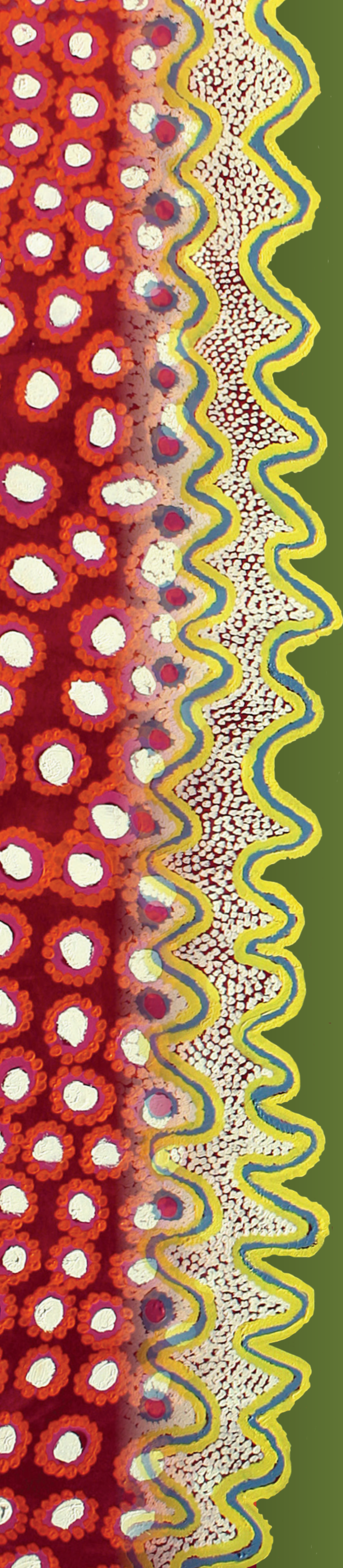

Managing Two Worlds Together

Stage 3: Improving Aboriginal Patient Journeys— **City Sites Case Studies**

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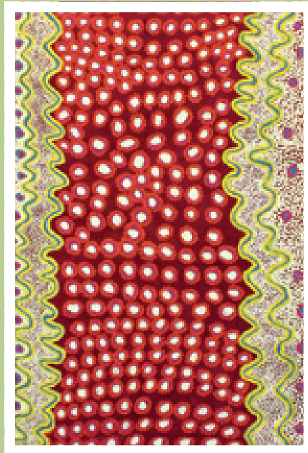
Natalie McCabe
Wendy McInnes
Michael Kirkbride
Amy Graham
Damian Rigney
Annapurna Nori



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Kuntjanu – Mingkiri Tjuta Tjukurpa (Marsupial Mouse Dreaming)

by Rama Sampson painting (no.74), courtesy Better World Arts

Managing Two Worlds Together

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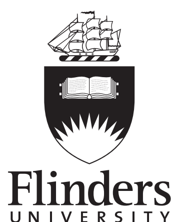

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Downloadable pdfs of the *Managing Two Worlds Together. Stage 3: Improving Aboriginal Patient Journeys—City Sites Case Studies* and the other four Case Studies, along with printed copies and a pdf of the Study Report and a writeable pdf of the Workbook, can be obtained from:

Department of Health Care Management
Flinders University
Bedford Park, SA 5042 AUSTRALIA

T: +61 8 8201 7755
F: +61 8 8201 7766
E: tiffany.carlin@flinders.edu.au
W: www.flinders.edu.au

The Lowitja Institute
PO Box 650, Carlton South
Vic. 3053 AUSTRALIA

T: +61 3 8341 5555
F: +61 3 8341 5599
E: publications@lowitja.org.au
W: www.lowitja.org.au

Authors: Janet Kelly, Natalie McCabe, Wendy McInnes, Michael Kirkbride, Amy Graham, Damian Rigney and Annapurna Nori

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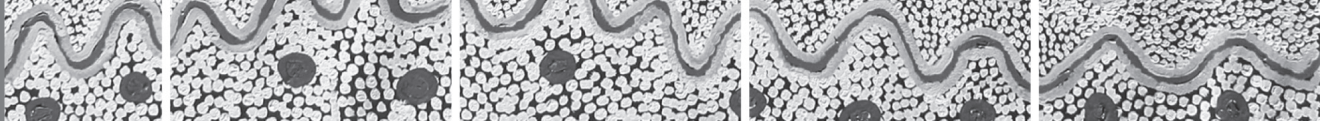

The Managing Two Worlds Together Project

The Improving Aboriginal Patient Journeys (IAPJ) study is the third stage of the Managing Two Worlds Together (MTWT) project. The MTWT project investigated what works well and what needs improvement in the health system for Aboriginal people who travel for hospital and specialist care from rural and remote areas of South Australia and the Northern Territory to city hospitals.

Stage 1 (2008–11) focused on understanding the problems that occur within and across patient journeys, and the barriers and enablers to access, quality and continuity of care. Challenges and strategies from the perspectives of individual Aboriginal patients, their families, and health and support staff and managers were examined using interviews, focus groups and patient journey mapping. Complex patient journeys were analysed and a patient journey analysis tool was developed collaboratively with staff, patients and carers.

Stage 2 (2012) focused on possible solutions and strategies. As the research team shared findings with health care providers, case managers and educators in a range of different health and education settings, the potential and scope of the Aboriginal patient journey mapping (PJM) tools for quality improvement, training and education emerged. The resulting tools consist of a set of tables that enable an entire patient journey to be mapped across multiple health and geographic sites, from the perspective of the patient, their family and health staff in each location.

Stage 3 (2013–15) involved an expanded research team and staff participants working together in a range of health care and education settings in South Australia and the Northern Territory. The aim was to modify, adapt and test the Aboriginal PJM tools developed in Stages 1 and 2. As the project progressed the basic set of tools was further developed with flexible adaptations for each site. This involved three steps – Preparing to map the patient journey, Using the tools and Taking action on the findings – organised into 13 tasks with prompt questions. Careful consideration was given as to how the information that emerged from the use of the tools could best highlight communication, coordination and collaboration gaps within and between different health care providers (staff, services and organisations) so as to inform the design of effective strategies for improvement. These were compared and combined with existing policies, practice and protocols.

Diagram 1 (below) sets out these three stages, along with the focus and outcomes of each stage.

