Hospitals like H1, and H5 had initial intercultural training programs in place funded by the HSE which have since be discontinued due to inadequate budgets. Equally, the HSE moratorium on recruitment coupled with recent voluntary redundancy programmes have led to labour shortages in the frontline staff. This in turn as previously mentioned in chapter 5, has reduced staff available to attend training programmes including intercultural training. Considering the importance of intercultural training and cultural competency in the delivery of quality healthcare services to members of MECs, the results clearly indicate that hospitals are not undertaking adequate intercultural training.

6.3.3 Strand 3: Support to intercultural training

Evidence indicates awareness of the importance of interpretation services in hospitals which is a critical element for providing culturally appropriate health care. However, there is a need for the provision of translated signage in public areas and the use of translated websites in

the key languages of service users.These constraints are affected by inadequate budgets and financial cut backs and it can be inferred that they are less of a priority in the current economic context.

6.4 Managerial contributions, implications and recommendations

This research contributes to the management of ethno-cultural differences in Irish hospitals in several ways. Firstly the research serves as a new means for the HSE and individual hospital management to classify, compare and contrast individual hospital efforts concerning the implementation of the WOA framework. Secondly, the research identifies the strengths and weaknesses of each healthcare organisation and explains the reasons for the varying levels of implementation in each hospital. Specific areas/parameters of the framework that are not implemented in the 6 hospitals are highlighted and those that are partially implemented but need amelioration are addressed. Thirdly, the research findings indicate those elements that influence the implementation of a top down national framework policy in 6 hospitals. 7 key factors that influence the promotion of the implementation of the WOA framework in hospitals are identified. Fourthly, the 93 parameters that were used to test the WOA in this study serve present and future healthcare managers as a framework of best practices that can be used to manage ethno-cultural differences in healthcare service delivery in healthcare settings. Furthermore, managers can determine which parameters are most appropriate and of higher priority depending on the contextual needs of the hospital, thanks to the those observations of the research findings that categorise the 93 parameters into those related to service user and service provider ethno-cultural differences. Finally, this study provides general recommendations for the Irish health sector and for each hospital to improve the management of ethno-cultural differences in healthcare service delivery. Specific areas of the WOA that require improvement or implementation are identified and presented for each hospital. Also, potential challenges that emerged from the findings such as succession planning and integration of multicultural teams that hospital management risk to encounter in the future are addressed.

6.4.1 General recommendations for hospital managers

This research has provided recommendations to each individual hospital with regard to advancing the implementation of the specific elements of the WOA. In general these recommendations address those critical areas, or parameters of the WOA, that have not been sufficiently implemented or simply not implemented at all. An examination of the most

common ‘non-implemented’ parameters of the WOA identifies critical areas such as measurement and evaluation, and intercultural training as areas that need to be improved.

Therefore one recommendation for Irish hospital management is to address inadequate measurement and evaluation of diversity and cultural competent care outputs and performance management. The reasons for this lack of measurement are threefold and include the fact that cultural competent care is not an important part of accreditation, it is beneficial to have but not a requirement. Secondly, there is a (relaxed) culture of measuring and evaluating diversity and cultural competent efforts in Irish hospitals and thirdly, there is an over reliance of Irish hospitals on anecdotal evidence to assess outcomes of their initiatives to manage of ethno-cultural differences. Quantitative and qualitative measurement and evaluation methods need to be strengthened or put in place to evaluate returns on investment and improvements that are a result of implementing the WOA approach. The reality is that more scientific economic measures of return on investments are required and less dependence on anecdotal idealism. Irish hospitals need to move away from idealistic anecdotal measurements and evaluation practices to more economic driven, hard data analysis of outcomes and change effects. This will demonstrate the added value and return on investment of diversity management inputs and provision of culturally competent care. In the competitive environment of securing funding within hospital management, hard data analysis around productivity, efficiency and effectiveness will enhance and prioritise the provision of culturally competent health care in hospitals.

A second recommendation relates to the area of intercultural training. The findings indicate that Irish hospitals need to invest in more systematic, mandatory, cost effective, on-going intercultural training and particularly in the field of multicultural team training. The current intercultural training levels are inadequate but there is scope for improvement across the 6 hospitals. A tiered approach should be mandatory for all members and grades of staff and the introduction of multicultural team training is necessary given the significant composition of ethno-culturally diverse employees in Irish healthcare workplaces. Furthermore, management in the context of an economic crisis will have to develop new innovative methods to conduct training through online platforms and e-learning. The following issues emerging from the interviews offer effective methods to facilitate the implementation of intercultural training in the current Irish economic context. These include the increased use of ‘train the trainer’ programmes in the field of intercultural training where internal staff who have been sufficiently trained in cultural competent health care can deliver the training during shift breaks in the hospital wards (see H3). Also, the increase use of lunch time training and

talks on intercultural healthcare issues (see H3 and H5). Finally, the absence of sufficient budgets to provide intercultural training, renders it necessary to ensure that all discipline training programmes include aspects of intercultural training into their programmes (see H4 and H6).The areas of measurement and evaluation and professional development and training are vital in the long term success of the management of ethno-cultural differences in Irish healthcare service delivery.

A third recommendation refers to several measures that hospitals should endeavour to improve in areas such as the usage of cultural mediators or the introduction of translated signage and website translation in the key languages of service users. These areas are more conditional on cost-benefit analysis and are more reliant on the contextual needs of individual hospitals.

A fourth recommendation for hospital management to better manage ethno-cultural differences in healthcare service delivery is the importance of the cultivation of diversity champions to direct diversity task committees and lead the diversity agenda. The findings indicate that some hospitals are effective in this area such as H3. The findings also indicate that those hospitals that have active, focused, stand alone diversity committees that are multiethnic, multidisciplinary, policy driven, and are led ideally by a champion who is, or associated with senior management in the HR department, perform the best in managing ethno-cultural differences in healthcare delivery.

6.4.2 Potential managerial problems emerging from the findings

Two potential challenges that hospital management risk to encounter, emerged from the research findings and interview data. These problems are related to the significant influx of non-Irish nationals into the Irish health system. These problems are twofold and include firstly career and succession planning issues and secondly difficulties in multicultural teams.

6.4.2.1 Career and succession planning

The research indicated potential problems in hospital management as a result of recruitment of non-Irish nationals into the health system. For example, there is evidence in H2, H5 and H6 that non-Irish nationals are more hesitant to apply for promotion and career development due to financial and cultural factors. This may lead to succession planning problems in the Irish health system in the future. It is thus recommended that hospitals address the issues in

the short term to avoid middle and long term gaps in middle and senior management in the future.

6.4.2.2 Multicultural team problems and tensions

There is evidence based on the respondents in H1, H2, and H6 that there are tensions between Irish and non-Irish nationals working together in certain areas of the hospital. Given the absence of multicultural team training and the urgent and stressful nature of working teams in hospital settings, this may lead to morale and performance difficulties. Findings demonstrated the conflict and tensions and perceived challenges of managing and participating in multicultural work teams in Irish hospitals. These problems can lead to inefficient and underperforming performance outcomes in team based environments (Adler 1991). It is recommended that hospitals refrain from minimizing and underplaying the problem and take proactive actions to assess tensions on the hospital floor and put in place the necessary professional education and training.

6.4.3 The factors that constrain the implementation of the WOA approach framework

The implementation of the WOA is not optimal in the Irish healthcare sector. In analysing some of the main reasons for this, this study highlights the influence of 7 key factors. Some of these factors are fixed, unchangeable, and less manageable form the point of view of managing ethno-cultural differences in healthcare delivery and implementing the WOA. For example the location, function and size of the hospital all influence and can constrain the extent of the implementation of the WOA and these areas can not be adapted easily. Also the population of the service users from ethnic minority backgrounds is not under the control of management or even the extent of workforce diversity is less flexible than other factors. The factors which are more controllable are the existence of diversity champions and task committees, links to migrant friendly projects with the HSE, and the utilisation of resources to fund diversity initiatives. The findings suggest that the absence of any of these factors can constrain the implementation of the WOA. The 2 least performing hospitals in the context of this study did not have a strong tradition of established links with the HSE regarding MF health care.

In the case of this research the findings indicate that one of the primary reasons for the implementation of the WOA not being optimal was due to the unprecedented economic crisis that Ireland has experienced since 2008 and its limiting effect on resources available to hospitals. This crisis has effected hospital management and resulted in reduced financial

resources across the health sector. This has lead to sharp budgets restraints effecting key elements of the WOA such as provision of training. Furthermore, a mandatory recruitment moratorium, and national redundancy initiatives targeted in the health sector have resulted in staff shortages, lending to a reduction in access to training.

Also in the context of economic decline the notion that immigrants are returning home and leaving an economically crippled Ireland could perhaps leave a 'why bother' attitude towards the provision of migrant friendly care.

The economic crisis has led to priorities changing due to budget reductions and the danger that hospital management are focusing only on their statutory responsibilities towards equality and health care is emerging. There are no specific budgets set aside for diversity with the exception of interpretation services, and there are no formal diversity departments or diversity managers.

6.5 Methodological contributions, implications and recommendations

6.5.1 The Irish WOA

This research project involved a review of the academic and professional literature to explore how health systems were managing ethno-cultural differences and particularly in the context of hospital settings. The literature revealed that the objective of hospitals in providing migrant friendly health care and managing ethno-cultural differences in service users was to provide culturally competent care at an individual and organisation level. This involves using an organisation wide approach incorporating intercultural training at an individual level and appropriate systems and policies at the organisational level. The search in the literature of international institutional approaches presented a series of, declarations, questionnaires, standards, and guidelines to promote MF health care, equity and culturally competent health care delivery. The Irish health sector authorities developed their own approach entitled the "Whole Organisation Approach" which is an organisational wide approach to managing ethno-cultural differences in healthcare settings. However, this framework distinguishes itself from other international approaches as it proposes a specific framework consisting of three strands and 12 sub-elements and not lists of standards, guidelines or questions. The WOA has evolved from its original form at the beginning of this study and has become a more complex framework involving two evolutions as illustrated in figure 6.1.

Figure 6.1: Evolution of the WOA framework through the course of this study

6.5.2 Evolution 1

Having assessed the WOA framework and the associated recommendations proposed by the HSE through the research of Thrive Consulting in 2005, it was considered by the author that the WOA is a good basis but was synthetic and needed to evolve to become a new framework for Irish hospitals that is more complex, is contextualised to the national legal environment and less generic. This is often the case that academic models and frameworks can be limited and lack context, and need adaptation and more accuracy. Most parts are universal and generic but some parts need to be contextualised to the local realities. There is no absolute model and no "one size fits all" framework. As referred to in chapter 3 the research methodology utilised in this research consisted of a meta analysis of the various international approaches to managing ethno-cultural differences in health care. Each sub-element and corresponding recommendations of the WOA as proposed by the HSE (Thrive Consulting 2005) were examined and additional parameters were added and drawn from 6 other international institutional approaches to supplement the WOA (see chapter 3). Parameters were chosen based on a synthetic approach identifying common elements. The 93 parameters were assembled and positioned in these sub-elements with 37 in Strand 1, 33 in Strand 2 and 23 in Strand 3, in order to assess to what extent the WOA was being implemented in Irish hospitals. Critical measurement and evaluation parameters were included. In constructing the 93 parameters, contextual considerations were taken into

account referring to the legal environment in the Irish health sector. For example the recommendation from the CLAS standards to recruit ethno-culturally diverse staff who are representative of the demographic of the characteristics of the service user population, often referred to as “mirror imaging” was not included as a parameter in the WOA. This was because Irish equality legislation prohibits targeting employee candidates based on their ethnic profiles. So by combining international approaches and supplementing the information with the Irish WOA approach, a more comprehensive and complete framework was developed. This became a more complete method to analyse the efforts made by individual hospital management for the purpose of managing ethno-cultural differences in healthcare service delivery.

