



Improving the Culture Of Hospitals Project

Final Report

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Table of Contents

Authors	4
Acknowledgements	4
CHAPTER ONE	5
Phase I: Project Establishment	5
Introduction	5
Background	5
Project Objectives	7
CHAPTER TWO	10
Phase II: Literature Review – Making Acute Health Services Culturally Sensitive – A CQI Approach	10
Introduction	10
History and context	10
Methodological and Conceptual Considerations	18
Literature Search Method	19
Findings and Analysis	19
Discussion	26
Conclusion	27
CHAPTER THREE	28
Phase III: Exploring some success stories – Case studies from hospitals successfully responding to Aboriginal people	28
Introduction	28
Methods	28
Findings	30
Conclusions	34
CHAPTER FOUR	38
Phase IV: Trialling the Continuous Quality Improvement Framework and Toolkit	38
Introduction	38
Nomination and selection of the participating hospitals	38
Site visits	39
CQI Projects	40
Communication and support between site visits	41
Findings	42
Recommendations	53
CHAPTER FIVE	55
Phase V: Further Toolkit development and Round Table	55
Introduction	55
Options for Phase V	55
Additional components	56
Round Table	57
Conclusion	58
CHAPTER SIX	59
Phase VI: Conclusions and Recommendations	59
Introduction	59
Research Aim and Question	59
Project Outcomes and Recommendations	59
Conclusion	65
APPENDICES	67
Appendix One – Advisory Committee Members	67
Appendix Two – Legislation Review	68
Appendix Three - Expression of Interest Questionnaire	81
Appendix Four – Phase III Detailed Findings	82
Maitland Hospital Case Study 12th August 2008	82

Royal Adelaide Hospital Case Study 11 th August 2008.....	85
St Vincent’s Hospital Case Study 20 th August 2008.....	89
Goulburn Valley Health Case Study 10 th September 2008	93
Royal Children’s Hospital.....	96
Appendix Five – Phase IV Introductory Session – First site visit.....	100
Appendix Six - Phase IV Feedback Session – Second Site Visit.....	102
Appendix Seven - Development, delivery and evaluation of Aboriginal staff in hospitals training program	103
Appendix Eight - Newsletter No. 1 October 2008	121
Appendix Nine - Newsletter No. 2 June 2009	122
Appendix Ten - Final Newsletter No. 3 April 2010.....	123
Appendix Eleven – Journal Article submitted to ANZAME for publication “Building on success stories from hospitals responding effectively to Aboriginal and Torres Strait Islander communities”	124
ANNOTATED BIBLIOGRAPHY	136
REFERENCES.....	165

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Chapter One

Phase I: Project Establishment

Introduction

The *Improving the Culture of Hospitals Project* (ICHP) was initiated and funded by the Cooperative Research Centre for Aboriginal Health (CRCAH), project-managed by the Australian Institute for Primary Care, La Trobe University with The University of Melbourne (Onemda, Vichealth Koori Health Unit) and the Aboriginal Health Council of South Australia. The project has been guided by an Advisory Committee consisting of representatives from the **Aboriginal Health Council of South Australia**, University of Melbourne, St Vincent’s Hospital, Australian Institute for Primary Care at La Trobe University, Royal Adelaide Hospital, Government of South Australia (Department of Health), Office of Aboriginal and Torres Strait Islander Health (OATSIH), and the Tasmanian Department of Health and Human Services.

The project’s Chief Investigator was Russell Renhard, Manager, Policy and Evidence, Office of the Director, Public Health Branch, Department of Public Health, Department of Human Services. The project manager for the project was John Willis, Australian Institute for Primary Care, La Trobe University, with project team members Alwin Chong, Research and Ethics Officer, Aboriginal Health Council of South Australia, Angela Clarke, Deputy Director/Senior Lecturer, Onemda, VicHealth Koori Health Unit, University of Melbourne, Gai Wilson, Senior Research Fellow, University of Melbourne, and Monica Lawrence, Regional Manager, Clinical Services Development, Aboriginal Health, Southern Adelaide Health Services.

Background

The health status of Indigenous peoples is a global concern, with mortality and hospitalisation data indicating that the health of Indigenous groups falls below that of other ethnic groups within their countries (Wilson, 2003). As Kevin Rudd, then Prime Minister of Australia, commented when signing the statement of intent to close the gap on Indigenous life expectancy, “Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities”.¹ The Australian Government has acknowledged its responsibility to respond to this issue and ensure that the health gap between Aboriginal and non-Aboriginal Australians is closed. The ICHP can contribute to closing this gap by developing a range of resources, tools and guidelines to assist hospitals across Australia to improve their services to Aboriginal and Torres Strait Islander² people.

1 Hon. Kevin Rudd MP, Apology to Australia’s Indigenous Peoples, 13 February 2008

2 The term ‘Aboriginal’ will be used for the remainder of this article and refers to ‘Aboriginal and Torres Strait Islander’ unless otherwise stated

This study followed from previous work undertaken by Renhard and Anderson. The *Aboriginal and Torres Strait Islander Accreditation Report* (Renhard & Anderson, 2002) gave a detailed analysis of the need for accurate data and the connection this has with continuous quality improvement (CQI) in the hospital context. It outlined that data accuracy regarding Aboriginal or Torres Strait Islander status is due to two general factors: the effectiveness and consistency of administration practices and systems and the preparedness of Aboriginal people to disclose their Indigenous status. This link between data accuracy and status disclosure leads to the need to develop culturally safe services, which is closely aligned with the strength of relationships between health services and Aboriginal organisations and communities. The report also outlined that the need to bring about organisational change requires an explicit accountability framework complemented by data collection and analysis. Therefore, the level of effectiveness of developing strong relationships with Aboriginal organisations and communities will be determined by the absence or presence of management systems.

This project therefore examined successful Aboriginal programs undertaken by hospitals, within a quality improvement framework, to see how this work could be replicated and sustained across a wide range of hospital environments. This information was then used to generate a framework which incorporates a continuous quality improvement process that has accompanying tools and guidelines for each stage of the process, all of which seem to be effective instruments to sustain cultural change within the hospital environment. This project will support an ongoing reform strategy to ensure sustainability of improvements regarding Aboriginal health in line with key responsibilities of each state and territory jurisdiction.

There is evidence that a quality improvement approach in the human services sector, if coupled with other factors, is successful in instituting change. The review undertaken by Renhard examining the effectiveness of quality initiatives in human services found that the “key determinant of success of a quality (approach), is not the initiative itself but the nature of the organisation in which it is used” (Renhard, 2001). The characteristics of organisations that successfully implement quality initiatives or adopt a CQI approach include:

- Use of problem-solving approaches based on statistical analysis and relevant ‘soft’ data. This involves analysing and monitoring data over time to measure improvement
- Focus of analytical processes being on underlying organisational processes and systems rather than blaming individuals
- Use of cross-functional employee teams in continuous improvement activities. If the system needs to be changed to resolve a problem then the solution needs to include all those involved in the system and contributes to collective ownership of new strategies
- Employee empowerment to identify problems and opportunities for improved care and to take the necessary action
- Explicit focus on both internal and external consumers. This includes people who are directly and indirectly involved, with internal referring to those providing the service and external those who are receiving the service.

The key overarching component to ensure success is that of management support for these approaches.

Renhard argues there is little evidence that a ‘manage down’ approach to promoting quality through a punitive approach has been successful. On the contrary, limited evidence suggests this approach may suppress information critical to identifying issues at a system level (Renhard, 2001). To ensure that quality services are delivered governments need to promote a CQI approach to quality through their policy frameworks and funding arrangements, but in the absence of a CQI culture within an organisation, it is unlikely to influence quality at the service delivery level (Renhard, 2001).

Therefore, to assist governments and service providers to improve services and to plug the gap between policy and improved consumer outcomes, managers need specific tools, processes and guidelines to support their clinicians in identifying and making the necessary changes, ultimately to encourage a change to a CQI workplace culture. The ICHP focused on developing a CQI process and a set of tools to specifically assist hospital clinicians in identifying and implementing the changes necessary to improve service outcomes for Aboriginal consumers.

Project Objectives

The primary objectives of the ICHP were to deliver:

- Comprehensive understanding of the diversity, rationale and effectiveness of tools, processes and guidelines that have been used to improve the culture of hospitals from the perspective of Aboriginal people.
- Comprehensive understanding of the characteristics that Aboriginal people believe would make hospitals more culturally appropriate.
- Comprehensive understanding of the government and accreditation policy conditions that need to be in place to ensure that cultural improvement can be linked into mainstream accountability processes.
- Publication of tools and handbooks describing various stakeholders’ roles in successfully developing a culturally sensitive hospital facility.
- National network of Aboriginal people able to effectively participate in conventional continuous improvement activities that improve the culture of hospitals and health services. This was to be achieved by offering formal and appropriate training to Aboriginal community members.
- Accreditation processes that emphasise the use of tools and processes that encourage cultural reform in hospitals.

The project consisted of six phases. The first three phases involved consultation with Aboriginal and mainstream health providers, a review of operating contexts within hospitals and the development of case studies within hospitals. The last three phases involved the testing of interventions including culturally sensitive continuous quality improvement tools, processes and guidelines on location.

Each phase made up the key components of the project. A brief summary of each phase is as follows.

Phase I – Consultation with Aboriginal and Mainstream Peak Bodies, and Government Officials

Consultation was undertaken with the National Aboriginal Community Controlled Health Organisation (NACCHO), other relevant peak bodies and state and Commonwealth officers responsible for Aboriginal Health services. This aimed to raise awareness of the research project, and included: understanding of CRCAH endorsement; clarification of roles in the project; finalisation of governance and advisory structures and adjustments required; endorsement for the project; establish communication strategy and obtain intelligence on key information types and sources (see Chapter One for more details).

Phase II – Review of the Operational Context

The aim of Phase II was to identify influences (structural, legislative and policy) that impacted on the capacity of hospitals to undertake a process of cultural change. It identified Aboriginal community initiatives (e.g., workforce development programs) that impacted on the capacity of hospitals to pursue a program of cultural reform. Key policy documents and initiatives were reviewed, and telephone interviews and site visits were conducted with identified personnel, with the assistance of the national reference group. Government, non-government and Aboriginal controlled community organisations were involved in this process (see Chapter Two for more details).

Phase III – Gathering of information

The purpose of this phase of the project was to identify the key elements that characterised those hospitals that, in the opinion of Aboriginal stakeholder organisations, were successfully providing services to Aboriginal people. We did not aim to undertake an in-depth case study that analysed all aspects of hospital practice. These elements were then used to generate a quality framework and toolkit (see Chapter Three for more details).

Using the experience of Aboriginal people as the central reference point, five systematic hospital case studies were undertaken, each with different levels of experience in attempting to make their organisational services and surrounds more culturally sensitive to the needs of Aboriginal patients, their families and friends. Information was gathered to inform the development and implementation of relevant tools and processes to support a CQI approach to improving cultural sensitivity in these institutions. The key objective was to produce tools, processes and guidelines that would assist hospitals to engage with their local Aboriginal communities in a collaborative exercise of quality improvement for organisational cultural reform.

Phase IV – Trials of tools and processes and the organisational readiness concept

This phase involved the recruitment of a further five hospitals to be case studies in the trial of the tools and processes developed in Phase III. These five hospitals were not involved in the previous phase to ensure that the tools and processes—many of which were familiar to those hospitals engaged in Phase III—were tested in hospital environments that were not biased through their previous exposure to them. This enabled an assessment of the utility of the tools and processes. Hospitals were selected on the basis

of theoretical representativeness but superimposed on this was an assessment of their readiness to engage in a trial of the tools and processes. Hospitals that indicated they were highly ready to change were selected.

Aboriginal staff involved in the collection of data were assisted to document the Aboriginal experience of implementing the tools and processes. These staff were also offered a certificate level IV training program to assist them to develop skills for documenting their experiences, engaging in the CQI process and analysing the data that arose out of community discussions. This will assist them in future to be involved in the implementation of the tools and processes (see Chapter Four for more details).

Phase V – Further Trial of Toolkit

A sample of six hospitals was intended to be invited to participate in a further trial of the tools and processes. In comparison with the previous phase, the primary emphasis in this phase was intended to be on researching the strategies that can improve the effectiveness of tools and processes by addressing factors that influence organisational readiness for change. The sample was intended to include a range of hospitals across the readiness for change spectrum. The purpose for choosing a range was to reflect real-world scenarios where hospitals are diverse in terms of readiness to change but also willing to use the tools and processes. As for the other phases, Aboriginal people who were going to be involved in documenting the research activities and findings and participating in continuous improvement activities were to be invited to participate in training activities. This phase was discontinued for a range of reasons; full details are provided further in this report (see Chapter Five for more details).

Phase VI – Finalisation of Processes Tools and Guidelines

In this phase the research team comprehensively documented the research process, the research findings, institutional recommendations and guidelines for using the tools and processes effectively; the tools and processes designed to assist hospitals to culturally improve from an Aboriginal perspective and accreditation models that incorporate the tools and processes.

This phase has also included consultation with accreditation bodies including the Australian Council on Healthcare Standards (ACHS). The consultation process involved the conducting of a Round Table meeting with ACHS and key jurisdictional policy-makers across Australia. Feedback was invited on the outcomes from the trial of the tools and processes to ensure that they are practical within the usual accountability requirements of hospitals.

The final version of the tools was published and made available to: all state and Commonwealth health offices; participating hospitals; major accreditation bodies; state and national Aboriginal Controlled Community Health Organisations; and selected research institutions. A summary of the key findings were developed in the form of a newsletter for hospitals, Aboriginal people and Aboriginal community organisations, which described the role of each in successfully developing a culturally sensitive facility (see Chapter Six for more details).

Chapter Two

Phase II: Literature Review – Making Acute Health Services Culturally Sensitive – A CQI Approach

Introduction

CQI methods and techniques and the basic “learning-from-doing” approach has been shown to be effective in Aboriginal controlled organisations in Australia, suggesting that CQI methods and techniques represent a culturally acceptable framework for mainstream acute health care facilities to work towards improving their cultural sensitivity (Baillie, 2007).

The aim of this paper is to examine the evidence for the role of CQI processes and techniques as a means of increasing the cultural sensitivity of acute health care institutions. The published literature is reviewed to identify the evidence base for the use of CQI methods to promote improved cultural sensitivity in the way acute health services are provided to Indigenous peoples.

History and context

Aboriginal health

The health status of Indigenous peoples is a global concern, with mortality and hospitalisation data showing that the health of Indigenous groups falls below that of other ethnic groups within their countries (Wilson, 2003).

From an Australian perspective, Aboriginal people generally have higher rates of hypertension, heart disease, respiratory ailments, stroke, diabetes, cancer and renal failure. Mental health, drug dependence, violence and other indicators of social marginalisation and cultural disintegration also attest to the relatively poor health of Aboriginal Australians (Hunter, 1998). Aboriginal children are more likely to be born prematurely and have lower birth weights. They exhibit slower growth, higher hospital admission rates and greater mortality in the first year of life (Australian Institute of Health and Welfare [AIHW], 2002). These indicators combine to reveal that, on average, the health status of Aboriginal and Torres Strait Islander peoples is 17 years below that of non-Indigenous Australian citizens (Australian Bureau of Statistics [ABS] & AIHW, 2008).

The latest data on the use of hospital care is the report, *Australian Hospital Statistics 2007-08*, published by the Australian Institute of Health and Welfare. This report indicates that Indigenous Australians are 2.6 times more likely to be admitted to hospital than other Australians³. In 2007–08, the age-standardised separation rate for *Indigenous Australians* (915.8 per 1,000 persons) was about two and a half times the rate for *other Australians* (356.8 per 1,000 persons [AIHW, 2009, p.11]).

³ This figure excludes ACT and Tasmania data and data quality issues need to be considered when interpreting this statistic (AIHW 2009, p.215).

Nationally, 4.4 per cent of all patients presenting to an emergency department identified as being of Aboriginal and/or Torres Strait Islander origin. The Northern Territory had the highest proportion of emergency department presentations involving Indigenous people (42.6%), and Victoria recorded the lowest proportion (1.2%). Indigenous status was not reported for about 5 per cent of presentations (AIHW, 2009, pp. 111–112).

Aboriginal people and hospital care

The *National Aboriginal and Torres Strait Islander Health Survey Australia 2004–05* showed that around one in six Indigenous people (16%) had been admitted to hospital in the 12 months prior to the 2004–05 survey. After adjusting for age differences between the two populations, Indigenous people were 1.3 times more likely than non-Indigenous people to have been hospitalised in the previous 12 months. Indigenous Australians were admitted to hospital more often than non-Indigenous Australians across all age groups (apart from people aged 25–34 years, where rates were similar). These statistics indicate the demand for acute care services by Aboriginal people is significantly higher than for the rest of the population; and underscores the importance of making acute care services more culturally appropriate to help improve health outcomes for Aboriginal patients (AIHW, 2009).

National Aboriginal Health Strategy

The National Aboriginal and Torres Strait Islander Health Strategy (NAHS) was released in 2001 as a consultative document produced by the National Aboriginal and Torres Strait Islander Health Council. Although not specifically addressing hospitals, it highlights their obligation to provide quality and effective health services to all Australians, including Aboriginal people.

The NAHS outlines nine principles to guide national action, ensuring implementation strategies to support the vision for healthy Aboriginal communities. Strategies contained in the NAHS focus on cultural security, holistic approaches, capacity building, community control, promotion and prevention, accountability, health sector responsibility, localised decision-making and working together. All these principles are important but two areas are significant for hospital care. Health sector responsibility includes that of ensuring equity in health service access for the most disadvantaged. The strategy also notes that the provision of quality health care services to people is a core responsibility of the whole health sector and not just that of the Aboriginal community controlled health sector. The other key area is working together, which asserts that a combined effort must involve all stakeholder groups.

Following from the NAHS is the National Strategic Framework for Aboriginal and Torres Strait Islander Health, which has similar principles and outcomes. This framework is the guide for government action to address Aboriginal health and wellbeing. It was endorsed in July 2003 by the Australian Health Ministers' Conference.

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009, commissioned by the Australian Health Ministers Advisory Council (AHMAC), recognised the poor standard of health of Aboriginal and Torres Strait Islander people compared with those of the broader Australian population. The framework was developed to provide guiding principles for policy-making

and service delivery by jurisdictions as they implement initiatives to address their respective needs. In particular, the focus of the principles contained in the Cultural Respect Framework guide the development, establishment and strengthening of relationships between the health care system and Aboriginal peoples. This guiding national framework states that cultural respect is about shared respect and responsibility, which is only able to be achieved when the health system is a safe environment for Aboriginal people, where cultural differences are respected. It is a commitment to the principles that the construct and provision of services offered by the Australian health care system will not and does not knowingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal people.

The goal and vision of the framework is to uphold the rights of Aboriginal people to maintain, protect and develop their culture and achieve equitable health outcomes. It aims to influence corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for Aboriginal people. The framework emphasises that the health and cultural wellbeing of Aboriginal people within mainstream health settings requires special attention. It identifies many factors that contribute to poor standards of Aboriginal health and wellbeing, including the low levels of confidence Aboriginal people have in being able to access acceptable mainstream health services.

Closing the Gap commitment

The key purpose of the ‘Closing the Gap’ initiative is outlined in the statement of intent between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organisations to:

Work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.

Closing the Gap Statement of Intent 2008

As outlined in the statement, one area that needs to be addressed to ensure equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services:

For Indigenous peoples to participate in Australian society as equals requires that we be able to live our lives free from assumptions by others about what is best for us. It requires recognition of our values, culture and traditions so that they can co-exist with those of mainstream society. It requires respecting our difference and celebrating it within the diversity of the nation.

Dr William Jonas
Closing the Gap 2008

Cultural sensitivity

There is voluminous literature on cultural sensitivity but few papers that have a particular focus on culturally sensitive hospital care for Aboriginal people. From a systems perspective, cultural security can be seen as a commitment that the arrangement and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. Taking a culturally sensitive approach recognises and responds to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration (Houston, 2002).

Cultural sensitivity needs to take a system-wide approach to be effective. One traditional approach taken by organisations to deal with the issue of culturally insensitive care has been to provide cultural awareness training to staff. While necessary, this approach, on its own appears to be ineffective with at least one author, Coffin, arguing that improved cultural awareness through training for individual health workers and administrators does not lead to improved health outcomes. To respond appropriately, hospitals need to adopt practices and policies that recognise cultural security as a systemic, imbedded domain to hospital care. Coffin describes an approach to the creation of culturally sensitive care starting with an organisation undertaking an honest self-assessment of its current status as a culturally sensitive organisation. With this assessment as the basis for awareness, the organisation must then examine brokerage, safety, protocol, security, and finally sustainability, and then move forward from there. The two key elements are brokerage and protocols. Brokerage involves a range of components including: respect and two-way communication, where both parties are equally informed and important; it must be developed with the Aboriginal community; faith and trust need to be built; the largest part of brokerage is listening and *yarning*. Protocols involve formalising the fact that, in an Aboriginal context, health care delivery and programs need to be carried out with Elders and key stakeholders within the particular community. Communities become partners in an equitable, culturally secure provision of service; cultural awareness alone is not enough (Coffin, 2007).

From a hospital perspective-providing culturally sensitive care should be based on acknowledgment of and respect for Aboriginal cultural views. The publication *Lookin' after our own*, written by Aboriginal Health Unit staff at the Royal Children's Hospital in Melbourne, highlights the need to respect Koori (Aboriginal people from south east Australia) culture as being fundamental to improved cultural sensitivity and the need for all initiatives and developments to take this into account (Clarke et al., 2000):

All our initiatives for the Koori program were set up to work toward making the hospital experience for our families as culturally affirming as possible. It is the right of our families to be able to express and be proud of their culture. We, as Kooris, acknowledge that western culture is no more or less important than our own culture. We do not force or inflict our views on others and we ask that our families be afforded the same courteously—without the expectation that they conform to non-Aboriginal ways.

Clarke et al., 2000

Cultural sensitivity and health outcomes for Indigenous people

The connection between cultural sensitivity and health outcomes for Indigenous peoples can be understood by considering a range of influences. The first major influence is the impact of colonisation and how this affects the social determinants of health.

A clear example is outlined by Richards regarding the experience of Aboriginal Canadians: over the 20th century there was a dramatic shift of Aboriginal people from rural to city areas. According to Richards, in 1951, seven per cent of registered Aboriginal Canadians were living in cities, compared with 50 per cent in 1996. Richards argues that, although non-Aboriginal people undertook this change, they did so nowhere near as quickly (Richards, 2003):

Non-Aboriginal Canadians undertook analogous change, but their ancestors did so over the course of a millennium or more. Given the speed of Aboriginals' transition, it is not surprising that they have experienced a great deal of social distress, including worse health outcomes than among other Canadians.

Richards, 2003

From an Aboriginal perspective, this change has had a significant social impact:

I think it was the suddenness of it all that hurt us so. We did not have time to adjust to the startling upheaval among us. We seemed to have lost what we had without replacement for it. We did not have time to take our 20th century progress and eat it little by little and digest it. It was forced feeding from the start and our stomachs turned sick and we vomited.

Chief Dan George, cited in Richards, 2003

This migration of Aboriginal Canadian people also highlights the shift from predominantly hunter–gather societies in the earlier decades of the 20th century to that of modern Western lifestyles emphasising the huge social and economic changes Aboriginal people have undergone in a relatively short timeframe. These rapid changes in the social environment for Indigenous people across the globe have had a significant impact on their health. These changes occurred too quickly for their societies to adapt appropriately and have resulted in social dislocation and upheaval. Understanding the historical context and responding appropriately to these social determinants is fundamental to any health response for Aboriginal people and emphasises the importance of considering cultural issues when designing and delivering health care (Richards, 2003).

Several Australian authors have highlighted the importance of hospitals understanding the Aboriginal cultural context (Tanner et al., 2005; Nangala et al., 2008); whether it be understanding the kinship relationships of desert Aboriginal people when dealing with an unconscious patient or appreciating the cultural shock experienced by the Indigenous parents of a child from a remote community who is admitted to a metropolitan hospital. To ensure the best outcomes for the patient and their families, hospital staff need to be aware of these issues and know how to respond to them appropriately. As Tanner et al. claim, the isolation of coming into a hospital is not merely geographic but intricately linked to their health and wellbeing (Tanner et al., 2005).

The social upheaval caused by colonisation experienced by Aboriginal Australians has had a negative impact on their health status similar to other Indigenous peoples. There is, however, significant differences in the way colonial governments have attempted to redress this discrepancy in health status. Ring and Firman examine the health status of Aboriginal and Torres Strait Islander peoples in Western Australia and the Northern Territory and identified that it is relatively poor compared with that of Maori and Native Americans. It also showed little, if any, improvement over the past 20 years. The authors assert that although the three Indigenous groups each have a different heritage and culture, they share common experiences in their history. They are minority cultures in affluent nations dispossessed of their country and marginalised (Ring & Firman, 1998).

Maori and Native Americans have made rapid gains in health and life expectancy over the past two decades. This progress has been characterised by an initial rapid fall in death rates, followed by a more gradual decline as levels of the non-Indigenous population are approached. In Australia there is little evidence that similar gains are being made in the Indigenous population. Ring and Firman argue that the health problems of Australia's Indigenous people, and the circumstances responsible, are not unique. This raises the question of why has the health of Australia's Indigenous people failed to match the improvement seen in other countries. Ring and Furman highlight several factors that may have contributed to the lack of improvement in health, including the lack of a nationally consistent policy on Indigenous land custodianship and programs (Ring & Firman, 1998).

In more recent times, competition for Australian federal health funding by state government and non-government bodies has meant that efforts to improve Indigenous health have lacked coordination. Other factors identified include the lack of a sense of a single identity in many present-day Indigenous communities, which were created artificially by gathering together people from many different tribal groups. Ring and Firman also suggest that the sense of control people have over their lives and the sense of hope that this creates are important determinants of health status. This view is also held by other authors and there is a substantial body of research evidence to support it. The authors argue that colonial paternalism, an official policy of assimilation, and a lack of formal recognition through treaties have together acted to create and reinforce a sense of powerlessness in Australian Indigenous people, which is relatively less in other Indigenous groups around the world (Ring & Firman, 1998):

The Treaty of Waitangi has been central to the relationship between Maori and other New Zealanders, and in the United States treaties established some status for Native Americans in their relationships with the "invading" Europeans, although these treaties were often abused. It is therefore difficult to entirely discount the suggestion that the absence of a treaty is a factor in the relative lack of progress in improving Australian Indigenous health. Treaties, no matter how loosely worded, have appeared to play a significant and useful role in the development of health services, and in social and economic issues, for the Indigenous people of New Zealand, the United States and Canada.

Ring & Firman, 1998, p. 533

Ring and Firman suggest that these intangible factors are adversely affecting Indigenous health in Australia. As highlighted by the experience of other Indigenous people around the world, this generates

considerable confidence that effective action in Australia is likely to produce substantial changes in Indigenous health. Ring and Firman recommend that progress is needed in five key areas including infrastructure, self-determination of health services, access to a network of community-controlled primary healthcare services delivering effective health services for priority issues, an adequate level of resources, and a skilled workforce (Ring & Firman, 1998).

Cultural security and health service delivery

When focusing on the delivery of health services, the cultural sensitivity of service provision can have a significant influence on health outcomes for cultural minority groups. In the November 2007 issue of *Satisfaction Snapshot*, the disparity in care provided to minority groups is highlighted. It is argued that the health system simply does not treat all patients the same. The article proposes that culturally sensitive health care includes: respecting the beliefs, attitudes and cultural lifestyles of its patients; acknowledging that health and illness are in a large part moulded by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations; the culturally constructed meaning of illness is a valid concern of clinical care; understands that the goal is to acknowledge that health care decisions are made by individuals, not groups; and there is often as much intra-cultural variation in beliefs and behaviours as there is interculturally (Satisfaction Snapshot, 2007).

Scrimgeour and Scrimgeour discuss findings from a study on access and attitudes to health care by Torres Strait Islander peoples living in urban centres on mainland Australia. They highlight that in general Torres Strait Islander peoples are not comfortable seeking medical treatment and therefore delayed accessing any health service. Most used Aboriginal Community Controlled Health Services, followed by private medical services and hospital outpatient services. The most common reason given for the choice of service type was convenience (Scrimgeour & Scrimgeour 2008).

Valery et al. **conducted a study to** assess the differences in disease stage at cancer diagnosis, treatment, and survival between **Indigenous and non-Indigenous** populations in Queensland. They found that Aboriginal patients were less likely to have had treatment for cancer and waited longer for surgery than non-Indigenous patients. Non-Indigenous cancer patients survive longer than Indigenous ones, even after adjustment for stage at diagnosis, cancer treatment, and greater co-morbidity in Indigenous cases. The authors believe that better understanding of cultural differences in attitudes to cancer and its treatment could translate into meaningful public-health and clinical interventions to improve cancer survival in Indigenous Australians (Valery et al., 2006).

The literature review undertaken by Scrimgeour and Scrimgeour identifies that one of the barriers to health care access by Aboriginal and Torres Strait Islander people living in urban areas is the poor performance of the health system in meeting the needs of those with complex and multiple health conditions. The review highlights that this problem is not just confined to Aboriginal and Torres Strait Islander people but includes groups with complex health problems who present challenges for the health care system, such as newly arrived refugees and people living with HIV. The authors argue there is evidence that a fee-for-service primary medical care policy does not deal well with the complex health problems with which many Aboriginal and Torres Strait Islander people present; keeping in mind that complex health problems occur with greater frequency within the Aboriginal population. Further, this

failure of the primary care system probably contributes to the higher rate of admission for Aboriginal and Torres Strait Islander people to hospital with ambulatory-sensitive conditions. The paper then goes on to explain the challenges facing the acute health system in responding to those with complex needs and the need to negotiate many speciality areas (Scrimgeour & Scrimgeour, 2008):

Once in hospital, individuals are usually admitted under a particular speciality that deals with the presenting problem, but not necessarily with related conditions, which may be seen as the responsibility of other specialties. After discharge from hospital, Aboriginal and Torres Strait Islander patients do not always receive the follow-up that is required. In addition, there are particular health issues that are more common within the Aboriginal and Torres Strait Islander population (particularly mental health problems and alcohol and other drug misuse) that are not well managed within the present health care system.

Scrimgeour & Scrimgeour, 2008, p. 32

CQI in the hospital setting

One mechanism for making hospitals more culturally secure is CQI. This approach was born out of a realisation that learnings from experience, as compared to more formal research, were occurring constantly in the workplace.

CQI can be described as the principles, methods and techniques that have been developed so that the application of the learnings that come from experience are captured. CQI is both a management approach that allows it to occur and the methods and techniques that are used in its application. Quality improvement occurs when opportunities for an obvious change to practice for the better present themselves. It also occurs as the result of test projects where opportunities for improvement are analysed and the change strategy is planned, implemented and evaluated. Based on the evaluation, a decision is then made about whether or not the new practices are adopted. This project-based approach to the evaluation of new practices is called the Plan, Do, Study, Act (PDSA) cycle. This management approach, which allows opportunities and planned CQI activities to occur, is characterised by the following widely accepted tenets:

1. Problem-solving based on statistical analysis and relevant ‘soft’ data.
2. Analytical processes that focus on underlying organisational processes and systems, rather than blaming individuals.
3. Cross-functional employee teams in continuous improvement activities.
4. Employee empowerment to identify problems and opportunities for improved care and to take the necessary action.
5. An explicit focus on both internal and external consumers.