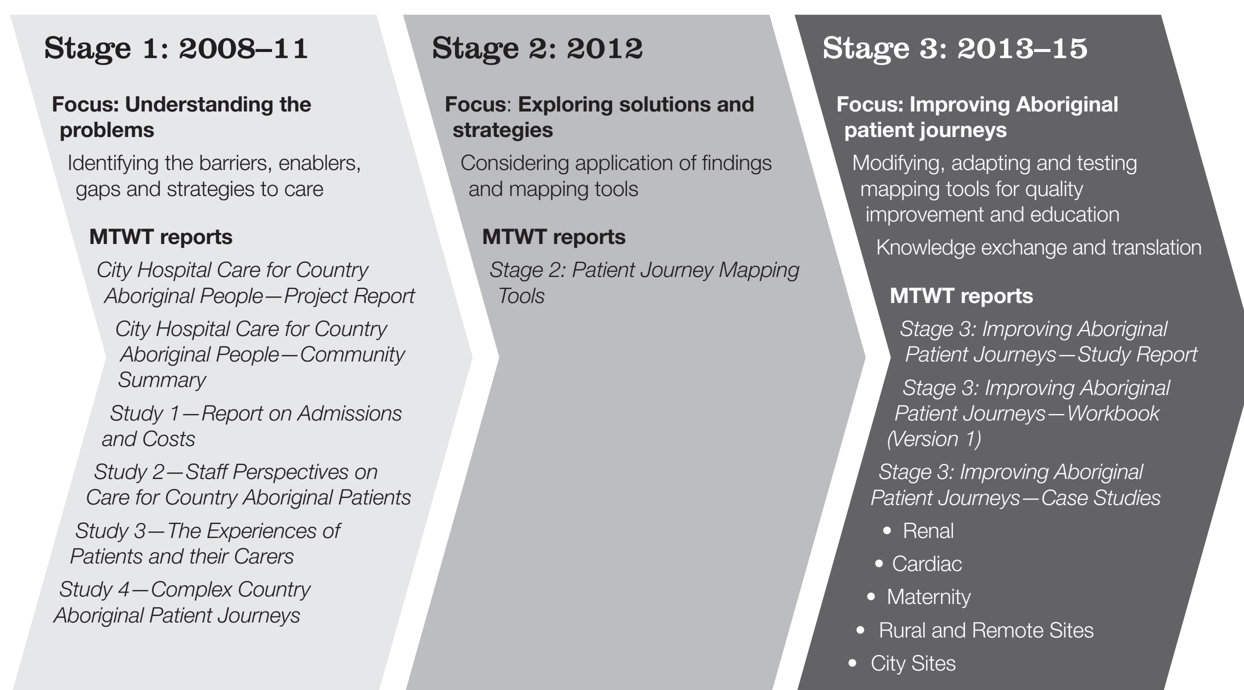

Diagram 1: The three stages, focus and outcomes of the Managing Two Worlds Together project

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Abbreviations and Terms

ALO	Aboriginal Liaison Officer
APPO	Aboriginal Patient Pathway Officer
ED	Emergency Department
GP	General Practitioner
IAPJ	Improving Aboriginal Patient Journeys
MTWT	Managing Two Worlds Together
OPD	Outpatients Department
PATS	Patient Assistance Transport/Travel Scheme – South Australia/Northern Territory
PJM	Patient Journey Mapping
RFDS	Royal Flying Doctor Service
TQEH	The Queen Elizabeth Hospital

Terminology

The use of the terms 'Aboriginal', 'Aboriginal and Torres Strait Islander', 'Indigenous' and 'Elder' reflect the preference of the people with whom we worked.

Aboriginal Patient Pathway Officer or APPO – A patient coordination role funded through the Council of Australian Governments; most of these positions are no longer funded.

Case study – The use of the term 'case study' refers to specific problem-solving activities undertaken by participating health staff to better understand and improve care for their patients. We also recognise individual patients as 'people' rather than 'cases'.

End of life – The point in a person's life where doctors identify that a person's health is deteriorating and they don't have long to live, and they move to a conservative health care pathway.

Key stakeholders – People who are impacted by, or may affect, the patient journey and the mapping exercise.

Patient – We have used the word 'patient' to identify the person undergoing a health care journey. In some services other terms may be used such as 'client'. At all times we recognise that 'patients' are individual people with unique personal, family and/or cultural needs and priorities.

Patient journey – The health care journey as experienced and perceived by a person, the family and staff.

About the City Sites Case Studies

This report on City Sites Case Studies is complemented by reports on four others – dealing with Renal, Cardiac, Maternity, and Rural and Remote Sites – published as part of the Improving Aboriginal Patient Journeys study, Stage 3 of the Managing Two Worlds Together project.

Four case studies from city sites are presented in this report:

- **Case Study A:** Supporting Patients in a Metropolitan Hospital
- **Case Study B:** Using the Tools across Disciplines
- **Case Study C:** Using the Tools in an Emergency Department
- **Case Study D:** Adapting the Tools for a Youth Health Assessment Tool.

All four describe the ways in which city-based staff adapted and used the MTWT patient journey mapping tools for use with Aboriginal patients in Adelaide. Aboriginal patients residing in Adelaide, as well as rural and remote Aboriginal people visiting Adelaide and using health care services(hospital and primary health care), were considered.

Case Studies A and B are based at the Queen Elizabeth Hospital and on the work of an Aboriginal Patient Pathway Officer (APPO) and a vascular nurse practitioner in quality improvement for patient care. Case Study C describes how an emergency nurse practitioner at the Lyell McEwin Hospital used the tools to highlight important aspects of patient-focused care, and Case Study D describes how the tools were adapted and used with a youth health audit tool.

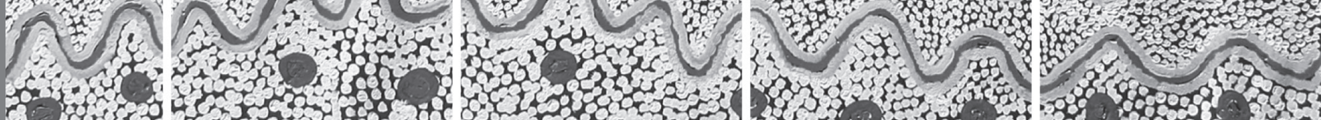
The purpose of these case studies is to:

- provide examples of how the MTWT patient journey mapping tools can be adapted and used in city health care settings for quality improvement and education
- identify communication, coordination and collaboration gaps and strategies
- provide hospital-based and primary health care examples of complex patient journeys.

Case Study A follows a similar format as described in the IAPJ Workbook and in Diagram 2. The other case studies provide an overview of what occurred. These activities are either works in progress, or part of larger projects where the case study itself will be reported in full by the participants. This report discusses the development and use of the tools, rather than the completed findings of each patient journey.

Key identifying factors in each patient journey have been omitted or changed to protect the privacy of people and their families. Ethics approval for the study was provided by Flinders University, the Aboriginal Health Research and Ethics Committee, The Queen Elizabeth Hospital Human Research Ethics Committee, the Central Australian Human Research Ethics Committee, and Menzies School of Health Research. Required governance arrangements (Site Specific Assessments) were also completed with each SA Health site involved.

Health professionals are invited to use the tools in their own setting, and to adapt and adopt them by adding columns or rows to focus on specific issues and concerns. Information on how to use the tools is available in the *Stage 3 Improving Aboriginal Patient Journeys—Workbook*. The Workbook, Study Report and the four other Case Studies are available at: www.lowitja.org.au/lowitja-publishing.



Contact details

For further information on the Improving Aboriginal Patient Journeys study, contact Dr Janet Kelly, IAPJ Study Leader at E: Janet.kelly@flinders.edu.au or T: +61 8 8201 7765.

To discuss case study details with the participants involved, please contact them directly:

- **Case Study A:**

  Natalie McCabe, *formerly* Aboriginal Patient Pathway Officer, at E: natalie.mccabe@tafesa.edu.au

  Elizabeth Sloggett, *formerly* Manager, The Queen Elizabeth Hospital, at E: Elizabeth.Sloggett@health.sa.gov.au

- **Case Study B:** Wendy McInnes, Vascular Nurse Practitioner, The Queen Elizabeth Hospital, at E: Wendy.McInnes@health.sa.gov.au

- **Case Study C:** Michael Kirkbride, Emergency Nurse Practitioner Emergency Department, Lyell McEwin Hospital, at E: michael.kirkbride@health.sa.gov.au

- **Case Study D:**

  Amy Graham, Aboriginal Clinical Health Worker and researcher, Watto Purrunna Aboriginal Primary Health Care, at E: Amy.Graham@health.sa.gov.au

  Damian Rigney, Aboriginal Clinical Health Worker and researcher, Watto Purrunna Aboriginal Primary Health Care, at E: Damian.Rigney@health.sa.gov.au

  Dr Annapurna Nori, Public Health Physician, Watto Purrunna Aboriginal Health Service, at E: annapurna.nori@health.sa.gov.au.