6.5.3 Evolution 2

A second evolution of the WOA approach is that the 93 parameters can be organised depending on the contextual need of each individual hospital. These 93 parameters can be divided into 40 parameters which are related to the management of service provider diversity and 53 that are more geared to service user ethno-cultural diversity. The 53 parameters can be further sub-divided into two categories and their implementation be prioritised. Category 1 consists of 21 parameters which can be considered fundamental for every hospital that serves ethno-culturally diverse service users. The second category consists of 32 parameters that are more sensitive to the extent and size of the service user community that a hospital serves. This serves to indicate to hospital management where to start in terms of implementing initiatives to manage ethno-cultural differences in healthcare service delivery.

6.5.4 Recommendation

It is recommended that healthcare managers and researchers incorporate this more comprehensive WOA used in this study, consisting of 93 parameters aligned to the 12 sub-elements and 3 strands of the WOA. In practice it could serve as a complete and contextualised best practice organisational framework for management in Irish hospitals and healthcare settings. It is recommended that a more explicit emphasis on measurement and evaluation beyond equality legislation in the context of the Irish accreditation and legal environment be added to the WOA. The accreditation culture in Ireland at the time of this study was not as advanced as other countries such as the USA.

6.6 Theoretical considerations

This research contributes to the academic literature by firstly conforming to the contents of Gardenswartz and Rowe's framework in maximising cultural diversity in organisations and fostering anti-racism, equality and interculturalism. The results indicate that the management in hospitals in Ireland have implemented to varying extents the steps in Gardenswartz and Rowe's process framework. Thus the research contributes by confirming the contents proposed by them. Secondly, the research findings illustrate that in the sample of hospitals selected for this study, certain components and steps in both frameworks (WOA and Gardenswartz and Rowe) are consistently more implemented than others. For example, Gardenswartz and Rowe's framework emphasize the need for leadership and commitment from the top, which corresponds to and is confirmed by the results in Irish hospitals which show that the majority of the hospitals are advanced in this aspect. Alternatively, components and steps relating to measurement and evaluation, and intercultural training portrayed in Gardenswartz and Rowe's framework are less implemented in Irish hospitals according to research findings.

6.7 Limits and constraints of the study

All research projects are limited and are subject to constraints and restrictions. This research is no different and these limitations are addressed accordingly. One limitation is the fact that no patients were surveyed regarding their experiences in the hospitals in the course of this research project. Thus the research could not test the quality of the healthcare service delivery in the context of culturally appropriate care. This is due to the difficulty to access patients or patient data in Irish hospitals. Such data is extremely limited to specific biological and medical research and there is a reluctance on the part of hospital management to release the names and contact details of current or past patients as it is considered sensitive information. The process of applying for permission to research in hospitals in Ireland frequently involves application for permission and attendance at ethical committees as previously explained in chapter 3. This is a lengthy and costly process and the researcher was advised by healthcare administrators, that research which focuses on patient surveys for non-biological and medical research is frequently refused. This was particularly frustrating as none of the hospitals factored culturally appropriate healthcare indicators in their patient satisfaction surveys and consequently there was no way to assess patient satisfaction levels. This limitation opens the door for future research to correlate the quality of service provision

and patient satisfaction levels in the context of managing ethno-cultural differences in healthcare delivery in Ireland.

This study also has geographical limitations as it focuses on hospitals in the capital city of the Republic of Ireland and not in other cities or regions. Therefore the findings are limited to the main population area of Ireland and therefore are less representative of other diverse regions around the island. The research was limited to Dublin due to the fact that the geographic distribution of immigrants indicates that the majority of non-Irish nationals live in urban areas with 76% of non-Irish nationals living in urban areas and 42.7 % living in cities and suburbs (Non-Irish nationals living in Ireland, Census 2006). Also as the costs of travel and lodgement were considerable, this limited the opportunities to access hospitals in other regions.

It is important to note that both the NIHS and WOA framework are not specific to the hospital sector alone and cater to primary care and other health sectors such as asylum seekers health, community nursing, therapeutic services, general practitioners or graduate education. This research leans on a sample of 5 voluntary hospitals and 1 public hospital from the acute hospital sector. It does not take into account other hospital settings even though the challenge of managing ethno-cultural differences is equally relevant in all healthcare settings. These other sectors could be the subject of future research upon completion of this project.

A further limitation of the research is that interviews were undertaken with 93 healthcare personnel who perhaps not all may have been completely knowledgeable of all the key initiatives that their hospital had put in place in order to better service ethnic minority community members. Moreover, certain respondents may not have been able to recall the specific policies and procedures that were put in place for each element of the WOA at the time of questioning. Also observer bias such as two people seeing the same thing differently is common in research of any nature. An attempt was made to minimize the effects of these constraints by conducting interviews with between 12 and 18 employees in each hospital who had at least one years experience and knowledge of the policies and systems of the hospital.

Efforts were made to invite non-Irish national participants from different ethnic origins including Asian, Filipino, Indian, African, Eastern European, Pakistani etc. It was noted on occasion that certain respondents from Asia were very hesitant to speak in what they

perceived as a negative manner towards the hospital and their employer. Some were very conscientious of not portraying themselves as being negative towards their employer or fellow employees. The fact that the researcher was Irish but working and living in France for over a decade may have contributed to minimizing this effect. This is because respondents did not see the interviewer as being typically Irish, or part of the established status-quo, but rather one who could understand what it means to be a non-national working and living in a foreign country and culture and were thus, more willing to exchange.

Finally, the recruitment moratorium that was imposed by the Irish government in public services was in place during the time of the data collection. This limited the time and availability of personnel, particularly frontline medical employees such as Doctors, to participate in this research as they had difficulty being replaced on the wards. This resulted in a restricted number of medical doctors being interviewed in this research.

6.8 Recommendations for future research

At the beginning of this research journey, the original research proposal was to investigate how hospitals in Ireland were managing the ethno-cultural differences of their newly recruited multicultural workforces from a human resource management perspective. This objective was abandoned following preliminary research indicating that ethno-cultural differences in service users were deemed more problematic by the majority of the 9 healthcare associated bodies interviewed. However, the research findings and frequent interview testimonials indicate that “tensions” and “unpleasantries” exist between non-Irish and Irish national employees in the workplace. This is particularly relevant as none of the hospitals in this study conducted multicultural team training. In addition, there is a lack of academic research on multicultural team performances in the Irish healthcare context which is surprising given the large influx of overseas Filipino and Indian nurses that entered the healthcare system during the economic boom period in Ireland. It is for these reasons that upon completing this research a recommendation can be made to study and evaluate multicultural team performances and related process problems in the context of managing human resources in Irish healthcare settings in Ireland.

A second recommendation for future research is related to the fact that several HR managers testified to possible future problems regarding succession planning and career advancement of non-Irish nursing staff. Interview responses alluded to non-Irish nationals in

nursing not being interested in evolving to management positions. The reasons cited for this management dilemma are two-fold. Firstly, many management level grades do not offer overtime income earning opportunities and this is a deterrent for many non-Irish national nurses who came to Ireland to maximise their earnings in order to repatriate money to their extended families in their countries of origin. Secondly cultural specific challenges such as peer pressure can be the cause of non-Irish nationals refraining from seeking advancement in their careers in Ireland. This poses a serious problem for the development of management level grades in the Irish hospital sector in the short to middle term especially given the significant quantity of non-Irish nationals working in the Irish healthcare system.

Furthermore results in this research indicated that Irish hospitals which provided maternity and children health services were the most advanced in implementing the WOA and managing ethno-cultural differences. A third recommendation that merits future research is that the findings in this research could be used as a basis to further investigate international case study comparisons of how maternity and children's hospitals in international health systems such as France, have managed ethno-cultural differences in healthcare service delivery. In doing so, a fourth future research avenue opens up to explore how service providers manage ethno-cultural healthcare service delivery to service users in two different national health sectors that have contrasting philosophies and approaches towards communitarianism, assimilation and multiculturalism. Ireland and France are examples of two societies with different approaches and philosophies towards communitarianism, assimilation and multiculturalism. For example the hypothesis that France has no top down, specific approach to managing ethno-cultural differences due to its assimilation and non-communitarian philosophy, while Ireland being a country that has recently experienced inward migration and has a communitarian multicultural approach provides an interesting contrast in the management of health care. It would be thus interesting to compare how service providers (hospitals) manage ethno-cultural differences when providing healthcare service delivery to service users in a communitarian society such as Ireland, and a society that refuses communitarianism such as France. This research would contribute to the academic literature by establishing the differences in approaches and investigating if there are transfers of learning opportunities between the different approaches.

This research project has effectively studied the diversity inputs that hospitals have implemented to manage ethno-cultural differences in healthcare service delivery in hospitals in Ireland. What is missing is an evaluation of these inputs by measuring the intended organisational performance outputs. Therefore a fifth recommendation for future research

would be to assess the change effects and organisational performance outcomes that are a result of implementing the WOA. The inclusion of an evaluation of patient satisfaction levels incorporating feedback from patients who are members of MECs or from representative MEC advocacy groups would add to the richness of the research.

Finally a sixth recommendation for future research is that the WOA be tested across a wider range of healthcare settings and to a larger sample of hospitals throughout Ireland. This would provide scope for a comparative analysis of how the WOA has been implemented in different contextual environments and provide data to scrutinise the validity of the findings of this research.

6.9 Chapter summary

It would appear that the Irish health sector reacted rapidly to the challenges of immigration, and put in place best practice plans to manage ethno-cultural diversity as a matter of priority. The HSE's top down strategy was planned at a time of unprecedented economic prosperity, immigration, and employment gaps in Ireland. It was also when the Ministry of Health had the necessary financial resources and political will which permitted the HSE to react appropriately by producing the WOA in 2005 and incorporating it into its five year NIHS 2007-2012. As of 2008, Ireland has experienced an unprecedented economic crisis, leading to a return to high unemployment, rapidly growing emigration, public spending cutbacks, and a moratorium on recruitment in public services resulting in a new Irish economic reality.