There has been widespread utilisation of CQI principles, methods and techniques in most industries throughout the world. Like most management approaches, its effectiveness is variable. The research literature reflects this in that there are many examples of the successful utilisation of CQI and there are those that show it does not always have a discernable impact. It is not the purpose of this review to

examine in detail the research literature on CQI. This has been done elsewhere and readers are referred to McLaughlin and Kaluzny, and to Renhard for more comprehensive descriptions of the research basis for CQI (McLaughlin & Kaluzny, 2004; Renhard, 2001). It is well-established that CQI can be successful if it is conducted in a receptive organisation where external constraints are manageable and it is well-executed internally. Proper execution most often includes routine training and some investment in infrastructure such as information technologies.

Historically, the focus of CQI activity in hospitals has been on concrete clinical practices and the use of *hard* data such as biomedical impact data. As the consumer focus of the CQI movement has become more sophisticated the CQI focus has broadened to include consumer experience and satisfaction. This broader focus has been promoted by quality considerations related to people with chronic conditions. In these circumstances where, by definition, a cure is not possible, the consumer perception of quality of life and service become the important measures of quality.

Methodological and Conceptual Considerations

As described earlier, the CQI process is composed of a number of well-defined concepts that inform generic practices called the PDSA cycle. In this review some of the studies examined do not include an analysis of all aspects of the PDSA cycle. A publication was included for review provided sufficient detail about the intervention was provided to enable the elements of the PDSA cycle to be identified. This approach pertains primarily to studies that examine Indigenous health throughout the world.

To ensure that relevant published studies were identified, the search and selection criteria included interventions aimed at improving cultural sensitivity to Indigenous people or other disadvantaged population groups. Through this approach published studies were selected that examined interventions containing one or more elements from the PDSA cycle and intended to improve cultural sensitivity to Indigenous people and other disadvantaged groups. The literature generally shows that CQI methods and techniques can be effective and that they are culturally acceptable to Indigenous Australians. This legitimises the inclusion of intervention studies that do not necessarily contain all elements of the CQI process.

Typically, literature review methods place randomised controlled trials at the head of the evidence hierarchy. CQI as an intervention is complex, multi-factorial and subject to influence at many points in the process. This limits the value of randomised controlled trials for examining this type of intervention. See Solberg et al. (1996) for further discussion about the value of controlled trial methods for CQI interventions.

CQI interventions and the study of their impact are theory-driven and represent a comprehensive, multidisciplinary perspective. The complexity of CQI interventions involving trialling of their application in healthcare institutions lies in the interplay between policy-making, practice development and data collection. Based on these considerations, the review and analysis of intervention research is fundamental to understanding the potential for CQI to be used to improve cultural sensitivity to Aboriginal patients and families when using acute health care facilities. Findings from complex intervention studies can reveal the critical success factors for CQI interventions that can alter organisational culture. From this

perspective case studies are a powerful source of evidence of the potential of CQI to influence cultural reform.

Literature Search Method

This study has reviewed and analysed published literature and selected grey literature which relates to the use of CQI methods and techniques to improve the cultural sensitivity of acute health care services. This review examined literature predominantly published on or after 2000 (with some minor exceptions), produced in English, that focused on studies examining cultural improvement in hospitals for Indigenous populations both in Australia and internationally. Also included in this review are studies and reports on CQI activities for other minority groups including migrants.

The search framework used to identify current literature relating to continuous quality improvement initiatives and policies in hospitals for Aboriginal people involved an electronic search of current literature and expert and key stakeholder interviews.

Key words

Aboriginal, cultural sensitivity, cultural safety, cultural security, cultural competence, partnerships with Aboriginal organisations, cultural shift, organisational change, minority groups, migrants, institutional safety, continuous quality improvement, tools and processes, organisation readiness for change, cyclic continuous quality improvement.

Electronic search for current literature

HealthInfoNet, Archi, Informit, Google.

Expert Interviews

A number of expert interviews were undertaken including with health service and government staff in order to identify and locate other relevant articles and government policies.

Findings and Analysis

The review process uncovered little in the way of controlled trials of CQI-facilitated cultural reform and none could be found which examined services to Indigenous peoples. This review is therefore based on an analysis of case studies and short-term interventions. The findings from short-term interventions need to be interpreted with caution, however, as there is widespread agreement that the impact of a CQI approach can only properly be assessed through long-term study. Successful case studies in the general CQI literature demonstrate that it takes a minimum of two to three years to see the full impact of cultural reform of a CQI program.

The findings from this review fall into two areas: learnings from Indigenous-specific articles and learnings from other disadvantaged, culturally distinct groups. The analysis examines the impact of CQI as a measure of cultural reform within the organisation under the Plan, Do, Study, Act components of the cycle using the following headings: identifying the quality improvement opportunities; developing a

planned intervention; implementing an intervention; evaluating the outcomes; and imbedding the findings throughout the organisation.

In total, 12 studies identified described the use of CQI or CQI-like methods, where the intervention had one or more of the characteristics of CQI designed to improve the culture of acute health services for Indigenous patient care.

Findings from Indigenous-specific studies

Key findings from the *Aboriginal and Torres Strait Islander Accreditation Report* provide a starting point from which to review more recent literature that describes a CQI approach for Aboriginal health in hospitals. This report contains a review and analysis of national and international literature in relation to hospital service accreditation and standards, utilisation of acute care services by Aboriginal and Torres Strait Islander people, the policy context for acute care reform for Aboriginal and Torres Strait Islander health, hospital funding, and cultural safety. The study was based on eight case studies of Victorian hospitals that had a central focus on the effectiveness of the existing funding approach to Aboriginal health, the development and trial of a *Framework for (Quality) Review* and the development of an accreditation methodology. The findings also included an analysis of the role of accurate data, Aboriginal health services and identity of Aboriginal patients, and the connection this has with CQI. It concludes that data accuracy on Aboriginal and Torres Strait Islander status is influenced by two primary factors. The first being the effectiveness and consistency of administration practices and systems; and the second being the preparedness of Aboriginal people to disclose their Indigenous status. This link between data accuracy and status disclosure emphasises the imperative to develop culturally sensitive services, which is closely associated with the strength of the relationship between health services and Aboriginal organisations and communities. The report also concludes that organisational change requires an explicit accountability framework complemented by data collection and analysis. The authors argue that the effectiveness of developing strong relationships with Aboriginal organisations and communities will be determined by the absence or presence of management systems. As the relationships between acute health services and Aboriginal organisations develop and the feedback moves from celebrations and artwork to discussion about practices and outcomes, the long-term effect on the quality of service provided to Aboriginal communities will be felt (Renhard & Anderson, 2002). This report clearly outlined the key elements required when taking a CQI approach to Aboriginal health in hospitals; providing the evidence and sample framework to support health services undertaking this work.

Sinnott and Wittmann examined the need to educate non-Aboriginal staff (medical practitioners) about phenomena such as cultural shock, and making them aware of related factors to facilitate positive experiences with Indigenous patients. Results showed that this intervention improved the awareness of doctors and was seen as beneficial by Aboriginal hospital liaison officers. This study had a number of CQI elements including identifying the issue of concern, implementing an intervention or strategy and measuring the effectiveness (evaluating outcomes) of the intervention (Sinnott & Wittmann, 2001). The sustainability of these impacts was not assessed.

Preliminary findings from a qualitative study involving 23 New Zealand Maori women offer insights into issues impacting on the health status of Indigenous people. This study explored the role nursing practices

play in improving access and use of health services by Indigenous people. The findings suggest strategies that nurses can utilise within their practice when working with the local Indigenous population. The authors highlight the fundamental importance of gaining Indigenous consumer feedback to provide guidance on the design of an intervention (Wilson, 2003).

Larkin and Buckskin describe the findings from an action research study that explored the impact of, and issues related to, racism. The study examined a partnership approach between two non-Aboriginal staff and two Aboriginal women who shared their experiences and understandings. Their deliberations led to them advocating for the appointment of an Aboriginal Hospital Liaison Officer (AHLO). The Aboriginal women subsequently became a support group for the AHLO. The AHLO noted in the article that she was supervised by the social work manager, highlighting that management commitment is important to success. The findings showed the importance of an open and supportive working environment and staff working to change themselves and their institutions to break down barriers (Larkin & Buckskin, 1995). The study identified a number of CQI elements including identifying the CQI opportunity (action research with Aboriginal consumers on the issue of racism), developing a strategy (creation of an AHLO position) and implementing an intervention (appointment of AHLO). The missing element is an ongoing evaluation and feedback mechanism regarding the role and its function, though there is discussion on how the role varied from that of social workers and the positive impact that role had on the hospital's operations. As mentioned earlier, research has shown that leadership and taking a consumer focus are two key components for success in changes promoted through CQI methods and techniques; this study highlights the importance of both these elements (Baillie, 2007).

The Royal Darwin Hospital reported on CQI approaches being used to explore communication dynamics and the role this played in service quality. The study involved the identification of an opportunity for improvement (discharge summaries not arriving), development of a strategy (collection data recommendations for improvement) and the implementation of an intervention (recommended changes to improve patient follow-up and communication between the hospital and isolated Aboriginal community clinics in the Northern Territory). Hospital staff members were interviewed and an audit was carried out on discharge summaries. The audit findings showed that 18 per cent of discharge summaries never arrived. Conclusions and outcomes from this study included the giving of discharge summaries to patients at discharge, the appointment of an Aboriginal health worker within the hospital and a discharge manual produced for communities (Mckenzie & Currie, 1999). This study does not evaluate outcomes after the intervention or recommence the cycle.

Willis and colleagues (Willis et al., 2006) demonstrated the importance of identifying opportunities for improvement by utilising a culturally appropriate evaluation process involving Aboriginal community members and organisations. This study identified the opportunities for improvement by undertaking an evaluation of an Aboriginal Hospital Liaison Officer program with a focus on improving the quality of service provided to Aboriginal patients. The results were used to develop a range of strategies to address key outcomes including unrealistic expectations of Aboriginal staff, the need to keep community agencies and extended family informed (with the patient's consent), a whole-of-health service response for achieving success, partnership with the Aboriginal community (including regular communication regarding staffing changes and advisory committee updates) and undertaking ongoing quality

improvement projects (medication and discharge planning tool trials). This study highlights several elements of the CQI cycle, including the implementation of a range of interventions, ongoing project evaluations and ongoing engagement with the CQI cycle.

Mooney and colleagues (Mooney et al., 2005) evaluated an Aboriginal cultural awareness training program in an urban health service in NSW. This study, based on a half-day Aboriginal cultural awareness training program for non-Aboriginal health professionals, examined the impact of the training on perceptions, familiarity, friendships, attitudes, knowledge and health issues affecting Australian Aboriginal people. The evaluation results showed a positive impact on familiarity and friendships with Aboriginal people and an increase in knowledge regarding the complex nature of conditions affecting Aboriginal people. The training did not have a major influence in changing people's perceptions or attitudes. The authors concluded that to have a significant impact on beliefs and attitudes, resources could be better put to the identification and implementation of more effective strategies. This study followed some of the CQI elements including identifying the issue (effectiveness of the cultural awareness training and collection of data, evaluation of training), developing a strategy (how to address an increase in knowledge but little change in perception and attitude by providing recommendations). To sustain a quality improvement approach these findings need to be incorporated into an overall CQI framework. This would involve implementing recommendations and re-assessing perceptions and attitudes over time.

In the report *Lookin' After their Own* (Clarke et al., 2000) the authors describe major changes in the direction and delivery of hospital services with the aim of improving access by Aboriginal children and their families. The report discusses a number of issues including: access by Aboriginal people to tertiary specialist hospitals; the traditional liaison officer model; barriers faced by Aboriginal families in hospitals; why hospitals need Kooris to work with Kooris; why organisations need to employ more than one Aboriginal staff member; bringing about change; the Aboriginal Policy Advisory Committee; cultural change; and lessons which can be learnt from the experience of facilitating change. The report emphasises CQI-type elements including identifying the opportunities for improvement (access issues and a traditional Aboriginal staffing model), developing a strategy (more Aboriginal staff), implementing interventions (a different model of working), evaluating outcomes (lessons learnt), and recommencing the cycle (the development of an Aboriginal Policy Advisory Committee).

Stamp and colleagues (Stamp et al., 2006) investigated the experiences of Aboriginal people travelling to city hospitals from rural and remote areas. Three Aboriginal health workers were interviewed and the issues identified included travel costs and organisation, culturally inappropriate accommodation, privacy, and the lack of inclusion of Aboriginal families, which has a major impact on willingness to attend hospital services. Services include surgery, social work support and outpatient appointments for follow-up treatment. Possible strategies for addressing these include Aboriginal liaison officers, changes in how particular issues are communicated to patients, improved hospital transfers, and provision of a campfire space for traditional families to gather in the hospital grounds.

A comprehensive study into cardiac care for remote Indigenous patients coming to a major tertiary hospital was carried out by Lawrence (2007). This analysis showed significant numbers of Aboriginal patients who were not showing up for surgery or had surgery cancelled due to being psychologically and

clinically unprepared. The recommended intervention to improve health outcomes was to establish a remote area liaison cardiac nurse position to assist in preparing patients, including ensuring all patients were mentally prepared for surgery and engaging previous patients to tell of their experience in their own language. Over a two- to three-year pilot period the new nursing position reduced the ‘no shows’ to zero. The analysis portrays an example of a CQI cycle being used to improve the cultural sensitivity and health outcomes for an Aboriginal health service. The quality improvement opportunity was identified using hospital data from referrals and subsequent admissions, the planning of an intervention based on Aboriginal patient experiences, the implementation of the intervention based on the new remote nurse role and finally the evaluation or study of the impact using data analysis which showed the reduction in no shows to zero (Lawrence, 2007).

Comino and colleagues reviewed the accuracy of identification of Aboriginal infants at an urban hospital by using data from a number of sources and supplementing this with local health worker knowledge about the Aboriginal status of infants. This work highlighted the importance of antenatal services; systematically seeking information on the Aboriginal status of both parents; of providing opportunities for timely feedback on the data quality to maternity service providers; and ensuring that the data are used to inform the development of culturally appropriate services. This study emphasises a number of key CQI elements including identifying the opportunity for improvement (inaccurate identification), planning an intervention (collecting data systematically from both Aboriginal workers and data systems), implementing an intervention and evaluating outcomes and recommencing the cycle. The impact of this CQI process is that the services now routinely identify infants with an Aboriginal father as well as those with an Aboriginal mother (Comino et al., 2007).

Learnings from other disadvantaged culturally distinct groups

The culturally and linguistically diverse (CALD) research literature was reviewed with the aim of identifying findings from CQI-type activities that might be transferable to acute health care settings to improve cultural sensitivity for Indigenous patients. To ensure there is no confusion, it needs to be emphasised that Australian Aboriginal peoples (and arguably all Indigenous peoples across the world) have a unique place in the Australian context, being a First Nation peoples and not an immigrant population. This is highlighted by the health status of Indigenous peoples as a global issue with mortality and hospitalisation data indicating that the health of Indigenous groups falls below that of other ethnic groups within their countries (Wilson, 2003). This reinforces the argument that the cultural concerns of Aboriginal people should not be seen as similar to other ethnic groups. This does not mean that CQI processes used for improving services to CALD patient populations will not have lessons for the planning of CQI approaches to improving cultural sensitivity for Indigenous acute health care patients.

Possible lessons for Australian healthcare services are explored in a European Union, Migrant Friendly Hospitals (MFH) project that aimed to enhance responsiveness by hospitals to culturally diverse populations. The project report outlines that, while economic and legal issues arise for healthcare services from the movements of different peoples, access and quality of care stand out as the most significant challenges. In particular, the ways in which healthcare services respond in a systematic way to culture and diversity was identified. Responding effectively to cultural diversity is a challenge throughout the world.

This project developed a number of networks to assist in stimulating and sustaining change, including: information and communication; partnerships and international contacts; working groups and their activities; organisation and infrastructures; and champions, change agents and enablers. The literature review component of this project highlighted that partnerships with migrant organisations are important for hospitals to improve quality of care. The discussion about quality emphasised that improving the quality of health care encompasses six aims: safety; effectiveness; patient-centeredness; timeliness; efficiency; and equity. Equity was highlighted as the most crucial. A health care system or institution is not providing quality care if it is not providing quality care to *all* its patients. Quality in terms of equity is thus a key issue in migrant and minority health care. The report discusses the political nature of the issue as a national health care system is supposed to provide health care equally to all its citizens. In conclusion, the report recommends that migrant and minority health care issues be framed as quality issues and also include migrant and minority health care issues in quality monitoring. It was also recommended that cultural humility should be the desired goal in medical education, not cultural competence, as it promotes a life-long commitment to self-critique and self-evaluation (Fawkes & Chiarenza, 2004).

Learnings from the above project reinforce many CQI principles and are particularly apposite when considering CQI approaches focusing on Aboriginal people. Here the access issues are considered quality issues and the inclusion in quality monitoring is strongly supported by this study for Aboriginal health in acute care. The partnership component is also strongly endorsed.

A Summary of the Literature Review through a CQI Lens

This review of the literature is an attempt to synthesise the findings from a small but significant body of Aboriginal health research literature that covers elements of a CQI approach with the aim of improving cultural sensitivity of acute health care services. Of the 12 studies that were identified as having some characteristics of CQI, four contained most components of the complete CQI cycle (Clarke et al., 2000; Renhard & Anderson, 2002; Willis et al., 2006, Lawrence, 2007). Of these, one was an overall sector review (Renhard & Anderson, 2002).

As discussed in the overview of the CQI literature, other concepts and practices that relate to the success of CQI include leadership and effective people management (with, in particular, a strong customer focus) as key predictors of performance within the CQI framework (Bailie et al., 2007). Without attention to these aspects of organisational change the likelihood of significant sustained change is greatly reduced. Of the publications reviewed here only one article explicitly highlighted the need for leadership to achieve change (Larkin & Buckskin, 1995), with another two outlining the need for a management structure to undertake the ongoing monitoring component associated with CQI-induced change (Clarke et al., 2000; Willis et al., 2006). People management in the area of Aboriginal health can involve more strategic employment, training and support for Aboriginal staff in acute health settings to play a role in the quality improvement process. This can include training suitably skilled Aboriginal staff to have greater involvement in quality issues regarding Aboriginal patient care; but, as indicated, this needs to be undertaken with strong leadership and commitment from management.

Identifying the Quality Improvement Opportunity

All the studies covered in this review included variable processes for identifying the CQI opportunity for improvement. Several reviewed used hospital data or an audit of data as the starting point to identify the opportunity for improvement (Lawrence, 2007; Mackenzie & Currie, 1999; Comino et al., 2007). Other studies used feedback from the Aboriginal community as the key source of information for identifying the opportunities (Stamp et al., 2006; Wilson, 2003; Larkin & Buckskin, 1995). Two studies utilised feedback from both Aboriginal consumers (patients) and the Aboriginal community (Clarke et al., 2000; Willis et al., 2006). One study undertook a specific data collection process (Mooney et al., 2005). The process undertaken in another study was unclear (Sinnott & Wittmann, 2001).

Developing a strategy – Concept papers

A number of the studies highlighted the issue and made suggestions for quality improvement strategies but did not progress any further along the CQI process (Stamp et al., 2006; Mooney et al., 2005; Wilson, 2003). Empirically speaking, this means that the validity of the suggestions remains untested in practice. From the remaining studies that did develop a strategy or intervention in response to the identified opportunity for improvement, several studies that involved Aboriginal consumers or communities in the identification stage also used them in the development of the intervention (Wilson, 2003; Willis et al., 2006; Larkin & Buckskin, 1995; Clarke et al., 2000). Two other studies appear to include Aboriginal community members for the first time in this stage of the process (Lawrence, 2007; Comino et al., 2007). Of the remaining studies it was not clear what process was undertaken to develop the strategy. Drawing on the wider literature regarding involvement of Aboriginal people in the design, development and implementation of any services for their communities, it is strongly recommended that Aboriginal people are involved in this stage. Reviewed projects that have involved Aboriginal people in the design and development of an intervention indicate a greater capacity to sustain change over the longer term and provide more appropriate services.

Implementing an intervention

Several studies undertook this stage of implementing an intervention (Wilson, 2003; Willis et al., 2006; Larkin & Buckskin, 1995; Clarke et al., 2000, Lawrence, 2007; Mackenzie & Currie, 1999; Comino et al., 2007; Sinnott & Wittmann, 2001). Three of these studies specifically used or employed Aboriginal staff to undertake this work with support from non-Aboriginal staff (Willis et al., 2006; Larkin & Buckskin, 1995; Clarke et al., 2000). One study involved past Aboriginal patients to assist (Lawrence, 2007). Again, this Aboriginal involvement within the mainstream health environment appears to be a crucial component in developing and implementing effective cultural reform strategies.

Evaluating outcomes (Study or Check phase of the CQI Cycle)

Five studies appear to have undertaken this stage of the process (Willis et al., 2006; Larkin & Buckskin, 1995; Clarke et al., 2000; Comino et al., 2007; Lawrence, 2007). Evaluating the intervention to assess its merit is crucial to ongoing quality improvement work. To undertake this element successfully requires that the organisation has a relationship with the Aboriginal community so the feedback process is

achievable in an ongoing way (Renhard & Anderson, 2002). This will assist in the development of new culturally appropriate measures, if required, to assist in ongoing monitoring of progress. The importance of developing relationships in particular with Aboriginal organisations to monitor the impact of CQI strategies is also supported by the CALD study on Migrant Friendly Hospitals (Fawkes & Chiarenza, 2004). The literature review in this work emphasised that partnerships with migrant organisations are important for hospitals to improve the quality of patient care.

Recommencing the cycle

Three of the studies reviewed gave an indication of an ongoing process of review (Clarke et al., 2000; Willis et al., 2006; Renhard & Anderson, 2002), with one of these involving an analysis of a sector, as opposed to an individual organisational setting (Renhard & Anderson, 2002). This was the predominant component missing from most of the studies reviewed and means that an ongoing system of data collection and an evaluation process is needed to indicate how well the organisational systems are functioning. This ongoing monitoring of progress and the continuation of the quality improvement cycle is a crucial component to sustain change over time (Renhard & Anderson, 2002). Most studies looked at an individual issue and made recommendations but did not examine the issue, implement a strategy and monitor changes within a CQI framework. The two programs that had an ongoing process of review in place appear to sustain a high level of quality (Clarke et al., 2000; Willis et al., 2006).

Discussion

CQI methods and techniques are routinely used internationally in acute health care institutions. A significant body of research supports the view that CQI can contribute to cultural reform when used in mainstream organisations. Australian research suggests that CQI processes are culturally acceptable to Aboriginal people. The Plan, Do, Study/Check, Act cycle has been used in numerous Aboriginal controlled organisations in Australia. Therefore the authors propose that working with Aboriginal communities—and not just with individual Aboriginal patients—using CQI methods and techniques is a viable approach to working to improve the culture of hospitals. It is culturally important that Aboriginal community perspectives be integrated into the CQI process as these perspectives are fundamental to shaping the views of Aboriginal people that relate to how they value acute health care services.

The research literature emphasises the value of Aboriginal community involvement in the design, development, monitoring and ongoing operation of cultural reform initiatives in acute health care services. This is consistent with the customer focus of the CQI approach and with the national health framework on Indigenous health, and is supported by the Closing the Gap campaign. This involvement in health care is also supported by research—Indigenous people having a sense of control over their lives creates a sense of hope, which is an important determinant for improving health status. Having a sense of control is strongly argued to be one of the key elements that have seen other countries, including Canada, New Zealand and the United States, make considerable improvements in the health status of their Indigenous populations compared to Australia.

Western medicine and hospitals in particular have their own subculture. This culture reflects a hierarchical decision-making approach based on the dominance of the medical view of the body as a

mechanical entity. This cultural belief about the primary purpose of a hospital is not congruent with the beliefs of Aboriginal people where the cultural perspective on illness and health is based on an ecological understanding of the world, with mind, body and spirit all part of any disease process. CQI is one approach that can be used to bridge this cultural divide. The primary cultural reforms required in hospitals are based on respect for cultural perspectives that are different to the mechanistic disease paradigm; and policies and practices need to be adopted to reflect these. This cultural transformation can be addressed through a systematic approach to changes in practice and the refinement of these based on a culturally acceptable evaluation of the impact of the changes.

Research findings suggest that the capacity of CQI methods to be used to improve cultural sensitivity and the resultant changes in practice depends on two main factors. One is the acceptance of culturally sound ways of measuring change or impact. The second is to develop culturally sound communication methods that allow for an ongoing dialogue between healthcare institutions and Aboriginal communities about the cultural change process. Tools are needed to foster both these developments. There is also a significant need for tools and guidelines to ensure that the need for change and its nature are not hindered because of broader organisational factors. Tools and guidelines that promote the necessary awareness and procedures to promote uptake of the findings from CQI processes need to be made available.

It takes several years for CQI to become a feature in a whole-of-institution cultural shift. Most research occurs over a much shorter period of time than this. Applied to a local situation cultural reform is measured according to cultural acceptability norms. This means that how the impact of cultural reform strategies is measured is local and subjective. This process itself takes time and is an essential component of developing processes for implementing and evaluating an incremental program of reform that is culturally sound.

Conclusion

CQI offers potential as a mechanism for making hospitals more culturally acceptable to Aboriginal people. The key success factors that need to underpin a CQI reform effort appear to be culturally sound communication practices and methods of measuring impact. A cultural change in hospitals that accepts a broader range of indicators to those that are traditional in CQI processes is necessary. CQI mechanisms and structures must embrace culturally sound ways of measuring and evaluating the impact of changes made through the CQI process. These changes are more likely when there is a systematic approach to understanding cultural perspectives in relation to the meaning of data; and when these new perspectives are applied directly to CQI mechanisms and structures.

Chapter Three

Phase III: Exploring some success stories – Case studies from hospitals successfully responding to Aboriginal people

Introduction

The purpose of this phase of the project was to identify the key elements that characterised those hospitals that were, in the opinion of Aboriginal stakeholder organisations, successfully providing services to Aboriginal people. We did not aim to undertake an in-depth case study that analysed all aspects of hospital practice; rather, key elements were identified and used to generate a quality framework and toolkit.

This chapter presents: the methods used to undertake the research; the findings, separated into the nomination process and the case studies themselves; and the conclusions drawn.

Methods

In each jurisdiction of Australia the NACCHO affiliate was informed of the project and asked to nominate hospitals that, in their view, were serving the Aboriginal community well. They were also asked to consider the following criteria when making their nominations: which hospitals had put a substantial, sustained and successful effort into implementing Aboriginal health initiatives?

This request was then followed up with emails and phone calls to assist in successfully engaging these agencies. All hospitals nominated were then contacted and sent an expression of interest questionnaire. This questionnaire consisted of the following questions:

- a) Can you please describe your partnership with the local Aboriginal community and what outcomes have been achieved through this partnership?
- b) Can you please describe any Aboriginal health initiatives that you have developed and how they may have involved local community support?
- c) How long have these initiatives been in place?
- d) Have you established any systematic monitoring and/or evaluation processes for the above initiatives? If yes can you please provide details?
- e) Can you outline how these initiatives have been supported within your organisation?
- f) Can you provide details on how these initiatives have been funded?
- g) Has your hospital identified any clinical champions and/or executive sponsors to support these particular health initiatives? If so could you please provide details?
- h) Can you please provide details if any of these initiatives impact on practices in more than one department across your organisation?

The submitted expression of interest questionnaires were then assessed by the project team along with the supporting documentation. Five hospitals were chosen. All nominated hospitals, as well as the Aboriginal community organisation involved in their nomination, were notified in writing of the outcome of the selection process and those not selected were advised that they may be approached in later phases of the project. All hospitals were offered inclusion on a project database so they could be kept updated regarding the progress of the project. Those hospitals that were successful were contacted by email and phone to discuss the project in more detail and to arrange a site visit.

Having finalised the selection of hospitals, information about their structure, processes and practices was then gathered primarily via printed documentation and a site visit consisting of discussions with key informants.

Prior to each site visit hospitals were encouraged to provide the project team with any background information about the local context and other relevant current information. This included annual reports, strategic planning documents, action plans and program review reports. This information was analysed prior to the site visit.

Each site visit involved members of the project team—Aboriginal and non-Aboriginal researchers—attending meetings with a range of staff. The meeting schedule was negotiated with each hospital and generally involved a full day of individual and group interviews.

The literature review undertaken as part of Phase II of the project emphasised that to create a culturally sensitive service one needs to take a system-wide approach to be effective. Consequently the team negotiated meetings with as many staff across each organisation as possible. The roles held by staff who met with the team included:

- Aboriginal Hospital Liaison Officer
- Aboriginal and Torres Strait Islander Unit Manager
- Aboriginal program administration staff
- Aboriginal Nurse
- Chief Executive Officer
- Director
- Executive Director
- Chief Medical Officer and other senior medical staff
- Head of Departments
- Chief Social Worker and other social workers
- Occupational Therapy Manager
- Quality Manager
- Human Resource Manager
- Mental Health staff
- Emergency department staff

- Maternity department staff
- Health Information Systems staff
- Public Relations Manager.

We developed a set of questions (which varied slightly for each site depending on information previously provided during the expression of interest stage) to explore their successful initiatives. An indicative example of some of the themes that were explored included: staff training; action plans; evaluation processes; community feedback processes; data audits; and sustainability.

Each team member took notes during the meetings. Each site visit also resulted in additional policy and planning documents being provided to the team. These additional documents, along with team's notes, were reviewed and summarised. Each case study was then written up by the team leader integrating findings from all team members including both Aboriginal and non-Aboriginal researchers. A draft summary of discussions at each hospital was prepared and circulated to key participants at each site, with requests for any inaccuracies to be noted. All documentation was subjected to a content analysis and initial key themes were identified. At the conclusion of this process all team members, Aboriginal and non-Aboriginal, discussed and finalised the key themes that emerged from each case study.

Findings

Nomination process

A number of issues emerged during this process that had implications for the research. All five hospitals identified and used as case studies for this phase of the project were from two jurisdictions, Victoria and South Australia. This in itself is a key finding from this phase of the project. The approach taken during the nomination and selection process relied on negotiating with the NACCHO affiliate in each jurisdiction. In some cases, due to a lack of engagement, no hospitals were nominated from some jurisdictions.

Case studies

Findings from the case studies were summarised under key themes and highlighted common elements. These themes included: strong partnerships with Aboriginal communities; enabling state and federal policy environments; leadership by hospital Boards, CEOs and key clinical staff; strategic policies within hospitals; structural and resource supports; and a supported Aboriginal workforce.

The following is a summary of the key findings from each hospital site. For detailed findings please refer to Appendix One – Detailed Findings.