The Patient Journey Mapping Process

By the end of the study the process of mapping Aboriginal patient journeys consists of three main steps:

- Step 1: Preparing to map the patient journey
- Step 2: Using the tools
- Step 3: Taking action on the findings

Each step involves a number of tasks that were developed throughout the project by pulling together the experiences of staff participants involved in testing and using the Aboriginal PJM tools. Diagram 2 (below) provides an overview of these tasks.

It is important to note that in this and other Case Studies not all of the tasks described here are carried out fully in every case study. This is because the case study activities occurred before the final version of the tools and tasks were developed.

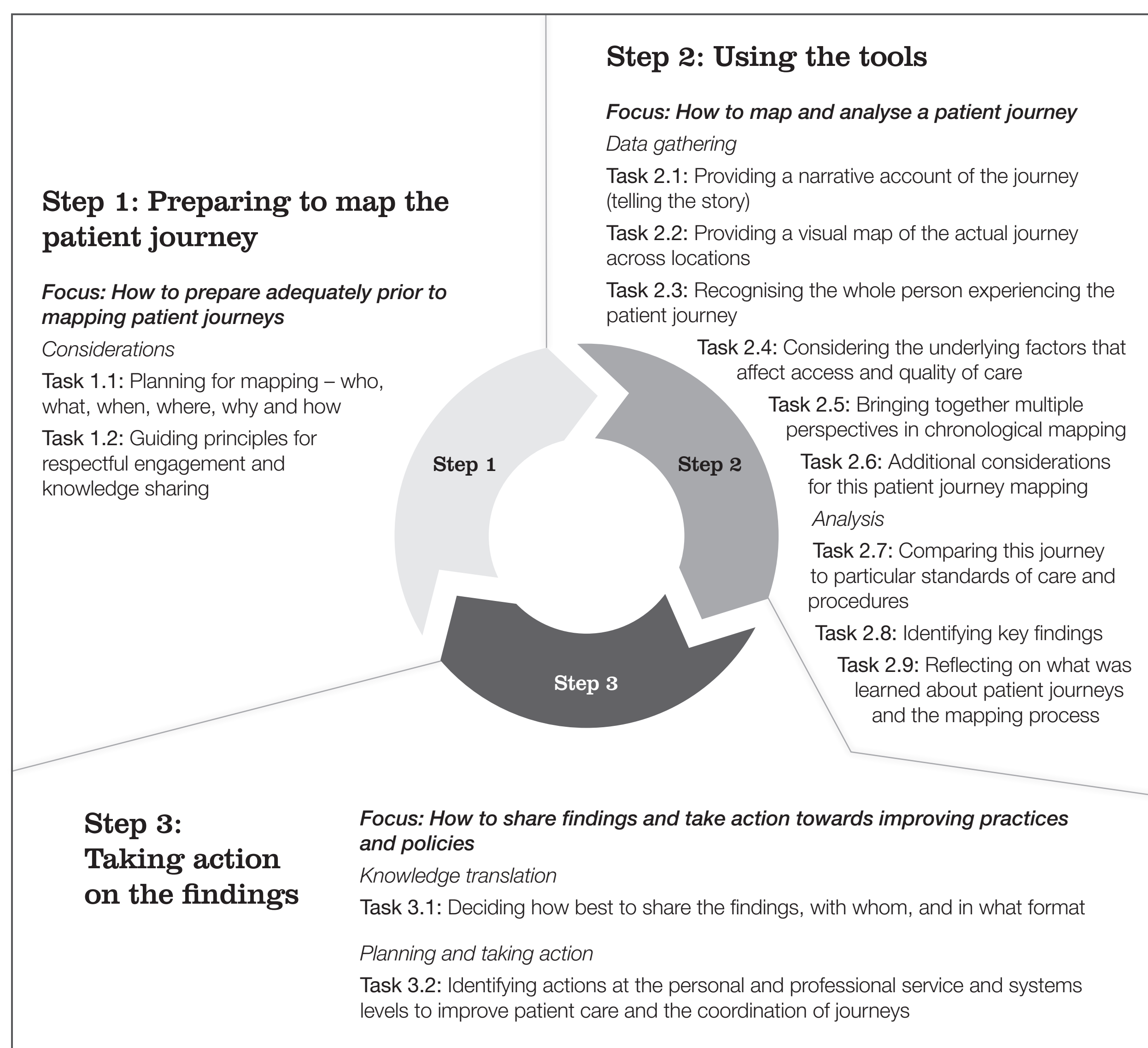


Diagram 2: The process of using the Aboriginal PJM tools – an overview

Case Study A: Supporting Patients in a Metropolitan Hospital

Authors: Natalie McCabe and Janet Kelly

Who was involved in the mapping?

Natalie McCabe worked as an Aboriginal Patient Pathway Officer at the Flinders Medical Centre and The Queen Elizabeth Hospital (TQEH). She became interested in mapping patient journeys as a way to record her work and began mapping journeys at TQEH with the support of her manager. Natalie has worked in a wide range of Aboriginal community-controlled and mainstream health services in South Australia and the Northern Territory.

The focus of this case study

This case study describes how an APPO adapted and used the tools to record the (often unrecognised) levels of coordination and support she provided for Aboriginal patients. It also includes an emphasis on discharge planning, which the hospital was focusing on improving at the time.

Step 1: Preparing to map the patient journey

Task 1.1: Planning for mapping – who, what, when, where, why and how

Natalie was involved in supporting a young woman who came to TQEH for assessment and treatment. This young woman lived interstate and had significant personal, social, family and cultural concerns. Natalie determined that the aim of mapping this journey was to:

- present the patient's perspective of hospitalisation
- identify the different staff involved in in-hospital care of one patient
- highlight the important role of supporting Aboriginal patients and coordinating Aboriginal patient journeys
- identify the gaps, timing and effectiveness of discharge planning.

Task 1.2: Guiding principles for respectful engagement and knowledge sharing

This case study was conducted retrospectively using case notes; however, Natalie was very mindful of engaging respectfully with patients, their families and staff, and of providing a range of viewpoints. During follow-up appointments the patient was made aware of plans to review patient journeys as a hospital quality improvement process. The patient provided feedback that was used to present the patient's perspective in Tables 1 and 2. Information about the MTWT Stage 2 project was provided as part of the informed consent process and Natalie took care to de-identify specific aspects of patient journeys if they were discussed outside the hospital setting.

In the process of writing this case study:

- Natalie and Janet met to discuss the tools and how they could be adapted
- Natalie used case notes, emails and her daily log book to map the patient journey and her role within it
- Natalie and Janet met to discuss where exactly some aspects could be placed within the tools.

Natalie discussed the findings with her manager, particularly those relating to discharge planning. These findings were taken to management meetings for action.