The economic crisis has undoubtedly had adverse consequences on the implementation of the WOA in relation to critical areas such as training, support to training and recruitment. These elements are crucial to the long term success of providing appropriate cultural sensitive health care to ethnic minorities in Irish society. The NIHS in Ireland runs from 2007 to 2012 and evidence would suggest that if the Irish health sector is to succeed in providing comprehensive culturally sensitive healthcare provision to members of MECs, it will need to provide the necessary financial resources to ensure that all strands of the WOA can be fully implemented.

One of the principal reasons this study is relevant for the hospital sector is that it is the first assessment of the Irish approach to managing ethno-cultural differences in health care. The research has highlighted the admirable strengths of the HSE and individual Irish hospital

reactions to bridging cultural gaps in the provision of appropriate health care. The research findings have more importantly raised awareness on critical areas that need to be developed or put in place in Irish hospitals to sustain progress in managing ethno-cultural differences in healthcare service delivery in the 21st century.

Glossary

Asylum Seeker

An asylum seeker is a person seeking to be recognized as a refugee under the 1951 United Nations Convention Relating to the Status of Refugees (NIHS 2009), p125.

Benchmarking

Benchmarking relies on data collection and monitoring through ethnic or equality monitoring to establish targets and measure progress against those targets. It serves to set and reach targets within a timescale (NIHS 2009), p125.

Chaplaincy

The role of the Chaplain is about expressing respect and care, about listening in a compassionate way and about helping to create a space which recognises the spiritual and emotional needs of the patient, family and staff (O'Carroll 2005), p20.

Culture

Culture is a dynamic process that is changing continually and thus requires continual analysis. Schein (1985) defines culture as "a pattern of basic assumptions invented, developed or discovered by a given group in learning to cope with problems of external adaptation and internal integration that has worked well enough to be considered valid and therefore be taught to new members as the correct way to perceive, think and feel in relation to those problems".

Cultural diversity

Refers to the variations and differences among and between cultural groups resulting from differences in life ways, languages, values, norms, and other cultural aspects (Leininger and McFarland 2002). "Universal Declaration of Cultural Diversity" approved in Paris in 2001 the common heritage of humanity, which "takes diverse forms across time and space. This diversity is embodied in the uniqueness and plurality of the identities of the groups and societies making up humankind" (UNESCO 2002), p4.

Cultural Mediation

Cultural mediation is a service provided by a professionally trained third party in assisting a person bridge the gap between his/her culture and the new culture that they find themselves in using a service such as health care (HSIG 2009). Cultural mediators increase the capacity of healthcare professionals to diagnose problems specific to ethnic populations and facilitate

the interpretation of medical information by assisting patients to understand the diagnosis and treatment (Perez Carratalà et al. 2010).

Data Collection

Refers to the process of capturing data from one or more primary or secondary sources. Some key data categories are ethnicity, country of birth, religion and language (NIHS 2009), p125.

Dignity at Work

The Dignity at Work Policy for the Health Service "aims to ensure that the working environment is respectful of employees' dignity and employees know what to do if they are being subjected to inappropriate behaviour". The policy involves communicating the policy to staff and preventing bullying and any form of harassment from occurring. Also it involves grievance procedures and complaints processes and aims to resolve complaints at a local level. (HSE 2009, People Management: the Legal Framework Reference Book for Line Managers), p47.

Emergency Multilingual Aid Box

An Emergency Multilingual Aid Box was developed by the HSE to assist healthcare professionals communicate with patients in acute or emergency situations. It consists of health related phrase books translated into 20 languages.

Equality proofing

Ensuring that all policies and decisions have taken full account of the needs of different equality groups and considered the possible impact of policies on different groups (Watt and McGaughey 2006).

Equality Auditing & Equality Impact Assessment

"Equality auditing requires the systematic evaluation of business goals and objectives, identifying diversity gaps and equality issues, and creating solutions to enable success. An Equality Impact Assessment is an exercise carried out on a new policy or service at a design stage or on a new employment strategy. Its aim is to ensure that the policy, service provision or employment strategy will benefit all groups covered under the equality legislation. It is based on assessing the capacity of the policy, or of the service, in its design and delivery, or of the employment strategy, to accommodate diversity across the nine grounds.

An Equality Impact Assessment on a policy, service or employment strategy consists of the following steps:

1. Selection of a policy/service/strategy to be assessed. The selection process should be informed by the scope and scale of the initiative chosen.

2. Screening to identify which of the nine grounds should be included in an Equality Impact Assessment. This is a filtering mechanism to ensure a focus on groups whose diversity has practical implications for the particular policy, service or employment strategy to be assessed.

3. Data is gathered to establish a basis for understanding the diversity that is to be accommodated within the policy, service or strategy and the practical implications of this diversity. Relevant data should be considered on each group's situation, experience and identity. Situation refers to areas such as the economic, health, education or accommodation status of the group. Experience refers to the relationships between the group and members of the wider society. Identity refers to the values, beliefs and fields of communication of the group.

4. An assessment is made of the capacity of the policy, service or strategy in its design and delivery to accommodate the diversity of the different groups identified.

5. Formal consultation is organised with representative groups from the grounds selected. In the absence of local groups, national groups can be contacted for assistance. This consultation explores the quality of the data gathered and of the assessment of impact.

6. A decision on how to best design and deliver the policy, service or strategy must be taken.

7. Monitoring will help to ensure that the implementation of the policy, service or employment strategy will not have an adverse impact for any of the identified grounds.

The definition of the nine grounds of discrimination based on the Equal Status Acts of 2000 to 2004

The Gender ground - A man, a woman or a transsexual person.

The Marital status ground - Single, married, separated, divorced or widowed.

The Family status ground - Pregnant, a parent or a person in loco parent is, of a person under 18 years, or a parent or resident primary carer of a person with a disability.

The Sexual orientation ground- Heterosexual, gay, lesbian or bisexual.

The Religion ground - Different religious belief, background, outlook or none.

The Age ground - This only applies to people over 18 (except for the provision of car insurance to licensed drivers under that age).

The Disability ground - This is broadly defined including people with all physical, sensory and intellectual disabilities and mental health issues.

The Race ground - A particular race, skin colour, nationality or ethnic or national origin.
The Membership of the Traveller Community ground - People who are commonly called Travellers and who are identified, both by Travellers and others, as people with a shared history, culture and traditions identified historically as a nomadic way of life on the island of Ireland."
Extracted from the Equality Authority Pamphlet on Equal Status Acts 2000 to 2004 and Provision of Health Services a joint initiative of the Department of Health and Children, the Health Service Executive and The Equality Authority:
http://www.equality.ie/Files/EqualStatusActsandProvisionofHealthServicesRTF.rtf

Ethnic Group
Ethnic groups share history, ancestry, language and geographic origin. Their shared identity exists independent of nationality (HSIG 2009).

Ethnic Identifier
A system and procedure of collecting appropriate data of service users.

Ethnic Monitoring / Equality monitoring
"Ethnic monitoring is the process you use to collect, store, and analyses data about people's ethnic backgrounds. You can use ethnic monitoring to highlight possible inequalities, investigate their underlying causes; and remove any unfairness or disadvantage."
(Commission for Racial Equality: www.cre.gov.uk/duty/grr/glossary.htlm)

Health Promoting Hospitals Network (HPHN)
The HPHN is part of the WHO which was responsible for organising the Task Force on Migrant-Friendly Hospitals which focuses on promoting the health and health-related knowledge and competence of migrants and minority ethnic groups, on improving hospital services for these patient groups. This network aims to improve the health and literacy of minority ethnic groups as well as to improve hospital services for these patient groups such as improvement in interpretation services and communication and developing cultural competency training at a European and national level. It promotes the implementation of the recommendations proposed by the Amsterdam Declaration of 2004 towards Migrant friendly Hospitals in an ethno-culturally diverse Europe.

Hospice Friendly Hospital Project (HFHP)

The HFHP is a national programme aimed at improving all aspects of End of Life Care in the hospital setting. This is a programme introduced by the Irish Hospice Foundation in collaboration with the HSE and supported by the Health Information and Quality Authority. (http://www.hospicefriendlyhospitals.net)

Interculturalism

Interculturalism is essentially about interaction between majority and minority cultures to foster understanding and respect. It is about ensuring that cultural diversity is acknowledged and catered for (Watt and McGaughey 2006). It involves "developing a more inclusive and intercultural society is about inclusion by design, not as an add-on or afterthought. It is essentially about creating the conditions for interaction, equality of opportunity, understanding and respect". (Department of Justice, Equality and Law Reform, 2005 Planning for Diversity, The National Action Plan Against Racism), p38.

Migration

Migration signifies the movement of a person or group of persons across administrative, political, or geographical borders, with a view to settling temporarily or permanently in a place other than their place of origin (International Organisation for Migration 2003).

Migrant Friendly Hospital Project (MFHP)

The MFHP is sometimes referred to as the European Migrant Friendly Hospital Project (EMFHP) involved 12 European partner hospitals in different European countries and coordinated by the Ludwig Boltzman Institute for Sociology of Health and Medicine, Vienna. The project took two and half years and was developed to respond to the care needs of culturally diverse patients in hospital settings. Experiences and results of the 12 European hospitals were presented at a final conference entitled, "Hospitals in a Culturally Diverse Europe" in Amsterdam in December 2004.

Migrant worker

"A person who is to be engaged, is engaged or has been engaged in remunerated activity in a state of which he or she is not a national" as defined by article 2 United Nations International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families" (NIHS 2007), p129.

Multiculturalism

Multiculturalism acknowledges the need for recognition and celebration of different cultures. However it has been said that the emphasis of the multicultural approach is on the need for tolerance and "better community relations" rather than on acknowledging the need to change the attitudes and practices of the majority population (Farrell and Watt 2001), p26-27. Multiculturalism varies from one country to the next and can be criticized for allowing parallel communities to grow with little interaction between them (NIHS 2007), p129.

National Intercultural Hospital Initiative (NIHI)

A national project established as a result of the Migrant Friendly Hospitals Project (MFHP). The purpose of the project is to manage and advise the dissemination and further development of the EMFHP in the Irish healthcare setting. One such outcome of this initiative was the implementation of the Emergency Multilingual Aid in Irish health care settings which came about from H1s participation at a European level in the MFHP.

The National Intercultural Health Project (NIHP)

The NIHP was a HSE led project led by the HSE's department of Social Inclusion, focusing on implementing intercultural care in acute hospitals and primary care settings. The project aim was to provide strategic leadership and expertise across service directorates to support the hospitals in the delivery of health and social services to meet the needs of MECs.

National Intercultural Health Strategy 2007-2012 (NIHS)

The NIHS was launched by the Minister of Health and Children in February 2008 and aims at planning and delivering services that "are provided equally to all and respond appropriately to the specific health and social care needs of new and well established minority communities", the CEO of the HSE Brendan Drum, NIHS (2007) p2. According to the NIHS, "*the primary objective of the intercultural health strategy is to provide a framework through which service users and providers are supported in addressing the unique care and support needs of people from diverse cultural and ethnic backgrounds",* p28*.*

Racism

Is a specific form of discrimination and exclusion faced by minority ethnic groups? It is based on the false belief that some "races" are inherently superior to others because of different skin colour, nationality, ethnic or cultural background (Watt and McGaughey 2006), p169.