1. Maitland Hospital (Yorke and Lower North Health Service, South Australia)

The Maitland Hospital is a rural hospital that provides both inpatient and aged care services. Among its key Aboriginal health developments were a comprehensive feedback process from the Aboriginal community and Aboriginal patients as well as an Aboriginal employment strategy.

To focus on improving the Aboriginal patient experience the Aboriginal worker at Maitland Hospital spent four years asking the community what they wanted from the hospital. Focus groups were a systematic component in the initial development phase but are now only used as required. This ongoing focus on consumer feedback has led managers to ask for Aboriginal feedback where historically it was not seen as important. This has also resulted in participants from consumer focus groups becoming involved in the Aboriginal Services Improvement Plan that now guides activities at the hospital.

Historically, Maitland Hospital focused on the employment of an Aboriginal Liaison Officer but then broadened this focus to develop other Aboriginal-specific roles including management trainee positions. This change required the relocation of funds, including to a part-time position to oversee the training program and provide support to the trainees. The employment and training of Aboriginal staff within the hospital was initially challenging but has worked in the long term. Commitment from key staff and support from management has enabled the recruitment and retention of staff. The program has allowed non-Aboriginal staff to learn about the Aboriginal community by working alongside Aboriginal staff. Another positive outcome has been the employment of younger Aboriginal people and the positive impact this has had on changing the overall hospital staff culture and attitudes. It was also acknowledged that both Aboriginal and non-Aboriginal staff have made sacrifices to bring about changes.

In relation to cultural awareness training, an Aboriginal Nurse was employed at Maitland Hospital to implement cultural awareness training for board and executive staff. Five executives attended different cultural awareness sessions and then provided leadership in this area to other staff. Some executive staff also attended one- and two-day courses on Aboriginal culture as well as participating in a rural camping trip for two to three days.

2. Royal Adelaide Hospital (South Australia)

The Royal Adelaide Hospital (RAH) is a metropolitan hospital providing a wide range of services with a dedicated Aboriginal and Torres Strait Islander Liaison Unit.

The idea to have a particular focus on Aboriginal health was taken up by the General Manager after it was first raised by the Consumer Advisory Council in 2002. The RAH then developed its relationships with the Aboriginal community starting with meetings with the Aboriginal Health Council of South Australia. Following this, the RAH documented Aboriginal patient stories (pathways) with information from focus groups that included success and failures stories regarding patient access. Moving to a more systematic process the RAH generated an Aboriginal Health Framework and an Action Plan. The RAH ATSI Health Action Plan was the key technique for making issues for Aboriginal patients concrete and was the same process used for other population groups including homeless and CALD people.

The ATSI Unit at the RAH reports back on its progress to the ASTI Steering Committee, which meets bi-monthly to review progress on the Action Plan. Progress is documented by Safety and Quality Unit staff under each of the headings in the Action Plan including the steps taken, products developed and any achievements. The Steering Committee also allocates actions to different parts of the hospital highlighting that the Action Plan is for all staff. The general executive has responsibility for providing resources and ensuring accountability.

One key goal of the RAH had been to change staff attitudes regarding Aboriginal health. To achieve this, the RAH undertook a number of initiatives including the employment of Aboriginal staff. Initially the Aboriginal Nurse and Aboriginal Liaison Officers (ALOs) were located in different units but increased support and capacity has been achieved by establishing a specific unit. The Aboriginal and Torres Strait Islander (ATSI) Unit also has a manager position to undertake community networking as ALOs are too busy with direct patient support. The General Manager made a commitment to establish the ASTI Unit and to provide space to house it. Through the creation of a separate ATSI Unit the profile of Aboriginal staff and the team across the hospital has been raised.

3. St Vincent's Hospital (Melbourne, Victoria)

St Vincent's Hospital is an inner city metropolitan hospital that provides a wide range of services. It has had a long-standing Aboriginal Hospital Liaison Officer (AHLO) program with strong executive support and a comprehensive range of policies to support ongoing development. The Victorian Government policy known as Improving the Care for Aboriginal and Torres Strait Islander Patients (ICAP) has also provided a useful framework to improve relations with the Aboriginal community and to implement a range of initiatives that have seen an improved service response to Aboriginal patients.

At St Vincent's the AHLO works within the emergency department and other areas of the hospital to facilitate access and coordinate treatment for Aboriginal patients. The AHLO plays a key role in linking the hospital to the community, guiding program development and ensuring the delivery of culturally sensitive services to the Aboriginal community. St Vincent's has also added a new Aboriginal position in recent years to assist in the development, coordination and delivery of a cultural awareness training program to staff and facilitate the relationship with the community.

In 2005, St Vincent's conducted a review of its AHLO Program involving feedback from Aboriginal patients and organisations. The results of this review were disseminated via a journal article and a poster. The review also informed the development of a more effective discharge communication tool for Aboriginal patients that involves both Aboriginal and non-Aboriginal staff. The discharge communication tool has become another way to ensure improved communication between clinicians and other staff regarding the complex care management/discharge planning required for some Aboriginal patients.

Cultural awareness training at St Vincent's is viewed as experiential learning and involves a range of activities including the social work buddy system, co-worker model, and Aboriginal and non-Aboriginal staff visiting Aboriginal agencies and NAIDOC celebrations. In addition, some medical staff have undertaken orientation at the local Aboriginal health service. Despite some limitations to cultural awareness training as a method in itself, St Vincent's has implemented it in recognition that the

development of cultural competence is a process involving information, knowledge building and asking and answering questions. St Vincent's future goals include concentrating on developing and resourcing clinical champions from many areas and disciplines to extend the reach and impact of cultural awareness and safety principles.

4. Goulburn Valley Health (Shepparton, Victoria)

Goulburn Valley Health (GVH) is a rural hospital providing services to a wide geographical area and has a long-established formal partnership with Rumbalara Aboriginal Cooperative—the local Aboriginal community controlled health organisation.

GVH utilises a range of strategies related to cultural awareness training including formal sessions and opportunistic approaches. GVH management believes that Aboriginal staff in the hospital play a crucial role in changing the culture and that the most effective way to change staff attitudes in the longer term is to have Aboriginal staff working alongside them day to day.

The current committee structure to support Aboriginal health developments at GVH involves the Aboriginal Health Taskforce as a subcommittee of the GVH Board. Membership of the Taskforce includes the Chief Executive Officer, an executive sponsor, Mental Health Manager, Nursing Manager and two Board members. From Rumbalara's side, membership includes the Chief Executive Officer, other senior staff and community elders. This taskforce has also developed an Aboriginal Health Outcomes Agreement which is annually reviewed and is the key vehicle for GVH maintaining dialogue with the Aboriginal community. All proposals regarding Aboriginal developments at GVH go through the Taskforce, including the recent 'Closing the Gap' initiative that is now on the agenda. Another indication of the GVH Board commitment is that Aboriginal health is a standing agenda item at all Board meetings.

5. Royal Children's Hospital (Melbourne, Victoria)

The Royal Children's Hospital (RCH) is a metropolitan-based hospital specialising in the care of children, which has recently developed a specific Aboriginal model of care that incorporates a stand-alone clinic for Aboriginal patients and their families.

The new model of care for Aboriginal children and their families involves the creation of a new paediatric clinic specifically for Aboriginal patients. The funding for this initiative was supplied by the RCH Foundation following support from the Chief Executive Officer and the hospital Board. The governance structure for the clinic will include a dual reporting line to an executive director and a senior medical staff member. This new model of care will be more holistic and focus not just on the patient's physical condition but also other on issues including looking at other family siblings. Key outcomes expected from the clinic include an increase in the number of Aboriginal patients attending, earlier presentations, that families more readily follow through a course of treatment, and parents take on guidance more readily.

The RCH have had a long-running committee known as the Aboriginal Liaison Policy Advisory Committee (ALPAC) that has been the key structure for RCH in developing its relationship with the Aboriginal community and provides a voice for the community at the hospital. There is representation from both the community and hospital on the committee and all hospital policies/programs relating to Aboriginal families must be discussed and endorsed at a committee meeting. ALPAC is co-chaired by an Aboriginal and non-Aboriginal and at times meets at a local Aboriginal organisation, usually with the RCH Aboriginal Emotional Wellbeing Committee. ALPAC raises awareness within the hospital, has influenced the Chief Executive Officer and is effective at an organisational level. Minutes and agendas for ALPAC meetings are always sent to Aboriginal organisations.

RCH has undertaken a number of reviews of its program including a review of attendance rates for outpatient appointments and a historical review culminating in a comprehensive report entitled “Lookin’ after our own”. This report documented the history of the Aboriginal health program at RCH, outlining the culture and evolution of the program along with a program review. It included feedback and stories from Koori patients, staff, elders and community members and has guided future developments.

Conclusions

Nomination process

As a result of the lack of engagement from some jurisdictions it was agreed by the project advisory committee that for Phase IV of the project contact would be made with both the NACCHO affiliates and the health departments in each jurisdiction and ask them to nominate hospitals. In line with Aboriginal research principles, any nomination from the NACCHO affiliates will be given priority. Parties in each jurisdiction will be kept involved of progress and outcomes.

As some hospitals did not participate in this phase of the project due to resource issues, a newsletter was created and sent to each jurisdiction along with the NACCHO affiliates across Australia to enhance the possibility that jurisdictions would fund hospitals to participate.

Case studies

Findings from the case studies indicated that hospitals considered to be successfully addressing the issues of their Aboriginal patients shared strong partnerships with Aboriginal communities; enabling state and federal policy environments; leadership by hospital Boards, CEOs and key clinical staff; strategic policies within their hospitals; structural and resource supports; and a supported Aboriginal workforce.

It was clear that generating strong partnerships with Aboriginal communities was the foundation for any attempt to improve services to Aboriginal people and required commitment, time and resources. Consultations with various Aboriginal communities, organisations and leaders, conducted by Aboriginal staff from most of the hospitals, usually resulted in the development of formal agreements. These formal agreements provided a mechanism for ongoing relationships and information sharing. They also articulated specific goals, specified improvements in services and incorporated accountability requirements.

Strategies for maintaining a dialogue with the Aboriginal community also included a range of other activities such as the establishment of an Aboriginal Health Advisory Council and other advisory committees. Some hospitals also provide shared care, community-based and outreach services, in particular to Aboriginal communities and some primary care services. Variations between the hospitals in the case studies seemed to be more related to specific internal and local factors (staffing and resources) and organisations (capacity to participate in consultations) rather than whether they were large or small or rural- or city-based.

Some hospitals were operating within and clearly influenced by specific state and federal policies that aimed to improve the health of Aboriginal patients. At the national level the hospitals were required to implement initiatives to achieve specific Aboriginal health outcomes as outlined in the Health Care agreements negotiated at COAG.

All of the hospitals in the case studies referred to the national Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 and indicated that they had undertaken a range of activities related to it. Senior staff at one hospital were also attempting to implement the National Health and Medical Research Council's guide, "Cultural Competency in health: A guide for policy, partnerships and participation".

At the state level, Victorian hospitals have been operationalising the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) policy that requires them to improve their partnerships with Aboriginal communities. This policy supports, for example, the creation of health outcomes' agreements with the local Aboriginal communities that have been developed by rural hospitals.

In South Australia, the Department of Health established Aboriginal Health Advisory Councils (AHACs). These regional committees were initially established to provide advice to hospital Boards. After boards were disbanded AHACs were maintained to advise hospitals on regional issues; they also send one Aboriginal representative to Aboriginal Health Council of South Australia Board of Management meetings to provide statewide advice to the South Australian Government on Aboriginal health issues. In South Australia, the state government continues to support AHACs and one regional hospital has used this structure effectively to gain feedback from the Aboriginal community.

There was considerable variation between the states and the states' and the federal government's policy requirements for hospital services to Aboriginal patients. It would be most advantageous if these policy requirements were consistent.

It is important to note that in some cases the policy requirements and associated funding had been most influential in enabling some hospitals to address the issue of the health of their Aboriginal patients. However, for other hospitals this focus and funding was a welcome support to work that had been already been initiated by key hospital staff and or other Aboriginal organisations.

It was no surprise that all the hospitals, regardless of size or location, had Board members, CEOs and clinical staff who exhibited leadership in relation to improving services to Aboriginal patients. Their formal responsibility for effecting cultural and organisational change and improvements to Aboriginal

health were acknowledged by the hospital boards in a range of ways, including allocating portfolios, demanding targets and agreements, requiring regular reports and allocating resources. Some also undertook cultural awareness training and or were participants of particular implementation committees.

All the hospitals had generated a number of internal strategic policies aimed at improving the health of Aboriginal patients. Nearly all hospitals had produced documents, such as vision and mission statements, which incorporated explicit value statements regarding the hospital's commitment to caring for Aboriginal people. All had a range of change management strategies that were often implemented via their quality improvement mechanisms. The five hospitals had between them developed new Aboriginal health frameworks, action plans, key performance measures, training, protocols, guidelines and models of care. Three had also monitored and reviewed these. Frameworks linked to quality improvement mechanisms and action plans with clear, achievable aims and allocated personnel seemed to be most effective.

All the hospitals had policies that required some staff to attend cultural awareness training, which was usually delivered by Aboriginal people. Some of the hospital staff exhibited a more complex understanding of the dimensions of cultural change, often because they had been attempting it for a longer period. They considered cultural awareness to be a multi-faceted ongoing process of information exchange, debate and review of practice rather than something that could be accomplished consequent of a one-off training session. One hospital had incorporated the attendance at cultural awareness training into all position descriptions.

As part of their ongoing commitment to an improved understanding of and relationship with Aboriginal communities, some hospitals had policies that facilitated Aboriginal ceremonies and events within the hospital. Again, this achievement seemed to be related to the quality and extent of the established relationship rather than the size or location of the hospital.

Not surprisingly, structural and resource supports seemed to be essential if the hospital was to focus on improving Aboriginal patients' health. Some of the hospitals had linked their initiatives to quality improvement mechanisms, such as the Quality and Safety Committee, in part to formally identify support staff and resources. All had established a formal Aboriginal Hospital Liaison Officer or an Aboriginal Health Liaison Worker role. Some had a specific Aboriginal and Torres Strait Islander Steering Committee and an Aboriginal unit or an Aboriginal health team. All had increased or re-allocated funding for Aboriginal staff. It is important to note that some hospitals undertook these initiatives with specific additional funds and others re-prioritised within their ongoing budgets.

Additional resources were provided by some hospitals for the purchase of Aboriginal artwork, posters and resources, and particular rooms and spaces for Aboriginal people within the hospital area were identified. In addition, some hospitals arranged for funding that would allow hospital staff to provide services in the Aboriginal community. Most hospitals utilised internal newsletters and bulletins to inform staff of particular events, goals and progress.

Finally, the importance of policies, resources and practices that support the hospital's Aboriginal workforce cannot be overestimated. Key findings from the case studies indicate that essential factors include: targets set for increasing the Aboriginal workforce; well-articulated role statements for Aboriginal Health Liaison Workers and all Aboriginal staff; the establishment of Aboriginal teams rather than sole workers; Aboriginal staff employed in mainstream positions not just Aboriginal Hospital Liaison Officer roles; time allocations for Aboriginal workers to maintain relationships with community organisations, visit Aboriginal patients and fulfill their community responsibilities; clearly defined lines of accountability; and supportive senior management staff who are committed to the cultural change program. Most importantly, the hospital must promulgate the explicit understanding that improved outcomes for Aboriginal patients are the responsibility of all hospital staff, not just the Aboriginal workers.

Chapter Four

Phase IV: Trialling the Continuous Quality Improvement Framework and Toolkit

Introduction

This chapter describes the fourth phase of the project, which involved piloting the Continuous Quality Improvement Framework and Toolkit that had been generated from previous research work, the literature review (Phase two) and the case study exploration (Phase three) documented in previous chapters.

Phase four aimed to trial the draft Framework and Toolkit with five hospitals varying in nature, size and location.

What follows is a summary of the processes undertaken to: nominate and select the participating hospitals; conduct the two site visits per hospital; evaluate the strengths and weaknesses of the Framework and Toolkit and identify specific gaps; identify key facilitators for and barriers to the use of the Framework and Toolkit; and generate recommendations for the improvement of the Framework and Toolkit and its continued utilisation.

Nomination and selection of the participating hospitals

Nomination

Geographic representativeness was of primary importance because of the different policy environments in different jurisdictions. While the nature of the social context is important, the primary focus of this project was on the processes that are established within each hospital. Due to the limit of five hospitals and the involvement of South Australia and Victoria in Phase III, it was recommended that trial jurisdictions for Phase IV be Western Australia, Northern Territory, New South Wales (including the Australian Capital Territory) and Queensland. It was also recommended that the Tasmanian state NACCHO affiliate and the Tasmanian Department of Health and Community Services be approached, and, if a trial was feasible, then Tasmania would also be included. Within the four (or five) jurisdictions a range of characteristics were considered when identifying suitable trial sites. These were:

- Executive support – willingness to engage in a comprehensive planning process
- Strong relationship or connections to the local Aboriginal community
- Dedication of resources
- Establishment of an internal project planning and evaluation function
- An operational Quality Improvement Committee
- A significant Aboriginal patient throughput
- An Aboriginal person who can support the CQI process
- Capacity to work with the jurisdiction and Commonwealth policy context.

In those selected jurisdictions the NACCHO affiliate, along with the jurisdictional health department, was notified of this phase of the project to request further nominations. Those hospitals nominated for Phase III but not selected were also considered.

Each jurisdiction undertook a different process to provide nominations. For example, in NSW the Department of Health wrote to each region requesting nominations and these were provided to the project team. This information was then discussed with the Aboriginal Health and Medical Research Council of NSW (NACCHO affiliate) to finalise a nomination for NSW. In other jurisdictions it required several emails and letters with follow-up meetings by the project manager with both the NACCHO affiliate and the jurisdictional health department to finalise the nomination process.

Selection

After consideration of nominations by the research project team and the project advisory group, five sites were selected. They were:

1. Campbelltown Hospital (NSW).
2. Mater Hospital (QLD).
3. Derby Hospital (WA).
4. Royal Brisbane and Women's Hospital (QLD).
5. Katherine Hospital (NT).

Site visits

Each hospital received two site visits from members of the research team, with the exception of Katherine Hospital, which withdrew due to internal time pressures following the first site visit.

Initial site visit

The first site visit occurred at the commencement of the trial period and usually involved: a presentation by senior management about the context and characteristics of their hospital; discussions with key staff regarding their current roles and their relationship to continuous quality improvement processes and or their contacts with the Aboriginal community; and a presentation by the research team on the project, the aims of the trial phase, the support we could provide and our expectations of hospital staff. Participants in this initial mutual orientation process included: Acting Executive Director; General Manager; Executive Director Medical Services; Deputy Executive Director Medical Services; Medical Director; Director of Safety and Quality; District Managers; Executive Director of Mission; Aboriginal Liaison Officers; Aboriginal Liaison Unit Managers; Project Manager Indigenous Health; Principle Indigenous Health Co-ordinator; Coordinators or Managers of Clinical, Quality and Safety Units; Nurse Manager; Social Support Team Leader; Senior Welfare Worker; Registered Midwife; Patient Representative; Human Resources Officer; Regional Clinical Practice Improvement Coordinator; and Regional Director Corporate Services and Planning.

Following these initial presentations and meetings the research team then met with those staff who would be directly involved with the trial. As a whole these meetings included: Executive Director of Mission; Aboriginal Liaison Officers; Project Manager Indigenous Health; Principle Indigenous Health Coordinator; Coordinator or Manager of Clinical, Quality and Safety Units; Safety and Quality Officer; Executive Director Critical Care and Clinical Support; Nursing Director; Social Support Team Leader; Nurse Manager Emergency Department; Discharge Planner; Clinical Nurse Co-ordinator; Nurse Practitioners; Deputy Director of Aboriginal Health SSWAHS; and Project Officer Aboriginal Chronic Care Project.

These meetings aimed to further clarify the purpose and responsibilities for all parties involved in the trial phase and its scope. Detailed presentations and discussions occurred regarding the content of the Continuous Quality Improvement Framework and the Toolkit and the research team demonstrated its use. The research team and staff then focused on delineating potential projects that would be utilised to trial the Continuous Quality Improvement Framework and the Toolkit. In some situations the hospital staff had given considerable thought to this before the arrival of the research team and tabled detailed project proposals, whilst at other settings the staff had yet to finalise the options or select a particular focus. In some cases the ideas for the projects had arisen directly from feedback given to Aboriginal Liaison Officers by their Aboriginal patients, whereas in others the impetus had been more directly related to key performance requirements articulated in recent funding agreements with state governments, often informed by the federal government's Close the Gap policy commitments.

In all these preliminary discussions the research team focused the conversations on the first few processes in the Continuous Quality Improvement Framework; the consequence being that particular attention was given to the importance of the project plan emerging from a consultative phase with local Aboriginal communities. In addition, the value of senior staff providing leadership and support was emphasised. The research team also outlined the Continuous Quality Improvement Training Program that was offered to two Aboriginal Liaison Officers from each participating site and initial discussions occurred regarding which staff would be most interested in and benefit from this opportunity. Details of this Training Program are provided in Appendix Eight of this report.

At the conclusion of the first two-day visit agreement was reached regarding the focus of the project to be undertaken and that a detailed project plan, including objectives, strategies, key performance indicators, people responsible, timelines and required resources, would be generated and forwarded to the research team within a specified time. A project coordinator was appointed with responsibility for managing the project and the trial at the hospital and maintaining contact with the research team project manager. Following the site visit the hospital project coordinator was sent a list of evaluative questions linked to each Quality Improvement Framework Process and Toolkit.

CQI Projects

The final four participating hospitals generated project plans for their trial of the Framework and Toolkit. The projects included the following:

- Campbelltown Hospital – To improve the process of follow-up referral of Aboriginal patients from the Emergency Department by the Nurse Practitioner
- Royal Brisbane and Women’s Hospital – An Antenatal and Birthing Services project focusing on the continuous improvement of antenatal and birthing services for Aboriginal and/or Torres Strait Islander women
- Derby Hospital – Create a culturally appropriate family meeting space within Derby Hospital that enables family conferencing, communication with extended family and the sharing of significant health information with extended family
- Mater Hospital – Improve Indigenous identification to improve the quality of services for Aboriginal patients.

Communication and support between site visits

Following the first site visit the research project manager maintained active communication with key project people at each site and supported the staff to complete their initial project plans and timelines. He sourced additional material related to the various project foci from other hospitals in Australia and made this material available to the staff. As the projects progressed he provided advice and further information. Importantly he networked members of the hospital project teams with other staff working in similar areas at other hospitals or institutions. He also provided advice and support to the ALOs when they participated in the Melbourne-based Training Program.

Final site visit

The final site visit provided the opportunity for the hospital team to report on their progress regarding their project and, most importantly for the research purposes, their use of and views about the Continuous Quality Improvement Framework and Toolkit. Some participants generated PowerPoint presentations on their projects and or progress reports. Specifically, the research team conducted structured focus groups and or key informant interviews with members of the hospital project team and some other significant stakeholders nominated by them. Participants in this evaluative phase included: Aboriginal Liaison Officers; Project Manager Indigenous Health; Principle Indigenous Health Co-ordinator; General Manager; Director of Mission; Health District Operations Manager; Senior Medical Officer; Quality Coordinator; Safety and Quality Officer; Nurse Manager Emergency Department; Discharge Planner; Clinical Nurse Co-ordinator; Nurse Practitioners; Transitional Nurse Practitioner; Social Support Team Leader; Deputy Director of Aboriginal Health SSWAHS; Project Officer Aboriginal Chronic Care Project; and Regional Quality Coordinator; ATSI Health Liaison Officer for Women’s and Newborn; and Acting Director Safety and Quality Unit. A total of 26 people participated.

All informants were asked a set of general questions regarding the Framework and Toolkit and then a series of specific questions about each process. These questions included the following:

- What was useful?
- What wasn’t useful?
- What else did you need?

- What facilitated the use of the Framework and Toolkit?
- What were the barriers to its use?

A series of prompts was also utilised to deepen the discussion about the adequacy of the Framework and Toolkit and to identify additional material that may have been required. Members of the research team noted the discussions. The findings were sorted according to the question categories and unexpected additional categories. Themes and patterns in the data were generated and discussed by members of the research team.

Creation of final version of toolkit

Feedback from the trial was then used to update and expand the draft toolkit. This updated version was then sent to all hospitals involved in the project including Phase III and IV hospitals to verification changes made and requests any final comments.

Findings

The findings are presented in the following order: general overall comments; general positive feedback; increased focus on ATSI people's needs; increased focus on ATSI people's views of hospital services; increased focus on linking ATSI people's needs to the Hospital CQI structure; better understanding of the role and value of ALOs; external credibility and legitimacy; network and training; ACHS and accreditation; national implementation; implementation training and support; structure; and content.

Suggestions for changes included: additional content; developing the Toolkit as a training device; modifying structure, presentation and style; and generating guiding principles and more illustrative examples.

Factors that facilitated the use of the Framework and or Toolkit are then presented and incorporated: Commonwealth, state and territory health funding requirements; leadership and support from senior managers; mentoring provided to ATSI staff; an externally accredited training program; credible and respected external researchers; and the provision of external advice and support by Indigenous and non-Indigenous researchers.

Key aspects that appeared to impede the use of the Framework and or Toolkit were: a lack of recognition of the particular needs of ATSI communities; an absence of a coordinated vision for ATSI CQI initiatives; variations in ATSI communities and hospital characteristics; competing demands; and a lack of intensive initial training on the Framework and Toolkit.

Recommendations emerging from the analysis of the findings conclude this section.

General overall comments

All participants were asked for their initial overall comments about the framework and the Toolkit. All provided general positive feedback; for example:

I think the concept is really useful.

I think this is a fabulous Framework.

I think this is a great Framework, the 1 to 9 processes are good.

Loved it because you could open it up and the whole process was there and explained.

I think this is a really important research process. I'm a big fan of it.

Increased focus on ATSI people's needs in general

Specifically some interviewees highlighted that participating in the trial and utilising the Framework and Toolkit had increased staff focus on ATSI people's needs in general. As some explained it:

The really valuable thing your initiative has done is to put us on a pathway to do a range of things...this is just the beginning for us and our rather small team has been energised by the possibilities.

Made us put it on the agenda so that was very useful and positive.

Assisted hospital staff to improve their focus on the needs of ATSI people.

Helped us think about building relationships with the communities in a strategic way not just in terms of developing an antenatal leaflet.

Others noted that:

This Toolkit explicitly identifies consultation with ATSI communities which is often missed in other processes.

Focuses attention on how important it is.

Strategically useful...made it easier to sell the idea of cultural reform to some hospital staff...and in the region.

To get agreement to bring a Toolkit, in itself it makes them set up a whole set of processes.

It has had a lot of spinoffs already...in our department we have mandated cultural awareness training for everyone.

I got a lot of cultural awareness just from reading the Toolkit.

Increased focus on ATSI people's views of hospital services

Use of the Framework and Toolkit had, for many interviewees, resulted in an increased focus on specifically collecting ATSI people's views about the hospital services:

We need more resources like this that help us gather information from families and people...that help us say 'tell us your story' rather than rely on complaints procedures.

It helps us seek information from the patient about the care they want...and assists the staff to directly seek that information from the patient.

The Toolkit can help [for example] the discharge person to understand the social context of the patient...unless there is some work being done in the hospital about this then the discharge will fail. This is the key to making a difference.

Any feedback will be a massive, massive cultural shift...

We knew we had to do something but we just didn't know how.

Most significantly some ATSI interviewees noted that the Framework and Toolkit could assist them to advocate for and respond to ATSI people's needs in a more systematic way. As one ALO explained:

It was something I can actually do [at the hospital] to make things better instead of just being a taxi driver.

Increased focus on linking ATSI people's needs to the Hospital CQI structure

Most interviewees noted that the Framework and Toolkit had highlighted the importance of linking the needs of ATSI peoples to the CQI structure in the hospital. Many said that this had not occurred before the trial as they, and many of their colleagues, had been responding to the needs of, or issues related to ATSI peoples in an ad-hoc manner. Further, they had primarily been relying on the ATSI staff or social workers to respond. Participating in the research project and implementing the Toolkit highlighted the need for a more complex, multi-faceted and systematic response to those needs and service issues. For them the Framework provided an explicit model for building a relationship with local ATSI communities and then linking their needs to the CQI structure in the hospital, the Quality and Safety Unit or the specialised Quality staff. It underscored that many of the issues they had been dealing with were in fact quality issues. As one senior manager explained:

The whole hospital is responsible for responding to ATSI service gaps...but someone would say something and someone would do something...but without the quality process...we now realise that what was missing was the formal quality process.

And another:

The disconnect between hospital quality processes and ATSI issues is huge...quality is seen as what is done clinically and not necessarily taking in the broader context in which that clinical care occurs.

In addition, there was strong support for the ALOs to be formally linked into the hospital's quality structure and processes, although the ways of doing this would necessarily vary from site to site. One Quality Coordinator said that:

People working in the quality role need to support ALOs being involved in quality and need to link their projects into the quality cycle...it is important to close the loop.

Better understanding of the role and value of ALOs

Some participants indicated that they, other hospital staff and ALOs themselves had a deeper understanding of the role of the ALOs and the significance of their work.

As one person explained:

The ICHP has also been invaluable in identifying for our Aboriginal Liaison workers the range of initiatives we can engage in that may have an impact on the whole organisation, demonstrating the strategic importance of their work; and that it has a broader impact than the very good one-on-one care they provide to individual patients and their families.

External credibility and legitimacy

Many interviewees expressed the view that although some policy and hospital directives identified the health of ATSI peoples as a priority, effective action within their hospital was not always taken. That the project was initiated and conducted by an external, university-based research team with legitimacy and credibility added significance to the importance of the issue of addressing ATSI health and also bolstered the value of the Framework and Toolkit itself. As some staff explained, the issues and the Toolkit:

have credibility and legitimacy and status.

...is externally recognised...and so has status.

Network and Training linked to Framework and Toolkit

Two key components associated with the implementation of the Framework and Toolkit were highly regarded by the interviewees. Many interviewees stressed the value of the network of Indigenous and non-Indigenous staff who were associated with CQI and who were utilising the Framework and Toolkit.

For example:

...the other thing that I think is really positive is the network that underlies the toolkit. Because it gives an opportunity not only for you to read about those things, but to be able to pick up the phone and call the person at that spot. And I think that the network is really important.

In addition, the specialised training program, 'Short Course: Improving the Culture of Hospitals - Quality Improvement training for Aboriginal staff in hospitals', linked to the Framework and Toolkit for ATSI staff was considered an essential component for the successful implementation of the Framework. The training program, conducted by Indigenous and non-Indigenous trainers, was highly valued by ALO staff and other non-Indigenous staff. Some interviewees observed that some ALO staff had manifested new CQI knowledge and skills.

Most significantly perhaps, as a result of the training, some ALO staff had been enabled and supported by non-Indigenous staff to participate in CQI activities for the first time. As one person explained:

We have talked about involving the ALOs in quality but we never have.