Step 2: Using the tools

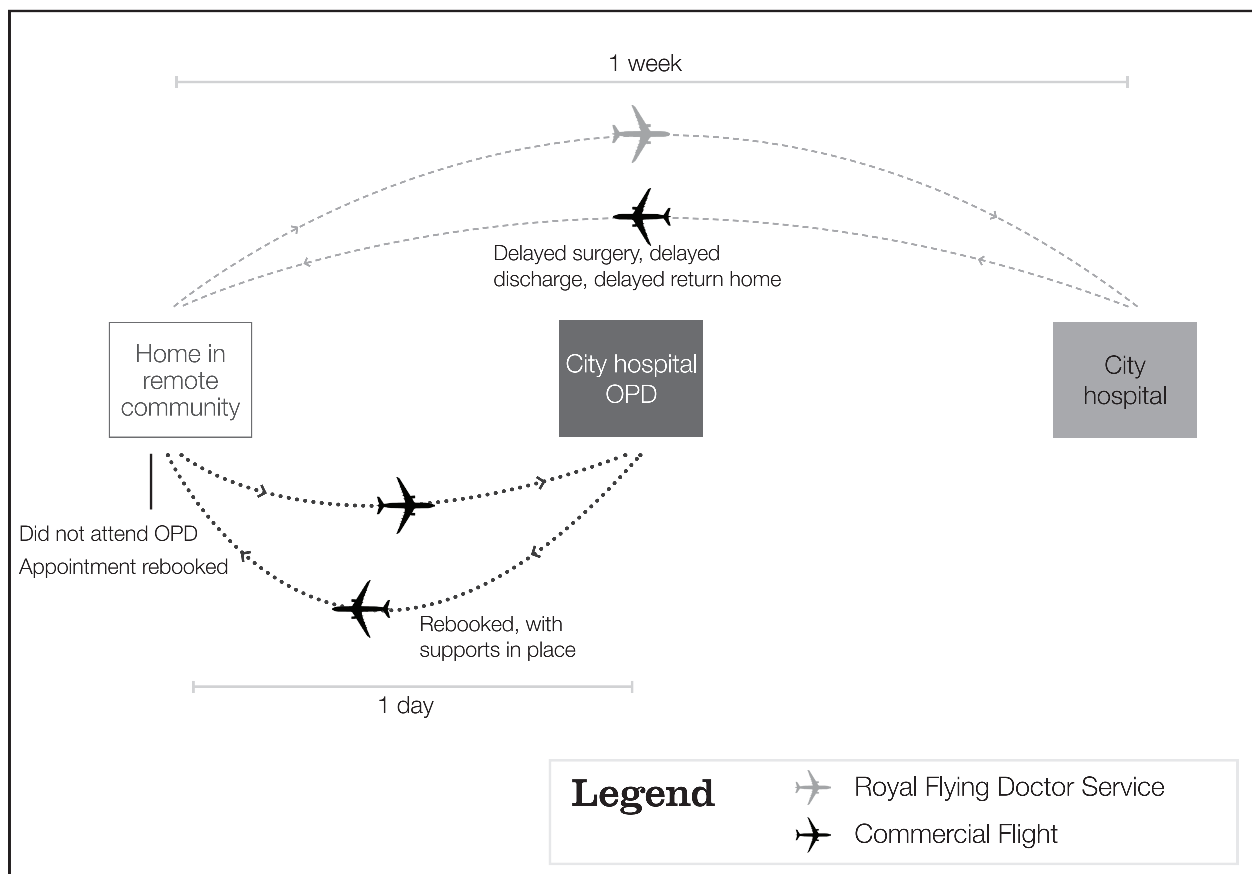
Task 2.1: Providing a narrative account of the journey (telling the story)

A brief and modified description is given to maintain confidentiality of the patient.

A young woman was flown to Adelaide for health care and treatment following a violent incident. She cares for a family member and wished to return home as soon as possible. She was very fearful of being in a city hospital alone because previous family members who had gone to city hospitals had died there. Specific strategies and coordination were required to meet her complex social, financial and cultural needs. Her surgery was delayed and much support was needed to prevent self-discharge. Although rapid discharge following surgery was planned, a communication breakdown between staff prevented this from occurring. Once discharged, the woman did not wish to return for her Outpatients Department (OPD) appointment and specialised X-ray. The APPO and the woman's local Aboriginal Health Worker arranged a day trip with increased support for her follow-up appointment, which she did attend.

Task 2.2: Providing a visual map of the actual journey across locations

This visual map highlights the repeated nature of this patient journey.



Case Study A – Figure 1: Visual mapping

Task 2.3: Recognising the whole person experiencing the patient journey

Natalie modified Table 1 to record the woman's other aspects of health.

Case Study A – Table 1: Dimensions of health

Dimension of health	Situation	
	Local community	**City/regional hospital**
Social and emotional wellbeing **Family and community commitments** **Personal, spiritual and cultural considerations**	Young woman who usually lives interstate with a family member for whom she is a carer, and in close proximity to extended family The local Aboriginal health service noted that she does not usually engage with health services, has a history of social issues including alcohol misuse, family breakdown, and domestic violence with past emergency admissions to the local hospital	Really fearful of leaving her community and being alone in the city – scared of extended admissions and not being able to return home Concerned about her family member and who is looking after them Concerned to be leaving family due to recent deaths of family members, including in hospitals
Physical and biological	Usually well, but involved in a violent incident	Face injury, with speech preserved

Task 2.4: Considering the underlying factors affecting access and quality of care

Natalie expanded and adapted Table 2 to include the issues and details about the actions taken, particularly regarding cultural safety. This table enabled Natalie and her manager to demonstrate often unrecognised patient perspectives and needs and the complex support work that Aboriginal staff provide.

Case Study A – Table 2: Underlying factors

Underlying factor	Impact of location and access	
	Issues	**Details and action taken**
Rural and remote/city	RFDS flight to Adelaide – patient is concerned about flying out	The local rural hospital ALO provided intensive support to seek patient consent for the trip; the patient only agreed after being advised there was an ALO who could support her on arrival
	Patient transfer back to airport	Nursing Specialist identified patient required staff support while travelling to airport – APPO arranged Corporate Shuttle and assured staff this would be culturally appropriate
	Outpatient follow-up but patient did not attend	APPO arranged with the rural health centre that they be informed of patient travel times and arrival so that they could ensure Corporate Shuttle was booked, but patient did not attend due to overnight travel
	Follow-up appointment	APPO contacted health centre to discuss reason, and arranged for follow-up rescheduling; agreed to meet the patient on arrival and supported her to attend OPD appointment and liaise with staff to negotiate completion of treatment to avoid returning for another planned OPD appointment Patient was much happier with additional support and arrangements that OPD appointment was fly in/fly out on the same day resulting in no overnight absence from family

Case Study A – Table 2 cont...