Refugee

According to the 1951 United Nations Convention Relating to the Status of Refugees, *"a refugee is a person who has left his/her country and cannot return due to a well founded fear of persecution on the basis of their race, religion, nationality or membership of a particular social group or political opinion".*

Service provider

Employees of healthcare organisations who are responsible for provision of healthcare services to service users.

Service user

Patients or clients of a hospital or healthcare setting.

Traveller Community

"Travelers are an indigenous minority, documented as being part of Irish society for centuries. Travelers have a long shared history and value system which make them a distinct group. They have their own language, customs and traditions".
(Pavee Point www.paveepoint.ie/pav_culture_a.htlm)

Trust in Care Policy

The Health Service employers and unions developed a Trust in Care Policy on upholding the dignity and welfare of patients and managing allegations of abuse. *"The policy emphasises the role of the Line Manager in promoting high standards of care and intervening promptly to address any form of behaviour that undermines the dignity of patients and clients. The Trust in care policy outlines the role of HR tools such as induction, probation and performance management in maintaining high standards of care. The policy also sets out the responsibilities of a manager to communicate the policy to employees and making employees aware of their duty to be vigilant and to report any concerns regarding the welfare of patients and managing complaints of abuse"* (HSE 2009, People Management The Legal Framework Reference Book for Line Managers), p55.

Whole Organisation Approach

Is a holistic approach to address racism and support inclusive, intercultural strategies within an organisation with reference to equality policies and equality action plans (Watt and McGaughey 2006), p169.

Appendices

Appendices

Appendix 1a: The Amsterdam Declaration towards migrant friendly hospitals in an ethno-culturally diverse Europe

1. Developing a migrant-friendly hospital is an investment in more individualised and more person-oriented services for all patients and clients as well as their families.

2. Increased awareness will be needed of migrant population experiences and existing health disparities and inequities, including those that are gender-related, leading to changes in communication, organisational routines and resource allocations.

3. Focusing on ethno-cultural diversity implies the risk of stereotyping - but migrant status, ethnic descent, cultural background and religious affiliation are just a few of the many dimensions of the complexity of human beings.

4. Developing partnerships with local community organisations and advocacy groups who are knowledgeable about migrant and minority ethnic group issues is an important step that can facilitate the development of a more culturally and linguistically appropriate service delivery system.

Hospital owners / Management / Quality Management

5. It will be important to define aims and objectives (mission, vision and value statement, policies and procedures).

6. Adequate resources (working time, financial resources, qualification) must be provided if changes are to be realised.

7. An organisational development process should be initiated, supported and monitored by leadership, management and quality management.

8. As an important step, the needs and assets of stakeholders - users (patients, relatives, community) and providers (staff) - should be monitored.

9. Outcomes as well as the structures and processes that influence outcomes should be monitored.

10. Concerns, complaints and grievances related to service delivery should be tracked and appropriately addressed.

11. Investment in capacity building with regard to staff's cultural and linguistic competence is needed (selection, training, evaluation).

Staff / Health professions

12. An important step will be to find consensus on criteria for migrant-friendliness/cultural competence / diversity competence adapted to their specific situation and to integrate them into professional standards and enforce that they are realised in everyday practice. The principles applied in the MFH project can serve as starting point for this development.

13. Professionals and other staff will have to build capacities concerning cross-cultural and communicative and diversity-related competencies.

14. Clinical practice, preventive services and health promotion action should be appropriately tailored for use with diverse populations. Preventive services and health promotion that rely strongly on communicative interventions are especially dependent on the cultural and linguistic competencies of professionals if they are to be effective.

15. Taking the literacy and health literacy of users systematically into account at all levels of services will be an important prerequisite. This implies monitoring, the development of adequate orientation systems/information material as well as patient education programmes.

16. Potentially traumatic migration experiences mean that heightened awareness of mental health issues is important in hospital care for migrants.

Users (actual and potential patients, relatives) / Representatives of community groups

17. Patient organisations should incorporate the diversity of their clientele into their strategies and policies and should act as advocates for these diverse patient populations.

18. Migrant/minority community representatives can contribute not only by advocating but also by mediating. They should act as advocates for adequate access to and quality of services, and they should also become agents for the development of greater health literacy within their communities.

19. By investing in improvements in their health literacy, all members of migrant/minority communities can contribute to their own better health and better use of health services.

Health policy and administration

20. Health policy should provide a framework to make migrant-friendly quality development relevant and feasible for each hospital (legal, financial, and organisational regulations).

21. A framework for health-oriented community development for migrants and ethnic minorities has the potential to be most helpful in developing these groups' health literacy.

22. Policy and administration have an important role to play in facilitating knowledge development for example in initiating and funding research, reviews, standards development and dissemination (networking, education, exchange of experience).

Health sciences

23. Ethnic and migrant background information should be included as a relevant category in epidemiological, socio-behavioural, clinical, health service and health system research.

24. Scientific experts should be prepared to assist other stakeholders in planning, monitoring and evaluating their efforts by providing reviews, assessment tools, designs and tools for evaluation.

25. Scientifically based efforts can contribute to combating racism, prejudice, discrimination and exclusion by providing information on the negative consequences of these processes.

26. Participatory, multi-method research and evaluation efforts should be carried out in partnership and consultation with communities.

Adapted from The Amsterdam Declaration Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe. http://www.mfh-eu.net

Appendix 1b : Migrant friendliness quality questionnaire

1. General resources to facilitate communication and information
2. Accessibility, pre-entry and entry into hospital
3. Accessibility whilst in hospital
4. Medical/ Nursing treatment
5. Discharge
6. MF patient education/health promotion/empowerment
7. General quality system in hospital
8. Does the hospital have a written MF policy
9. MF Budget
10. Is specific management structure in place
11. Involvement of migrant representatives in organisational change
12. Marketing of MF internally
13. External marketing of MF care to the public
14. MF training and education for staff
15. Monitoring of migrant clientele
16. Monitoring of migrant-specific service outcomes
17. Method/approach used for monitoring migrant data
18. Monitoring of MF impact on organisational quality
19. Reporting system on MF activities and impact
20. Partnerships and partner alliances

Adapted from MFH Homepage www.mfh-eu.net

Appendix 1c: TF MFCCH Project to develop standards for equity in health care for migrants and other vulnerable groups

Standard 1: Equity in Policy

Objective of the standard:
- To define how the organisation should develop policies, governance and performance monitoring systems which promote equity.

Sub-standards:
1.1 The organisation has governance systems in place to ensure that decisions promote equity at all levels.
1.2 The organisation's research, monitoring and evaluation systems measure equity performance
1.3 The organisation has a fully resourced plan in place which describes how it will develop capacity to promote equity, which is integrated with existing management instruments and is reviewed annually.
1.4 The organisation ensures that staff at all levels have relevant awareness and competence to address inequities in health care.
1.5 The organisation has a champion for equity at a senior / executive level.
1.6 Equity is explicit in the annual performance objectives of all managers (including senior and executive managers).

Standard 2: Equitable accesses and utilisation The organisation ensures for equal need, equitable access to available care and utilisation.

Objective of the standard:
- To encourage the health organisation to eliminate
- Legal barriers
- Multiple diversity barriers
- Linguistic barriers
- Information barriers
- Organisational barriers
- Financial barriers
- Resource barriers

2.1 The organisation ensures the implementation of the right to health for all, in particular for disadvantaged groups.
2.2 The organisation has a good understanding of the characteristics of its population, including health inequalities.
2.3 The organisation ensures that physical accessibility to and distribution of health services are equitable and acceptable to all.
2.4 The organisation ensures that communication, health literacy and mistrust are not barriers to health services.

Standard 3: Equitable quality of care The organisation provides high quality of care for all, acknowledging the unique characteristics of the individual and acting on these not only to improve individual health (through care, prevention and health promotion), but also social wellbeing. This means providing person centred care.

Objective of the standard:
- To assist the organisation in developing the following areas so that they respect the uniqueness of patients:
- Patient assessment
- Staff / patient interactions
- Safe environment
- Discharge and continuity of care

3.1 The organisation ensures that procedures are in place to assess the needs of a multiple-diversity patient and population
3.2 The organisation has systems in place to recognise individual patients' experiences and living conditions, and is able to take account of the diverse concepts about health and illness in meeting their health care needs.
3.3 The organisation demonstrates that it is able to take into account the social context of the patient in order to improve the quality of care for the patient.
3.4 The organisation ensures that systems are in place to obtain feedback from all patients and that this information is used in service improvement.
3.5 The organisation is able to create an environment that is safe for the patient where there is no assault, challenge or denial of his/her identity.
3.6 The organisation is able to acknowledge and address the enactment of inequity, discrimination and racism.

Standard 4: Community involvement
The organisation provides for effective information and intervention through proactive and outreach group engagement of its community. Groups in the community are seen as active participants rather then passive recipients.

Objective of the standard:
- To support the organisation in the involvement of relevant communities in health service delivery and improvement.

4.1 The organisation has effective channels of communication with its communities.
4.2 The organisation works in partnership with community based mediators/social workers, etc. to engage with communities in an inclusive way.
4.3 The organisation monitors the range of people who take part in participation activities.
4.4 The organisation has built evaluation into its participation processes.

Standard 5: Promoting equity
The organisation understands that it is part of a wider system and is able to promote the principles of equity across services.

Objective of the standard:
- To support the organisation in promoting equity externally in its wider environment through:
- Advocacy and lobbying
- Facilitating capacity building
- Disseminating research
- Developing education and promotional work

5.1 The organisation is an active participant in policy networks / think tanks/research initiatives which promote equitable approaches
5.2 The organisation actively diffuses the results of research and practice, locally, regionally, nationally and internationally.
5.3 The organisation ensures that equity is reflected in all partnership agreements and relationships, suppliers, including contracted services and joint collaborations

Adapted from Project to Develop Standards for Equity in Health Care for Migrants and other Vulnerable Groups. Self Assessment Tool for Pilot Testing in Health Care Organisations. (2011) TF MFCCH Web site www.ausl.re.it

Appendix 1d: National standards on culturally and linguistically appropriate standards in health care in the United States

(1) Healthcare organisations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

(2) Healthcare organisations should implement strategies to recruit, retain, and promote at all levels of the organisation a diverse staff and leadership that are representative of the demographic characteristics of the service area.

(3) Healthcare organisations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

(4) Healthcare organisations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency (LEP) at all points of contact, in a timely manner during all hours of operation.

(5) Healthcare organisations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

(6) Healthcare organisations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpreting services (except on request by the patient/ consumer).

(7) Healthcare organisations must make available easily understood patient related materials and signposting in the languages of the commonly encountered groups and/or groups represented in the service area.

(8) Healthcare organisations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

(9) Healthcare organisations should conduct initial and ongoing organisational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

(10) Healthcare organisations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organisation's management information systems, and is periodically updated.