Australian Council of Healthcare Standards (ACHS) and accreditation

In order to maintain a focus on systematic CQI approaches to improve hospital outcomes for ATSI people, a number of interviewees commented on the need to formally link the Framework and Toolkit to current hospital accreditation technologies. Specifically, many suggested that the Framework and the Toolkit constituted resources that could be formally linked to the ACHS Evaluation and Quality Improvement Program (EQuIP). Many suggested that the research team should pursue this link as it would strengthen the legitimacy of the Framework and Toolkit and hence its uptake within the hospital environment. As one person explained:

It's just so good as a Framework, but it doesn't have the legitimacy like this one [EQuIP] does when it comes to accreditation.

Another hospital executive suggested that:

We need EQuIP to include a standard that specifically refers to ATSI cultural sensitivity. It could be framed in a cultural way like 'how well is the ATSI patient's milieu taken into account in the provision of care'... and then links the Toolkit as a resource... to assist hospital staff to respond to the standard.

National implementation

That the Toolkit be implemented nationally and remain a dynamic resource was strongly recommended by some interviewees. One person requested Australia-wide ongoing evaluation of specific ATSI-focused CQI strategies and that the findings from these evaluations be regularly incorporated into the Toolkit. She suggested that:

What we need to do is constantly test out how they're working and then get feedback from Aboriginal and Torres Strait Islander people...There's the micro process that you're within the hospital checking that the process is actually meeting the needs of the patients. Then there's the macro process which is actually checking that the Aboriginal and Torres Strait Islander-specific quality improvement process and tools that you are suggesting is being constantly tested, not in just a narrow evaluation...It's big, but what you're actually trying to do is big, in the sense that you're trying to develop a quality improvement process that will work across hospitals across Australia.

Support, assistance and training

Some interviewees said that although the Framework and Toolkit were extremely valuable they were inadequate on their own. They said that they had required the support, assistance and training from the research team to make effective use of the resources. As one Aboriginal staff member explained, she required:

...more meetings with you guys where we actually talked about processes and steps to completing it, or more engagement with project people... I think it would be useful to meet others from other hospitals who are doing it, and we could... see what other hospitals are doing.

Many others also suggested that the successful implementation of the Framework and Toolkit also required an ongoing training program for ATSI staff.

Concept and structure

Overall, the concept of a Framework with tools, resources and examples was strongly endorsed as a technique for building systematic CQI initiatives and improving staff knowledge and practice:

I think that it's really useful for a particular audience, that is people who haven't had previous exposure to the major documents like cultural respect framework and all of those sorts of things, and it's a good way of bringing all that together for [them].

Many people made positive comments about the structure, presentation and style of the Framework and Toolkit:

The Toolkit is an action learning model...it follows a learning cycle and project development framework... and that resonated with me because that is how we work.

I was actually surprised again, how easy it was for me to go through because you look at the book and you think, "oh boy".

I flicked to the CQI Process one-pager often because it helped contain the project and show us the steps we needed to get through.

Perhaps not surprisingly some preferred to use the paper version, especially when working with a team, while others were more comfortable with the electronic format:

If I had had a paper copy I would have used it more because I felt better with paper.

To me it flows well. I actually didn't use the paper form, I used the computer and it flowed well. I did flip through the book as well, and I found it so much easier electronically.

Really liked the CD and the hyper links were really good.

Content

All participants referred to the particular content of the Framework and Toolkit and all thought that most case studies and examples were extremely helpful, interesting and informative. Indicative comments include the following:

It matches up really well with other tools I have used as a Quality Coordinator.

I thought a lot of them were really good. They had a lot of information in them. Like this one [Victorian Government policy] had some really good stuff there, about key things.

...you have fantastic information in there.

The examples that were used in there were good examples.

The words of the ALO are very powerful...their stories were very useful.

The questions for each stage of the process document was really useful

The one page of tips is really helpful...it clarified potential sticking points...and helped us not get stuck in the mud.

The evidence was really good and the patient journeys were really powerful testimonies – we need more of that.

The Mapping the Journey and the Royal Adelaide Hospital Action Plan were fantastic.

The Cultural Framework to guide data collection was very helpful and made sense.

Suggestions for changes or additions

A number of interviewees made some very helpful suggestions for changes and additions to the Framework and Toolkit.

Developing the Toolkit as a training device

That the Toolkit should be more explicitly educational with stated learning objectives and outcomes was strongly recommended by two people. They suggested that the Toolkit be re-designed to be more like a Training Manual and that it should incorporate “Train the Trainer” components. They suggested, for example, that elements be added that delineate what the:

objectives of the lesson are, and what the deliverables are or the learning outcomes you want from these processes.

and elements:

that a trainer could take to teach [a] quality committee about looking at things from different perspectives.

Structure

The structure, presentation and style of the Toolkit were sometimes commented on. Two people at different sites suggested some radical editing of the Framework and the Toolkit. One said that:

I thought that was too long-winded. I think some of those processes could be put into the one step.

And another that there were:

Too many steps, we condensed it, we went back to the PDSA cycle...it was easier to explain it when we were working with other staff.

A number of interviewees made suggestions for improving the accessibility of the document including:

- A simple statement outlining the intended audiences for and purpose of the Framework and Toolkit
- A snapshot summary contents page that listed all the steps for each process
- Succinct explanations for each process at the beginning of each section
- A summary document with dot points and then a second larger section with examples
- Using four main PDSA steps with other processes summarised below
- Aboriginal people should be replaced with Aboriginal and Torres Strait Islander peoples
- Inserting the Cultural Respect Framework into the first few pages
- A separate section for all case studies
- More plain English explanations
- More dot point lists
- More visual charts, diagrams, pictures and cartoons
- More use of multimedia; for example, CDs, DVDs, internet
- Colour coding and tabs, to discriminate between sections

- Numbered pages
- Larger script in QIC diagram
- A glossary of acronyms.

Additional content: guiding principles and more illustrative examples

A set of guiding high-level principles specifying, for example, self-determination for ATSI peoples and community participation as it relates to them, could be generated and added to the introductory section of the Toolkit. Two interviewees felt that these principles, although reflected in the trialled Toolkit, should be more explicitly stated.

One Aboriginal interviewee specifically requested that a set of principles be generated for the Quality and Safety Committee. She suggested that:

This quality committee should have a responsibility...about looking at things from an Aboriginal perspective.

She felt that this would assist ATSI staff to work with non-Indigenous Quality Committee staff in a more supported way:

...because that will then help when the Aboriginal person is floundering under the pressure of mainstream and you get these arguments bombarding you, and you know with your gut as an Aboriginal person that it's wrong, because it's not following the cultural protocol, but you have trouble reaching that barrage of mainstream way of doing things. And you need something that can pull that committee up that says, "But you're not following this principle."

In addition, many interviewees requested that the Toolkit include more 'best practice' examples. While valuing the case studies and examples that were included in the Toolkit nearly all interviewees requested more case studies and 'worked illustrations of all the processes'. This was particularly so in relation to building partnerships with Aboriginal communities, understanding their perspectives and working with Aboriginal people within the hospital. For example:

If you're saying, "train that committee on looking at it from an Aboriginal perspective" [then] maybe some examples of how you might be able to point out the difference in perspective, even stories that you could tell the quality committee, or you could do something with the quality committee around some case study, or hypothetical and you look at it from this perspective, or this perspective, and this is how you come out with two different conclusions.

Some people requested case studies that specifically addressed their professional roles, such as:

...dedicated tools for midwives in relation to pregnancy health record before they discharge... and [how]to engage nurse educators [in midwifery].

Others also requested more case studies of ALOs being involved in CQI projects.

Some interviewees noted that many examples were from Victoria and South Australia. Whilst agreeing that there was a shortage of illustrative case studies from other states and territories they stressed the importance of practitioners being able to read about case studies that reflected their policy and health department context, geographic location, population groups and type of hospital services, size, staffing and funding.

In addition to case studies some interviewees requested more detailed templates and examples of: a protocol for initiating contact with local ATSI peoples; checklist of likely key community stakeholders; agreements with ATSI communities in remote areas; tips for using open questions when consulting with ATSI peoples; vignettes of consultations; tips on how to prioritise issues; ATSI CQI project plans, questionnaires, surveys, and reports; ALO position descriptions in a range of contexts, including in remote areas; tips for ALOs; tips on conducting cultural awareness training; examples of ALO roles linking into quality activities; diagrams of quality structures and decision-making processes in different sized hospitals; one page of dot points on General Manager's leadership and support strategies; culturally safe admission and discharge procedures for ATSI patients; and troubleshooting tips.

Some also requested a resource list about, and hyper links to, ATSI population health databases.

One person thought that verbal case studies would benefit some users of the Toolkit:

I think the idea of having verbal stories would be good, someone talking so someone could just listen on a tape. If you click on a link and you have someone telling their story about how they set up.

Factors that facilitated the use of the Framework and or Toolkit

Many interviewees listed a range of factors that, in their opinion, had significantly facilitated their use of the Framework and Toolkit.

Commonwealth and state and territory health funding requirements

A number of General Managers and Executive Directors referred to their current health funding agreements that required improved outcomes for ATSI patients. They all noted that these deliverables had increased their focus on the particular needs of ATSI peoples, even though, in some cases, they had been actively addressing improved outcomes for some time. Some referred to the Close the Gap initiative and indicated that it had positively motivated some of their staff. Others also noted the importance of coordinated active support for such initiatives at the regional level. Some specifically said that, strategically, the Framework and Toolkit need to be recognised and their use recommended by regional and state health authorities. They argued that such requirements could be manifested in funding agreements.

Leadership and support from senior managers

Many participants emphasised that they could not have participated in the research or progressed their projects without direction from the General Manager or Executive Director. Direct project involvement from them was not necessarily required; however, their leadership support, instructions to other senior staff, and demands for reports and accountability were.

Mentoring and support provided to ATSI staff

It was clear that ALOs who worked effectively on a CQI project during the trial phase were actively encouraged, supported and fostered by their managers and other key hospital staff. Such support included discussions on the content of the Toolkit, positive feedback on plans, explicit recognition of and time allocated to the project work and negotiations with senior management on their behalf.

Externally accredited training program for ATSI staff

All ALOs who attended the training program, with the exception of one who was not working at a hospital that participated in the trial, indicated that the content of the Training Program assisted them to understand and utilise the Toolkit. Importantly many considered that, without the training, they would have found the Toolkit too complex and would not have made such effective use of it. Getting together at the training event also facilitated the sharing of experiences and knowledge related to CQI and ATSI projects, increased participants' networks and enabled them to contact each other during the project to discuss aspects of the Toolkit. Some noted that the training should have occurred shortly after the research team's first site visit.

In addition, some non-Indigenous staff requested copies of the training program so that they understood what had been included and could more effectively support and mentor ATSI staff who attended.

Credible and respected external researchers

Credible and respected external researchers provided much-needed legitimacy for hospital staff, including ALOs, to focus on the particular needs of ATSI peoples and generate a specific CQI project for them. This was especially so given the many competing demands on staff time by other obligations, including accreditation. In addition, it was considered essential that the research team requested a plan, timeline and progress updates. These deliverables aided the project staff to gain permission from department and clinical managers to spend time on their ATSI CQI project. Some staff also added that the nature and standing of the research assisted them to undertake their CQI ATSI project as part of their university postgraduate assessment requirements and to gain study leave to do so.

Back-up support provided by the Indigenous and non-Indigenous research team

The support, assistance and training from the research team had facilitated more effective use of resources. Participating staff benefitted from in-depth discussions with members of the research team about aspects of the Framework and Toolkit. In particular, the information provided by the Indigenous members of the team was especially important. They frequently contributed valuable advice, support and

their own examples of practice during site visits. It was clear that the ATSI staff especially and non-Indigenous staff generally found their involvement significant.

Barriers that impeded the use of the Framework and or Toolkit

Lack of recognition of the particular needs of ATSI communities

Some interviewees articulated frustrations with a few members of staff who did not seem to recognise the need for a more contextually rich understanding of the needs of their local ATSI communities. They felt that this lack of knowledge, interest and commitment impeded the progress of improved services to those communities.

An absence a of coordinated vision for ATSI CQI initiatives

Some interviewees were unclear about how specific CQI initiatives for ATSI people would be coordinated throughout their hospital. This concern reflected the importance of senior management leadership and coordinated CQI plans, such as those represented in the Royal Adelaide Hospital's Action Plan. This aspect could be emphasised further in the Toolkit.

Variations in ATSI communities and hospital characteristics

The trial sites reflected a range of geographic locations, kinds of ATSI communities and types of hospital services, size, staffing and funding. It was noted by some interviewees that they were hindered by a lack of specific examples that reflected their particular contexts. These differences could be further represented by case studies and examples in the Framework and Toolkit.

Competing demands

All interviewees referred to the number of competing demands on their time and the difficulty of undertaking additional projects. Some stressed that projects with additional external funding and those that were strongly endorsed by senior management would be more likely to be prioritised.

Lack of intensive initial training on Framework and Toolkit

Nearly all interviewees said they would have benefitted from the research team delivering an intensive two-day workshop that provided detailed training on the Framework and Toolkit and applied it to their proposed CQI projects. They noted that this would have been a more time-efficient way of orienting them to the approach and the material and referred to other training sessions that accompany other program initiatives with the hospital as models.

Recommendations

Clearly, participants found the ATSI CQI Framework, Toolkit and Training Program in the trial to be essential, important, credible, practical, useful and timely. They also identified a number of aspects that require further attention. Some of these have been addressed during the research project, such as some

practical additions and restructuring of the Framework and Toolkit, and others will require another phase of research and development.

The recommendations that flow from the trial phase include the following:

Recommendation 1

That Commonwealth and state and territory health funding agreements recommend and support the use of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. In particular, specific funding support should be provided for a national ATSI CQI Unit and resource clearinghouse.

Effective use and implementation of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit* will occur if hospital staff have access to a support unit that can provide initial intensive training and then ongoing additional advice, coaching and resources. This unit should also include a regularly maintained website with a range of evidence-based electronic resources.

Recommendation 2

That state and territory and regional health funding agreements recommend and fund the use of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. In particular, specific funding support should be provided for the ALO Training Program and maintenance of the network of ATSI CQI workers.

Recommendation 3

That ACHS and EQuIP accreditation include more standards related specifically to ATSI people; for example, building relationships and partnerships with Aboriginal communities and improving feedback from ATSI patients. That the EQuIP accreditation documentation include references to the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*.

Recommendation 4

That Commonwealth, state and territory health funding be made available for a second phase of research and development of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. This would enable more evidence-based case studies and a Train the Trainer component to be generated.

Recommendation 5

That an evaluation of Aboriginal-specific CQI process and tools be conducted in two years in order to continue to build an evidence base and ensure that the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit* remains dynamic and up to date.

Chapter Five

Phase V: Further Toolkit development and Round Table

Introduction

The purpose of Phase V was to undertake a further trial of the tools and processes. In comparison with the previous phase, the primary emphasis was initially to research strategies that could improve the effectiveness of the tools and processes by addressing factors that influence organisational readiness for change. The aim was to include a range of hospitals across the readiness-for-change spectrum to reflect real-world scenarios where hospitals are diverse in terms of readiness to change but also willing to use the tools and processes.

The other key aim of this phase was the facilitation of a Round Table discussion with key policy-makers from the jurisdictions, state and territory governments along with the Australian Council of Healthcare Standards (ACHS). The Draft Toolkit, along with findings from the case studies, was to be presented to a national Round Table meeting of senior key stakeholders in health to explore implementation and future research issues.

Options for Phase V

As a result of the increased time required to negotiate with the trial sites and implementing Phase IV, the project team reassessed how Phase V would be undertaken. Phase V was initially intended to be a repeat of Phase IV, involving a new set of hospitals but focusing on the readiness to change concept. As with Phase IV, it was also intended that training for Aboriginal staff would be provided.

Given the reduced project time available, alternative options were canvassed. One option was a modified trial of the toolkit involving just one site visit to introduce the Toolkit and then followup via phone and email to gain feedback. This approach was based on the assumption that hospitals involved in Phase V would be at a reasonably high level of understanding about how to implement a quality improvement process focused on cultural reform. This assumption was also based on the aim to develop a toolkit that was self-explanatory, where only phone support is required. One of the key learnings from Phase IV was the need to re-evaluate the assumption that hospitals would be able to trial the Toolkit with minimal support. Hospitals clearly required a higher level of support than originally envisaged to trial the Toolkit effectively.

Another finding from Phase IV was the importance of the quality improvement training provided to Aboriginal staff to assist in their engagement with the quality improvement process. The training package developed and delivered to Aboriginal staff in Phase IV involved a week-long residential program and was most beneficial when it occurred between the two sites visits. With the modified trial suggested for Phase V this would not be possible and would further impede any likelihood of successfully trialling the toolkit.

After discussion, the research team and the Project Advisory Committee concluded that it was not feasible to undertake this extra trial of the Toolkit as part of this current project. Within the limited resources available this further trial could not be supported to the level which the research team had determined would be effective.

Additional components

As a result of the re-design of Phase V, the project team provided a range of additional components whilst ensuring that the original project outcomes were still delivered. Additional components agreed to and delivered were:

- Increased number of case study sites in both Phases III and IV. The original proposal indicated four sites would be involved in each phase but, as a result of the type and mix of applications received, it was decided by the research team to engage five hospital sites for each of these phases.
- A more comprehensive version of the Toolkit was produced in line with feedback received from Phase IV trial sites including:
 - flow chart on how to use the kit
 - clear rationale for the kit being used
 - sample presentations for Aboriginal hospital staff to use when gathering feedback from the local Aboriginal organisations
 - examples of the complete quality improvement cycle.

(Full copy of the toolkit can be found at

<http://www.svhm.org.au/aboutus/community/Pages/Aboriginalhealthcare.aspx>)

- Additional knowledge transfer documentation in the form of one academic research paper, completed and submitted to a peer review journal (see Appendix Eleven).
- Presented project findings at one national conference (LIME Connection III –Melbourne, December 2009) and one Victorian conference (Talkin’ it up! Showcasing Aboriginal Health Care, Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) State-wide Conference – Melbourne, November 2009).
- Offered separate workshops to the two jurisdictions that had not been involved in the project (Tasmania and the ACT) to ensure national coverage. Only one of these offers was taken up (Tasmania) and the workshop provided in November 2009 included an overview of the project, an outline of the content of the Toolkit, how to apply it and the rationale to jurisdictional staff to engage them in discussion on how to support its implementation.

Round Table

A Round Table meeting was convened in Melbourne on 15 October 2009, with senior political and policy staff from federal, state and territory governments along with staff of the Australian Council Healthcare Standards (ACHS), to present the project's findings, and to develop ideas around how these findings can be used as a catalyst for change in practice as widely as possible. The roles of those attending included:

- Deputy Chief Executive, Acute Care
- A/Area Performance Manager, Project Director State-wide Redesign Program, Health Services Performance Improvement Branch
- Senior Project Officer, Centre for Healthcare Improvement
- Director of Primary Health in the Department of Health
- Manager, Quality and Strategy, State-wide Quality Branch
- Manager, Koori Services
- Executive Director, Aboriginal Health Country Health
- Director, Acute Care Strategy Branch
- Assistant Secretary
- Assistant Director, Quality and Accreditation
- Senior Project Officer, Development
- Treasurer
- National Manager, Aboriginal and Torres Strait Islander Program
- Policy and Network Manager
- Director, Centre for Health and Society, School of Population Health
- Manager, Policy and Evidence, Office of the Director, Public Health Branch
- Professor of Medicine and Head of Department of Medicine
- Deputy Director
- Senior Research and Ethics Officer
- Senior Research Fellow
- Project Manager
- Program Manager, Comprehensive Primary Health Care, Health Systems and Workforce Program.

The engagement of the ICHP team with high-level jurisdictional staff involved in acute policy monitoring and development was a useful process that enabled the exploration of options to develop findings from the project. Participants acknowledged that the Toolkit developed by the ICHP bridges the gap between

policy and health standards, and is a practical way to operationalise policy into action. The need for the finalised Toolkit to be integrated with relevant jurisdictional policies was also emphasised.

The most significant outcome from the Round Table was the agreement by the Cooperative Research Centre for Aboriginal Health (CRCAH) to work with the Australian Council of Healthcare Standards (ACHS) to further develop specific standards for Aboriginal patient care as part of its review process for EQuIP4. The inclusion of specific standards on Aboriginal patient care has been seen by many stakeholders as a key component to ensure that the acute healthcare sector engages systematically to improve their services to Aboriginal communities. Other outcomes included recognition of the need for further implementation work and ongoing support for hospitals to ensure the wider successful uptake of the ICHP Toolkit including infrastructure support (resources), access to mentors, and access to education and training.

Conclusion

The knowledge transfer activities undertaken during this phase have assisted in promoting the project findings to a wider audience. The practical nature of the Framework and Toolkit along with the case examples assists acute health services in embedding these learnings into practice.

The agreed outcome from the Round Table meeting for the CRCAH to work with the ACHS in the development of Aboriginal-specific standards for inclusion in EQuIP is a key task that requires implementation.

Chapter Six

Phase VI: Conclusions and Recommendations

Introduction

The ICHP has taken a systemic quality improvement approach to addressing the cultural needs of Aboriginal patients in acute care organisations. The project developed a Framework and Toolkit to assist in facilitating the organisational cultural change required to undertake this work. This chapter will summarise key findings and recommendations that have been generated by the project in line with the projected outcomes, and provide extra recommendations for future research and sector support.

Research Aim and Question

Overall, the aim of this research project was to contribute to quality assurance and improvement with a focus on the cultural development of acute health care institutions to support delivering services to Aboriginal people in ways that include recognising and responding to culturally based values, needs and preferences. The specific research questions for the project were:

What tools are currently available for use in hospital settings to ensure quality assurance/improvement, and how can these be developed to improve practicalities and processes relevant to needs of Aboriginal patients and staff? What tools and processes exist or can be developed that will effectively guide hospitals and Aboriginal communities to work collaboratively and using continuous improvement methods to enhance hospital culture in regard to services provided to Aboriginal people?

Project Outcomes and Recommendations

This section will outline each projected outcome developed at the commencement of the project and provide key findings and recommendations for each. For more details please refer to the relevant chapter(s) and appendix(cies) in this report.

1. A comprehensive understanding of the diversity, rationale and effectiveness of tools and processes that have been used to improve the culture of hospitals from the perspective of Aboriginal patients, friends, family and carers

The project team gathered a range of resources, processes, stories and tools from those hospitals that were nominated by the Aboriginal community as performing well in Aboriginal health. This information included successful utilisation of resources already available, locally developed processes and materials used to implement positive change, and the use of stories and experiences to assist in creating additional materials. The diversity of information gathered emphasised the variation between hospitals, including the needs of their local Aboriginal communities. This reinforced the requirement of a guiding framework that allows hospitals and Aboriginal communities flexibility in their partnership approach to improving services.

One key rationale for the need to utilise this Toolkit was highlighted during the Phase IV Toolkit trial, with most interviewees emphasising the importance of linking the needs of Aboriginal peoples to the continuous quality improvement (CQI) structure in the hospital. It was reported this had not occurred before the trial and that hospital staff had been responding to the needs of, or issues related to, Aboriginal peoples in an ad hoc manner. Often, responding to these issues was primarily left to Aboriginal staff or social workers. Participation in this research project and implementing the Toolkit highlighted to hospital staff the need for a more complex, multi-faceted and systematic response to those needs and service issues. The Framework provided an explicit model for building a relationship with local Aboriginal communities and then linking their needs to the CQI structure in the hospital, the Quality and Safety Unit or the specialised quality staff. It underscored that many of the issues that hospital staff had been dealing with were in fact quality issues. As one senior manager explained:

The whole hospital is responsible for responding to Aboriginal and Torres Strait Islander service gaps...but someone would say something and someone would do something...but without the quality process...we now realise that what was missing was the formal quality process.

2. A comprehensive understanding of the characteristics that Aboriginal people believe would make hospitals more culturally appropriate

Findings for this outcome came from both the literature review process and case studies. These case studies highlighted that a range of components need to be in place for a hospital to be considered successful in addressing the issues of their Aboriginal patients and making their hospital more culturally appropriate. These areas included strong partnerships with Aboriginal communities; enabling state and federal policy environments; leadership by hospital Boards, Chief Executive Officers and key clinical staff; strategic policies within the hospital; structural and resource supports; and a supported Aboriginal workforce. Each hospital case study had a different way of undertaking these components, but all these elements played a part in providing a culturally appropriate hospital environment.

From the literature review a number of areas were examined regarding how organisations make their services and environments more culturally sensitive. One concept known as cultural security can be seen as a commitment that the arrangement and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. Taking a culturally sensitive approach recognises, appreciates and responds to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration (Houston, 2002). This systemic approach to achieving a culturally sensitive organisation was reinforced by other research that critically examined the effectiveness of cultural awareness training. The traditional approach often taken by organisations to deal with the issue of culturally insensitive care has been to provide cultural awareness training to staff. This approach on its own, while necessary, appears ineffective, with one author arguing that improved cultural awareness through training for individual health workers and administrators does not lead to improved health outcomes. It was stated that to respond appropriately, hospitals need to adopt practices and policies that recognise cultural security as a systemic, imbedded domain to hospital care (Coffin, 2007).

Another component that the literature review identified as one of the barriers to health care access by Aboriginal people living in urban areas was the poor performance of the health system in meeting the needs of those with complex and multiple health conditions (Scrimgeour & Scrimgeour, 2008). This not only points to the difficulty of a system based on clinical specialty areas to respond to Aboriginal patients with complex needs but highlights the need for system (organisational) change so a holistically response can be delivered (National Aboriginal and Torres Strait Islander Health Strategy, 2001).

3. A comprehensive understanding of the government and accreditation policy conditions that need to be in place to ensure that cultural improvement can be linked into mainstream accountability processes

The project examined key legislation at a Commonwealth, state and territory level, relevant to hospital care of Aboriginal patients. This review identified barriers or enhancing components that may impact on hospitals undertaking a process of cultural reform by implementing a continuous quality improvement approach to Aboriginal health.

Some areas of current state and territory policy and or legislation do not completely support a CQI approach. The practical CQI approach developed by this project to change hospital culture and improve responsiveness to Aboriginal people requires hospital staff, both Aboriginal and non-Aboriginal, to work together with Aboriginal communities. This partnership approach assists in the process of exploring issues, developing solutions and implementing improvements that are continually reviewed over time. This requires each hospital to develop and maintain a relationship with its local Aboriginal communities so that issues can be continually addressed.

The key component of this approach requires an ongoing feedback process with the Aboriginal communities directly to the hospital to facilitate and strengthen those relationships. In an attempt to hold hospitals accountable, some jurisdictions have undertaken the initial data-gathering and analysis component, then provided hospitals with a list of required changes. This inhibits the goal of hospitals building the required long-term relationship with their local Aboriginal communities to ensure continuous feedback for sustainable change over time. One option to encourage hospitals to gather community feedback would be ensure this component is embedded with the Australian Council of Healthcare Standards (ACHS) EQuIP accreditation process. This would facilitate hospitals gaining first-hand experience of community feedback and therefore receiving the benefit of direct community consultation that enhances their potential to bring about the cultural reform required.

Many jurisdictions are developing and utilising key performance indicators (KPIs) as the key drivers for hospital management to improve services to the Aboriginal community. One area of concern with this approach has been the high number of indicators that managers have, with potential for the small number of Aboriginal-related indicators not receiving the attention and focus required. Other concerns include organisations taking a narrow approach to fulfilling their KPIs and ignoring the wider issues that may have high importance to local Aboriginal communities. The policy platform needs to encourage hospitals to maintain an effective engagement process, through a partnership approach with the local Aboriginal communities, to ensure an ongoing process of review.

Interviewees involved in the Phase IV trial stated that although the Framework and Toolkit were extremely valuable they were inadequate on their own. They said that they had required the support, assistance and training from the research team to make effective use of the resources. As one Aboriginal staff member explained, she required:

...more meetings with you guys where we actually talked about processes and steps to completing it, or more engagement with project people... I think it would be useful to meet others from other hospitals who are doing it, and we could... see what other hospitals are doing.

To improve the uptake of the ICHP Toolkit a range of components need to be in place including infrastructure support (resources), access to mentors, and access to education and training. It was recommended that the Framework and Toolkit be implemented nationally and remain a dynamic resource. Therefore the key recommendation from Phase IV regarding government and accreditation policy conditions is:

Recommendation: That Commonwealth, state and territory health funding agreements should recommend and support the use of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. In particular, specific funding support should be provided for a national Aboriginal CQI Unit and resource clearinghouse.

(Effective use and implementation of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit* will occur if hospital staff have access to a support unit that can provide initial intensive training and then ongoing additional advice, coaching and resources. This unit should also include a regularly maintained website with a range of evidence-based electronic resources.)

4. The publication of tools and a handbook describing various stakeholders' roles in successfully developing a culturally sensitive hospital facility

The final Framework and Toolkit developed as part of this project was created using evidence-based examples, and was then trialled. Even though this project has concluded with a final version being produced as a web-based tool, this Framework and Toolkit should be viewed as a work in progress and requires ongoing updating as new initiatives, policies and projects are developed and evaluated.

The trial of the draft Toolkit, which included role statements for various stakeholders and case studies highlighting examples, provided useful feedback from hospitals. This feedback included: increased focus on Aboriginal people's needs; increased focus on Aboriginal people's views of hospital services; increased focus on linking Aboriginal people's needs to the hospital CQI structure; improved understanding of the role and value of AHLOs; and Toolkit had external credibility and legitimacy.

A number of factors facilitated and impeded the use of the Framework and Toolkit. Aspects that facilitated its use included: Commonwealth, state and territory health funding requirements; leadership and support from senior managers; mentoring provided to Aboriginal staff; an externally accredited training program; credible and respected external researchers; and the provision of external advice and support by Indigenous and non-Indigenous researchers. Those aspects that appeared to impede its use

were: a lack of recognition of the particular needs of Aboriginal communities; an absence of a coordinated vision for Aboriginal CQI initiatives; variations in Aboriginal communities and hospital characteristics; competing demands; and a lack of intensive initial training on the Framework and Toolkit.

5. A national network of Aboriginal people who are able to effectively participate in conventional continuous improvement activities aimed at improving the culture of hospitals and health services

During the life of the project Aboriginal staff within a number of organisations were involved, including all hospitals involved in the project, NACCHO affiliates, ACCHOs and jurisdictions. Communication was predominately via email with occasional phone contact and included email updates, newsletters and other correspondence to assist in selecting hospital sites, communicate progress and disseminate findings as the project progressed.

The key network for the project involved Aboriginal staff from hospitals involved in Phase IV of the project. These staff were offered training as part of the trial phase of the Framework and Toolkit, resulting in 10 Aboriginal staff participating in a five-day residential training program. Two units were delivered including ‘manage quality’ and ‘develop and implement policy’. This training course was evaluated, and included feedback from participants and supervisors. Participants rated course materials, course delivery and course presenters quite highly and almost all supervisors interviewed commented that their staff had returned from the course with a better understanding of quality systems and with ideas about how they could advocate for change through those processes. In one instance the supervisor noted that the trainee had returned with the realisation that he had to engage with management and quality improvement personnel in order to effect change in service delivery, whereas previously he had not felt in a position to do so. Feedback on the course also highlighted that a number of participants had limited contact with the quality improvement systems and processes in their workplace prior to the training but that steps had been taken to initiate activities following course delivery. Examples of this include:

- At Derby Hospital the ICHP had prompted the Quality Improvement Team (QIT) to review involvement of the Aboriginal Liaison Officer (ALO). The ALO had prepared a PDSA (Plan, Do Study, Act) quality cycle to improve the feedback process from Aboriginal patients. This objective resulted in the increased responsiveness of the QIT to Aboriginal Liaison input.
- At Campbelltown Hospital the Aboriginal Hospital Liaison Officer (AHLO) became a member of the Quality Improvement Committee, which in turn had developed a support plan for her.
- At the Mater Hospital in Brisbane it was reported by her supervisor that the AHLO has become more strategically involved in linking service issues to the quality improvement process.