Underlying factor	Impact of location and access	
	Issues	**Details and action taken**
Impact of illness or injury	Alleged assault	Staff concerned patient will return to harmful environment and seek APPO input to discuss with patient APPO makes necessary links with rural health and support services for ongoing support, to enable a safe patient discharge plan
	Facture of the mandible	Jaw movement was impaired but speech preserved
	Alcohol dependency	Placed on alcohol withdrawal support for the first 24 hours of admission, did not require further treatment
	Surgery delayed	Patient anxious to leave hospital, willing to self-discharge when informed that surgery would be delayed Very anxious and asked that staff arrange return trip home immediately; APPO support to remain in hospital (ALO on leave)
	Follow-up care	Not willing to wait for recovery after surgery – APPO negotiates with staff that patient can return home immediately – writes up discharge plans
Language and communication	English is main language Anxiety is creating barriers for communication	Can use English for everyday conversation and to obtain consent Patient expressing fear through anger and requires APPO support to discourage self-discharge and reassure patient of discharge plans to support return home as soon as possible APPO provides brokerage supports to staff and specialist team to ensure culturally appropriate inpatient care and discharge planning is provided by explaining history, current concerns and informing staff of agreements/arrangements with patient and rural health carers
Financial resources	Low income recipient Emergency admission with domestic violence factors	Low income and emergency flight to Adelaide results in patient travelling without any clothing, shoes, identification, bank cards or cash Patient unable to have TV due to no money – APPO negotiates with Social Work to connect TV for three days to help provide patient with some comfort while waiting for surgery APPO arranges clothing and shoes, toiletries and writing material
	Smoker	Patient is a smoker and has no funds to purchase cigarettes, which adds to her anxiety and willingness to self-discharge Patient declines Quit patches, and resolves issue by obtaining smokes from other people in smoking areas
	Banking concerns	Patient requests short-term leave to go to the bank, but this request declined by specialist staff due to concerns she will self-discharge APPO negotiates to take patient but ward concerned patient will not return Patient concerned that she needs to withdraw her Centrelink payment from her bank before it can be withdrawn, leaving no food money for the family member she cares for, and herself APPO arranges dial out phone access so the patient can liaise with Centrelink support workers to modify payment destination

Case Study A – Table 2 cont...

Underlying factor	Impact of location and access	
	Issues	**Details and action taken**
	Travel requirements	According to the policy of her local PATS office the patient is required to pay her own way home and then claim a reimbursement, but the patient has no financial resources APPO seeks support from local Aboriginal Health Centre to obtain pre-approval from PATS for patient flights – not successful due to the fact that the patient's flight will be on weekend and PATS pre-approval requires discharge sign-off with a date of flight Discharge date cannot be given by Ward until after surgery and assessed in recovery APPO liaises with Rural Liaison and Specialist Staff who approve for TQEH to arrange flight and TQEH will pay and then seek reimbursement from PATS
Cultural safety	City hospital is foreign and scary	Patient has never been to a city hospital before Many family members have died in Adelaide hospitals and it is considered a one-way trip She has no known family living in Adelaide and feels isolated and alone, as she usually spends the majority of her time with family members On admission staff assumed the patient was accompanied by a family member, but she travelled alone Nurse Specialist consults with the patient soon after arrival and recognises need for cultural support – makes referrals to ALO and then APPO ALO on leave during patient admission – patient was expecting ALO support; staff contacted APPO for ALO support APPO liaised with home community hospital for background information relating to engagement, fears and follow-up care (local rural hospital unable to provide follow-up care) APPO liaised with local Aboriginal Health Service to arrange referrals and ongoing outreach support to ensure patient continuity of care and assist with return OPD appointments in Adelaide

Task 2.5: Bringing together multiple perspectives in chronological mapping

Natalie worked on bringing together the multiple perspectives of the woman and various staff members. At the time of this mapping, the hospital was emphasising the importance of early discharge planning, and so Natalie and her manager incorporated an emphasis on discharge planning by adding it to row and column headings. Natalie also wished to highlight the many different people and services within the hospital that were involved in this young woman's care, and so listed them and identified their involvement by ticking the places within the journey that they worked with or for the patient.

Case Study A – Table 3 (Part a): Multiple perspectives – first diagnosis to surgery

Perspective	Patient history	Trip to city	Admission	Care surgery/ treatment	Discharge/ transfer	Referrals in-hospital + external	OPD/ follow-ups	Trip home	Follow-up
Patient's journey	Assault Alcohol Domestic violence	RFDS	Admitted to ward to await surgery	Plastic surgery	Possible self-discharge Flight to be booked after surgery and recovery PATS won't pay upfront costs	APPO Social Work Centrelink Aboriginal Health Centre (home community)	OPD patient did not attend Local Aboriginal Health Service aware of missed flight but not aware of issues Rearranged with APPO support	Arrange RFDS flight direct to home	Specialist follow-up X-ray not available near home – needs to return to city
Family journey	Family breakdown	No family travel with patient	Mother calls throughout admission – encourages admission but but argues with patient (reason unknown)				No family travel with patient for OPD appointment		
Patient priorities, concerns commitments		Away from family and home Fear of dying in city hospital Concerned about her brother's care Cultural concerns = low trust	Delays to trip home No money for TV, clothes smokes etc. Centrelink concerns	Fearful of surgery Surgery delayed + increased anxiety = anger and communication barriers with staff	Homesick Patient delayed by one day due to staff not reading back through notes/ handing over arrangements Patient anxious but relieved to know flight confirmed		Prefers local follow-up in own state, but is booked for OPD in Adelaide	Immediate return home after surgery Ward staff agree to book flight as soon as possible	Patient prefers to engage with local health service for ongoing follow-up care

Case Study A – Table 3 (Part a) cont...

Perspective	Patient history	Trip to city	Admission	Care surgery/ treatment	Discharge/ transfer	Referrals in-hospital + external	OPD/ follow-ups	Trip home	Follow-up
Discharge planning			APPO provides cultural brokerage between patient, specialist staff and ward staff to ensure patient needs and concerns are considered		Discharge planned for Saturday or Sunday – but did not occur as ward staff did not read notes or share information at handovers regarding flight arrangements – waited for ALO/APPO/ Rural Liaison to book on Monday	APPO referral to local Aboriginal Health Centre for patient travel arrangements and ongoing care	APPO referral to local Aboriginal Health Centre for patient travel arrangements to attend OPD appointment		
Rural ALO	✓	✓							
APPO	✓		✓	✓	✓	✓	✓	✓	✓
ALO TQEH	On leave								
Ward staff			✓	✓	✓	✓		✓	
Specialist Nurse			✓	✓	✓	✓		✓	✓
Registrar			✓	✓	✓				
Rural Liaison Nurse								✓	

Case Study A – Table 3 (Part a) cont...

Perspective	Patient history	Trip to city	Admission	Care surgery/ treatment	Discharge/ transfer	Referrals in-hospital + external	OPD/ follow-ups	Trip home	Follow-up
Social Work			✓						
Ward Clerk			✓						
OPD staff							✓		
Volunteers			✓						
Rural health interstate						✓	✓	✓	✓
Transport – bus							✓	✓	
What is working well		Liaison between Ward, Nursing Specialist and APPO		Collaboration between ward and specialist staff, APPO and Rural Liaison Nurse APPO + local health providers	Referrals by Nursing Specialist to APPO	Alerts by local health provider + APPO coordination			Information sharing/use of networks between interstate Health/ Aboriginal Health and APPO
Gaps/ disconnects		No escort No money No ALO Centrelink access and arrangements	Delays in surgery	Staff communication – poor handover of information between shifts				Different PATS requirements between states	

Task 2.6: Additional considerations for this patient journey mapping

Not required for this case study.

Task 2.7: Comparing this journey to particular standards of care and procedures

This case study was compared to the discharge policy of the hospital and it was found that there were key communication and planning gaps occurring in practice. These included discharge planning not being discussed by all staff as early in the patient's hospital stay as the policy suggested, and communication breakdown between staff members when a plan was put in place.

Task 2.8: Identifying key findings

Natalie and her manager summarised the key findings.