(11) Healthcare organisations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

(12) Healthcare organisations should develop participatory, collaborative partnerships with communities and utilise a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.

(13) Healthcare organisations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

(14) Healthcare organisations are encouraged to regularly make available to the public, information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Adapted from www.omhrc.gov/clas

Appendix 1e: Building a culturally competent organisation: the quest for equity in health care, Health Research and Education Trust 2011

1. Collect race, ethnicity and language preference (REAL) data.
- Do you systematically collect data on race, ethnicity and language preferences of all your patients?

2. Identify and report disparities
- Do you use REAL data to look for variations in clinical outcomes, resource utilization, length of stay, and frequency of readmissions within your hospital?
- Do you compare patient satisfaction ratings among diverse groups and act on the information?
- Do you actively use REAL data for strategic and outreach planning?

3. Provide culturally and linguistically competent care.
- Have your patient representatives, social workers, discharge planners, financial counsellors and other key patient and family resource employees received special training in diversity issues?
- Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?
- Are your written communications with patients and families available in a variety of languages that reflect the ethnic and cultural makeup of your community?
- Based on the racial and ethnic diversity of the patients you serve, as well as those in your service area, do you educate your staff at orientation and on a continuing basis, about cultural issues important to your patients?
- Has your hospital developed a "language resource," identifying qualified people inside and outside your organization who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?

4. Develop culturally competent disease management programs.
- Does your hospital gather information to determine conditions of high prevalence within your community's minority populations?
- Does your hospital offer disease management programs that effectively address these conditions?
- Do your disease management programs address the barriers to care that are particularly challenging for minority patients?

5. Increase diversity and minority workforce pipelines.
- Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race or ethnicity?
- Are search firms required to present a mix of candidates reflecting your community's diversity?
- Do your recruitment efforts include strategies to reach out to racial and ethnic minorities in your community?
- Do you acknowledge and honour diversity in your employee communications, awards programs and other internal celebrations?
- Does your human resources department have a system in place to measure diversity progress and report it to you and your board?

6. Involve the community.
- Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes?
- Do you have a strategy to partner with community leaders to work on health issues important to community members?

7. Make cultural competency an institutional priority.
- Has your board set goals on improving organizational diversity, providing culturally competent care and eliminating disparities in care as part of your strategic plan?
- Is diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers?

Adapted from the Health Research & Educational Trust, Institute for Diversity in Health Management. Building a Culturally Competent Organisation: The Quest for Equity in Health Care. Chicago, IL: Health Research& Educational Trust. July 2011 www.hret.org/cultural-competency

Appendix 1f: Guidelines for newcomers to the health system in Canada

1) Be accessible to all who need them.

2) Be offered in an inclusive manner, respectful of, and sensitive to diversity.

3) Empower clients.

4) Respond to needs as defined by users.

5) Take account of the complex, multifaceted, interrelated dimensions of settlement and integration.

6) Be delivered in a manner that fully respects the rights and dignity of the individual.

7) Be delivered in a manner that is culturally sensitive.

8) Promote the development of newcomer communities and newcomer participation in the wider community, and develop communities that are welcoming of newcomers.

9) Be delivered in a spirit of collaboration.

10) Be made accountable to communities served.

11) Be oriented towards promoting positive change in the lives of newcomers and in the capacity of society to offer equality of opportunity for all.

12) Be based on reliable up-to-date information.

Gagnon, A. J. (2002). "Responsiveness of the Canadian Health Care System towards Newcomers." *Commission on the Future of Health Care in Canada*. Montreal, McGill University.Extracted from Bischoff (2003), Report on Caring for Migrant and minority patients in European Hospitals, A review of effective interventions.

Appendix 2: Table and timeframe of contacts and meetings during the research project

Contact	Period Year 2009	Purpose
Assistant Director Trinity College Nursing department:	May 2009	Preliminary research
Employer Relations/Human Resource Senior executive Health Service Executive Employers Agency	May 2009	Preliminary research
Employer Relations/Human Resource Executive Health Service Executive Employers Agency	May 2009	Preliminary research
Training & Development Manager, Hospital 4	May 2009	Preliminary research
Nursing HR Manager Hospital 5	May 2009	Preliminary research
Director of Nursing Hospital 3	May 2009	Preliminary Research
Clinical Patient Services Manager Hospital 3		Preliminary Research
Independent Cultural, Diversity Trainer in Irish Hospitals	May 2009	Preliminary Research
Diversity Officer, Irish Business Employers Confederation	May 2009	Preliminary Research
Senior HR Executive responsible for hospital sector, Irish Business Employers Confederation	May 2009	Preliminary Research
2nd Senior HR Executive responsible for hospital sector, Irish Business Employers Confederation	May 2009	Preliminary Research
Equality Officer Irish Business Employers Confederation	May 2009	Preliminary Research
HR Manager Hospital 2	May 2009	Preliminary Research
Director of Nursing Hospital 2	May 2009	Preliminary Research
International Officer in Nursing department Dublin City University	May 2009	Preliminary Research
HR Manager Hospital 1	September 2009	Exploratory Research
HR Manager Hospital 2	September 2009	Exploratory Research
HR Manager Hospital 3	September 2009	Exploratory Research
Training and Development Manager Hospital 4	September 2009	Exploratory Research
HR Director/ Director of Nursing Hospital 5	September 2009	Exploratory Research

HSE Executive Social Inclusion	Feb 2010	Exploratory Research
HSE Executive Responsible of Thrive Consulting report Social Inclusion	Feb 2010	Exploratory Research & information about WOA
Transcultural Nurse specialist HSE, Balseskin Refugee Holding Centre	Feb 2010	Exploratory Research
Diversity consultant to HSE on diversity issues Horizons Training		Exploratory Research
President Migrant Alsace Santé, France	Feb 2010	Exploratory Research
Vice President Migrant Alsace Santé, France	Feb 2010	Exploratory Research
Psychologist, EPSAN, France	Feb 2010	Exploratory Research
Director of Quality, CHU Strasbourg, France	March 2010	Exploratory Research
HSE Director Social Inclusion, telephone conference	March 2010	Explain project
Executive Irish Equality Authority	March 2010	Equality and pilot interview guide
Representative Haute Authorité Santé, France	March 2010	Exploratory Research
HR Director Kaiser Permanente Regional, Buffalo, NY, USA	April 2010	Exploratory Research
Director of Diversity, Roswell Cancer Hospital Buffalo, NY, USA	April 2010	Exploratory Research
(12 Healthcare professionals) P2 Healthcare professionals of NY Buffalo, NY, USA	April 2010	Exploratory Research
Medical doctor, Kaiser Permanent Buffalo, NY, USA	April 2010	Exploratory Research
Nurse by telephone, Kaiser Permanent Buffalo, NY, USA	April 2010	Exploratory Research
Healthcare contact. Council of Europe, France	May 2010	Policy implementation in Europe
Conference on Patient Diversity, 65 attendees, EM Strasbourg, France	June 2010	French preliminary research
Programme manager of diversity and inclusion, Oregon Health and Science University, Oregon, USA	July 2010	Pilot Interview guide
Diversity specialist and researcher (Dr Anita Rowe) Oregon, USA	July 2010	Pilot Interview guide
Medical Doctor and Head of Diversity, Oregon Health and Science University, Oregon.	July 2010	Pilot Interview guide

Workshop for healthcare professionals, Intercultural Competence in Health Care Oregon, USA	July 2010	presented project to specialists in cultural competence care in Health care
Health Care Diversity trainer Kaiser Permanente California, Oregon, USA	July 2010	Presented project
Ethics Committee, oral presentation Hospital 4	July 2010	Ethics committee application
Ethics Committee, oral presentation Hospital 5	July 2010	Ethics committee application
40 interviews in 3 Hospitals in Ireland	Sept 2010	Empirical research
Directeur général adjoint Régionale de Santé Alsace,	Oct 2010	French exploratory research
53 interviews in 3 Hospitals	Nov 2010	Empirical research
5 French hospitals, 19 interviews with French hospital healthcare professionals	Nov, Dec, Jan 2011	Empirical research France
Prof Betencourt Harvard Business School in Ireland	July 2011	Lit Review
Prof Papalapolous Middlesex University in Ireland	July 2011	Lit Review
Director Social Inclusion HSE	July 2011	Presented project and results
Commission des Usagers CHU Strasbourg France	Jan 2012	Presented project

Appendix 3: Profile of interviewees in the 6 hospitals

HOSPITAL	H1	H2	H3	H4	H5	H6
Management						
Director of Mission Effectiveness, Board of Directors						X
HR Director / Manager	X	X	X	X	X	X
HR Managing Nursing			X			
Training & Developement Manager		X	X		X	
Risk Manager					X	
Director Quality & Risk			X			
Quality & Accreditation Manager	X					X
Clinical & Patient Services Manager	X					
Nursing Support Services Manager					X	
Medical staff						
Paediatrician Dr	X					
Head of Physiologist Ontology Dr			X			
Obstetric Gynaecologist Dr		X				
Medical Director /Dr				X		
Director Midwife Nursing / Director of Nursing		X	X	X	X	
Assistant Director Nursing			X			
Clinical Nurse Manager	X			X X X	X X	
Staff Nurse/ neo-natal / midwife		X X X	X			X
Bereavement midwife nurse		X				
Clinical Placement Overseas Coordinator / nurse						X
Nursing Practitioner Development Facilitator			X			X
Post Graduate Education Coordinator Nurse	X					
Education Coordinator Student and Nurse				X		
Non Clinical / Administrative staff						
Head/Senior Social Worker	X	X				
Social Worker / Medical	X			X		X
Psychiatric Social Worker	X					
Senior Speech and Language Therapist				X		
Dietician / Manager			X	X		
Catering Manager / Officer		X			X	X
Assistant Catering Manager		X				
Catering Employee Supervisor		X				
Patient Service Officer / Manager		X			X	X
Allied Services Manager				X		
Healthcare Records Manager	X					X
Porter / Head Porter / General Services Manager	X		X X	X		X
Contract Cleaning Manager						X
Clerical Officer Ambulance Dept / Supervisor A&E			X		X	
Health Promotion Coordinator	X				X	X
CHIC (Children Hospital Information Coordinator)	X					
Training & Development Coordinator						X
Emergency Support Officer	X					
Team Leader Administration		X X X				
Assistant Administration Cardiology			X			
Health Care Assistant		X	X X		X	
Other						
Chaplain	X	X	X	X	X	XXX
Chaplain Educator Coordinator			X			

Appendix 4: Interview Guideline

Name :
Function :
Establishment/Hospital :
Date:
Time: Begin_____ End_____

How long have you worked in this establishment?
How many years experience do you have in the health sector?

Identification of challenges.
Q1.
(a) From your experiences do problems exist related to cultural diversity when providing health care services to ethnic minorities?

(b) If yes please describe some examples that you may have encountered in your professional work life.