In reference to the quality improvement training provided to Aboriginal staff it was considered that seeking the involvement of and support by AHLO workplace supervisors (e.g. Social Workers and/or quality improvement officers), may have provided significant benefits for participants. This would have represented a stronger commitment by the organisation to the program and could potentially lead to stronger links between the role of the AHLO and the decision-making processes within the hospital. It is acknowledged that Aboriginal workers in mainstream organisations require both cultural and organisational support. The key recommendation from the evaluation of the training program included:

Recommendation: That senior hospital personnel involved in the ICHP be engaged in the training program in order to foster greater support, mentoring and shared commitment to undertaking hospital-based projects.

(This could result in the completion of a unit of competence related to working effectively with Aboriginal and/or Torres Strait Islander people.)

The following recommendation from Phase IV highlights the ongoing support required by jurisdictions to maintain and build the national Aboriginal network required to support this work.

Recommendation: That state, territory and regional health funding agreements should recommend and fund the use of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. In particular, that specific funding support be provided for the Aboriginal Hospital Liaison Officer Training Program and maintenance of the network of Aboriginal CQI workers.

(These components are vital to initiate and establish the change in focus for AHLOs from direct patient support and advocacy to knowledge building of CQI and participating in the system change process. It was also suggested that the successful implementation of the Framework and Toolkit requires an ongoing training program for Aboriginal staff.)

1. Recommendations for accreditation processes which emphasise the use of tools and processes that encourage cultural reform in hospitals making them more appropriate for Aboriginal patients and staff

One key recommendation generated from this project that was reinforced by several hospitals involved was the inclusion of specific standard(s) within the EQuIP framework focused on Aboriginal patient care. This was seen as the key driver to change in hospitals regarding Aboriginal health. The recommendation from Phase IV was:

Recommendation: That the Australian Council of Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP) include more standards related specifically to Aboriginal people. For example, building relationships and partnerships with Aboriginal communities and improving feedback from Aboriginal patients. That the EQuIP accreditation documentation include references to the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*.

(The core ACHS accreditation program is EQuIP, which guides acute care organisations through a four-year cycle of Self-Assessment, Organisation-Wide Survey and Periodic Review to meet ACHS standards. ACHS is currently reviewing EQuIP4 and the latest draft includes two specific Aboriginal standards.)

Further to the recommendation above, the ICHP team and advisory committee facilitated a Round Table meeting with ACHS and high-level jurisdictional staff from the Commonwealth, states and territories responsible for acute care policy monitoring and development. This meeting was a useful process that enabled the exploration of options to develop findings from the project. Participants acknowledged that the Toolkit developed by the ICHP bridges the gap between policy and health standards, and is a practical way to operationalise policy into action. The need for the finalised Toolkit to be integrated with relevant

jurisdictional policies was also emphasised. The key outcome from the Round Table was the agreement by the Cooperative Research Centre for Aboriginal Health (CRAH) to work with the ACHS to further develop specific standards for Aboriginal patient care as part of its review process for EQuIP4. The inclusion of specific standards on Aboriginal patient care has been seen by many stakeholders as a key component to ensure that the acute healthcare sector engages systematically to improve their services to the Aboriginal community.

2. Further Research

Recommendations that do not fit clearly under the outcome areas above include recognition of the need for further research to ensure the widest possible implementation of the Toolkit. These recommendations are:

Recommendation: That Commonwealth, state and territory health funding be made available for a second phase of research and development of the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit*. This would enable more evidence-based case studies and a Train the Trainer component to be generated.

Recommendation: That an evaluation of Aboriginal-specific CQI process and tools should be conducted in two years in order to continue to build an evidence base and ensure that the *Improving the Culture of Hospitals Quality Improvement Process Framework and Toolkit* remain dynamic and up to date.

Conclusion

The ICHP has provided hospitals with a culturally appropriate quality improvement process along with a set of evidence-based tools and guidelines to facilitate a sustainable approach to Aboriginal health. The capacity of hospitals to respond more effectively to Aboriginal patients is increased by making Aboriginal health a quality issue. This will not only build the capacity of hospitals to improve their response to Aboriginal communities but also improve their effectiveness in engaging with a range of other patients with complex needs.

Clearly the Framework, Toolkit and Training Program for Aboriginal staff has been found to be essential, important, credible, practical, useful and timely. The capacity of Aboriginal staff and communities to engage in a meaningful and effective way with hospital reform has increased by this process. The ICHP has increased the involvement and effectiveness of non-Aboriginal clinical staff by engaging them in projects that require them to work alongside Aboriginal staff and Aboriginal communities to improve hospital service delivery to Aboriginal patients.

The potential to set in place a process for continuous quality improvement for cultural reform in hospitals has been increased by the ICHP, which provides a systematic approach for local communities to develop strategies in partnership with the hospital in their area. This process will take time but will build the capacity and sustainability of both hospitals and their local communities to make a difference in Aboriginal health.

In conclusion, hospitals need senior management to support this work as a priority and to ensure Aboriginal staff are trained to facilitate the process. It is recommended that further research be undertaken to build the evidence that supports the involvement of the quality units within hospitals to ensure learnings are adopted across the organisation in a systemic way. Finally, the inclusion of an Aboriginal patient-specific standard in the ACHS EQuIP accreditation system, informed by Aboriginal key stakeholder organisations, is seen as a key driver to assist this change.

APPENDICES

Appendix One – Advisory Committee Members

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Invitation outstanding: NACCHO

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Appendix Two – Legislation Review

Introduction

Purpose of this review

This review will examine key legislation at a federal, state and territory level that is relevant to hospital care of Aboriginal patients, to identify any barriers or enhancing components that may impact on hospitals implementing a continuous quality improvement (CQI) approach to Aboriginal health. The policy environment will be examined to assess its suitability to supporting a CQI approach. The leadership role that jurisdictions have to drive policy development is coupled with the attempt to connect policy with practice. The challenges regarding the implementation of these policies in the acute health care sector are well-known, including the institutional failures, particularly at the hospital/primary care interface. This connection of policy with practice is at the core of the ICHP.

Background

There is evidence that a quality improvement approach in the human services sector is successful in instituting change. The review undertaken by Renhard (2001) examining the effectiveness of quality initiatives in human services found that the “key determinant of success of a quality (approach) is not the initiative itself but the nature of the organisation in which it is used”. There are a number of characteristics that these organisations have to successfully implement quality initiatives or adopt a CQI approach but the key overarching component to ensure success is that of management support for these approaches. But this support should not be a ‘manage down’ approach to promoting quality through a punitive approach as there is limited evidence to suggest that this is successful and may suppress information which is critical to identifying issues at a system level (Renhard, 2001, pp. 10-11). To ensure that quality services are delivered governments need to promote a CQI approach to quality through their policy frameworks and funding arrangements, but in the absence of a CQI culture within an organisation, it is unlikely to influence quality at the service delivery level (Renhard, 2001, pp. 13).

Structure

This review will commence with a summary of the findings from this review and how well they align with the CQI approach taken by the ICHP. Then follows a summary of key policies at a national level that provide guidance to jurisdictions on Aboriginal health care in hospitals. As the jurisdictions are currently the key influence on hospital care—with the role of funding and monitoring performance of acute health care facilities—this review will then explore the policy platform in each jurisdiction.

Key Findings

General

This review has examined key legislation at a Commonwealth, state and territory level relevant to hospital care of Aboriginal patients, to identify any barriers or enhancing components that may impact on hospitals undertaking a process of cultural reform, by implementing a continuous quality improvement approach to Aboriginal health.

Some components of current state and territory legislation do not completely support a CQI approach. The key component of this approach requires an ongoing feedback process from the Aboriginal community directly to the hospital to facilitate and strengthen that relationship. In an attempt to hold hospitals accountable, some jurisdictions have undertaken the initial data-gathering and analysis component and then provided hospitals with a list of required changes. This inhibits the goal that hospitals need to build the required long-term relationship with their local Aboriginal community to ensure that there is continuous feedback to ensure sustainable change over time. One option to encourage hospitals to gather community feedback would be ensure this component is embedded with the ACHS EQuIP accreditation process. This would facilitate hospitals gaining first-hand experience of community feedback and therefore receive the benefit that direct community consultation provides and will enhance their potential to bring about the organisational cultural reform required.

One approach used by jurisdictions has been the use of Key performance indicators (KPIs). These KPIs are used as key drivers for management but may lead to other issues being ignored, particularly at a local level and possibly of high importance to the local Aboriginal community. The policy platform needs to encourage hospitals to maintain an effective engagement process through a partnership approach with the local Aboriginal community to ensure an ongoing process of review.

National policies

The two key policy documents from a federal policy perspective are the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 and the Closing the Gap initiative.

The Cultural Respect Framework provides useful guiding principles for policy-makers and service delivery by jurisdictions as they implement initiatives to address their respective needs. In particular, the focus of the principles guide the development, establishment and strengthening of relationships between the health care system and Aboriginal people which supports the CQI approach. The goal and vision of the Framework is to uphold the rights of Aboriginal people to maintain, protect and develop their culture and achieve equitable health outcomes. It aims to influence corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for Aboriginal people. The Framework emphasises that the health and cultural wellbeing of Aboriginal people within mainstream health settings requires special attention. It identifies many factors that contribute to poor standards of Aboriginal health and wellbeing, including the low levels of confidence Aboriginal people have in being able to access acceptable mainstream health services. All these components fit well with a CQI approach.

The Closing the Gap initiative, the aim of which is to close the life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, outlines a number of areas that need to be addressed. One area that is highlighted to ensure equal access to health services is by ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services. Again, this approach strongly supports the CQI approach.

State and Territory Policies

An example of a policy platform that supports a CQI approach and facilitates hospitals developing their own relationships with Aboriginal organisations is the Victorian policy Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP). This policy includes funding guidelines which provide reporting procedures for health services that receive the 30% Aboriginal Weighted Inlier Equivalent Separations (WIES) supplement eligible for all Aboriginal identified inpatients. ICAP outlines the quality improvement and reporting requirements of health services in receipt of the supplement that includes:

1. Establish and maintain relationships with Aboriginal organisations.
2. Provide or coordinate cross-cultural awareness training for hospital staff.
3. Set up and maintain service planning and evaluation processes that ensure the cultural needs of Aboriginal people are addressed when referrals and services needs are being considered, particularly in regard to discharge planning.
4. Establish referral arrangements to support all hospital staff to make effective primary care referrals and seek the involvement of Aboriginal workers and agencies.

The Victorian policy platform has been built on a CQI approach to hospital service development and improvement for Aboriginal people. This platform encourages hospitals to engage at a local level with Aboriginal communities in an ongoing relationship to facilitate continuous service/policy review and improvement.

Another jurisdictional policy—Aboriginal Cultural Security, which has been adopted in the Northern Territory—is focused on all health and community services. This policy has the key elements of the CQI approach and is being implemented at a regional level but is not specifically focused on hospitals. The four key elements of the policy include:

- Identification of the elements of Aboriginal culture that intersect with the delivery of health and community services
- Review the practice and custom of these services to ensure it does not unnecessarily conflict with Aboriginal peoples culture and values
- Initiate action to modify the practice and custom of services as required
- Monitor service activity to ensure ongoing compliance with cultural standards and practice.

This policy acknowledges that individual cultural awareness training is not sufficient to improve services as the system needs changing. System reform includes workplace development and reform, monitoring and accountability, and community engagement. There is also acknowledgement that this policy will have variations depending on the local situation. One possible missing component with this policy, when undertaking a CQI approach in an acute setting, is the need for the individual hospitals to be responsible to developing and maintaining their relationship with their local community to ensure that the ongoing monitoring process involves ongoing local Aboriginal input.

The Cultural Security policy as outlined by WA Health is similar to the NT policy and supports a CQI approach. The focus of reform promoted by cultural partnerships including review and practice development fits well with a culturally appropriate CQI process. The approach of encouraging health services to evaluate how they provide services and that the development of partnerships with Aboriginal organisations and people will ensure that services are culturally appropriate and accessible, is noted as a key strength in the policy (Office of Aboriginal Health, Western Australian Health Department, 2005, pg 2).

The NSW Walgan Tilly project focuses on developing practical steps and real solutions to improving access to services for Aboriginal families and communities, building working relationships between Aboriginal and chronic disease services, and identifying and sharing of best practice in meeting the needs of Aboriginal people with chronic disease. All these components are supported by the ICHP approach which outlines a process for hospital staff to be involved in developing, trialling and evaluating solutions for Aboriginal patients. This work needs to be undertaken in partnership with the community through each step of the quality improvement process and by the utilisation of the Toolkit, which provides many best practice examples of how other hospitals have gone about initiatives.

National and Jurisdictional Policies

National Policy Environment

The National Aboriginal and Torres Strait Islander Health Strategy (NAHS) was released in 2001 as a consultative document produced by the National Aboriginal and Torres Strait Islander Health Council. Although not specifically addressing hospitals, it highlights their obligation to provide quality and effective health services to all Australians, including Aboriginal people.

The NAHS strategy outlines nine principles to guide national action, ensuring implementation strategies support the vision for healthy Aboriginal communities. Strategies contained in the NAHS focus on cultural security, holistic approaches, capacity building, community control, promotion and prevention, accountability, health sector responsibility, localised decision-making and working together. All these principles are important but two areas are significant for hospital care. Health sector responsibility includes the provision of ensuring equity in health service access for the most disadvantaged. The strategy also notes that the provision of quality health care services to people is a core responsibility of the whole of the health sector and not just that of the Aboriginal community control health sector. The other key area is working together, which asserts that a combined effort is needed between all stakeholders.

Following from the NAHS strategy is the National Strategic Framework for Aboriginal and Torres Strait Islander Health that has similar principles and outcomes. This Framework is the guide for government action to address Aboriginal health and wellbeing and was initially endorsed in July 2003 by the Australian Health Ministers' Conference. This Framework has recently been updated and is now known as the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013, Australian Government Implementation Plan 2007–2013.

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009, commissioned by the Australian Health Ministers Advisory Council (AHMAC), recognised the comparatively poor standard of health between Aboriginal people and that of the broader Australian population. The Framework was developed to provide guiding principles for policy construction and service delivery by jurisdictions as they implement initiatives to address their respective needs. In particular, the focus of the principles contained in the Cultural Respect Framework guide the development, establishment and strengthening of relationships between the health care system and Aboriginal people. This guiding national Framework states that cultural respect is about shared respect and responsibility, which is only able to be achieved when the health system is a safe environment for Aboriginal people, where cultural differences are respected. It is a commitment to the principles that the construct and provision of services offered by the Australian health care system will not and does not wittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal people.

The goal and vision of the Framework is to uphold the rights of Aboriginal people to maintain, protect and develop their culture and achieve equitable health outcomes. It aims to influence corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for Aboriginal people. The Framework further highlights that the health and cultural wellbeing of Aboriginal people within mainstream health settings requires special attention. It associates many contributing factors to poor standards of Aboriginal wellbeing including the lack of confidence of Aboriginal people in accessing mainstream health services.

The key purpose of the 'Closing the Gap' initiative is outlined in the statement of intent between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organisations to:

work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.

Closing the Gap Statement of Intent 2008

As outlined in the initiative one area that needs to be addressed to ensure equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services. As outlined by Jones as part of the support for the Closing the Gap initiative:

For Indigenous peoples to participate in Australian society as equals requires that we be able to live our lives free from assumptions by others about what is best for us. It requires recognition of our values, culture and traditions so that they can co-exist with those of mainstream society. It requires respecting our difference and celebrating it within the diversity of the nation.

**Dr William Jonas
Closing the Gap 2008**

Another report that the Commonwealth Government uses to monitor performance in the area of Indigenous disadvantage is the Framework for Reporting on Indigenous Disadvantage released by the Productivity Commission. This report is released every two years (the latest being 2009) and outlines the trends in different indicators relating to Indigenous disadvantage. Several indicators make mention of hospital care and are related to access to health care services but there is not a specific measure relating to access or suitability of service provision.

In December 2007, the Council of Australian Governments' (COAG) meeting agreed to a comprehensive Indigenous reform agenda to be undertaken by all levels of governments in partnership with Aboriginal and Torres Strait Islander communities. COAG committed to closing the gap in life expectancy within a generation (by 2030) and to halve the gap in mortality rates for Indigenous children under five within a decade (by 2018). This led to the signing of the 'Close the Gap Statement of Intent' in March 2008.

The National Health and Hospitals Reform Commission released its final report entitled 'A Healthier Future For All Australians' in July 2009. At the time of writing, this report is yet to be endorsed by the Commonwealth. It has a number of recommendations related to hospital care of Aboriginal patients including:

- Strengthening accrediting organisations' criteria around cultural safety (this has implications for Australian Council on Healthcare Standards EQuIP program for hospitals that is currently being reviewed)
- Additional investment includes the funding of strategies to build an Aboriginal health workforce across all disciplines (increase the number of Aboriginal people employed in the hospital system)
- That young families, Aboriginal people, and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, coordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes (this potentially will have significant impact on hospitals and Aboriginal Community Controlled Organisations, increasing the need for improved partnerships).

Victorian Policy Context

In relation to acute health services in Victoria the first key report was the Aboriginal and Torres Strait Islander Hospital Accreditation Project undertaken in 2002. The Department of Human Services Victoria (DHS), in partnership with the Metropolitan Health and Aged Care Services Division, commissioned the project with the aim of developing a strategy for accreditation of public hospitals in regard to the reporting and provision of hospital services for Aboriginal patients. The study made numerous

recommendations concerning accurate identification, data collection and appropriate service provision to Aboriginal patients including a list of well-evidenced ways to measure quality of care and cultural safety:

- Staff values, skills and knowledge related to cultural sensitivity in the provision of services to Aboriginal people
- Relationships with Aboriginal organisations and services
- Inter-agency and interdisciplinary planning and evaluation processes which focus on the particular cultural and social needs of Aboriginal people
- Systems and resources to support staff to make timely relevant referrals and seek appropriate involvement of Aboriginal workers and agencies
- Information technology systems that support the recording of Aboriginal status and communication between staff and departments
- Evaluation of the effectiveness and recording system.

The findings were used to develop a quality framework referred to as the Developing a New Approach to Koori Hospital Liaison Services, Hospital Accreditation Framework (December, 2004). The final project report, entitled Developing a New Approach to Koori Hospital Liaison Services, Final Report 2004, presents key guidelines designed to act as an accountability framework for Victorian acute health care providers focusing on relationships with Aboriginal organisations, culturally aware staff, discharge planning and primary care referrals. This report led to the development of the Improving Care for Aboriginal and Torres Straight Islander Patients (ICAP) policy, also launched in 2004, and included funding guidelines which provide reporting procedures for health services that receive the 30% Aboriginal Weighted Inlier Equivalent Separations (WIES) supplement eligible for all Aboriginal identified inpatients. ICAP outlines the quality improvement and reporting requirements of health services in receipt of the supplement that includes:

1. Establish and maintain relationships with Aboriginal organisations.
2. Provide or coordinate cross-cultural awareness training for hospital staff.
3. Set up and maintain service planning and evaluation processes that ensure the cultural needs of Aboriginal people are addressed when referrals and services needs are being considered particularly in regard to discharge planning.
4. Establish referral arrangements to support all hospital staff to make effective primary care referrals and seek the involvement of Aboriginal workers and agencies.

The Victorian policy platform has been built on a CQI approach to hospital service development and improvement for Aboriginal people. This platform encourages hospitals to engage at a local level with Aboriginal communities in an ongoing relationship to facilitate continuous service and policy review and improvement.

Northern Territory Policy Context

Aboriginal Cultural Security, released in 2007, is the key policy document guiding hospital reform in the Northern Territory (NT). This policy has the key elements of a continuous quality improvement approach and is being implemented at a regional level but is not specifically focused on hospitals. The four key elements of the policy include:

- Identification of the elements of Aboriginal culture that intersect with the delivery of health and community services
- Review of the practice and custom of these services to ensure it does not unnecessarily conflict with Aboriginal people's culture and values
- Initiate action to modify the practice and custom of services as required
- Monitor service activity to ensure ongoing compliance with cultural standards and practice.

This policy acknowledges that individual cultural awareness training is not sufficient to improve services as the system needs changing. System reform includes workplace development and reform, monitoring and accountability, and community engagement. There is also acknowledgement that this policy will have variations depending on the local situation.

As a starting point to the implementation of the cultural security policy the NT Government undertook a territory-wide data collection process which involved speaking to different professional working groups, Aboriginal organisations and Aboriginal elders. This process has resulted in the detailed plans for each region regarding the key issues that need to be addressed.

New South Wales Policy Context

The overarching policy document that guides how the NSW Government engages with the Aboriginal community is the Two Ways Together, Partnerships: A New Way of Doing Business with Aboriginal People, New South Wales Aboriginal Affairs Plan 2003–2012. This report outlines how Aboriginal people and the NSW Government will work in partnership to lessen and remove social disadvantage, to ensure that all citizens of NSW share in the benefits that the state has to offer. The policy makes the important acknowledgement that Aboriginal people know best the needs of their community and ensures that Aboriginal people have a strong voice in planning and deciding how their needs and aspirations are met. The policy also states that this will occur at both a local and regional level.

From a health perspective NSW has several policy documents including the *NSW State Health Plan* that provides the broad strategic direction for health service development across the state. This provides a platform for regional plans; for example, *A New Direction For Sydney South West: Health Service Strategic Plan – Towards 2010*. These plans provide broad direction with general policy approaches to Aboriginal patient care alongside multicultural services.

As for specific policy regarding Aboriginal hospital patient care there is the *Chronic Care for Aboriginal People Program*, which was developed from the *Clinical Services Redesign project (Walgan Tilly)*. This program has developed from a number of initiatives to address the disparities in health care, improve

access to and utilisation of chronic care services for Aboriginal people in NSW. The main goals of the project were to:

- Develop practical steps and real solutions to improving access to chronic disease services for Aboriginal families and communities.
- Build working relationships between Aboriginal and chronic disease services.
- Identify and share of best practice in meeting the needs of Aboriginal people with chronic disease.

The *Walgan Tilly Project* interviewed and surveyed many Aboriginal patients, carers, staff and community representatives. Many issues were discovered and solutions identified to overcome these issues. There are six state-wide *Walgan Tilly Solutions* including:

1. Model of Care for Aboriginal people.
2. Integration of Aboriginal Health and mainstream chronic care.
3. Greater Aboriginal cultural awareness and cultural sensitivity of services.
4. Justice Health linkages.
5. Improved access to primary care.
6. Improved data quality.

Walgan Tilly is a comprehensive policy approach that is attempting to address all issues relating to the treatment of chronic disease for Aboriginal people in NSW. There are many projects operating across the health system and findings and best practice solutions are shared at forums, conferences etc. The overall approach of the program is well-suited to the ICHP CQI approach. Some concern may be found in the lack of focus on hospital care and how these organisations create and maintain effective relationships with their local Aboriginal community and Aboriginal organisations, in a process of ongoing review.

South Australian Policy Context

In South Australia the key health policy document is South Australia: Our Health and Health Services 2008 that provides a comprehensive picture of the health status of South Australians and includes a chapter on Aboriginal people. This policy provides a through outline of the latest data available regarding health status and health service access by different groups within the community. The report comments on the importance of assessing the health status of minority population groups to understand the relationship between fair and reasonable access to appropriate health services and overall health outcomes. It also outlines that access and equity issues for Aboriginal people are difficult to analyse and require a level of qualitative assessment through the use of a number of indirect measures. The components that affect the uptake and use of health services include:

- Physical location.
- Levels of health expenditure
- Provision of culturally appropriate environments.

The willingness of Aboriginal people to use health services may be influenced by:

- Community control of the health service
- Gender and age characteristics of staff
- Availability of Aboriginal staff.

South Australia also has a 30% WIES Supplement that means Aboriginal and Torres Strait Islander patients attract a 30% increase in funding compared to non-Aboriginal patients. There is no specific requirement to be undertaken in order to receive this supplement.

Western Australian Policy Context

The policy approach in Western Australia (WA) is similar to the NT with a focus on cultural security. In ITS background paper the Department of Health outlines why some previous attempts to change the health system have had limited impact and the justification for the new approach taken. The paper indicates that even after many years of Cultural Awareness training the health system continues to provide inappropriate care for the Aboriginal community. The key points mentioned in the background paper include:

- The disjointedness of the system's approach to managing diversity, including the limited opportunity for an organised assessment of organisational, clinical and administrative practices to ensure that an Aboriginal client's cultural values are not offended or ignored.
- The lack of specific knowledge about the cultural variables of different cultural groups and how these might be translated into doing things differently.
- The high turnover of staff, particularly in remote areas.
- The difficulties for graduates of awareness/sensitivity programs to effect change in clinical or organisational practice, including the implied expectation that aware individuals will effect and manage change.
- The lack of any monitored self-assessment by providers of the Cultural Awareness of services offered and the concomitant absence of accountability to funders and owners (Aboriginal Cultural Security - A Background Paper, Department of Health WA Government, pp. 13–14).

It is highlighted that the policy of Cultural Awareness does not facilitate the required system change but focuses on the individual worker. The report clearly indicates that future policy initiatives need to focus ongoing system reform and look at practice, skills and behaviours. The new approach entitled Cultural Security is focused on improving the competence of practitioners and administrators to incorporate Aboriginal cultural values into the design, delivery and evaluation of health services (Aboriginal Cultural Security - A Background Paper, Department of Health WA Government, pg 14).

The Cultural Security policy is a system wide policy and covers:

- a) Workforce development
- b) Workplace reform
- c) Purchasing of health services – that focuses on funding quality activities that promote culturally secure services
- d) Monitoring and accountability - building the measures and indicators of Cultural Security, and establishing valid and reliable data collections.
- e) Constructing monitoring processes to ensure maintenance of community confidence in the integrity of cultural property. Establishing the strategic feedback loops to clinicians, administrators, government, Aboriginal communities and the public.
- f) Public engagement (Aboriginal Cultural Security - A Background Paper, Department of Health WA Government, pp. 16-17).

The Cultural Security policy as outlined by WA Health clearly supports a CQI approach. The focus of reform promoted by cultural partnerships including review and practice development fits well with a culturally appropriate CQI process. The approach of encouraging health services to evaluate how they provide services and that the development of partnerships with Aboriginal organisations and people will ensure that services are culturally appropriate and accessible, is noted as a key strength in the policy (WA Health Aboriginal Cultural Respect – Implementation Framework, Western Australian Health Department, p 2).

Queensland Policy Context

In 2007, Queensland Health’s Executive Management Team (EMT) endorsed a new Aboriginal and Torres Strait Islander health strategy for Queensland Health. An important component of the EMT decision was an agreement to establish measurable accountabilities for Executive Managers at various levels throughout the organisation. This resulted in the development of a set of District- and state-wide indicators consistent with the national framework and reported for each District. These indicators are drawn principally from routine hospital administrative data and the perinatal data collection.

In April 2008, the Queensland Premier, the Minister for Health and the leader of the Opposition signed the Close the Gap Statement of Intent with representatives of Queensland Aboriginal and Torres Strait Islander health organisations. The target of closing the gap for Indigenous Queenslanders was further articulated in the ‘Advancing Health Action – Making Queenslanders Australia’s healthiest people’ in August 2008. The Queensland Government then signed the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes in November 2008.

Queensland Health has been facilitating the development of the Second Queensland Government Implementation Plan (2008-2013) for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. The Queensland cabinet then endorsed the plan, *Making Tracks: A state-wide plan towards closing the gap in health outcomes for Indigenous Queenslanders*. Key areas outlined in this plan are:

- Access to health services – improving the patient journey through more culturally responsive and better integrated services and programs. Improving discharge planning and follow-up, transport and accommodation near services and male health.
- Building on evidence – data and evidence to support continuous quality improvement of health service delivery.
- Workforce – developing and securing a culturally and clinically skilled workforce and expansion in maternal and child health, health promotion and mental health workforce.

This plan also outlines the key performance indicators (KPIs) that will guide Queensland Health. Indicators included are:

- Indigenous identification
- 5 or more antenatal visits
- Low birth weight babies
- Discharge against medical advice
- Smoking during pregnancy
- Potentially preventable hospitalisations
- Hospitalisation of children for selected conditions.

The *Making Tracks* policy clearly supports a CQI approach to improve health service delivery for Aboriginal people. The KPI approach outlined has the advantage of focusing attention on key issues that need addressing but can also cause health service management to take a narrow approach. As these KPIs are the key drivers for management other issues may be ignored particular at a local level and of high importance to the local Aboriginal community. The policy platform needs to encourage hospitals to maintain an effective engagement process through a partnership approach with the local Aboriginal community to ensure an ongoing process of review.

Australian Capital Territory Policy Context

A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011 outlines that existing health and wellbeing services for Aboriginal people in the ACT region, including primary health care services. The plan outlines that all general programs and services provided at the Canberra and Calvary Hospitals or by ACT Community Health are inclusive of Aboriginal people as part of the general population in the ACT region. It also highlights that work will continue on the development of culturally specific government and community programs for Aboriginal people in the ACT. Some of the specific elements outlined in the plan include:

- Facilitation of Aboriginal health service work experience for mainstream health workers so mainstream health workers gain experience in Aboriginal health
- Investigation of accommodation options for interstate patients of public hospitals and their families. Interstate Aboriginal patients and their families receive culturally appropriate support when attending hospitals.

This policy needs to be developed and engage hospital management and staff in a CQI process that facilitates partnership development with the Aboriginal community. The statement about inclusivity of services needs to be explored with more details on an approach to take to ensure that this is an achievable goal.

Tasmanian Policy Context

The *Aboriginal Health and Wellbeing Strategic Plan 2006–2010* is the key policy document driving healthcare reform and includes references to hospital care. The document makes reference to the commitment to employ Aboriginal Liaison Officers in the major hospitals in Tasmania. It also outlines other commitments including:

- Improve access by Aboriginal people to acute care and specialist services
- Improve awareness of acute care staff of issues within the Aboriginal community
- Explore options for increasing the numbers of permanent Aboriginal-identified positions within Hospitals and Ambulance Service
- Implement cultural awareness/safety training for acute care staff.

This policy has addressed the key issue of employing Aboriginal staff within acute health care organisations but has not articulated an approach that engages hospital management in an ongoing CQI process and relationship with the local Aboriginal community.

Conclusion

The ICHP has developed a practical CQI approach to bring about the changes required in hospital culture to improve their responsiveness to Aboriginal people. This approach requires hospital staff both Aboriginal and non-Aboriginal to work together with Aboriginal communities over time to explore issues, develop solutions and implement improvements that are continually reviewed over time. This requires each hospital to develop and maintain a relationship with its local Aboriginal community so that issues can be continually addressed.