Things that are working well:

- liaison between Ward, Nursing Specialist and APPO ensured culturally appropriate support
- collaboration between Ward and Specialist staff with APPO and Rural Liaison, and between APPO and local health providers, ensured culturally appropriate transfer planning
- referrals by Nursing Specialist to APPO prevented self-discharge and led to future engagement with local health service
- alerts by local health provider ensured APPO could coordinate OPD care with travel and ongoing care, which reduced stress for the patient and led to appropriate health outcomes relating to this admission
- information sharing and use of networks between the local Aboriginal Health Service and the city hospital APPO ensured ongoing support for this patient and enabled her to return for her follow-up appointment
- volunteers provided sleepware and thongs for admission.

Gaps and disconnects:

- patient arrived without identification, money or clothing
- lack of escort led to anxiety for patient; having no money limited her ability to call family for support
- Ward staff not aware that the ALO was on leave – no notification system hospital wide to alert wards and no arrangements in place to automatically divert referral to APPO
- delays in getting through to Centrelink to speak to a Client Service Officer or ALO created financial anxiety for patient
- delays in surgery increased patient desire to self-discharge
- lack of information sharing at handover led to delay in discharge for patient
- PATS required patient to pay upfront for return travel – problematic for emergency admission patients without money/identification.

Five main things regarding discharge planning that need to be discussed with management

1. When the ALO is on leave, alternative arrangements are required.
2. Need for identification of the main person coordinating discharge planning.
3. Lack of communication between different shifts of ward staff delayed discharge.
4. Significant time spent arranging discharge due to multiple external agencies involved.
5. Significant PATS/travel arrangements.

Task 2.9: Reflecting on what was learned about patient journeys and the mapping process

Natalie and her manager focused their reflections on the three tables that were used.

In Table 1 it made more sense to combine social, family, cultural and emotional factors as they are often interchangeable (grief and loss from recent funerals, for example).

Table 2 provided a way to highlight the significant (and often hidden) work that Natalie and the Aboriginal Liaison Officers do to assist in improving access and quality of care, particularly in relation to improving the patient's perception of cultural and personal safety and wellbeing. We were all surprised by how significant this table became in the final mapping.

In Table 3 both Natalie and her manager wished to focus on discharge planning within a patient journey, about when it begins, by whom, and how effective the communication between different staff and areas of the hospital are. Discharge planning was added as both a row and a column. In addition, all the staff involved in the woman's care were listed to highlight the myriad of people who are involved in patient care within a hospital, and the need for effective communication and coordination across all of these.

Step 3: Taking action on the findings

Task 3.1: Deciding how best to share the findings, with whom, and in what format

Natalie and her manager identified that this case study could be used in multiple ways for multiple audiences. It could be used for staff education about patient perspectives and the implications of communication breakdown, it could be taken to management-level meetings to assist in decision making about continuation of positions, and it had a role in patient satisfaction and quality improvement strategies and discussions.

Task 3.2: Identifying actions at personal, professional, local service and systems levels to improve patient care and coordination of journeys

Natalie found the mapping to be an effective way to conduct reflective practice personally and professionally and made a commitment to keep using the tools. She has now moved into a counselling role and has adapted the tools to assist with mapping student journeys through the education system to identify the underlying factors impacting on successful study pathways.

Natalie's manager used the mapping/cases study to argue for improvements in discharge planning and staff communication, and also to lobby for TQEH to maintain the APPO role beyond the current nationally funded contract. This latter action was successful, and Natalie was one of the few APPOs to be re-employed in Adelaide and South Australia following the end of the initial funding round.

Case Study B: Using the Tools across Disciplines

Authors: Natalie McCabe, Wendy McInnes and Janet Kelly

Who was involved in the mapping?

Natalie McCabe worked as an Aboriginal Patient Pathway Officer at the Flinders Medical Centre and The Queen Elizabeth Hospital (TQEH). She became interested in mapping patient journeys as a way to record her work and began mapping journeys at TQEH with the support of her manager. Natalie has worked in a wide range of Aboriginal community-controlled and mainstream health services in South Australia and the Northern Territory.

Wendy McInnes works as a Vascular Nurse Practitioner at The Queen Elizabeth Hospital. She works with patients who experience a range of health concerns including fistulas, diabetic complications, wound care and amputations. Wendy became involved in the study when Natalie approached her to map vascular patient journeys together.

The focus of this case study

This case study discusses how knowledge about, and experience in, adapting and using the tools was transferred from one staff member to another, with an emphasis on working together across disciplines and units for quality improvement and continuity of care post-discharge. Due to the focus of the case study being on this process of knowledge exchange between staff, rather than the patient journey itself, only some of the mapping tasks are discussed.

Step 1: Preparing to map the patient journey

Task 1.1: Planning for mapping – who, what, when, where, why and how

Natalie and her manager identified different wards and units that she could approach to explore the benefits of using the mapping tools more widely. Wendy McInnes was interested in being involved and met with Natalie and Janet. Together we discussed what kind of patient journeys could be mapped, what currently happens for patients, and where and how services are provided. We invited Wendy to reflect on 'what works' and on the current challenges in patient care and patient journeys. This enabled us to consider the format that the tools may need to take to record entire patient journeys. Wendy then identified some recent patients whose journeys she would like to map.

Task 1.2: Guiding principles for respectful engagement and knowledge sharing

Both Natalie and Wendy agreed that they would like to speak to the patients and invite their involvement in mapping their journeys for continuous quality improvement. These patients had already returned home to rural and remote locations but were contactable by phone or during follow-up visits.

Step 2: Using the tools

Wendy and Natalie contacted a young man who had a recent journey and sought his agreement; although he did not wish to be directly involved, he was happy to answer any questions they had. Wendy and Natalie used the case notes to begin mapping the patient journey, adapting the underlying factors and multiple perspectives tables as required. Steps 2.1–2.7 are not shown as they would too clearly identify the patient.

Task 2.8: Identifying key findings

During the process of mapping, Wendy discovered that the young man had not received the rehabilitation that she thought was arranged in a nearby regional town. A breakdown in communication meant that the young man had missed being followed up.

Task 2.9: Reflecting on what was learned about patient journeys and the mapping process

Both Natalie and Wendy found that it was easier doing this work together than alone. Pooling skills of the vascular nurse practitioner and Aboriginal support person enabled the different perspectives and aspects to be understood more easily. Natalie had found it difficult to know what was significant or not in the vascular journey without the specialist assistance, and Wendy found that Natalie identified social and cultural aspects that she may have overlooked.