Strand 1 : Organisational Ethos	***Interviewee comments***
Q 2. In what way does leadership and commitment from senior management cultivate a culture that promotes equality and values diversity? *(Diversity committees, mission statements etc)*	
Q 3. How has the hospital developed intercultural policies and services that are appropriate to the needs of a diverse and multi ethnic society? *(e.g. interfaith policy, diet services policy, interpretation service policy, intercultural recruitment policy, culture days, international food days, a diversity section on web site, codes of practices anti-racism)*	
Q 4. How does the hospital promote equality and diversity through service planning and delivery? *(e.g. Equality Framework equality audits, equality legal requirements)*	

Q 5. How does the hospital collect data and monitor ethnic diversity in patient populations?	
Strand 2: Workplace environment	***Interviewee comments***
Q 6. How does the hospital promote diversity in the profile of the workforce through attraction and retention initiatives?	
Q 7. How does the hospital promote training and development initiatives in the field of diversity management?	
Q 8. What support structures have been put in place to support staff in the workplace to manage issues relating to cultural diversity*? (e.g. resource packs , booklets etc)*	
Q 9. What initiatives have taken place to integrate and manage multicultural teams?	
Q 10. Who facilitates training? (e.g. co-facilitation of members of minority ethnic communities?)	

Strand 3: ***Service elements necessary to support intercultural training***	***Interviewee comments***
Q 11. How does the hospital acquire the knowledge about representative ethnic groups in order to provide services that are appropriate to the needs of a diverse and multiethnic society? *(e.g. information and awareness initiatives for minority ethnic service users on the processes and practices of the Irish health care system)*	
Q 12. How does the hospital provide information to minority ethnic service users about the process and the practice of the Irish health care system?	
Q 13. How does the hospital endeavour to be sensitive to the language needs of minority ethnic families? (e.g. signage, hospital literature, interpretation etc.) *(a) Signage* *(b) Literature* *(c) Interpretation*	

Appendix 5: Comparison of key elements of 5 international institutional approaches categorised into the WOA framework

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
Strand 1 Organisational ethos					
1.1. Specific initiatives that demonstrate the commitment and support of managers	Mission statement Strategic plan Equality statement Links to 3rd level research and teaching Senior management led initiatives Diversity committees multi-disciplinary and multi-ethnic Links with MECs MEC involvement	1.Mission statement, vision and value statement 6. Adequate resources, financial resources 7. Organisation development process supported and monitored by leadership, management and quality management 18. MECs/ Advocacy on committees	Is Migrant Friendliness (MF) an explicit aim in value or mission statement ? A MF strategic policy document specify MF care strategies and policies A MF action plan MF organisation manuals Does the hospital have a MF budget? Is there a project officer or manager responsible for MF? Multi-disciplinary MF committee Network of contacts	Strategic plan that outlines goals, policies, plans, accountability, initial and ongoing self assessments of CLAS, integrate cultural and linguistic competencies related measures in audits, patient satisfaction assessments and outcome based evaluations Encouraged to make public information about their progress and innovation Senior management lead equality and diversity initiatives or committees. Establishment of a diversity structure including MECs Equality and diversity measures built into performance management systems	1. Services should be accessible to all who need them 6. Be delivered in a manner that fully respects the right and dignity of the individual 7. Be delivered in a manner that is culturally sensitive 2. Be offered in an inclusive manner respectful of and sensitive to diversity 10. Be made accountable to the communities served

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
1.2. Up to date intercultural policy for health services	Code of practice anti-discrimination Clarify expectations of staff In approach to diversity e.g. bereavement Interfaith Diet Recruitment Cultural days Food Diversity website		Adequate food, Practice religion within hospital Family visits Provision of patient to be treated by gender same service provider (if possible) Provision to ensure that patients are able to consent to treatment in their own language Transcultural mental health service Policies for training migrant staff and policies on how to handle discrimination MF Newsletter MF annual presentations days etc List of MF staff & contacts Network migrant associations	Clear equality and diversity policies indicating staff expectations around diversity Policies and guidelines on diversity issues Spiritual issues in healthcare Interfaith policies Diet issues Healthcare organisations should implement strategies to recruit, retain, and promote at all levels of the organisation a diverse staff and leadership that are representative of the demographic characteristics of the service area.	9. Be delivered in a spirit of collaboration

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
1.3. Equality framework including culture proof of documents template for equality proofing, service planning and delivery	Equality auditing and proofing of service provision Staff aware of legal requirements Diversity benchmarking Culture proofing Seek advice Recruiters trained to eliminate discrimination	8. The need for staff, patients and community to be monitored and checked 10. Concerns, complaints and grievances tackled 9.Outcomes should be monitored (implicit) 20. Quality standards a framework to MF quality development organisational legal standards		Equality frameworks, govt, HR, Legal Equality and Diversity officer or dept Equality audits	6. Be delivered in a manner that fully respects the right and dignity of the individual 7. Be delivered in a manner that is culturally sensitive 5. Take account of the complex , multifaceted, interrelated dimensions of settlement and integration 11. Be oriented towards promoting positive change in the lives of newcomers and in the capacity of society to offer equality of opportunity for all
1.4. Ethnic Monitoring systems including an agreed framework for date collection and usage	Race Ethnicity Language Document problems, incidents and complaints	23. Ethnic and migrant background information for epidemiological socio-behavioural clinical	Country of origin, Ethnic background Legal status Language Occupation, Education level Is it used for service planning?	Collect data pertaining to ethnic origins and use it to inform diversity training Race, Ethnicity Spoken and written language Demographic Culture and epidemiological profile	12. Be based on reliable up to date information

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
Strand 2 Workplace Environment					
2.1. A tiered approach to intercultural training	Cultural awareness developed in consultation with stakeholders MECs consulted for training Training in-house or external Ad-hoc or coordinated: Train the trainer; are staff informed of need for cultural training; Is training part of corporate strategy; Is training offered as a core or optional add on English and foreign language courses; 3rd level schooling; Sessions on major ethnic groups e.g. travellers training Is training multidisciplinary For all frontline staff Is training over time to allow reflection? Online or face to face Do staff attend conferences?	3. Training 11. Investments in capacity building staff cultural and linguistic competence 13. Staff need to build capacity in cross cultural and communication and diversity related competencies 14. Clinical training levels 16. Mental heath awareness training	Policies of training and development for migrant staff MF training to staff communication, language interaction skills cultural competency Specific health problems prevalent to MECs Working with interpreters	Staff all levels receive ongoing training Extensive array of intercultural training English as a foreign language Train the trainers Courses face to face and on line	6. Be delivered in a manner that fully respects the right and dignity of the individual 7. Be delivered in a manner that is culturally sensitive 5. Take account of the complex , multifaceted, interrelated dimensions of settlement and integration

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
2.2. Workplace support structures to support staff to manage issues relating to cultural diversity	Resource packs readily available on cultural religious norms of MECs Bereavement info burial death and dying Multi-denominational chaplaincy service (staff reflect patients) Language guides/intra net, legislation, interpretation policy, cultural competence links Staff meetings on issues related Staff contact lists re cultural issues Harassment & bullying & grievance procedures Anti-discrimination guide		MF written process regulations, manuals, guidelines and standards	Booklets and brochures outlining policies to manage situations where health and culture clash Cultured proof booklets on health care issues Multi-denominational chaplaincy service Grievance procedures and conflict resolution for patients/consumers	

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
2.3. Development of initiatives to integrate and manage multicultural teams	Multicultural team training to all staff Career development Buddy and mentor system			Preparation work with existing staff Career development programs for overseas staff Mentor programmes and buddy systems	
2.4. Training method to include co-facilitation by MEC	Use MECs and travellers Does the hospital make resources available to MECs to build their capacity design? Deliver and evaluate training				
Strand 3: Support to intercultural training					
3.1. Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	Links to MECs conferences etc. Outreach information health education programmes to MEC associations Use cultural mediators support workers MECs to explain hospital procedures to patient advocates Patient involvement where MECs express needs	22. Networks, educational exchanges and research 21. Outreach literacy 2. Increased awareness of disparities through patient involvement programs 4. Development partnerships/links with MEC advocacy groups 15. Patient education programs 17. Patient forums with	Culturally sensitive patient education programmes Provision of culturally sensitive health promotion services External marketing MF newsletter MF Open house MF flyers in community	Collaborative partnerships formal/informal in designing and implementing CLAS activities Services accessible and inviting to MECs Outreach programs to MECs Prayer facilities Intercultural food projects Patient involvement	3. Empower clients 4. Respond to needs as defined by users 8. Promote the development of newcomer communities and newcomer participation in the wider community and develop communities that are welcoming of newcomers

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
		MECs 18. MECs/Advocates on committee		programmes led by senior management Proof patient information documentation Cultural Mediators Cultural support workers	
3.2. Signage particularly in reception and public areas in key languages of service users	Key areas translated Access to interpretation indicated Posters to promote intercultural health care and diversity Touch screens translated	15. Literacy and health literacy at all levels of service	Visual orientation system Sign posts pictograms	Publish the right to language service Provide signage in the language of the commonly encountered groups and representatives in the service area	
3.3. Literature in the key languages of service users	Relevant literature in key languages Proof read Website translated	15. Literacy and health literacy at all levels of service	Patient info translated into language of local community Patient info culturally specific pictographs Hospital info for prospective patients translated Hospital info culturally specific pictograms	Easily understood patient related materials	

WOA Framework Irish health service	Irish recommendations and international best practices UK / Australia 2005	EU Amsterdam Declaration 2004	Migrant Friendly Quality Questionnaire 2004	Culturally and linguistically Appropriate Services USA 2001	Canada "Best practice Guidelines for Health Service Delivery for Newcomers" 1998
			Hospital info available in community Provision or discharge or post discharge care translated Culturally appropriate forms		
3.4. A comprehensive interpretation service	Comprehensive service accessible to all staff Telephone, Face to face 24/7, is staff aware of service? Is staff trained to use interpreters? Is there a policy? Are there guidelines for staff? Staff as interpreters? Are interpreters qualified? Are interpreters trained in the medical field? Are hospital staff who speak more than one language are they used?	14. Need for cultural and linguistic competence of professionals if they are to be effective 15. Literacy and health literacy at all levels of service	Interpreting service Telephone External service Bilingual staff lists Cultural mediators Written procedures	Interpreters Bilingual staff No use of parents and friends with out request by patient Health care organisations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner that is compatible with their cultural health beliefs and practices and preferred language	

Appendix 6: Comparison of the building a culturally competent organisation: The Quest for Equity in Health Care 2011, the HPH TF MFCCH Project to develop Standards for equity in Health Care for Migrants and other vulnerable groups 2011, and a summary of the Irish WOA, including the Amsterdam Declaration, MFQQ, CLAS and the Canadian approaches, categorised into the WOA framework.