Some components of current state and territory legislation do not completely support a CQI approach. The key component of this approach requires an ongoing feedback process from the Aboriginal community directly to the hospital to facilitate and strengthen that relationship. In an attempt to hold hospitals accountable, some jurisdictions have undertaken the initial data-gathering and analysis component and then provided hospitals with a list of required changes. This inhibits the goal that hospitals need to build the required long-term relationship with their local Aboriginal community to ensure there is continuous feedback to ensure sustainable change over time. One option to encourage hospitals to gather community feedback would be ensure this component is embedded with the ACHS EQuIP accreditation process. This would facilitate hospitals gaining first hand experience of community feedback and therefore receive the benefit that direct community consultation provides and will enhance their potential to bring about the organisational cultural reform required.

Appendix Three - Expression of Interest Questionnaire

Note: Please feel free to answer with dot points and provide supporting documentation.

- a) Please describe your partnership with the local Aboriginal community and any outcomes that have been achieved through this partnership?
- b) Please describe any Aboriginal health initiatives supporting better interaction with Aboriginal people and/or their communities that you have developed, including how they may have involved local community support, and how long have these initiatives been in place.
- c) Please describe any systematic monitoring and/or evaluation processes that have been established for the above initiatives
- d) Please outline how your organisation has supported these initiatives. For example through funding, encouraging networking and information sharing, establishment of regular meetings etc.
- e) Please provide details on how initiatives have been funded
- f) Has your hospital identified any clinical champions and/or executive sponsors to support these particular health initiatives? If so could you please provide details?
- g) Can you please provide details if any of these initiatives impact on practices in more than one department across your organisation?

Deadline: Can you please forward completed questionnaires, any supporting documentation and follow-up contact details to John Willis by **Friday 27th June 2008**.

Process: The project team will assess all information provided by nominated hospitals and choose four hospitals to be involved in the first wave of case studies. Those not successful for the first wave maybe invited to be involved in a later phase.

Communication: All hospitals that were nominated and the Aboriginal community organisation involved in their nomination will be notified of the outcome of this selection process and then placed on an email list so we can keep you updated regarding the progress of the project.

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Appendix Four – Phase III Detailed Findings

Maitland Hospital Case Study 12th August 2008

Researchers

Alwin Chong, Monica Lawrence and John Willis

Introduction

These notes are a summary of the key points raised from the meetings held with a number of staff across Maitland Hospital. For a complete list of staff involved please see attached Maitland Meeting Schedule.

Notes

Relationship with Aboriginal community

- The Aboriginal worker at Maitland Hospital spent four years asking community what they wanted from the hospital. Focus groups were used as one method to gain this information but obtaining community feedback is fundamental. Focus groups were systematic in the initial development phase but now only used as required.
- Maitland Hospital has a community health service next door that include an aged care residential service. The community health service currently visit the local Aboriginal community at Point Pearce twice weekly which has increased the contact and improved staff understanding of what is going on in the community. This has led to the opportunity to encourage Aboriginal community members to visit aged care patients. This increased contact, including ongoing discussions with Elders coupled with the Aboriginal Hospital Liaison Officer (AHLO) located very close to the front desk of the hospital, has decreased admissions from the Aboriginal community by approximately 50-60%. Community health nurse at Point Pearce provides a triage service, which also assists in decreasing admissions.
- One key change has been the area of consumer feedback. Managers now look for Aboriginal feedback where historically it was not seen as important. People from consumer focus groups became involved in the Aboriginal Services Improvement Plan development which now guides activities at the hospital.

State & federal policy environment

- To assist in the process of change it has been accepted at a state and regional level that things were not working to improve the health outcomes for the Aboriginal community. Therefore, there has been a commitment by the Maitland Hospital management team to make changes. One change has been the requirement by all executives to participate in cultural respect training and this has been included in their position descriptions.
- Aboriginal Health Advisory Council (AHAC) is a regional board that has established criteria to accredit hospitals as Aboriginal friendly. One key area that the AHAC has requested hospitals to act on is the lack of discharge planning by metro health services, for example, discharging patients on a

Saturday morning with no support. Another initiative that has assisted in improving the discharge process has been the Patient Journey Network.

CEO/Board commitment and clinical champions

- Any initiative that is approved by the hospital management needs to have the Aboriginal patient's needs incorporated. This has been initiated and endorsed by senior management team. Management have ensured that staff view Aboriginal health as everybody's business, that Aboriginal patients are not marginalised but incorporated into mainstream business and that the key to improving services to Aboriginal patients is not just about paintings but people's attitudes. Cultural awareness training has been included in all staff position descriptions.
- When looking at funding allocations, management made mental health and Aboriginal health key priority areas. To ensure this was achieved Aboriginal health funding was quarantined. A policy framework was then put in place that made Aboriginal patients key partners in health. This has involved senior executives meeting with Pt Pearce Aboriginal Council to discuss health concerns and taking advice from the Elders on how to manage difficult issues.
- The hospital board has also undertaken cultural awareness training and visited communities. The board also accepts advice from AHAC including the adoption of the Inga Watta principle to guide board processes. The board also has an Aboriginal place but often a vacancy.
- When Aboriginal Nurse was employed the position focused on training board and executive staff. Attendance was positive with five executives attending different cultural awareness sessions and this provided leadership. Some executive staff have also attended 1 and 2 day courses on Aboriginal culture as well as participating in rural camping trips for 2 to 3 days.

Policy and strategic environment within the hospital

- Doctors generally operate as the funding system dictates, so to service the Aboriginal community more effectively required a different process. Funding was sought from the APHCAD to allow doctors to provide regular service to the Aboriginal community. Some of the outcomes from this process have been the improved relationship with local GPs and the Aboriginal community.
- Management has placed a target on increasing the Aboriginal workforce to 4%. Historically Maitland did have had up to 10% Aboriginal staff but this was focused at a low level with the focus on Aboriginal Health Workers or AHLO positions.
- An Action Plan has been developed. It includes key performance indicators and is annually reviewed. Reporting on progress is undertaken through quality framework and also through service agreement which has Aboriginal indicators.

Structural support

- The Aboriginal Health Team (AHT) is a community-based team that has a close working relationship with the AHLO particularly regarding discharge planning. All Maitland staff knows the staff in the AHT.

Aboriginal Workforce

- The hospital did not understand Aboriginal traditions and wanted to do things better clinically so they employed an Aboriginal nurse to assist Aboriginal Health Workers in the community. At the time an Aboriginal Hospital Liaison officer was employed in the Social Work department and this was ineffective at this that time. When the nursing position commenced it started on cultural awareness of staff and initially focused on executive staff.
- Historically there was a focus on Aboriginal Liaison Officer roles but now there is a focus on developing some management trainee positions and to do this has required the relocation of funds including a 0.5 EFT to oversee 2 trainees. This succession planning is in place with a focus on all levels. Traineeships and cadetships have worked well with the overall employment strategy quite successful. The employment and training of Aboriginal staff within the hospital was initially challenging but has worked in the long term with commitment from key staff and support from management has been able to recruit, attract and retain staff. Key learning's have included the need for flexibility when managing most Aboriginal staff and the program has allowed other staff to learn a lot about the Aboriginal community they otherwise would not have learnt by working alongside Aboriginal staff. One positive outcome has been the employment of younger Aboriginal people and the positive impact it has had on changing the staff culture and attitudes. There is also recognition that both Aboriginal and non-Aboriginal staff have made sacrifices to bring about changes.

Other

- Changing staff attitudes is essential and is a long term process and has involved a cultural awareness training program that is not just class based but includes interactive activities including for example staff participation in the local NAIDOC Walk. There is an acceptance that cultural awareness is at two levels, the high level undertaken by an external training consultant (outsourced) with the low level undertaken by local staff and community. This approach has executive support and is driven by management. The best programs and drive comes from local management. It has also been acknowledged that medical staff are a key staff group to ensuring attitudes change.
- Aboriginal patients are now telling nurses more about what is going on regarding their situation and Maitland is now seen as their hospital. This has come about in part by seeing staff when not in crisis in the community and when access to emergency services is required it is a less stressful experience when seeing a familiar face.
- Health staff have compulsory study days which has included Aboriginal cultural awareness. Normally nurses have mandated training which now has an Aboriginal component.

Royal Adelaide Hospital Case Study 11th August 2008

Researchers

Alwin Chong, Gai Wilson, Russell Renhard and John Willis

Introduction

These notes are a summary of the key points raised at the meetings held with a number of staff across the Royal Adelaide Hospital (RAH). For a complete list of staff involved please see attached RAH Meeting Schedule.

Notes

Relationship with Aboriginal community

- Staff highlighted the process undertaken at the RAH to commence working effectively on Aboriginal health. The idea to have a particular focus on Aboriginal health was taken on by the General Manager after it was first raised by the Consumer Advisory Council in 2002. The RAH then developed its relationships with the Aboriginal community starting with meetings with Aboriginal Health Council of SA. The RAH then documented Aboriginal patient stories (pathways) by establishing focus groups including success stories and failures regarding patient access. Then the reform process really began with the development of an action plan.
- In the Burns Unit, RAH staff have provided training to Aboriginal Health Workers (AHW) in Aboriginal organisations. Since undertaking health promotion on APY lands with doctors, nurses and community along with training for AHW there has been a 37% reduction in burns admissions. This unit also obtains feedback from Aboriginal staff regarding its training and health promotion to guide service development. This is a good element to a CQI process

State & federal policy environment

- Aboriginal cultural awareness training for staff was discussed, including orientation and ongoing training. No formal evidence of the effectiveness this training has been gathered but the RAH is looking at the development of a formal set of competencies to evaluate it across the northern region. Training has not been delivered to doctors but is seen as a good idea. It was felt that for this to be successful it would require leadership from senior doctors.
- The RAH's connection to Aboriginal policy makers in SA Government is seen as an important component to support the work at the RAH. The Central Northern Health Services region has established an executive director for ATSI who is a powerful committed person, which is seen a great support to the work at the RAH. SA Government is looking at developing a regional response for cultural awareness competencies for hospitals.
- The RAH is still trying to implement the national Cultural Respect Framework. Challenges include how to imbed cultural respect into cardio and oncology departments with a key challenge being how to ensure sustainability due to the intensive training offered by ATSI Unit manager is unsustainable.

- The RAH has undertaken Aboriginal cultural awareness training including the Cultural Respect Framework as part of the orientation program for staff (except medical staff). The undergraduate medical program is limited regarding Aboriginal health, therefore requires good quality presentations to students when on placement at the RAH. The offer of training to specific departments is now targeted because those who need training don't always come. RAH is looking at a regional approach to cultural awareness training so is looking at options to employ someone rather than using consultants. The RAH is like a small town with 5,000 staff so there is a need to constantly educate staff about ATSI Unit role. Each time an AHLO worker goes to a department about the needs of an ATSI patient they should explain the issues as part of educating staff. Lack of cultural awareness can lead to misdiagnosis.

CEO/Board commitment and clinical champions

- Several staff discussed the importance of having senior management support for Aboriginal health to ensure that any initiatives to improve services to Aboriginal patients are successfully implemented. The General Manager at the RAH has shown strong support and commitment along with other senior staff including the Manager of the Safety & Quality Unit where consumers are imbedded into the unit's operations to assist in driving change. Also a clear governance structure was established to guide the implementation of initiatives with accountability been held by the general executive.

Policy and strategic environment within the hospital

- Firstly the RAH Aboriginal Health Framework was developed to provide context for the Action Plan. The RAH ATSI Health Action Plan was the key technique for making issues for Aboriginal patients concrete and was the same process used for other groups including homeless and CALD.
- Aboriginal cultural awareness training for staff was discussed, including orientation and ongoing training. No formal evidence of the effectiveness of this training has been gathered but the RAH is looking at the development of a formal set of competencies to evaluate it across the northern region. Training has not been delivered to doctors but is seen as a good idea. It was felt that for this to be successful it would require leadership from senior doctors.
- All staff are now prepared to link with the ATSI Unit but the Unit doesn't have the capacity to respond quickly so staff get a bit frustrated. To assist staff an Aboriginal health resource booklet has been developed which is available in hard copy on every ward as well as being available on the staff intranet site so all staff can have access to relevant information. All staff are encouraged to contact Aboriginal organisations directly by accessing information on the intranet.
- If the Action Plan was evaluated it should indicate that there have been fewer complaints from Aboriginal patients. This has been achieved through the work of the Aboriginal Liaison officers and the Aboriginal nurse as they identify problems/issues before they become a real problem and mediate between patient and staff. This is a very valuable role and provides a buffer in the system. Success of the Action Plan should also indicate fewer requests for the ATSI Unit because staff are managing better but this is currently not happening. There is a need to continue to raise staff awareness of the Aboriginal Nurse role including when to refer and utilise social workers, not just dumping cases on Aboriginal staff.

- The RAH is looking at setting competency standards for different areas of Aboriginal health. For example, setting a number of cultural awareness training sessions that executives, managers and staff need to attend each year.

Structural support

- The ATSI Unit puts actions into place and reports back on progress to ASTI Steering Committee which meets bi-monthly to review Action Plan progress. This progress is documented by Safety & Quality Unit staff under each of the headings in the Action Plan including the steps taken, products developed and any achievements. Within the Action Plan the ‘who’ column is only half the picture because the Steering Committee locates actions to different parts of the hospital highlighting that the Action Plan is for all staff. The general executive has responsibility for providing resources and accountability of achievements.
- Staff across the hospital know that executive expects accountability and are supportive. Safety & Quality Unit facilitates that accountability by assisting Manager of ATSI Unit in writing reports. Quality & Safety Unit Manager is a champion and advocates with a strong commitment and leadership for consumers. Action plan has been reviewed after 12 months of operation.
- One area that has not been covered is how to successfully engage doctors in the Action Plan. How might an issue like this become identified as a systemic issue that the hospital can then respond to? Manager of ATSI Unit takes issue to ATSI Steering Committee who then allocates response to the right section of the hospital. Item is minuted and then followed up by committee.
- The RAH’s intention to make changes and influence staff attitudes has been undertaken through a number of activities and initiatives. The creation of specific Aboriginal areas, including Welcoming Room and an open space for Aboriginal patients, along with utilising Aboriginal language names for rooms and places around the hospital, have assisted in raising staff knowledge of Aboriginal culture. Aboriginal staff also have badges and arrange celebrations of specific Aboriginal events. As to the effectiveness of these initiatives, Aboriginal staff have observed that nurses no longer complain about a specific request from an ATSI patient. Some staff comments regarding the cultural difference between Aboriginal and non-Aboriginal people include: “Time rules are different”, “Here (in hospital) there are different timeframes”. The key issue for the RAH is the need to capture staff imagination with Aboriginal health as a key issue.

Aboriginal workforce

- One goal of the RAH has been to change staff attitudes regarding Aboriginal health. To achieve this, the RAH has undertaken a number of initiatives including the employment of Aboriginal staff who are all based in the one unit. Initially the Aboriginal Nurse and Aboriginal Liaison Officers (ALOs) were located in different units but increased capacity has been achieved by bringing them together as a team along with the development of an Aboriginal unit so Aboriginal staff can receive support from each other. The Aboriginal unit also has a manager position to undertake community networking as ALOs are too busy with direct patient support. The General Manager made a huge commitment to establishing the ATSI Unit and finding a space to house it. Through the creation of a separate ATSI unit the profile of Aboriginal staff and the team has risen

Other areas

- One area where it has been noticed that practice is changing has been the request for information from the male Aboriginal Liaison Officer by medical staff. Both doctors and nurses make requests for information regarding the Nunkaris healers. Another indication of positive change has been that Aboriginal patients are more relaxed when ceremonies are conducted. Medical staff have also noticed that the patients feel more at ease after the Nunkaris visit and after a special ‘cleansing’ ceremony.
- Evidence of the effectiveness of staff cultural awareness training includes positive verbal feedback from participants, less eye contact for NT community members is understood and an increased understanding and clinical practice about men’s and women’s business and male and female issues with nurses now contacting male liaison officer when required.
- At the RAH administration staff need cultural awareness training to encourage them to ask patients whether they are Aboriginal or Torres Strait Islander and imbed the process. Ward clerks should also be encouraged to ask the ATSI question. Aboriginal staff at the RAH have direct access to patient records and can correct status if required.
- Voluntary patient access to the RAH for Aboriginal patients has improved via better links with ATSI hostels. By housing patients in hostels prior to surgery this has resolved the issue of blocked beds by patients simply waiting for surgery.
- One good example of quality improvement in action at the RAH is in the Dialysis unit where Aboriginal patients were asked what they felt about resources available. Response was the current resources were not appropriate so the Dialysis unit has planned to work with the Safety & Quality and ATSI Units to improve their resources.

Useful suggestions

- Setting competency standards for Aboriginal as discussed is seen as a positive initiative and it is recommended that the RAH consider this option particularly for cultural awareness training.
- That the ATSI Steering committee considering inviting the Emergency Department to join the committee to facilitate a greater involvement in Aboriginal activities within ED.

St Vincent's Hospital Case Study 20th August 2008

Researchers

Alwin Chong, Monica Lawrence and John Willis

Introduction

These notes are a summary of the key points raised from the meetings held with a number of staff across St Vincent's. For a complete list of staff involved please see attached St Vincent's Meeting Schedule.

Notes

Relationship with Aboriginal community

- St Vincent's working relationship with the Victorian Aboriginal Health Service has improved particularly in response to development and implementation of discharge communication tool for Aboriginal patients. The current AHLO played a key role in the development and also in teaching other clinicians about how to use it.
- The partnership with the Aboriginal community was developed approximately 12 years ago as recommended by the then AHLO and the state government (Koori Human Services Unit). It was then principally seen as a support for the AHLO position and over the years has been formed and re-formed. The inception of the ICAP program has led to the committee being more of a genuine partnership with an Aboriginal Elder as co-chair and more equal membership and rotating meetings mostly held in Aboriginal community organisations.

State & federal policy environment

- St Vincent's has reviewed the NHMRC cultural competency guidelines and sees the value in the four dimensional approach. St Vincent's is now looking at future developments under these dimensions that include: systemic (policies, procedures, mechanisms), organisational (cultural competency as core business and it is supported and evaluated), professional (through education, professional development and standards development) and individual (maximising knowledge, attitudes, behaviours and support to work with diverse communities).
- St Vincent's has found the state government policy called ICAP has provided a useful framework to improve relations with the Aboriginal community and implement a range of initiatives that have seen an improved service response to Aboriginal patients.

CEO/Board commitment & clinical champions

- There are several champions regarding Aboriginal health, both clinical and non-clinical, but there are also many good staff at all levels supporting Aboriginal health. There is also strong support from senior medical staff who also supports initiatives.
- St Vincent's has two executive sponsors for Aboriginal health. The Director of Mission has a strategic role including linking with community, responsibility for the delivery of cultural awareness education for staff and reporting directly to the board regarding developments. The Director Aged Care and Allied Health manages the Koori Hospital Liaison Officer program.

- The CEO has shown strong support and has consistently resourced growth in the Aboriginal program area. St Vincent's win at the inaugural Victorian Public Healthcare Awards also assisted in positioning the organisation for this level of support. The Chief Nursing Officer has also put herself through Aboriginal culture awareness training outside the organisation and also offers strong support.

Policy & strategic environment within the hospital

- The St Vincent's Mission and Values outlines the culture of the organisation and dictates how staff should relate to each other and to patients. The culture of the organisation clearly supports Aboriginal health and is indicated by the flying of the Aboriginal flag and celebrating Aboriginal days of significance. The Aboriginal health scorecard and numerous research projects also assist in promoting Aboriginal health.
- Values are crucial to the successful engagement of Aboriginal and other marginalised patient groups at St Vincent's. Security and police use St Vincent's as a hospital of preference to diffuse and deal quickly with homeless patients.
- Nurse Unit Managers (NUM) are crucial to the organisational culture and St Vincent's has a low turnover of these staff. NUMs understand the culture and train and advise other staff. St Vincent's has found the most productive approach to gaining nursing staff and NUM buy-in on each ward is to progress a guideline/protocol-based approach.
- St Vincent's uses its Quality and Risk newsletter at times to highlight issues and actions regarding Aboriginal health but it is not targeted at any particular area but for general consumption, to build knowledge and awareness.
- St Vincent's emergency department staff meet with police and ambulance officers to discuss patient issues, with Aboriginal patients often discussed. Case management issues. Good relationship with police. Meetings are minuted. At present trialling a police handover form that is Aboriginal focused so that the hospital can gain more information prior to an emergency admission. Looking to imbed in hospital processes. Agreement with police re form. Form assists with responding to absconding issues. Improves communication process with challenging patients.
- Cultural awareness training at St Vincent's is viewed as experiential learning and involves many things including the social work buddy system, co-worker model, Aboriginal and non-Aboriginal staff visiting Aboriginal agencies and NAIDOC celebrations. Some medical staff have undertaken orientation at the local Aboriginal health service and currently St Vincent's is looking to broaden that to pharmacy staff. Research at St Vincent's has indicated there is evidence in available literature that cultural awareness training does not evaluate strongly but nevertheless it is being rolled out at St Vincent's in recognition that the development of cultural competence is a process involving information, knowledge building, asking and answering questions. These are just a beginning and a long way away from cultural competence so the goal at St Vincent's is to concentrate in the future on developing and resourcing clinical champions from many areas and disciplines to extend the reach and impact of cultural awareness and safety principles.
- In 2005 St Vincent's conducted a review of its AHLO Program involving feedback from Aboriginal patients and organisations. The results of this review formed the base of a journal article and also a

poster was developed for Research Week. This review also informed the development of the discharge communication tool. This tool was developed to assist in effectively discharging Aboriginal patients. The process involves both Aboriginal and non-Aboriginal staff with AHW and nurses discussing patient care and mainstream hospital staff and AHW's undertaking joint visits if required to break down risk factors. Use of the discharge communication tool is another way to identify whether clinicians are getting the messages re the risk factors and need for complex care management/discharge planning in certain cases.

- Social workers didn't understand Aboriginal patients and had no understanding of AHLO's responsibility back to community. There was no common ground between AHLO and social workers but now there is. Now there is open communication between social workers and AHLO, with social workers taking more responsibility and becoming more confident with Aboriginal patients. Informal dialogue and case-based discussions between individual clinicians and the AHLOs are seen as an integral part of awareness building in the social work team with these staff being the primary link for inpatient care for the AHLOs. It is agreed that protocols/guidelines are desirable in all areas and especially clinical; however, SW and the AHLO have adopted a dialogue-based model of co-working for now to build trust and mutual respect for each others' contribution. This has been evaluated twice through qualitative interviews with AHLO and SW staff and data mining exercise and again interviews. This approach has been seen as culturally safe by the AHLO.

Structural support

- The AHLO Program Supervisor and AHLOs historically drove the Aboriginal Health Advisory Committee but in more recent years the ICAP Project Officer Metro and the St V's Director of Mission (with formal allocation of Aboriginal Health to that position) have undertaken this role. The AHLO Program Supervisor with support of Aged Care & Allied Health Director presented to executive at the point of the introduction of the state government ICAP policy and this initiated the process of more support being given to Aboriginal health. The ICAP Project Officer has continued this and included presenting to the St Vincent's Board. The Mission Director maintains strong interface with Sisters of Charity Health Service National Board in this area also.
- Hospital Admission Risk Program is based in community health services and in the emergency department and play an important role along with the AHLO is coordinating care for complex Aboriginal patients. AHLO time was in demand from HARP clients but has reduced since mainstream staff are managing more appropriately. Aboriginal inpatient numbers have also dropped, possibly indicating Aboriginal patients being case managed better.
- St Vincent's has committed people in key positions across the organisation, including middle management, who work on things together. The statement used is they 'get it'. The AHLO consistently advocates strongly with key stakeholders about the issues and the new ICAP Coordinator position augments this role. This team effort with strong and influential champions is supported by the organisational values and mission which underpin efforts to further grow capacity.

Aboriginal workforce

- The AHLO works within the emergency department and other areas of the hospital and facilitates access and coordinates treatment for Aboriginal patients. The AHLO plays a key role at St Vincent's linking the hospital to the community and guiding the development and ensuring the delivery of culturally sensitive services to the Aboriginal community.
- St Vincent's has also added a new Aboriginal position in recent years to assist in the development, coordination and delivery of cultural awareness training program to staff and facilitate the relationship with the Community.

Other

- Complaints historically were only in writing. AHLO has had an effect on changing hospital policy so now AHLO offers assistance to patient to make complaints and advocates a change in policy when required. Aboriginal community complaints are now received more readily via community meetings, with patient complaints coming via AHLO feedback from patients or the Patient Liaison Officer, who will now come to the bedside to take complaints from Aboriginal patients.

Useful suggestions

- St Vincent's should consider drafting an action plan to assist in monitoring and reviewing developments within a continuous quality improvement framework; this might also assist in improving relationships with the Aboriginal community. The Aboriginal health scorecard could also be considered as a component in this process.
- As discussed, St Vincent's to consider a coordinated approach to cultural education across the organisation and including clinical champions and Nurse Educators along with Aboriginal staff.
- St Vincent's might consider reviewing the ALERT staff role in regards to certain Aboriginal patients by allowing ALERT staff to follow clients and maintain involvement if they are admitted as an inpatient to maintain continuity of care.
- St Vincent's to consider discussing discharge and referral processes with Aboriginal organisations taking into account that referrals are received from across Victoria.

Goulburn Valley Health Case Study 10th September 2008

Researchers

Alwin Chong and John Willis

Introduction

These notes are a summary of the key points raised from the meetings held with a number of staff across Goulburn Valley Health (GVH). For a complete list of staff involved please see attached GVH Meeting Schedule.

Notes

Relationship with Aboriginal community

- Aboriginal Health Taskforce, which is made up of senior executives from Goulburn Valley Health (GVH) and senior staff from Rumbalara Aboriginal Cooperative, has been imbedded into GVH culture and policy. This taskforce has developed an Aboriginal Health Outcomes Agreement which is annually reviewed and is the key vehicle for GVH maintaining dialogue with the Aboriginal community. All proposals regarding Aboriginal developments at GVH go through the Taskforce including the recent ‘Closing the Gap’ initiative that is now on the agenda. His Taskforce also reviews data. The Taskforce also reviews data produced by GVH to guide future developments. Mental Health did have a separate MOU with Rumbalara but that has been combined into the Taskforce documentation to provide a more seamless partnership between GVH and Rumbalara.
- From GVH’s experience the attitudes of key individual staff are crucial both within the hospital and the Aboriginal community to ensure success and this provides a willingness to come together to talk about solutions. Rumbalara is seen as the first point of call for all Aboriginal initiatives. Another example of the success of this partnership has included the use of the Aboriginal Community Policing Unit as an option when a code black is called at the hospital for an Aboriginal patient.
- Recently enthusiasm for the partnership was lacking so GVH Aboriginal team met with managers to discuss how to get elders re-involved. A morning tea with the community was suggested to reinvigorate interest which culminated in the Elders changing the time of Taskforce meeting. An external consultant evaluated the first taskforce and drafted the second health outcomes agreement but it was felt this was not the most effective approach. Next review was undertaken by internal GVH staff and the Action Plan created was more specific, making expectations more realistic. For example, the development of the Aboriginal birthing suite and artwork in the board room. This agreement saw decisions regarding celebrations and the development of the birthing suite driven by Aboriginal women.
- The Aboriginal birthing suite came out of the partnership with the original idea to have suite at Rumbalara but this was not possible so GVH was then proposed as a possibility. Painted appropriately with artefacts and Aboriginal paintings etc it was finally established at GVH. Also women can choose Rumbalara worker to come in and be involved in birth or have GVH staff, it is the patient’s choice.

- The GVH relationship with Rumbalara is very important. Maternal staff meet regularly from both organisations and there is enough respect so Aboriginal staff from Rumbalara go directly to GVH maternal manager with any issues. This respect has resulted in responding to patient and community needs.
- The Consumer Consultation Committee meets with other consumer groups, including the Taskforce, allowing this consumer committee to get informal advice from Aboriginal people that they otherwise would not receive.
- GVH has organised fundraisers in partnership with a local primary school with a large Aboriginal population through an art competition, bringing local Aboriginal communities into the hospital when they are not sick. This assists with educating staff regarding Aboriginal culture and knowledge of the local community.
- Evidence of success in the partnership with Rumbalara was seen through the first Emergency Department complex patient case meeting. The meeting saw a high number of Rumbalara staff attend to assist in developing a plan and a contract for the patient.

State & federal policy environment

- The initial agreement between GVH and Rumbalara was driven by the state government but then supported by GVH. The success of the partnership also relied on staff who were keen to see the agreement achieve success.
- The current state ICAP policy also supports the partnership and work of the taskforce with key result area 1 emphasising partnerships as the key driver to sustainable change.

CEO/Board commitment and clinical champions

- Senior hospital staff feel that their success in changing the GVH culture has included being good negotiators and being change managers. Good leadership and key relationships with the Aboriginal community have been crucial with managers needing to walk the talk. Another key component to the changing of the culture has been the support of the CEO and his ongoing commitment. This is highlighted by the CEO making a commitment to attending all Taskforce meetings and not delegating to other staff.
- The current committee structure at GVH has the Taskforce as a subcommittee of the GVH board with two board members on the Taskforce. This has ensured strong commitment from the board. From the GVH side, membership of the Taskforce includes the CEO, an executive sponsor, Mental Health manager, nursing manager along with the two board members. From the Aboriginal community side membership include Rumbalara CEO and other senior staff as well as community elders. Another indication of the GVH board commitment is that Aboriginal health is a standing agenda item at all board meetings.

Policy and strategic environment within the hospital

- At a strategic policy level GVH has Aboriginal health included in their statement of values which in turn sets expectations for staff. The GVH Strategic Plan also mentions of the partnership with

Rumbalara - 6.2.1 Market partnership with Rumbalara. This reinforces management's view that community support is important to the effectiveness of the hospital.

- GVH management look to any opportunity to improve staff awareness of Aboriginal culture including such projects as the ICHP and the case study interviews. These are seen as part of the overall cultural change strategy.
- The delivery of cultural awareness training is seen as opportunistic highlighting that not one size fits all with many different cultural opportunities possible. The includes cultural awareness at the bedside and cultural tours with the Aboriginal Hospital Liaison and Officers (AHLOs) playing a key role in training "individual" staff. Learning from the lived experience. Cultural training should be about talking to Aboriginal people.
- Formal cultural awareness training has been useful but Aboriginal staff in the hospital play a crucial role in changing the culture. All staff need formal training but also practical exposure. The most effective way to change staff attitudes in the longer term is to have Aboriginal staff working alongside them day to day.
- In response to the statement 'We treat everyone the same', senior GVH staff responded by saying that implies we provide a type of service and anyone can use it but it is inflexible. This is not in line with patient centred care, which emphasises flexibility and is particularly effective for Aboriginal patients. An example of this can be seen in the hospital's response to an Aboriginal patient's death. To ensure a positive outcome for the family and community it is essential that staff use the AHLO to guide process and be prepared to bend the rules. For example take time out to go outside and meet the family members to develop plan. Cleansing ceremonies are now also encouraged leading to an increase in interaction between GVH staff and Rumbalara staff and Elders.
- GVH has attempted to foster a solution/expectation of change atmosphere instead of a focus on problems. Hospitals are routine-based institutions which can be problematic for responding to cultural needs. GVH has attempted to be flexible in responding to patient needs that requires managers allowing staff to be flexible which can be more effective and quicker. Managers need to lead by example by taking a case and sitting down and discussing it with AHLO so staff get a greater understanding.