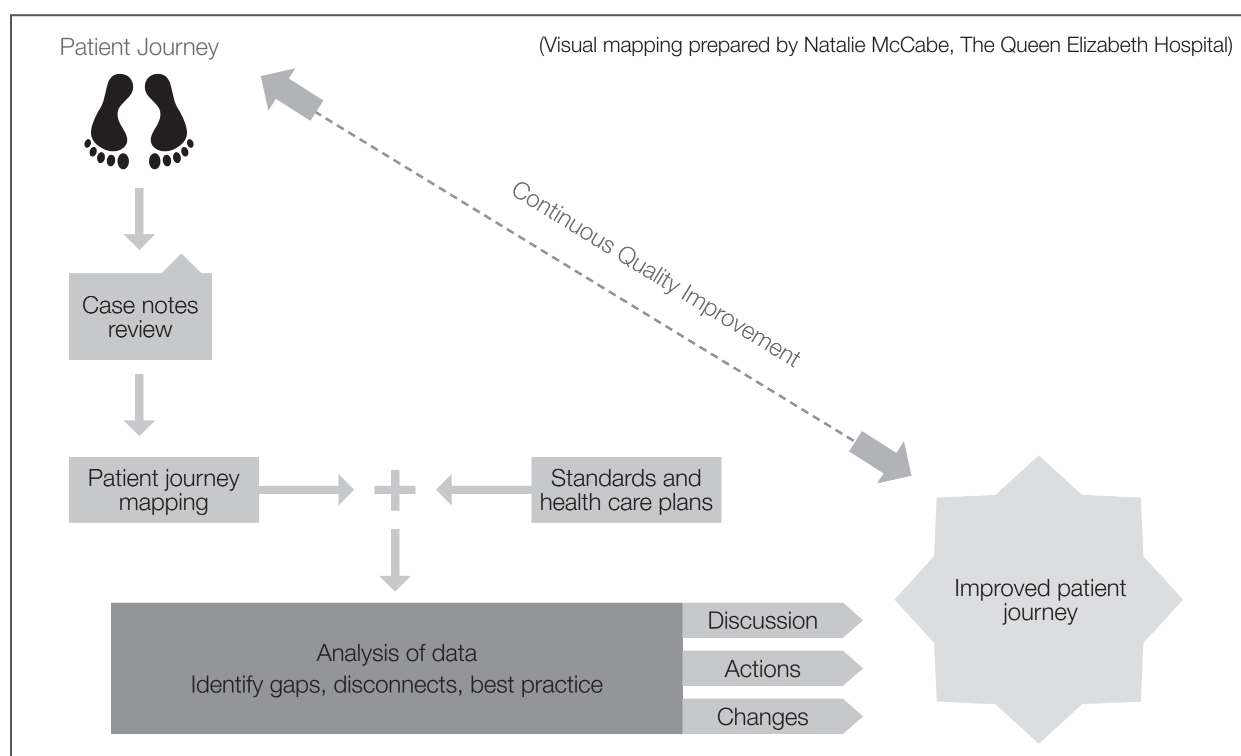
Natalie adapted the tools into an Excel spreadsheet, which enabled her and Wendy to include more indepth information.

Step 3: Taking action on the findings

Collectively and separately, Natalie and Wendy took multiple actions as a result of mapping this patient journey:

- Wendy spoke to the vascular unit about improved processes for follow-up care post discharge, and used this case study for the quality and safety audit later in the year; her time doing the mapping was recorded as part of her continuing professional development
- Natalie and Wendy used this case study (with the patient's permission) as a basis for a presentation at the Dignity in Care conference
- Natalie planned to continue mapping patient journeys with different units – however, this did not occur when she left the position.

One other action Natalie took was to design a single page diagram to explain the purpose, process and outcomes of mapping patient journeys (Figure 1 below). This was shared with other hospital staff and with this study.



Case Study B – Figure 1: Visual mapping – an explanation of the patient journey mapping purpose and process for city hospitals

Case Study C: Using the Tools in an Emergency Department

Authors: Michael Kirkbride and Janet Kelly

Who was involved in the mapping?

Michael Kirkbride works as an Emergency Department Nurse Practitioner at the Lyell McEwin Hospital in the northern suburbs of Adelaide. Michael has previously worked in rural and remote locations within South Australia and has a strong interest in improving quality care for Aboriginal people. He read about the patient journey mapping in Stage 1 and asked to become involved in Stage 3 of the project.

The focus of this case study

This case study describes a patient journey through a city hospital Emergency Department (ED) involving a nurse practitioner. It took place early in Stage 3 while the tools were still being developed and so involves the three main tables and only some of the tasks of the final version of the tools as described in the Workbook.

Step 1: Preparing to map the patient journey

Task 1.1: Planning for mapping – who, what, when, where, why and how

Michael had observed a number of interactions between staff and patients where communication breakdown and misunderstandings occurred and was seeking ways to educate ED staff about the complexity of patient journeys though hospital systems and health care, even in urban settings. He also wished to counter some the negative perceptions that some staff held about Aboriginal people, their behaviour, personal resources and motivations. We discussed the possibility of mapping two different patient journeys – one that worked well for the patient, the family and staff, and one that did not. Michael also wished to highlight the benefits for patients (particularly those for whom English was a second language) who were eligible to see a nurse practitioner and prevent being shuffled from one person to another in ED.

Task 1.2: Guiding principles for respectful engagement and knowledge sharing

Michael considered carefully which patient journeys he would like to map and contacted the patients involved to explain his intention and seek permission to use their journey stories. He sought to present the patients' perspective and how the hospital could best meet their needs.

Step 2: Using the tools

The prompt questions for the three tables were not yet developed. Through face-to-face meetings and ongoing email discussions, Michael and Janet discussed what belonged in each section of each table.

Task 2.1: Providing a narrative account of the journey (telling the story)

A young boy fell and sustained a nasty injury. The boy and his grandmother lived a distance from the hospital and did not have a car or ambulance cover, and his grandmother called for a local general practitioner (GP) locum to see him. The GP assessed his wound and dressed it, but gave minimal advice. The wound continued to cause problems for the boy and split open if he tried to do sport at school. After a few days his grandmother took him to the Lyell McEwin Hospital for assessment. They were quickly diverted to the nurse practitioner who introduced himself, asked the background story to the injury, assessed the wound and was able to provide/ coordinate appropriate treatment.

Task 2.3: Recognising the whole person experiencing the patient journey

Case Study C – Table 1: Dimensions of health

Dimension of health	Situation
Social and emotional wellbeing **Family and community commitments** **Personal, spiritual and cultural considerations**	This boy currently lives with his Grandmother in Adelaide in the northern suburbs and is from the Anangu Pitjantjatjara Yankunytjatjara Lands English is not the first language of either the boy or his Grandmother
Physical/biological	Young boy, no other physical illnesses

Task 2.4: Considering the underlying factors that affect access and quality of care

There were implications for the patient and family about their wider health journey, including the actions of a locum GP and ambulance service. An additional column was added to Table 2 to enable this to be included.

Case Study C – Table 2: Underlying factors

Underlying factor	Impact of location and access	
	Locum/GP – actions Ambulance	**Emergency Department**
Impact of illness or injury	Unable to go to school or play sport Inappropriate treatment originally given – his wound actually required sutures	Wound review, dressings, antibiotics, tetanus injection
Language and communication	First language Pitjantjatjara English is not the GP locum's first language No interpreter and effective communication difficult	Nurse practitioner speaks some Pitjantjatjara and enacts introduction and communication as per cultural norms
Financial resources	Cost of GP Do not have ambulance cover	Getting home – nurse practitioner arranges a taxi rather than having to catch buses to home post treatment
Cultural safety	Was seem in their home, but some cultural/ communication difficulties	Able to be diverted to nurse practitioner route reasonably quickly, which provided more personalised and responsive care

Task 2.5: Bringing together multiple perspectives in chronological mapping

In Table 3 (see next page), Michael wished to highlight that patient flow through ED involves travelling through multiple areas and seeing different staff members. Patients who meet the eligibility to see a nurse practitioner (based on the type and severity of illness) can bypass many of these areas and staff changes and receive a 'wrap around' service. This is particularly helpful in providing culturally safe, timely and streamlined care.

Benefits for the boy and his grandmother in seeing a nurse practitioner:

- able to be understood when speaking in their first language
- able to make connection and relationship to one person
- did not have to repeat their story again and again to each new practitioner
- wrap-around services and comprehensive care able to be provided in a timely manner
- considerations regarding how they would get home – rather than discharge at the ED door.