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
Strand 1 Organisational ethos			
1.1. Specific initiatives that demonstrate the commitment and support of managers	Make cultural competency an institutional priority. Has your board set goals on improving organizational diversity, providing culturally competent care and eliminating disparities in care as part of your strategic plan? Is diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers?	Standard 1: Equity in policy The organisation promotes equity by providing fair opportunities in Health care and contributes to reducing health differentials to the lowest possible level through the delivery of sustainable and cost effective policies. Objective of the standard: To define how the organisation should develop policies, governance and performance monitoring systems which promote equity. Sub-standards 1.3: The organisation has a fully resourced plan in place which describes how it will develop capacity to promote equity, which is integrated with existing management	Mission statement, vision or value statement or equality statement Strategic plan, policy or action plan referring to MF care Links to 3rd level research & teaching, educational exchanges and research Networks, Senior management led initiatives (monitored by leadership, management or quality management) (CLAS accountability, performance management systems linked to diversity and equality (competence measured in patient satisfaction and outcome based evaluations) encouraged to publish information about progress Diversity committees that include members of

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
		instruments and is reviewed annually. 1.5 : The organisation has a champion for equity at a senior/ executive level. 1.6 : Equity is explicit in the annual performance objectives of all managers. Standard 3:Equitable quality of care The organisation provides high quality of care for all, acknowledging the unique characteristics of the individual and acting on these not only to improve individual health (through care, prevention...), but also social wellbeing. This means providing person centred care. Objective of the standard: to assist the organisation in developing the following areas so that they respect the uniqueness of patients: patient assessment, staff / patient interactions, safe environment, discharge and continuity of care. Standard 5: Promoting equity The organisation understands that it is part of a wider system and is able to promote the principles of equity across services.	MECs and are multidisciplinary MEC involvement in committees, patient or advocacy groups. Adequate resources and financial resources i.e. Budget Is there a project leader or responsible for Diversity & Equality (a champion at senior level)?

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
		Objective of the standard: to support the organisation in promoting equity externally in its wider environment through: Advocacy and lobbying, facilitating capacity building, disseminating research, developing education and promotional work. 5.1 The organisation is an active participant in policy networks/ think tanks/research initiatives which promote equitable approaches. Standard 2:Equitable access and utilisation. The organisation ensures for equal need, equitable access to available care and utilisation. Objective of the standard: to encourage the health organisation to eliminate: legal barriers, multiple diversity barriers, linguistic barriers, information barriers, organisational barriers, financial barriers, resource barrier.	
1.2. Up to date intercultural policy for health services	4. Develop culturally competent disease management programs. • Does your hospital gather information to determine conditions of high prevalence within your community's minority populations?	3.2 The organisation has systems in place to recognise individual patients' experiences and living conditions, and is able to take account of the diverse concepts about health and illness in	Code of practice for anti-discrimination practices and policies for how to handle discrimination Clarify the expectation of staff regarding

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
	• Does your hospital offer disease management programs that effectively address these conditions? • Do your disease management programs address the barriers to care that are particularly challenging for minority patients? 5. Increase diversity and minority workforce pipelines. Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race or ethnicity? Are search firms required to present a mix of candidates reflecting your community's diversity? Do your recruitment efforts include strategies to reach out to racial and ethnic minorities in your community? Do you acknowledge and honour diversity in your employee communications, awards programmes and other internal celebrations? Does your human resources department have a system in place to measure diversity progress and report it to you and your board? Are core services in your hospital, such as	meeting their health care needs. 3.3 The organisation demonstrates that it is able to take into account the social context of the patient in order to improve the quality of care for the patient. 3.6 The organisation is able to acknowledge and address the enactment of inequity, discrimination and racism. 5.1 The organisation is an active participant in policy networks / think tanks / research initiatives which promote equitable approaches. 5.2 The organisation actively diffuses the results of research and practice, locally, regionally, nationally and internationally.	diversity issues Bereavement policies and guidelines appropriate mortuary, alters & symbols etc Adapted diet (halal etc.), revision of menus Interfaith policy including prayer rooms, multi-denominational chaplain services, MF culture days annual presentation days, diversity celebration weeks Interpretation policy Family visits policy Newsletter Policies for training migrant staff List of MF staff & contacts Network migrant associations / Consultation NGOs Policy of recruitment, retention and promotion of diverse staff (USA that are representative

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
	signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?		of the demographic of the characteristics of the service area (non Irish) A Diversity & Equality policy Consultation with staff & patients on intercultural health care
1.3. Equality framework including culture proof of documents template for equality proofing, service planning and delivery	2. Identify and report disparities: do you compare patient satisfaction ratings among diverse groups and act on the information?	1.1 The organisation has governance systems in place to ensure that decisions promote equity at all levels. 1.2 The organisation's research, monitoring and evaluation systems measure equity performance. 3.1 The organisation ensures that procedures are in place to assess the needs of a multiple-diversity patient and population. 3.4 The organisation ensures that systems are in place to obtain feedback from all patients and that this information is used in service improvement. 3.5 The organisation is able to create an environment that is safe for the patient where there is no assault, challenge or denial of his/her identity. 3.6 The organisation is able to acknowledge and address the enactment of inequity,	Culture proofing of documentation Equality auditing /Review *(equality impact assessments* *Equality/cultural* Proofing of service provision Staff aware of legal entitlements and requirements regarding equality *(handbook or circulars on 9 grounds)* Diversity benchmarking Seek advice externally IBEC, Cairde Recruiters trained to eliminate discrimination & recruitment process Need to evaluate staff, patient and community outcomes Links to quality standards (limited not

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
		discrimination and racism. 5.1 The organisation is an active participant in policy networks/ think tanks/research initiatives which promote equitable approaches 5.3 The organisation ensures that equity is reflected in all partnership agreements and relationships, suppliers, including contracted services and joint collaborations. 2.1 The organisation ensures the implementation of the right to health for all, in particular for disadvantaged groups. 2.3 The organisation ensures that physical accessibility to and distribution of health services are equitable and acceptable to all.	explicit) Grievance & complaints procedures (hospital incident reporting policy. Risk management occurrence, flagging diversity incidents, staff required to report incidents, staff supervisors required to investigate.
1.4. Ethnic Monitoring systems including an agreed framework for date collection and usage	1. Collect race, ethnicity and language preference (REAL) data. Do you systematically collect race, ethnicity and language preferences of all your patients? Identify and report disparities	2.2 The organisation has a good understanding of the characteristics of its population, including health inequalities.	Country of origin Race Ethnicity Language spoken and written Legal status

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
	Do you use REAL data to look for variations in clinical outcomes, resource utilization, length of stay, and frequency of readmissions within your hospital? Do you actively use REAL data for strategic and outreach planning?		Occupation Culture and epidemiological profile Migrant background Use information to inform diversity training
Strand 2 Workplace Environment			
2.1. A tiered approach to intercultural training (systematic)	Provide culturally and linguistically competent care. Have your patient representatives, social workers, discharge planners, financial counsellors and other key patient and family resources received special training in diversity issues? Based on the racial and ethnic diversity of the patients you serve, as well as those in your service area, do you educate your staff at orientation and on a continuing basis about cultural issues important to your patients?	1.4 The organisation ensures that staff at all levels have relevant awareness and competence to address inequities in health care.	Systematic and ongoing tiered approach Level 1 Orientation (equality and cultural diversity) Level 2 Cultural Awareness Level 3 Specific professionals Level 4 Intercultural Dialogue Level 5 Multicultural teams Level 6 Legal & business case Cultural awareness developed in consultation with stakeholders including members of MECs Training in-house or external Ad hoc or coordinated (periods of both) Train the trainer programmes

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
			Are staff informed of the need for cultural training Is training part of corporate strategy? Is training offered as core option or optional ? English as a foreign language / 3rd level schooling Training on major ethnic groups e.g. traveller community; Is training multidisciplinary? For all frontline staff? Is training over time to allow reflection? Online or face to face? Do staff attend conferences related to diversity ? Is there training on working with interpreters?
2.2. Workplace support structures to support staff to manage issues relating to cultural diversity			Resources packs readily available on cultural norms of MECs Bereavement and care for the dying packs Multidenominational chaplaincy services Language guides Point to picture cards/pictograms

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
			Intranet legislation Website on diversity or cultural competence in healthcare Interpretation policy and guidelines Staff meetings Staff contact lists regarding cultural issues Conflict resolution for patients and staff including bullying and harassment, grievance procedures Anti-discrimination guides, policies practices
2.3. Development of initiatives to integrate and manage multicultural teams			MCT to all staff Career development programs for overseas staff Buddy and mentor system Preparation work with existing staff
2.4. Training method to include co-facilitation by MEC			Use members of MECs to train e.g. members of the traveller community Does the hospital make resources available to staff who are members of MECs to build their capacity design, deliver and evaluate training?

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
Strand 3 Support to intercultural training			
3.1. Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	6. Involve the community - Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes? - Do you have a strategy to partner with community leaders to work on health issues important to community members?	Standard 4: Community involvement The organisation provides for effective information and intervention through proactive and outreach group engagement of its community. Groups in the community are seen as active participants rather than passive recipients. Objective of the standard: To support the organisation in the involvement of relevant communities in health service delivery and improvement. 4.1 The organisation has effective channels of communication with its communities. 4.2 The organisation works in partnership with community based mediators/social workers, etc. to engage with communities 4.3 The organisation monitors the range of people who take part in participation activities 4.4 The organisation has built evaluation into its processes. 2.4 The organisation ensures that communication, health literacy and mistrust	Links with MEC advocacy groups and on committees Links to MECs migrant health conferences Outreach information health education programmes to MEC associations Use cultural mediators support workers from MECs to explain hospital procedures to patient advocates Patient involvement where MECs express needs Outreach literacy Culturally sensitive patient education programmes Provision of culturally sensitive health promotion services External marketing: MF newsletter, MF Open house, MF flyers in community. Hospital info available in community Website explaining hospital systems etc (translated)

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
		are not barriers to health services.	
3.2. Signage particularly in reception and public areas in key languages of service users	3. Provide culturally and linguistically competent care. Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?		Key areas translated. Provide signage in the language of the commonly encountered groups and representatives in the service area Posters to promote intercultural health care & diversity Touch screens translated if applicable; Visual orientation system; Sign posts pictograms Publish the right to language service/ Access to interpretation indicated
3.3. Literature in the key languages of service users	3. Provide culturally and linguistically competent care. Are your written communications with patients and families available in a variety of languages that reflect the ethnic and cultural makeup of your community? Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?		Relevant literature in key languages Proof read. Culturally appropriate documentation Patient info culturally specific pictographs, Provision or discharge or post discharge care translated Easily understood patient related materials (easy English)

WOA Framework Irish health service	Building a Culturally Competent Organisation: The Quest for Equity in Health Care Health Research and Education Trust 2011	HPH TF MFCCH Project to develop Standards for equity in Health care for Migrants and other vulnerable groups 2011	Summary of Irish, EU Declaration, MFQQ, CLAS & Canadian
3.4. A comprehensive interpretation service	Has your hospital developed a "language resource", identifying qualified people inside and outside your organization who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?		Comprehensive service, accessible to all staff, Telephone, Face to face, 24/7. Is staff aware of service? Is staff trained to use interpreters? Is there a written policy? Are there guidelines for staff? Are interpreters qualified? Are interpreters trained in the medical field? Are hospital staff who speak more than one language used as interpreters? A need for cultural and linguistic competence of professionals if they are to be effective Are parents and friends used without request by patient?