Structural support

- When the Human Resources department provide orientation for new staff this includes a visit to Minah Barmah room where the AHLO gives a talk. In the new plans for the site GVH are planning to have this room moved to the front of the hospital which they feel is the more appropriate location to improve visibility.

Aboriginal workforce

- GVH feels that to achieve any kind of success it is absolutely fundamental to employ Aboriginal staff and these staff need to be able to engage with mainstream staff and the Aboriginal community. Examples of good practice at GVH include the joint home visits undertaken by Aboriginal and non-

Aboriginal staff when visiting Aboriginal clients and patients. Medical students also visit Rumbalara with the AHLO.

- GVH has AHLOs in specified positions but also have Aboriginal people in mainstream positions. When GVH employs AHLOs they are required to have local community knowledge and are seen by management as a key investment for the organisations.

Useful suggestions

- GVH may consider establishing an intranet site focused on Aboriginal health including contact information on Aboriginal organisations and information regarding AHLO role.
- To improve community understanding of the emergency department GVH might consider inviting Aboriginal Health Workers to tour ED and outline how it operates.
- The plan to develop an Indigenous garden with a mural is seen as a positive development.
- GVH to consider developing strategies so that the Aboriginal health outcomes agreement is more widely known across all staff teams and departments.
- Royal Children's Hospital Case Study 1st September 2008.

Royal Children's Hospital

Researchers

Angela Clarke and John Willis

Introduction

These notes are a summary of the key points raised from the meetings held with a number of staff across the Royal Children's Hospital (RCH). For a complete list of staff involved please see attached RCH Meeting Schedule.

Notes

Relationship with Aboriginal community

- The Aboriginal Liaison Policy Advisory Committee (ALPAC) has been the key structure for RCH's relationship with the Aboriginal community and provides a voice for the community at the hospital. There is representation from both the community and hospital on the committee and all hospital policies/programs relating to Aboriginal families must be discussed and endorsed at a committee meeting. ALPAC is co chaired by a Koori and non- Koori and at times meets at a Koori organisation, usually with the RCH Aboriginal Emotional Wellbeing committee. ALPAC raises awareness within the hospital, has influence particularly with the CEO and is effective at an organisational level. The minutes and agendas for ALPAC meetings are always sent to Aboriginal organisations. One key area that ALPAC works on is to use hospital language to embed Aboriginal policies within the hospital.
- RCH has had key Aboriginal leaders involved in its work for many years, including Uncle Kevin Coombs and Aunty Joy Murphy who have participated in many significant events at the hospital.

Local Koori elder Aunty Joy, through her relationship with the hospital, has fostered senior executives' cultural awareness and feeds on their need to know when appropriate.

- RCH has developed a strong partnership with the Victorian Aboriginal Health Service and this has assisted in establishing a fast tracking system for Aboriginal patients attending outpatient appointments. This initiative also became achievable because the outpatient manager was open to the idea and knew that management would support such an initiative.
- RCH consultation with the Aboriginal community often happens through the Koori staff at RCH who consult with the Community when something arises, like the new model of care clinic. RCH Koori staff went out to Community to consult around the ideas to see if the Community supported the new model of care and confirmed their support as well as adding extra ideas of their own to further improve the model. Koori staff often consult with the Community and they receive feedback in a variety of ways. Informally, Koori staff often attend Community events where Community members will comment on the service provided by the hospital. Formally, staff will meet with service providers at their organisation or service to consult on future programs or possible initiatives.
- RCH mental health services signed a MOU with the Victorian Aboriginal Health Service several years ago and this agreement has guided developments between the two agencies. Now the mental health area is working closer with ALPAC so there is a closer working relationship between mental health and the acute areas across RCH regarding Aboriginal health consultation and development.
- RCH is the only hospital in Australia to have an agreement with Aboriginal Hostels Inc to provide accommodation for Aboriginal families whose children are attending hospital. The Kevin Coombes Hostel is located on RCH property with accommodation and support services provided by Aboriginal Hostels Inc. The opening of the Kevin Coombes Hostel was seen as a significant marker to the hospital as a way of demonstrating commitment to Aboriginal health.

CEO/Board commitment and clinical champions

- RCH has strong CEO and executive support for Aboriginal health with approval to work across the organisational structure. The executive director responsible for Aboriginal programs reports monthly to CEO on developments. The RCH Board has also asked about the focus on Victorian Aboriginal issues. The Chair of the Board is very supportive and ALPAC invites the chair and the board to all cultural events within RCH.
- The Aboriginal program at RCH has benefitted greatly from senior medical staff who have had experience travelling and working in Aboriginal communities across Australia. This has also involved medical staff taking sabbatical leave and working in other Aboriginal units in hospital in other cities.

Policy and strategic environment within the hospital

- RCH has had a long history and acceptance that Aboriginal health is part of core business for the organisation. This is outlined in the ALPAC vision statement.
- RCH has an executive director responsible for all Aboriginal program developments who is actively involved in Aboriginal health and this assists in his role of clearly articulating to other executive members what is required.

- Every year non-Aboriginal staff member at RCH are responsible for organising events for Sorry Day. This activity attracts a high number of staff from a lot of different departments every year. The acknowledgement and celebration of different Aboriginal cultural days contributes to staff awareness around Indigenous issues.
- RCH has undertaken a number of reviews of its program including a review of attendance rates for outpatient appointments and also an historical review culminating in a comprehensive report entitled “Lookin’ after our own”. This report documented the history of the Aboriginal health program at RCH, outlining the culture and evolution of the program along with a program review. This report included feedback and stories from Koori patients, staff, elders and community members.
- RCH is currently developing a new model of care for Aboriginal children and their families and will involve the creation of a new paediatric clinic specifically for Aboriginal patients. The funding for this initiative was supplied by the RCH Foundation who was influenced by CEO and Board in making this decision. The governance structure for the clinic will include a dual reporting line to both an executive director and a senior medical staff member. This new model of care will incorporate an evaluation framework that is currently being developed in partnership with Onemda, Vichealth Koori Health Unit, University of Melbourne. This new model of care will be more holistic and focus not just on the physical issues but also other issues including looking at other family siblings as well. Key outcomes expected from the clinic include an increase in number of Aboriginal patients attending, earlier presentations, that families more readily follow through a course of treatment and parents taking on guidance more readily. The development of the new model of care has assisted in raising the awareness of Social Work staff, which now includes Aboriginal in staffs’ professional development.
- Through the development of cultural awareness training for Occupational Therapists, RCH has connected with Monash University to assist in the development. Currently RCH is developing an online cultural training package that will be accessible to all staff whether part- or full-time as they will be able to access it at their convenience. RCH will gain feedback from staff regarding the package and make changes as required.
- The normal risk management tool used by staff (Risk Man) is not suitable for reporting culturally inappropriate behaviour so Aboriginal staff deal with these complaints informally and report back to management when issues require system or process changes.

Aboriginal workforce

- The Aboriginal Family Support Unit employs a number of Aboriginal staff including the Aboriginal Community Development and Policy Officer (ACDPO), Koori Hospital Liaison Officers (KHLO’s), Clinic co-ordinator and the Aboriginal Administration and Outpatient Support Worker (AOSW). These roles ensure that Aboriginal families and program and policy developments are undertaken in a culturally sensitive manner and provide valuable cultural role modelling to other staff across the organisation. The RCH also employs a Koori Mental Health and Wellbeing Worker who, in response to feedback from Aboriginal organisations about the perceived lack of access to mental health services at RCH, now visits patients and families at Aboriginal organisations. Aboriginal cultural awareness is now also part of mental health staff position descriptions and part of the partnership agreement that the RCH Mental Health program has with the Community.

- The AOSW role is given a weekly printout of outpatient appointments for Koori families and rings all outpatients four days before their appointment to remind them and if necessary to assist with transport or accommodation. If they do not attend the AOSW will then follow up these patients, discuss any issues and make a new appointment time if appropriate. This system has significantly reduced the number of Do Not Attends for Aboriginal patients.

Useful suggestions

- RCH should consider Aboriginal health representation on the Quality Assurance/Control committee which reports directly to CEO/Board to ensure that Aboriginal health is maintained as a priority.
- The RCH ALPAC should consider the following policy options:
 - Review the current ALPAC structure and operations with a view to increasing involvement of the Aboriginal community and increase involvement from both nursing and medical areas.
 - Approach the RCH Quality Unit and inviting them to be part of the committee.
 - Develop an Aboriginal action plan overseen by ALPAC that incorporates all current developments with associated actions and responsibilities and regular reviews.
 - Invite HR to be part of ALPAC and discuss option of HR including Aboriginal health as part of orientation program for all new staff ALPAC to consider policy option that completion of the new online training module is made mandatory for all staff and monitored by Quality Unit similar to Fire Safety training.
 - Approach the Medical Staff Association at RCH and invite them to join the committee as they have a strong influence of hospital policy.
 - Allocate specific resources to ensure that cultural awareness training is delivered effectively across the organization.
 - Provide cultural awareness training to all executive staff.
- The state policy regarding hospital boards currently does not mandate Aboriginal health as a portfolio area and it was suggested that this would be a useful development. RCH to consider this option.
- The current state service contract with hospitals does not include Aboriginal performance indicators and it was suggested this might be a useful development.
- At present there is no known remuneration for Aboriginal organisations to train doctors. The federal department OATSIH should consider this as an option. State and federal government could also consider providing incentives for medical people to do sabbaticals in Aboriginal health in Victoria and across Australia. NHMRC could consider funding doctors to undertake MD or PhD in Aboriginal health. Federal government to consider funding rotations for doctors to Aboriginal community controlled organisations across the country.

Appendix Five – Phase IV Introductory Session – First site visit

1. Where did the project come from?
 - a. Need for improved cultural sensitivity
 - b. CQI is a known technology for change
 - c. CQI is also known as Safety and Quality

2. What is the project trying to achieve?
 - a. A clear process for hospitals to follow to improve their performance in serving the Aboriginal community

3. What is involved generally?
 - a. Quality improvement committee
 - b. Aboriginal staff
 - c. Data collection
 - d. Training

4. What support is available from the project team?
 - a. Phone and email contact during the project
 - b. Reviewing of project plans
 - c. Training for Aboriginal staff
 - d. Two on-site visits from Aboriginal and non-Aboriginal researchers

5. What does the project team need from you (the hospital)?
 - a. Feedback on the process and the tools

6. What is the level of involvement you have with the Aboriginal community?
 - a. Formal and informal
 - b. Any feedback process

7. What will be gained from your involvement?
 - a. An improved approach to Aboriginal health
 - b. Improved understanding of the issues facing Aboriginal patients
 - c. An understanding of an effective QI process that brings about real change for the Aboriginal community

8. Why your involvement is an investment?
 - a. Because you will learn a process that will assist you in all future quality improvement projects you may get involved with.
 - b. Because you will be part of the change process to bring about improved culturally sensitive hospital services for the Aboriginal community

9. Timelines for the project
 - a. First site visit approximately two days
 - b. Second site visit in 3 months time
 - c. Complete project and final report due by November 2009

10. How will the results be used?
 - a. Value to you
 - b. Value to Aboriginal community
 - c. Input into policy creation

Appendix Six - Phase IV Feedback Session – Second Site Visit

General questions:

1. Did you find the resources useful? If yes, how and why? If not, why not?
2. How did you use the resources?
3. Was the format user friendly or should the information be presented in a different format?
4. Was the 9 stage process as outlined in the draft toolkit useful/understandable? Should it be simplified or expanded?
5. Were the case studies useful? Did the case studies have the right amount of detail? Would it be useful to include some interactive case studies like on a website to guide readers thorough the process? Should a DVD be considered?

Process	Questions
1 Aboriginal people's experience of hospital care	a) Was there enough detail about the Aboriginal quality improvement role? b) Is more information required about the training and what is involved?
2 Hospital seeks information on Aboriginal patient experience	a) Was the information provided useful to working with local Aboriginal health organisations? b) What other resources would you include to improve the connection between the hospital and the Aboriginal community?
3 Information is given to hospital Quality Improvement Committee (QIC)	a) In understanding the unique pressures associated with being an Aboriginal staff member within the hospital environment, was the information provided detailed enough? b) Do you know of any other information that could be added? c) Is there any specific information that should be added for your state or territory?
4 QIC examines information from Aboriginal staff	a) Was the information provided to Quality Improvement committee including guidelines and role statements targeted at the right level with enough detail? b) Was the information on supervisors adequate?
5 QIC seeks to understand information from a cultural perspective	a) Did the process of gaining cultural feedback make sense? b) Was the justification outlining why this is necessary outlined clearly enough?
6 QIC seeks to develop culturally appropriate solution	a) Any comments or suggestions on what information and how it might be presented for this section?
7 Proposed solution is agreed to by all key stakeholders and implemented	a) Were the case examples useful? Should there have been more? b) Should there have been information about stakeholders along with examples?
8 Aboriginal hospital experience assessed again to see if improvement has occurred	a) Were there enough examples of program reviews and how these were undertaken?
9 If strategy successful implement changes in policy	a) Any comments or suggestions on what information should be included in this section?

Appendix Seven - Development, delivery and evaluation of Aboriginal staff in hospitals training program

Background

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Education and Training Unit was contracted to provide a five-day residential training program to Aboriginal Hospital Liaison Officers⁴ (AHLOs). The AHLOs were employed in health services that were participating in the ICHP conducted by La Trobe University, the Cooperative Research Centre for Aboriginal Health, the Aboriginal Health Council of South Australia and Onemda (VicHealth/Melbourne University).

VACCHO's project brief was to deliver a program based on two units of competence, identified by the ICHP team after consultation with the Community Services and Health Industry Training Advisory Board. The units were from the Community Services Training Package (CHC02). Initially, the program was intended to be based on a unit of competence developed especially for AHLOs. However, this unit had not been finalised and was therefore not available. The two units eventually decided as the basis for the program were:

- CHCORG19B – Develop and maintain the quality of service outcomes; and
- CHCPOL4A - Develop and implement policy

Note: These two units have since been superseded with the implementation of the latest version of the Community Services Training Package – CHC08; however, transition arrangements articulated in the Victorian State Purchasing Guide indicate equivalence.

The VACCHO Education and Training Unit had previously delivered the policy unit and other units based on quality/continuous improvement through the Diploma of Practice Management qualification.

Identifying Participants

Five mainstream health services participating in the ICHP were nominated by the research project team to provide participants. The services nominated to provide participants were Katherine, Derby, Campbelltown, Mater Brisbane and Royal Brisbane & Women's Hospitals. Hospitals from each State/Territory jurisdiction were required to nominate two representatives /AHLOs to attend the training program, resulting in five 'teams of two' AHLOs attending the program. This meant that some participants were nominated from sites not previously involved in the project including Darwin, Liverpool and Fitzroy Crossing. In most instances the nominees worked at separate sites and, while known to each other, didn't necessarily share the same roles, responsibilities or objectives. Consequently, this may have had a slightly negative impact upon the program in terms of the participants being familiar with each other prior to the program but not having a common understanding of organisational processes relating to quality and policy input.

⁴ This term is used generically for reporting purposes. It is recognised that the title of participant positions varied in different jurisdictions.

Program Development

Development of the training program was guided by an advisory group comprising the ICHP manager, an Onemda representative and the VACCHO ETU Manager. The final program was structured to include a balance of facilitated course work, guest speakers, site visits and social activity (see *Appendix 1: Timetable*).

VACCHO appointed a Senior Project Officer to prepare the course materials (Learner Resources and assessment materials) and coordinate the program in consultation with Advisory Group representatives.

The VACCHO ETU project team developed learning and assessment resources and materials that were contextualised to the specific Aboriginal Hospital Liaison Officer setting and linked these to the models of quality improvement and service development promoted through the ICHP “Toolkit”.

The development process included consultation with a number of AHLOs (and former AHLOs) employed in mainstream health services in Victoria to ensure that examples and activities were relevant. Program development also took into account the fact that hospitals participating in the ICHP were undertaking or developing local quality improvement projects. The training program endeavored to link learning activities with those projects, particularly through incorporating partial assessment based on workplace activities undertaken as part of the overarching quality improvement project and research.

It was recognised that not all hospitals were directly involved with the ICHP and that participants would have varying levels of experience with the topics presented. Consequently, course development adopted a reasonably generic approach to the subject material in recognition of the diversity of knowledge and experience within the training group.

Key elements of the competency standards for the “manage quality” unit include:

1. Evaluate outcomes for clients accessing the service.
2. Plan and implement changes/strategies to improve outcomes.
3. Ensure client service standards and codes of practice.
4. Manage quality assurance processes.

Course work activities in the Learner Resource were linked to the required performance criteria of those standards and included consideration of:

- organisational mission/vision statements and the influence of those on service development and delivery
- activities undertaken within the workplace to increase cultural appropriateness
- actions undertaken to obtain patient feedback on services, including patient satisfaction surveys
- the role and responsibility of individual workers in promoting cultural awareness
- quality improvement processes and an introduction to the “Plan-Do-Study-Act” quality improvement cycle.

Key elements for the “develop and implement policy” unit include:

1. Research and consult with others to develop policies.
2. Test draft policies.
3. Develop policy materials.
4. Implement and review policies.

Course work activities in the Learner Resource were linked to the required performance criteria of those units of competence and included consideration of:

- external and internal policy ‘drivers’
- identification and assessment of existing workplace policy, where available
- identification of key stakeholders, including community groups
- model policy formats and drafting policy documents.

In developing the course materials it was recognised that the time allocated to face-to-face delivery would be insufficient to ensuring participants developed all the skills and knowledge required and outlined in each unit of competence. It was decided, and as is common practice in competency-based training and assessment in the vocational education and training sector, to ensure that a level of learning on-the-job was included as a vital and contributing factor towards enabling candidates to demonstrate competence over time.

Additionally, follow-up and on-the-job interviews were incorporated into the program. Face-to-face interviews with participating AHLOs and their workplace supervisors provided an opportunity to collect evidence of competence and gain detailed feedback and evaluation about the course to complement written feedback. It also provided an opportunity to observe the application of the training within a workplace and cultural context.

Course presentation

The program was presented over five days commencing in June 2009. Participants arrived in Melbourne on Sunday 21st and were picked up from the airport and taken to their accommodation/course venue by the ICHP manager and the VACCHO ETU program coordinator.

The larger part of the program focused on the quality improvement unit. These sessions were facilitated by Ms Karen Milward, a Yorta Yorta woman and consultant with extensive experience in a wide range of Aboriginal health services, service development and management.

Delivery of the sessions for the policy unit was facilitated by the VACCHO ETU program coordinator. The overall program included presentations by a range of AHLOs, social workers and quality improvement personnel from hospitals in Victoria. These subject matter experts were selected to provide information from their own work sites and individual experiences that were directly related to particular areas of the syllabus (see *Appendix 1: Timetable*).

The program was delivered using a blend of facilitated discussion and ‘pedagogic’ sessions structured to follow the learners’ resource books, and to ensure that core information was addressed and specific assessment tasks were undertaken within the sessions.

Participants demonstrated a range of experience within the group and varying familiarity with the presented concepts. Throughout the week they were actively encouraged to share their own experiences and knowledge of current and relevant aspects of quality and policy processes, and to ensure that the principles of adult learning were incorporated and blended throughout the program.

Evaluation

A course evaluation sheet was distributed at the end of the face to face delivery component of the program. This evaluation sheet sought feedback on program materials, presentation and organisation (see *Appendix 2: Short Course Evaluation Summary*).

In general, participants rated course materials, course delivery and course presenters quite highly (between 4.0 and 4.4 for most aspects – the Likert scale being 1 = low, 5 = high). Interestingly, participants rated AHLO guest presenters slightly more highly than non-Indigenous presenters. Non-Indigenous presenters were recruited into the program by VACCHO ETU because of their current roles and experience of quality issues in mainstream health services or other relevant organisations).

Participants identified aspects of the program that did not meet their expectations as:

1. Site visits (Royal Children’s Hospital Aboriginal Liaison Unit and Ballarat Aboriginal Cooperative/Health Service).
2. Provision of pre-course information.

The latter was largely due to the fact that, despite being contacted individually prior to attendance and being sent an overview of the program including a timetable and details of materials required for program activities, there had been problems with participants receiving emails or there were difficulties contacting them by telephone (see *Commentary p8*).

Program information was also distributed to workplace supervisors. However, a number of the participants came from sites not directly involved in the ICHP (Darwin, Liverpool and Fitzroy Crossing). This meant that some supervisors and participants had limited sense of the context for the training and were not undertaking specific related quality improvement projects.

Anecdotally, during the subsequent site visits by the VACCHO ETU Program Coordinator, most participants reported that they had enjoyed the experience and found it mostly useful. In all cases the collegial approach taken for the program had engendered a strong sense of support and an informal network among the group (most have continued to contact each other via email).

Site visits/3rd Party Assessments

Site visits to conduct workplace assessments and supervisor interviews were conducted through August, after sufficient time had elapsed for course participants to demonstrate application of knowledge and skills and to provide ‘evidence of competence’.⁵ Most of these visits were undertaken concurrently with visits by the ICHP team meeting with key hospital staff, and included interviews and a formal assessment process with course participants and informal interviews with their workplace supervisors.

In most cases there was clear evidence that some aspects of the training were informing their workplace activity, and some participants appeared to have gained significant insight into the possibility that they could contribute to changing ‘the culture of hospitals’, despite their relatively low status in the hierarchy of their workplace.

“Manage quality” unit of competence

It is notable that almost all supervisors interviewed commented on the fact that AHLOs had returned from the course with a better understanding of quality systems and with ideas about how they could advocate for change through those processes. In one instance the supervisor noted that the trainee had returned with the realisation that he had to engage with management and quality improvement personnel in order to effect change in service delivery, whereas previously he had not felt in a position to do so.

It was clear from these visits that a number of participants had limited contact with the quality improvement systems and processes in their workplace, but that steps had been taken to initiate activities following course delivery. Examples of this include:

- At Derby Hospital the ICHP had prompted the Quality Improvement Team to review involvement of the Aboriginal Liaison Officer and the trainee had prepared a PDSA cycle with the objective of increasing responsiveness of the QIT to Aboriginal Liaison input.
- At Campbelltown Hospital the AHLO has become a member of the Quality Improvement Committee, which in turn had developed a support plan for her.
- At Brisbane Mater Hospital it was reported by her supervisor that the AHLO has become more strategically involved in linking service issues to the quality improvement process.

All but one participant provided sufficient evidence to fulfil the requirements of the quality improvement unit of competence. This participant had not completed the training course due to illness and was still off work at the time of the visit.

In one instance the supervisor (Quality Improvement Program) noted that there was limited opportunity for the trainee (or any AHLO) to feed directly into the quality improvement process, stating that it would

⁵ ‘Evidence of competence’ is a key factor in assessment in vocational education and training. It emphasises a distinction between ‘knowledge’ and ‘skills’. The ‘short course’ nature of this training program meant that those skills needed to be demonstrated in the workplace in order to assess competence.

normally be their manager or someone ‘higher up’ who would provide input: the ‘AHLO might be consulted’ but was not necessarily considered integral to service development.

“Develop and implement policy” unit of competence

It is notable that few of the hospital sites visited appear to have specific policies relating to the role of the AHLO, apart from generic employment policy or compliance with broad ‘multicultural’ accreditation standards. Participants from the Royal Brisbane and Women’s Hospital noted that it is guided by State Government policy regarding the provision of cultural awareness training for employees. This appears to be one of the few instances of an existing policy that informs the role of Aboriginal staff in mainstream services and encourages those organisations to deliver culturally appropriate health services.

The requirements for completion of this unit include demonstrating evidence of policy design, consultation and review after implementation—processes which cannot be expected to be completed within a short time-frame, especially given the limited capacity of many AHLOs to engage with workplace policy development processes. Accordingly, the VACCHO ETU program coordinator will continue to liaise with participants until the end of the academic year in order to complete this unit.

One course participant was able to provide sufficient evidence to satisfy the requirements of the policy unit of competence. This was largely due to her involvement in a range of activities outside of her employment role. In particular, she was able to demonstrate policy management in her capacity as a board member of an Aboriginal Legal Service and is currently involved in an amalgamation of two sites – a process which requires significant policy and procedural review.

Another two participants advised of their intention to submit evidence demonstrated in other settings that meets this unit of competence, thus satisfying the requirements of the unit of competence through recognition of prior learning and recognition of current competence demonstrated in a voluntary, community-serving role.

A number of the participants have been able to work with their supervisors and quality improvement systems to commence developing relevant policies. For example, the AHLOs at Campbelltown and Brisbane Mater hospitals have initiated discussion with their quality improvement committees to develop policy regarding Aboriginal identification.

In Fitzroy Crossing the AHLO proposes to work with the Director of Nursing and senior social worker to revise and update the organisation’s cultural awareness training policy and procedures.

These actions undertaken following the training program, while being incomplete or inconclusive at the time of reporting, suggest that the introduction of the unit has at least provided training participants with the knowledge and some confidence that they are able to work with appropriate groups and individuals within the hospital to effect longer term change.

Commentary

It is understood that the ICHP had completed several stages prior to the commencement of the training program. However, the selection of sites for this component (Phase IV), along with extra sites nominated by jurisdictions and not previously directly involved in the ICHP, meant that participants had varying degrees of understanding and engagement with the project.

While the training program appears to have been reasonably successful in terms of increasing the AHLOs' understanding of and capacity to contribute to quality improvement processes it has had limited short-term success in terms of providing evidence of involvement in policy development in their roles.⁶

It is apparent that in most instances the AHLO position does not have particularly high status in terms of where they sit in the organisation and their formal involvement in organisational quality improvement committees. Their roles are largely 'hands-on', providing assistance for patients to negotiate hospital systems. It would appear that targeting AHLOs to participate in the process of changing organisational culture is likely to be a positive factor, but hospitals need to ensure appropriate support mechanisms as highlighted by the ICHP in Phase III.

The ICHP was at widely different stages of implementation at each of the hospitals and not all sites were directly involved. At sites where the project was relatively advanced (e.g. Campbelltown, Royal Brisbane & Women's) there appeared to be high levels of support for the trainees. However, the same degree of support or commitment was not evident at hospitals not involved in the project (e.g. Darwin, Fitzroy Crossing, Liverpool). Establishing a uniform context may have provided a more meaningful dimension to the AHLO training and promoted higher levels of motivation and capacity to initiate action post-training.

With hindsight, the 'teams of two' approach taken may not have been the most effective strategy. It was important for participants to be culturally and socially supported through having an Aboriginal 'buddy' for the training and support, but it may have been more effective for that support to be another person from the same site and with a complementary role (e.g. another AHLO or a supervisor/manager) in order for specific follow-up actions to be taken in their workplace.

It is considered that seeking the involvement of and support by AHLO workplace supervisors (e.g. quality improvement officers,) may have provided a significant benefit for the participants. This would represent a stronger commitment by the organisation to the program, indicate a familiarity with the overarching research project, and could lead to a stronger link between the role of the AHLO and the decision-making processes within the hospital. It is recognised by the VACCHO ETU that Aboriginal workers in mainstream organisations require both cultural and organisational support.

⁶ This finding supports the evidence of how CQI technology is applied as indicated in the ICHP literature review. The process commences with specific quality improvement projects and after the successful completion of the quality improvement cycle the final stage is the implementation into policy. Taking a CQI approach is taking a long term but effective approach to policy development.

It is apparent that the majority of participants had the support of their supervisors to take a larger role, but the practical and immediate nature of their day-to-day duties can be an impediment to addressing more developmental or conceptual activities. The training would most likely have greater impact in the workplace when participants are supported to participate in and influence decision-making processes around continuous improvement and related policy-making processes.

While perhaps strategically appropriate, the choice of the two diploma level units may not have been the best option offered to participants. In other settings these units would typically be geared to managers or managerial aspirants. Given the range of knowledge, experience and opportunity to influence hospital systems within the group there may have been benefit to offer lower level training with a more practical focus, perhaps including:

- CHCORG423A – Maintain quality service delivery
- CHCPOL402B – Contribute to policy development
- CHCPOL403B – Undertake research

(See Appendix 3: Unit descriptors)

These units offer similar content, but remove the expectation that participants actually **lead the processes** (in line with Australian Qualifications Framework level descriptors) and may result in a program that more realistically aligns to the AHLO role and function.

Contact with prospective participants and their supervisors was difficult prior to delivery of the training program, largely due to the remote location of some sites and the inefficiency of technology (limited email access and mobile phone reception). This resulted in some degree of misunderstanding about the course requirements and also limited the capacity of the program coordinator to ascertain prior learning. Adjusting the program structure to accommodate a higher level of contact with participants prior to commencing delivery would improve orientation to the program. This emphasis prior to commencing training would ensure that information about individual participants (e.g. life and work experience, existing qualifications and actual job roles) could be collected and that a meaningful self-assessment could take place.

Recommendations

If such a program were to occur again it is recommended that:

1. A more refined training needs analysis should be undertaken prior to training program development.
2. Units of competence on which the program has been based should be reviewed, with a particular focus on reducing the emphasis on management level units for AHLOs.
3. Recognition of Prior Learning processes should be more rigorously applied.
4. Senior hospital personnel involved in the ICHP should be encouraged to become more engaged in the training program in order to foster greater support and shared commitment to undertaking hospital-based projects.

5. The program should establish specific work-based projects, and require senior hospital staff and/or management to concurrently mentor the AHLO throughout the process. This could result in the completion of a unit of competence related to working effectively with Aboriginal and/or Torres Strait Islander people (HLTHIR404B).
6. The training program should be conducted in two separate workshop clusters, with the first providing foundation skills and knowledge, and establishing group interaction and the opportunity to negotiate work-based projects; and the second cluster providing the opportunity to report on progress with the work-based project and review learnings. This would alleviate the pressure of an intensive short course and ensure learning would be reinforced by specific workplace activities.
7. The incorporation of e-learning and other information and communications technology into the promotion and delivery of the program would increase access to support and information for participants and host organisations and enable a more cost and time effective delivery.
8. The pricing of the program to be reviewed to allow for identified improvements.