Step 3: Taking action on the findings

Michael intends to use these case studies to alert staff to specific patient needs, to improve patient journeys through ED, and to improve communication and interactions between patients and staff in this city hospital.

Case Study C – Table 3: Multiple perspectives

<table>
<tr><th>Perspective</th><th>Presenting complaint</th><th>Triage nurse</th><th>Receptionist</th><th>Waiting room nurse T2</th><th>Area A Transit nurse</th><th>ED multiple staff members</th><th>Comments</th></tr>
<tr><td>Patient's journey</td><td>Wound injury</td><td>Assess</td><td>Patient details recorded</td><td>Tell details</td><td>Transfer to next area</td><td></td><td></td></tr>
<tr><td>Family/carer journey</td><td>Accompanied by Grandmother</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Patient and carer priorities, concerns and commitments</td><td>In pain and unable to play sport</td><td>Can they under stand me?</td><td>Have I got adequate identification?
Medicare card?</td><td>How long to wait?</td><td>How many people do I need to see?</td><td>Will each person understand me? With they treat me and my Grandmother respectfully?</td><td></td></tr>
<tr><td>Health care priorities</td><td>Treat wound</td><td>Effective triage</td><td>Medicare card details</td><td>Care while waiting</td><td>Take patient to next area</td><td>Ensure patient received needed care using existing health care resources and structures</td><td></td></tr>
<tr><td>How ED provides care generally</td><td>“</td><td>“</td><td>“</td><td colspan="3">The usual patient journey though ED involves meeting a series of nurses and doctors in different sections of ED and repeating one's story.</td><td></td></tr>
<tr><td>Nurse practitioner care</td><td>“</td><td>“</td><td>“</td><td colspan="3">The nurse practitioner is able to coordinate and provide the range of services needed with minimal other staff involvement, which enabled them to introduce themselves and take a history as they can speak some Pitjantjatjara
Once the relationship has been established they were able to assess the wound and provide immediate wound care including suturing and prevention of infection, arrange follow-up appointment and provide taxi voucher for the boy and his grandmother's return to home</td><td>Nurse practitioner is able to make ED journey less confusing</td></tr>
</table>

Case Study D: Adapting the Tools for a Youth Health Assessment Tool

Authors: Amy Graham, Damian Rigney and Annapurna Nori

Who was involved in the mapping?

Dr Annapurna Nori has worked in Aboriginal health in the central, western and northern suburbs of Adelaide. Through the 'Y Health – Staying Deadly' Community Based Translational Action Research Project at Watto Purrunna Aboriginal Health Service (AHS), Annapurna and the project team developed an Aboriginal and Torres Strait Islander youth assessment tool. Amy Graham and Damian Rigney, who are Aboriginal Health Workers based at Watto Purrunna (AHS), were involved in this youth project as early career researchers.

The focus of this case study

This case study discusses the ability of the Aboriginal patient journey mapping tools to be adapted for a city-based youth project involving the development of youth assessment tools.

Step 1: Preparing to map the patient journey

Task 1.1: Planning for mapping – who, what, when, where, why and how

Annapurna, Amy and Janet met (Damian joined the project later) to discuss the different projects and how they could share ideas, knowledge and tools. They discussed that Tables 1 and 2 may be more useful as prompt questions, but that the format of Table 3 was really useful because it brought together the different perspectives, rather than just a single perspective.

Janet began reworking the multiple perspectives table during the meeting, adapting columns and rows to fit the needs expressed. Table 1 shows how this table had been adapted by the end of their first meeting; this table was then further adapted.

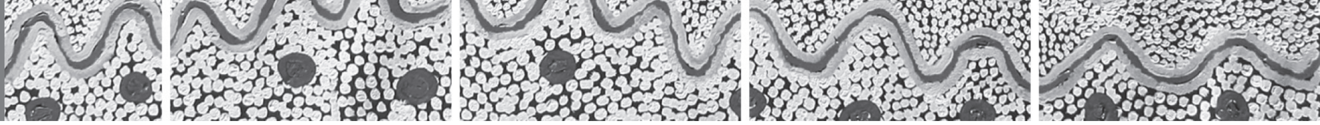
This became the first draft and was adapted as the project continued. Amy and Damian learned interview techniques with Annapurna and continued to adapt and develop the tool.

Task 1.2: Guiding principles for respectful engagement and knowledge sharing

The Y Health – Staying Deadly project was based on respectful engagement, confidentiality and knowledge sharing. The project predominantly worked with young people, including those from the Anangu Pitjantjatjara Yankunytjatjara Lands who were living in Adelaide each semester for high school education. The project considered the ethical implications in depth, and also the need for a responsive youth assessment tool.

Case Study D – Table 3: Multiple perspectives – youth project

Who	What happened – the trigger	What was the effect on you – feelings/ consequences	What did you do – why	Did you try to get help or advice – where, who from, how	What happened then	Details – $ Transport Missed/kept appointment	Follow-up	Who, what really helped you and how	What got in your way and how
Young person's journey	Trip home involved a traumatic event	Difficulty concentrating in school	Rang mum Spoke to friends Spoke to Support Worker	Friends Support Worker	Support Worker arranged GP visit	Medicare paid Support Worker took me	Mix up with next appointment	Friends came with me to talk to Support Worker	Not wanting to tell others about it
Timeline	Jan. 2013	March 2013	March 2013		March 2013	March 2013	April 2013	–	–
Staff from support service (maybe interview)	** came back from holidays and was not her usual self	She had trouble with school and was very quiet	Made time to talk when/ how ** preferred	Checked referral list/options	Made appointment with GP	Had to access Medicare card/ number	Difficultly making next appointment	Flexibility – good relationship between school and support services	School timetable – getting appointments at suitable times
Family									
Friends									
General Practice									
KPIs – ideal patient journey									



Step 2: Using the tools

The youth team conducted six preliminary interviews to test the revised interview tool. The tool was then refined and re-tested with four urban Aboriginal youths. The team is now in the process of refining the tool so that it is suitable for Anangu youth (young people from Anangu Pitjantjatjara Yankunytjatjara Lands). Amy and Damian identified the need to balance dual roles (clinical and research), build confidence, understand and apply research ethics, and to be comfortable with asking questions and knowing how to obtain information from a participant.

Step 3: Taking action on the findings

The youth team is intending to identify the journey young people make in regards to their health in order to ensure health care is as accessible as possible and meets their needs.

About the Authors

Janet Kelly

Study Leader, Improving Aboriginal Patient Journeys and Research Fellow, Flinders University, and Research Fellow, School of Nursing, University of Adelaide and Heart Foundation

Natalie McCabe

Aboriginal Patient Pathway Officer, The Queen Elizabeth Hospital

Wendy McInnes

Vascular Nurse Practitioner, The Queen Elizabeth Hospital

Michael Kirkbride

Emergency Nurse Practitioner, Emergency Department, Lyell McEwin Hospital

Amy Graham

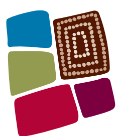
Aboriginal Clinical Health Worker and Researcher, Watto Purrunna Aboriginal Primary Health Care

Damian Rigney

Aboriginal Clinical Health Worker and Researcher, Watto Purrunna Aboriginal Primary Health Care

Annapurna Nori

Public Health Physician, Watto Purrunna Aboriginal Health Service



Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

The Lowitja Institute
PO Box 650, Carlton South
Vic. 3053 AUSTRALIA
T: +61 3 8341 5555
F: +61 3 8341 5599
E: publications@lowitja.org.au
W: www.lowitja.org.au