Appendix 7: Letter of application to ethics committee H4

Research Ethics Committee
H4

25th, June 2010

Dear Sir/Madam

I am a PhD student at the end of my second year of a three year program in the Ecole de Management Strasbourg, University of Strasbourg. Having spoken at length with Mr "X", Training and Development Manager, and with his agreement to be my sponsor for the purposes of this research, I am writing in application to conduct non-clinical research in the hospital with 15 members of personnel as part fulfilment of my PhD requirements.

My PhD research is entitled:
Managing Ethno-cultural Differences in Healthcare Service Delivery in Hospital Settings: The Irish Experience

Please find attached the following documents:

1. Application Form
2. My CV
3. Research Participant Information sheet and letter of invitation to participants
4. Research Participant consent form
5. Letter from my University PhD director.
6. Question and Discussion headings for interviewee.

The research will aim to collect information to ascertain to what extent Hospital X has implemented policies and procedures to promote interculturalism across the organisation.

This research will contribute to wider research in the hospital sector designed to obtain the following benefits:

- Enable the comparison of different Irish experiences in regard to how hospitals have adapted to multicultural patient care populations.
- Development of best practices in Ireland on how to best manage and implement diverse patient care service provision.
- Provide an overview of the problems encountered by hospitals implementing intercultural policies and strategies.
- Results of the research could serve for international cross-analysis studies with other countries such as for example how hospitals in Ireland and France have managed patient diversity. A transfer of learning approach between different national health systems regarding this field.
- The research will assist knowledge in regard to implementation of policies and influence future health policies in the field of diversity management. Also the establishment of best practices will have positive effects on the service provision to ethno-cultural diverse patient populations in the coming decades.

Should you have any further questions or concerns please do not hesitate to contact me.

Yours faithfully

Kevin Mac Gabhann
Lecturer
Ecole de Management Strasbourg
University of Strasbourg

Appendix 8: H5 Respondent consent form

Respondent / Participant Number /I.D.

Title of project:

Managing Ethno-cultural Differences in Healthcare Service Delivery in Hospital Settings: The Irish Experience

Name of Principal Investigator: Kevin Mac Gabhann

I confirm that I have read and fully understood all the information provided in the accompanying Information Sheet and each of my inquiries about the study has been answered.

YES [ ] NO [ ] Initials [ ]

I fully understand that my participation is completely voluntary and that I am free to withdraw at any given time without providing a reason and it will not affect my care in any way.

YES [ ] NO [ ] Initials [ ]

I understand that the Researchers involved in this Research Study will hold in confidence and securely all collected data and other relevant information. Additionally, I understand that I will not be identified as a participant/respondent in this study (unless a legal requirement) and that the Researchers may hold my personal information for a ____ year(s) duration.

YES [ ] NO [ ] Initials [ ]

I agree to participate in the above Research Study.

YES [ ] NO [ ] Initials [ ]

Name of Respondent/Participant:

Printed_____Signature_____Date

Name of Person Taking Consent:

Printed_____Signature_____Date

Name of Researcher:

Printed Kevin Mac Gabhann_____Signature_____Date

Kevin Mac Gabhann
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Appendix 9: Explanatory letter and invitation to participate

Dear Sir/Madam

My name is Kevin Mac Gabhann, I am Irish and I am a lecturer at the Ecole de Management Strasbourg which is the business school of the University of Strasbourg in France. I live and work in France and am currently undertaking my PhD entitled:

Managing Ethno-cultural Differences in Healthcare Service Delivery in Hospital Settings: The Irish Experience

My objective is to study how the Irish national health system has taken into account ethno-cultural diversity in patient populations.

I am writing in request for employees of Hospital X to take part in my research as this is a critical element of my study. However, before you decide whether or not to take part, it is important that you fully understand what the research is about and what you will be asked to do. It is important that you read the following information in order to make an informed decision and if you have any questions about any aspects of the study that are not clear to you do not hesitate to ask me (see my contact details below). Please make sure that you are satisfied before you decide to take part or not.

Thank you for your time and consideration of this invitation.

Background of the Research Study

According to the Central Statistics Office of Ireland's Census of 2006 there are 420,000 foreign nationals living in Ireland. Demographic trends estimate further increases from 10.4 percent to 18 percent in non-Irish nationals living in Ireland by 2030. The question of how the Irish health sector has coped with such diversity in the management of hospitals and the provision of healthcare services merits investigation.

Research aims:

1). How have health care organizations, i.e. hospitals, accommodated ethno-cultural differences in patient populations?

2). How have Irish hospitals managed the provision of appropriate culturally sensitive health care service delivery to members of ethnic minority communities?

Description of the area of interest.

I wish to investigate how the Irish national health system has managed ethno-cultural differences in the provision of service delivery. To what extent have Irish hospitals put in place policies and procedures to provide culturally appropriate service provision to increasingly diverse patient populations and create intercultural care environments.

Procedure and aims/hypotheses of what is going to be studied.

The research sets out to examine how health systems have implemented adequate planning and delivery of care and support services encompassing the needs of ethnic minority groups. It is therefore of interest to investigate to what extent health care organisations, i.e. hospitals, have accommodated patient care diversity and how such hospitals have implemented and managed the provision of quality diverse patient care service delivery?

The objective is to detail the initiatives that Hospital X has put in place from a management and leadership perspective, (e.g. diversity committee) training and working environment (e.g. training programs) perspective, and a support to training perspective (e.g. interpretation, religious and diet services etc.).

Questions will concern for example policies regarding diet and nutrition, religious policies, signage, training, diversity committees, recruitment and retention and any other initiatives etc.

The research will aim to collect information to ascertain to what extent Hospital X has implemented policies and procedures to promote interculturalism across the organisation.

Methodology will be qualitative, case study approach and include a triangulation design, involving semi-directed interviews with 15 members of the personnel from various

departments of Hospital X. Interviews will last approximately one hour with each interviewee. The Whole Organisation Approach as recommended by the National Intercultural Health Strategy will be used as an interviewing guide.

Why as a Participant / Respondent have I been asked to take part in this study?

I would like to conduct interviews with approximately 15 different members of personnel working in different areas of the hospital (e.g. HR, Training, Administration, Catering, Care workers , Nursing, Director of Nursing, Physician, Quality, Diversity Committee members, Religion services, interpretation contact if possible etc).

Interviews will be based on how each service/function has adapted to the ethnic diversity in patients concerning service provision (e.g. policies, procedures, problems, successes etc).

Participation:

Taking part in this research study is entirely on a voluntary basis. Additionally, you will be required to sign a standard consent form. However, if you do not wish to take part and if you change your mind at any time you can withdraw from the research study without giving a reason.

During the Study:

It is intended that interviews will take place during the month of September 1st to 30th. Interviews will take place on site in Hospital X where I will meet you at your convenience. The interview will be a once off meeting lasting no longer than an hour maximum with one interviewer (myself) and questions will be asked concerning your experiences.

Should you have questions or concerns or need more information please do not hesitate to contact me at the following:

Contact details: Kevin Mac Gabhann

Lecturer and PhD Student Ecole de Management Strasbourg, University of Strasbourg, 61 avenue de la Foret-Noire, 67000 Strasbourg.

Your participation in this research will aid in the data collection of how hospitals have implemented policies and indicatives in order to promote interculturalism and allow the hospital sector to better serve its changing patient population by implementing best practices.

The data collected in the research here in Hospital X will be critical information for the completion of my PhD research and all information will be analysed and interpreted for the purposes of learning and progress in the field of diversity and hospital management in the 21st Century.

Confidentiality:

This research is part of my PhD studies and has no external funding and all costs are covered by myself. All information will be stored on my computer files and password protected. All aspects of anonymity will be respected before publication concerning individual names and I will respect any requests of any nature concerning anonymity.

Yours faithfully

Kevin Mac Gabhann

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UNIVERSITÉ DE STRASBOURG

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Managing Ethno-cultural Differences in Healthcare Service Delivery in Hospital Settings: the Irish Experience

La prise en compte des différences ethnoculturelles dans la prise en charge du patient à l'hôpital : l'expérience irlandaise

L'élargissement de l'Union Européenne à vingt-sept états membres, les flux commerciaux constants et la migration des peuples ont engendré une forte diversité ethnique et culturelle au sein de cet espace géographique. La diversité ethnoculturelle croissante se répercute sur les différents systèmes de santé qui sont confrontés au défi de s'adapter à la diversité des prestataires de services médicaux et de leur personnel, ainsi qu'à la diversité des usagers des services médicaux.

Nos travaux ont comme point de départ le multiculturalisme apparu en Irlande dans les années 1990 et le processus suivi pour mettre en place une stratégie d'ensemble, ou « Whole Organisation Approach » (WOA), qui sert de cadre aux hôpitaux afin de répondre au mieux à la diversité de leur personnel et à la diversité ethnoculturelle de leurs usagers. Le système de santé en République d'Irlande est intéressant, car il a tenté de planifier et de mettre en œuvre des services de soins et de soutiens qui tiennent compte des besoins spécifiques des minorités ethniques présentes dans un état nouvellement multiculturel.

Nos travaux analysent l'étendue de la mise en œuvre de la WOA pour la gestion de la diversité ethnoculturelle dans six hôpitaux en Irlande grâce à la recherche qualitative et identifient les facteurs qui favorisent et freinent la bonne mise en œuvre des trois volets de la stratégie adoptée par l'Irlande qui sont la déclinaison organisationnelle des valeurs de l'organisation, l'environnement de travail et les éléments de service nécessaires à la formation interculturelle.

Mots-clé : Minorité ethnique / Diversité ethnoculturelle / Soins de santé / Les hôpitaux

Europe in the 21st century is a continent of cultural and ethnic diversity. Recent enlargement of the European Union to 27 states, constant flows of free trade and the migration of people have resulted in an increasingly diverse Europe. National health systems face the challenge of accommodating the cultural diversity of healthcare providers and service users. The Irish health system is an example of a national health system which has attempted to implement adequate planning and delivery of care and support services, encompassing the needs of minority ethnic communities (MECs) in a new and rapidly changing multicultural Ireland.

This research focuses on the challenges of recent multiculturalism in Ireland and describes the Irish health sector's process in the construction of the Whole Organisation Approach (WOA) as the framework for Irish hospitals to respond to the management of diversity and the provision of culturally sensitive healthcare service delivery to members of MECs.

The aim of the research is to investigate how six hospitals have implemented the Whole Organisation Approach as recommended in the Irish Health Services Executive's National Intercultural Health Strategy 2007-2012. Research findings indicate to what extent the Irish strategy has been implemented in each hospital and outline factors that promote and impede successful implementation at a hospital level and analyses how each of the three strands, i.e. organisational ethos, workplace environment and service elements necessary to support intercultural training, of the WOA have been implemented across the 6 hospitals.

Keywords: Ethnic minority / Etno-cultural diversity / Healthcare / Hospitals