Short Course: Improving the Culture of Hospitals: Timetable

Sunday – arrive Melbourne. Pick up at airport, take to accommodation

	9 – 10.30 am	11 - 12.30 am	1.30 – 3 pm	3.30- 5 pm	6 – 9pm
Monday 22	Welcome to Country Introduction and orientation to program (VACCHO)	Course work <i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i> <i>CHCPOL504B – Develop and Implement Policy</i>	Course work <i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i> <i>CHCPOL504B – Develop and Implement Policy</i>	“Case Study” Short presentation describing your workplace “project” within the context of quality improvement.	Social dinner (venue tbc)
	Overview of quality improvement: terminology, framework in the hospital setting (Marilyn Sneddon– ACHS)				
Tuesday 23	Quality service and hospital accreditation processes (Danielle Moss – St Vincent’s Hospital)	Quality service – making the systems work (Michelle Winters– St Vincent’s Hospital)	Links between the hospital, health services and the community (site visit – Ballarat)	Links between the hospital, health services and the community (site visit – Ballarat)	Dinner – Ballarat <i>Guest speaker – Karen Heap CEO Ballarat Aboriginal Cooperative</i>
	The workplace – a who what when and where view of quality improvement (Bonnie O’Shannessy – Bairnsdale Hospital)	Course work <i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i> <i>CHCPOL504B – Develop and Implement Policy</i>	Course work <i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i> <i>CHCPOL504B – Develop and Implement Policy</i>		

MORNING TEA

LUNCH

AFTERNOON TEA

Thursday 25	<p>Hospital activities to improve health outcomes for Aboriginal communities</p> <p>(Jane Middleton/Michelle Donovan – Mercy Hospital)</p>	<p>Course work</p> <p><i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i></p> <p><i>CHCPOL504B – Develop and Implement Policy</i></p>	<p>Course work</p> <p><i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i></p> <p><i>CHCPOL504B – Develop and Implement Policy</i></p>	<p>Developing culturally appropriate services</p> <p>(site visit – Royal Children’s Hospital – Wadja Health Clinic)</p> <p>Social activity or free time (tbc)</p>
Friday 26	<p>How Aboriginal health fits into a quality framework</p> <p>(Michelle McKinnon- – Dept Health SA)</p>	<p>Course work</p> <p><i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i></p> <p><i>CHCPOL504B – Develop and Implement Policy</i></p>	<p>Course work</p> <p><i>CHCORG619C – Manage quality of organisation’s service delivery outcomes</i></p> <p><i>CHCPOL504B – Develop and Implement Policy</i></p>	<p>“Case study/Course work”</p> <p>Presentation, review, feedback, wind-up</p> <p>MCG – football (Carlton v Essendon)</p>
<i>Saturday – depart Melbourne</i>				

Short Course Evaluation Summary

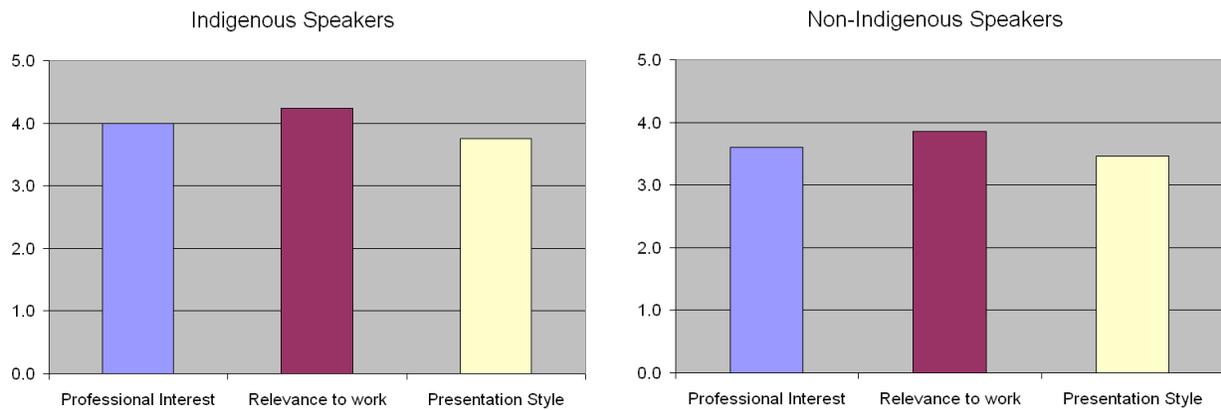
*It should be noted that the variation in results were very slight, therefore caution should be used when reading into detail of this evaluation.

1. Participants were asked to rate their opinion from 1 to 5 with 1 being the lowest if the short course achieved the following objectives based on quality service provision and outcomes for Indigenous patients in hospitals.

Objective	Averages
a) To consider frameworks currently in place for ensuring quality service provision and outcomes for Indigenous patients in hospitals	4.0
b) To identify relevant workplace policy and procedures that aim to ensure quality service provision and outcomes for Indigenous patients in hospitals	4.0
c) To develop recommendations and strategies that can be taken back to the workplace to improve quality service provision and outcomes for Indigenous patients in hospitals	4.2

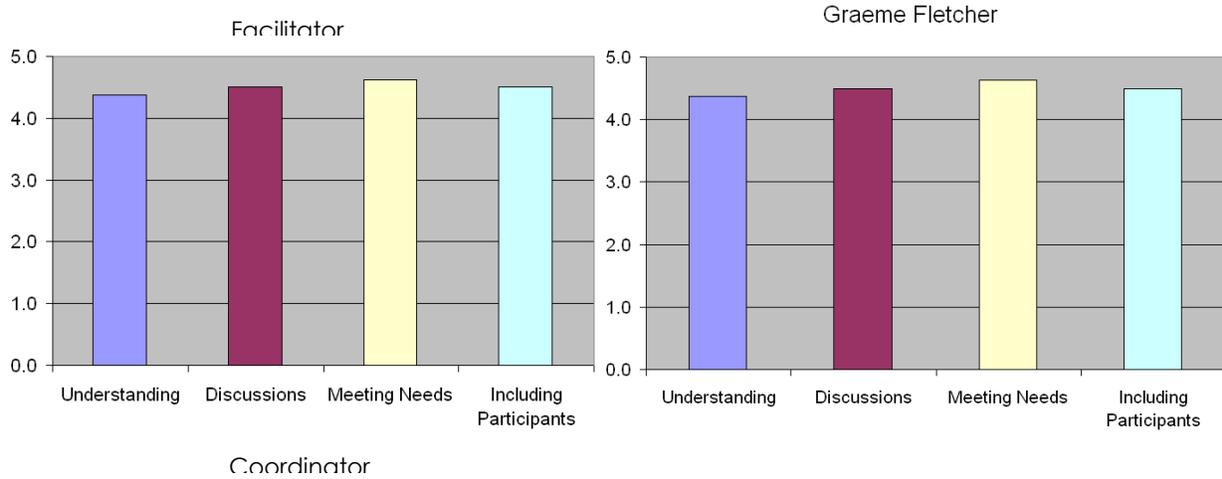
2. Participants were asked to rate the guest speakers from 1 to 5 with 1 being the lowest.

Averages:



3. Participants were asked to rate the program facilitator and the program coordinator from 1 to 5 with 1 being the lowest.

Averages:



4. The Learner Resource books were rated from 1 to 5 with 1 being the lowest.

Learner Resource Books	Averages
Ease of understanding	4.1
Relevancy	4.4
Usefulness	4.4

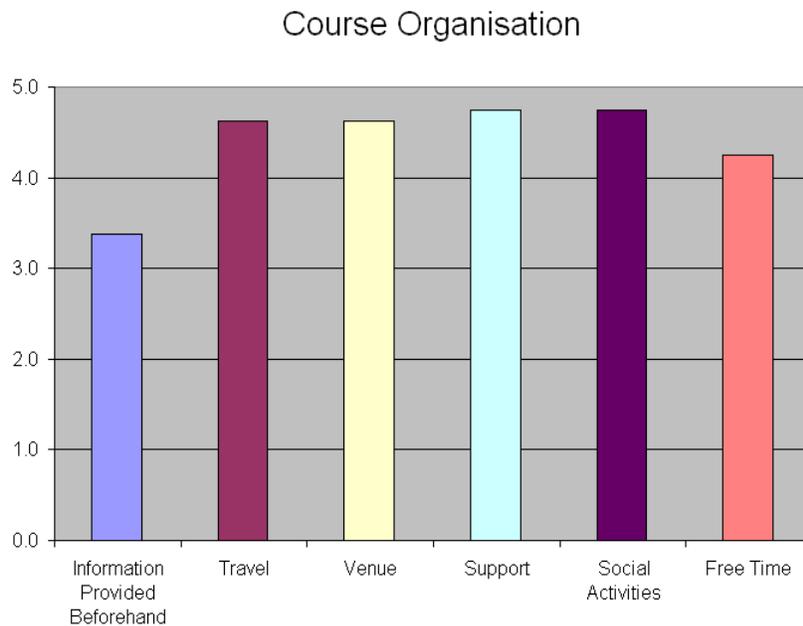
5. The site visits were rated from 1 to 5 with 1 being the lowest.

Site Visits	Averages
Ballarat Relevancy	4.0
Ballarat Usefulness	3.8
Royal Children’s Hospital Relevancy	3.4
Royal Children’s Hospital Usefulness	3.5

*It should be noted that the program at Ballarat altered due to non-availability of speakers on the day. Therefore caution should be used when reading these results.

6. Participants were asked to rate course organisation from 1 to 5 with 1 being the lowest.

Averages:



*Please take note that the information provided beforehand was rated lowest and may require further consideration when planning for future training courses.

Participants would have liked more of:

- Free time and social activities.

Participants would have liked less of:

- Cold weather.

7. Other comments:

Overall, the course was useful.

Unit Descriptors

Source: Australian Qualifications Framework Implementation Handbook 2007 (Guidelines, p33)

Table 8: Distinguishing Features: Certificate IV and Diploma

Certificate IV	Diploma
Do the Competencies enable an individual with this qualification to:	Do the Competencies enable an individual with this qualification to:
demonstrate understanding of a <i>broad knowledge base incorporating some theoretical concepts</i>	demonstrate understanding of a broad knowledge base incorporating theoretical concepts, <i>with substantial depth in some areas</i>
apply solutions to a <i>defined range of unpredictable problems</i>	<i>analyse and plan approaches to technical problems or management requirements</i>
<i>identify and apply skill and knowledge areas to a wide variety of contexts with depth in some areas</i>	<i>transfer and apply theoretical concepts and/or technical or creative skills to a range of situations</i>
<i>identify, analyse and evaluate information from a variety of sources</i>	evaluate information using it to <i>forecast for planning or research purposes</i>
take responsibility for own outputs <i>in relation to specified quality standards</i>	take responsibility for own outputs in relation to specified quality standards
take <i>limited responsibility for the quantity and quality of the output of others</i>	take some responsibility for the <i>achievement of group outcomes</i>

Note: In Table 8 italicised words emphasise distinguishing features of the competencies between qualifications. In order to assist determining the relevant qualification, the most compatible set of features should be selected. Not all features will necessarily apply.

CHCORG423A Maintain quality service delivery

Descriptor

This unit describes the knowledge and skills required to perform work within a legislative and ethical framework to ensure the provision of high quality service delivery which supports the rights and interests of clients.

ELEMENT	PERFORMANCE CRITERIA
<p>1. Demonstrate commitment to the delivery of high quality services to clients</p>	<p>1.1 Demonstrate consideration and understanding of the <i>context</i>, models of service delivery, <i>underpinning values and philosophy of the sector</i> in all work undertaken</p> <p>1.2 Ensure all work undertaken is consistent with relevant <i>current policies and legislative requirements</i></p> <p>1.3 Demonstrate understanding of the <i>issues</i> facing clients and their carers in all work</p> <p>1.4 Demonstrate <i>commitment to access and equity principles</i> in all work in the sector</p>
<p>2. Develop and implement a framework for quality service delivery</p>	<p>2.1 Devise strategies to ensure delivery of high quality services which continue to reflect best practice</p> <p>2.2 Establish and implement <i>protocols</i> and procedures to manage service delivery and reflect best practice work in community services industry</p> <p>2.3 Identify and address <i>barriers</i> in the organisation that impact on delivery of high quality service</p> <p>2.4 Regularly update procedures for managing service delivery to reflect current best practice, relevant legislative changes, and changing client <i>needs</i></p>
<p>3. Monitor and review <i>service delivery</i></p>	<p>3.1 Monitor implementation of <i>strategies</i> to evaluate delivery of services</p> <p>3.2 Review service delivery and revise procedures as required to reflect best practice work</p> <p>3.3 Ensure staff receive necessary competency development to support delivery of current best practice, address relevant legislative changes and respond appropriately to changing client needs</p>

CHCPOL402B Contribute to policy development

Descriptor

This unit describes the knowledge and skills required to develop and analyse policies which impact on the client group and the work of the organisation.

ELEMENT	PERFORMANCE CRITERIA
1. Review existing policies	1.1 Identify relevant organisation and other policies and assess them for relevance to the organisations objectives and effectiveness 1.2 Consult clients and other stakeholders about their views on policies 1.3 Document and present reviews of policies in a format appropriate to the purpose of the review, the context, and the receiver
2. Contribute to <i>research</i> for policy advice	2.1 Identify, plan and implement research and consultation strategies appropriate to the worker's role in the research process within timeframes, resource constraints and agreed processes 2.2 Collate, report and present research and consultation outcomes in a format appropriate to the research process, the purpose of the research, the context and the receiver 2.3 Identify factors impacting on quality or outcomes of research or consultation and incorporate in reports
3. Provide briefing materials on policy issues	3.1 Prepare briefing materials as required in a format appropriate to audience, purpose and context 3.2 Draw on expertise and role of worker and organisation for briefing materials 3.3 Incorporate reasoned argument and evidence into briefing materials

CHCPOL403B Undertake research activities

Descriptor

This unit describes the knowledge and skills required to implement research relevant to operations of the organisation and/or the community.

ELEMENT	PERFORMANCE CRITERIA
1. Prepare a research plan	1.1 Ensure views and interests of <i>stakeholders</i> are reflected in the research methodology and it is compatible with ethical considerations 1.2 Select research methodology suitable to needs, purposes and resources and to maximise credibility of outcomes 1.3 Select and use research strategies appropriate to client group, subject matter being researched, the outcomes sought and the resources available 1.4 Ensure research plan incorporates strategies for validating research outcomes
2. Implement appropriate research strategies	2.1 Determine and allocate resources needed to conduct research 2.2 Ensure collection, recording and storage of all relevant information is timely and will ensure validity, confidentiality and security 2.3 Identify a representative range of people and groups with an interest in the issues and consult them in appropriate ways to ensure validity of outcomes 2.4 Undertake consultation according to agreed practices and protocol of own and other agencies 2.5 Consider cultural sensitivities and ethical issues in all consultation
3. Organise and analyse information	3.1 Organise information in a form that allows analysis and suits the research purposes 3.2 Develop patterns in the data and derive explanations, maintaining validity and reliability

Appendix Eight - Newsletter No. 1 October 2008

Full copy of this newsletter can be found at <http://www.lowitja.org.au/craah/improving-culture-hospitals>

Newsletter No. 1 October 2008

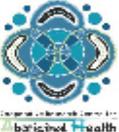
Improving the Culture of Hospitals

A research project that will provide concrete resources to assist hospitals improve the quality and sustainability of services for Aboriginal and Torres Strait Islander patients

Introduction

Aboriginal health is the biggest health issue facing Australia today. Governments have a responsibility to respond to this issue and ensure that the health gap between Aboriginal and non-Aboriginal Australians is closed. The *Improving the Culture of Hospitals* project can provide some of the answers and will develop a range of resources, tools and guidelines to assist hospitals across Australia improve their performance in this important area. The *Improving the Culture of Hospitals* project is funded by the Cooperative Research Centre for Aboriginal Health and project managed by the Australian Institute for Primary Care, La Trobe University with partners The University of Melbourne (Onemda, Vichealth Koori Health Unit) and the Aboriginal Health Council of South Australia. The project is focused on continuous quality improvement in hospitals and how they can improve their cultural sensitivity and imbed a process of cultural reform into their quality improvement processes. This project will support an ongoing reform strategy to ensure sustainability of improvements regarding Aboriginal health in line with the key responsibility of each state and territory jurisdiction.

This newsletter provides a brief summary of the project including the elements of the project, projected outcomes, timelines, the processes undertaken to complete the first round of case studies and those proposed for the trailing of the tools, guidelines and resources in subsequent phases.



Onemda
Vichealth Koori Health Unit

Appendix Nine - Newsletter No. 2 June 2009

Full copy of this newsletter can be found at <http://www.lowitja.org.au/craah/improving-culture-hospitals>

Newsletter No. 2 June 2009

Improving the Culture of Hospitals

A research project that will provide concrete resources to assist hospitals improve the quality and sustainability of services for Aboriginal and Torres Strait Islander patients

exploring success stories

We are pleased to provide this second newsletter, summarising progress of the *Improving the Culture of Hospitals* project. In this edition, we focus on the outcomes from Phase III, which included documenting the elements of successful practice provided by a group of hospitals to their Aboriginal and Torres Strait Islander¹ population.

What is the background?

The health status of indigenous peoples is a global concern with mortality and hospitalisation data indicating that the health of indigenous groups falls below that of other ethnic groups within their countries.² The Australian Federal Government has acknowledged their responsibility to respond to this issue and ensure that the health gap between Aboriginal and non Aboriginal Australians is addressed. The *Improving the Culture of Hospitals* project is contributing to closing this gap by developing a range of resources, tools and guidelines to assist hospitals across Australia tackle vital cultural reforms which can improve the way they provide services to Aboriginal people.

How are we conducting the Project?

The *Improving the Culture of Hospitals* project is funded by the Cooperative Research Centre for Aboriginal Health and project managed by the Australian Institute for Primary Care, La Trobe University and partner organisations, The University of Melbourne (Onemda, Vichealth Koori Health Unit) and the Aboriginal Health Council of South Australia. The project is guided by an Advisory Committee consisting of representatives from the Aboriginal Health Council of South Australia, The University of Melbourne, St.Vincent's Hospital (Melbourne), La Trobe University, Royal Adelaide Hospital, Government of South Australia (Department of Health), Office of Aboriginal and Torres Strait Islander Health and the Tasmanian Department of Health and Human Services.

What are our aims?

The aim of this project is to examine successful Aboriginal programs undertaken by hospitals, within a quality improvement framework. This information, and the experience of Aboriginal people, will be used to explore what would support replicating and sustaining this type of work across a wide range of hospital environments.

¹ For the remainder of this newsletter Aboriginal and Torres Strait Islander people will be referred to by the term Aboriginal unless using a specific title.

² Wilson D (2003). The nurse's role in improving indigenous health. *Contemporary Nurse*, Oct, 15 (3): 232-40

Appendix Ten - Final Newsletter No. 3 April 2010

Full copy of this newsletter can be found at <http://www.lowitja.org.au/craah/improving-culture-hospitals>

Newsletter No. 3 April 2010

Improving the Culture of Hospitals Project

A research project that has provided concrete resources, within a quality improvement framework, to assist hospitals improve the way they provide services for Aboriginal and Torres Strait Islander patients

What did we find?

We are pleased to provide this third newsletter, summarising the outcomes, recommendations and future activities that have been developed from the *Improving the Culture of Hospitals Project* (IHP). In this edition, we summarise the key findings and recommendations for hospitals, government policy, Australian Council of Healthcare Standards, future research and knowledge transfer activities.

What is the background?

The health status of Indigenous peoples is a global concern, with mortality and hospitalisation data indicating that the health of Indigenous groups falls below that of other ethnic groups within their countries.¹ The Australian Government has acknowledged its responsibility to respond to this issue and ensure that the health gap between Aboriginal and non-Aboriginal Australians is addressed. The IHP is contributing to closing this gap by developing a range of resources, tools and guidelines to assist hospitals across Australia tackle vital cultural reforms which can improve the way they provide services to Aboriginal and Torres Strait Islander people.

How we conducted the Project?

The IHP was funded by the Cooperative Research Centre for Aboriginal Health, now known as the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health (CRCATSIH), project managed by the Australian Institute for Primary Care, La Trobe University along with partner organisations The University of Melbourne (Onemda, Vichealth Koori Health Unit) and the Aboriginal Health Council of South Australia. The project has been guided by an Advisory Committee consisting of representatives from the Aboriginal Health Council of South Australia, The University of Melbourne, St. Vincent's Hospital (Melbourne), La Trobe University, Royal Adelaide Hospital, Government of South Australia (Department of Health), Office of Aboriginal and Torres Strait Islander Health and the Tasmanian Department of Health and Human Services.

What were the aims?

The aim of this project was to examine successful Aboriginal and Torres Strait Islander programs undertaken by hospitals, within a quality improvement framework. This information was used, as well as the experience of Aboriginal and Torres Strait Islander people, to explore what would support replicating and sustaining this type of work across a wide range of hospital environments. The project developed a Framework and Toolkit to assist in facilitating the organisational cultural change required to undertake this work effectively.

Appendix Eleven – Journal Article submitted to ANZAME for publication “Building on success stories from hospitals responding effectively to Aboriginal and Torres Strait Islander communities”

Alwin Chong(1), Russell Renhard(2), Gai Wilson(3), John Willis(4), Angela Clarke(5)

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Key words

Continuous quality improvement, hospitals, Aboriginal, cultural sensitivity, access and equity

Abstract

The continuous quality improvement (CQI) model is widely applied in hospitals in the developed world and is an effective means of improving health service practices and outcomes. Consumer research findings show that the most successful consumer centred reforms involve consumers in all phases of the plan, do, study, act cycle and culturally this is consistent with the expectations of Aboriginal Australians. Hospitals are already using the CQI process but what we argue and evidence shows is that this model will work for cultural standards.

The aim of the *Improving the Culture of Hospitals Project (IHP)* was to develop an evidence-based quality improvement framework (toolkit) for Australian acute health care facilities. This toolkit includes a range of resources, tools and guidelines to support them in designing and implementing a CQI strategy for improving cultural sensitivity as it relates to Indigenous Australians.

Hospital case studies were undertaken to develop, then trial, the toolkit. Training for Aboriginal staff in the use of CQI technology was also undertaken. The draft toolkit, along with the findings from the case studies, was then presented to a national Round Table meeting of senior key stakeholders in health to explore implementation and future research issues.

The findings show that hospitals that have improved cultural sensitivity share a number of characteristics including relationships with Aboriginal communities and commitment to supporting their Aboriginal workforce.

In conclusion, hospitals need senior management to support this work as a priority and to ensure Aboriginal staff are trained to facilitate the process. The inclusion of an Aboriginal specific standard in the Australian Council of Healthcare Standards is also seen as a key driver to assist change.

Introduction

The *Improving the Culture of Hospital Project* (ICHP) was funded by the Cooperative Research Centre for Aboriginal Health, project managed by Latrobe University and implemented in partnership with The University of Melbourne (Onemda, Vichealth Koori Health Unit) and the Aboriginal Health Council of South Australia. The project was also guided by an Advisory Committee consisting of representatives from the **Aboriginal Health Council of South Australia**, The University of Melbourne, St Vincent's Hospital (Melbourne), La Trobe University, Royal Adelaide Hospital, Government of South Australia (Department of Health), Office of Aboriginal and Torres Strait Islander Health and the Tasmanian Department of Health and Human Services. This national project focused on continuous quality improvement (CQI) in hospitals and how they can systematically improve their cultural sensitivity by imbedding a process of cultural reform into their organisations. It has produced resources that support an ongoing reform strategy to sustain a program of improvements leading to improved cultural sensitivity. This article details the aims of the ICHP, summarises relevant literature and outlines the method and findings from the research undertaken. Finally, detail of the conclusions are discussed including the need for ongoing application of the findings and further research.

Background

The health status of Indigenous peoples is a global concern with mortality and hospitalisation data showing that the health of Indigenous groups is below that of the population generally and other ethnic groups within their countries (Wilson, 2003). The Australian Federal Government has acknowledged its responsibility to respond to this issue and ensure that the health gap between Aboriginal and non-Aboriginal Australians is addressed. The ICHP project aimed to contribute to closing this gap by developing a range of resources, tools and guidelines to assist hospitals across Australia tackle vital cultural reforms which can improve the effectiveness of services to Aboriginal and Torres Strait Islander⁷ people.

Aim

The aim of ICHP was to develop a quality improvement framework for acute healthcare institutions, which included a culturally appropriate CQI process with accompanying tools and guidelines in order to facilitate a hospital cultural reform process that over time can improve health outcomes for Aboriginal communities. The project involved examining Aboriginal health initiatives undertaken by hospitals that were viewed by the Aboriginal community as successful. The framework incorporated a CQI process and accompanying tools and guidelines for each stage, many of which have been proven to be effective instruments to sustain cultural change within the hospital environment. This framework and toolkit was then trialled in another set of hospitals to gain feedback on the suitability and usefulness of the processes and resources.

⁷ The term 'Aboriginal' will be used for the remainder of this article and refers to 'Aboriginal and Torres Strait Islander' unless otherwise stated.

Key outputs of the ICHP project include:

- the development and publication of a comprehensive toolkit outlining a culturally appropriate CQI process with accompanying resources, tools and guidelines to support the culture improvement of hospitals from the perspective of Aboriginal people
- the development of a formal training program for Aboriginal staff in hospitals to assist them in engaging effectively in conventional quality improvement activities to improve the culture of hospitals
- the establishment of a national network of Aboriginal people working with hospitals.

Key Concepts, Practices and Data Emerging from Indigenous Research⁸

Indigenous access to acute hospital care

The report *Australian Hospital Statistics 2007-08* indicates that Indigenous Australians are 2.6 times more likely to be admitted to hospital than other Australians. In 2007–08, the age-standardised separation rate for *Indigenous Australians* (915.8 per 1,000 persons) was about two and a half times the rate for *Other Australians* (356.8 per 1,000 persons). Nationally, 4.4% of all patients presenting to an emergency department were identified as Aboriginal or Torres Strait Islander. The Northern Territory had the highest proportion of emergency department presentations involving Indigenous persons (42.6%), and Victoria recorded the lowest proportion (1.2%) (Australian Institute of Health and Welfare, 2009).

The *National Aboriginal and Torres Strait Islander Health Survey Australia results 2004–05* showed that around one in six Indigenous people (16%) had been admitted to hospital in the 12 months prior to the 2004–05 survey. Age adjusted differences between the two populations' shows that, Indigenous people were 1.3 times more likely than non-Indigenous people to have been hospitalised in the previous 12 months. Indigenous Australians were admitted to hospital more often than non-Indigenous Australians across all age groups (apart from people aged 25–34 years where rates were similar) (Australian Bureau of Statistics, 2006, pg12). The results from this survey confirm the hospital usage data that the demand for acute care services by Indigenous Australians is proportionally higher than that of non-Indigenous Australians.

Cultural sensitivity in hospitals

The high level of usage of acute healthcare services combined with poor health outcome data generally for Aboriginal people creates a strong argument for a culturally safe acute health care sector. While the health outcomes for Aboriginal people are partly attributable to a failure of social policy there is a strong evidence base which shows that these outcomes are partly attributable to institutional failure. There is a considerable evidence base to suggest that acute health care as it is generally provided in Australia is not

⁸ The literature review analysed published literature and selected grey literature which related to the use of CQI methods and techniques to improve the cultural sensitivity of acute health care services. This review examined predominately literature published on or after 2000 (with some minor exceptions) in English and focused on studies examining cultural improvement in hospitals for Indigenous populations both in Australia and internationally. Also included were studies and reports on CQI activities for other minority groups including migrants.

culturally appropriate to Aboriginal people (Scrimgeour and Scrimgeour, 2008). This characteristic in general is exemplified through data on premature discharge, different intervention rates between Aboriginal and non- Aboriginal patients and discharge follow up rates which are poorer for Aboriginal people (Valery et al., 2006).

The connection between cultural sensitivity and health outcomes for Indigenous peoples needs to be understood within the context of:

- the need for people to have a sense of control over their lives and the sense of hope it creates as an important determinant of health (Ring and Firman, 1998)
- hospital staff understanding Aboriginal cultural contexts to ensure the best outcomes for their Aboriginal patients (Nangala et al., 2008 and Tanner et al., 2005) the disparity in care provided to minority groups. The health system does not treat all patients the same (Satisfaction Snapshot, November 2007)
- Indigenous patients' are often not comfortable seeking medical treatment and delay accessing any health service. Reasons given include limited access, quality of the relationship and trust of the medical staff (Scrimgeour and Scrimgeour, 2008).

Continuous Quality Improvement and Cultural Sensitivity

CQI methods and techniques are routinely used internationally in acute health care institutions (Renhard, 2001). There is a significant body of research to support the view that when used in mainstream organisations CQI can contribute to cultural reform. Australian research suggests that CQI processes are culturally acceptable to Aboriginal people and the Plan, Do, Study, Act (PDSA) cycle has been used in many Aboriginal controlled organisations in Australia (Bailie et al., 2007). It is essential to work with Aboriginal communities, and not just with individual Aboriginal patients when using CQI methods and techniques in order to ensure that culturally important Aboriginal community perspectives are integrated into the CQI process.

The research literature emphasises the value of Aboriginal community involvement in the design, development, monitoring and ongoing operation of cultural reform initiatives in acute health care services (Renhard and Anderson, 2002). This is not only consistent with the customer focus of the CQI approach itself, but also with the national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* (Australian Health Ministers' Advisory Council, Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, 2004), and the Closing the Gap campaign (Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering Committee for Indigenous Health Equality, 2008). This approach is also supported by research which shows that when Indigenous people have a sense of control over their lives, some experience a sense of hope which in turn has been identified as an important determinant of health (Ring and Firman, 1998). The relationship between control and health has also been recognised as a key factor in achieving considerable improvements in the health status of Indigenous populations relative to Australia, such as Canada, New Zealand and the United States (Ring and Firman, 1998).

It is well documented that many Aboriginal people have a cultural perspective on illness and health that is based on an ecological understanding of the world where mind, body and spirit are all part of any disease process. This cultural belief is not always congruent with Western medicine and hospitals, in particular, which often have a culture that reflects a hierarchical decision making approach based on the dominance of the medical view of the body as a mechanical entity. CQI is one approach that can be used to bridge this cultural divide. Research findings suggest that the capacity of CQI methods to be used to improve cultural sensitivity and the resultant changes in practice depend on two main factors. One is the acceptance of culturally sound ways of measuring change or impact (Willis et al., 2006). The second is to develop culturally sound communication methods that allow for an ongoing dialogue between healthcare institutions and Aboriginal communities about the cultural change process (Renhard and Anderson, 2002). Processes and tools are needed to foster both of these developments. There is also a significant need for tools and guidelines to ensure that the required change, and the nature of that change, is not hindered by broader organisational factors. These tools and guidelines should incorporate procedures to promote the uptake of the findings from CQI processes.

Sustained and significant improvements in cultural sensitivity, as it relates to Aboriginal people, require a system wide approach. From a systems perspective, cultural security can be seen as a commitment that the arrangement and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. Taking a culturally sensitive approach recognises, appreciates and responds to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration (Houston, 2002). CQI can be a significant strategy for system redesign can play a major role in the development of system changes that improve the cultural sensitivity of acute health care services.

Method

First round case studies - hospitals successfully responding to Aboriginal people

The purpose of this phase of the project was to identify the key elements that characterised hospitals that were, in the opinion of Aboriginal stakeholder organisations, successfully providing services to the Aboriginal community. These elements were then used to generate the quality framework and toolkit.

In each jurisdiction of Australia the National Aboriginal Community Controlled Health Organisation affiliate was informed of the project and asked to nominate hospitals that, in their view, had put a substantial, sustained and successful effort into implementing Aboriginal health initiatives. The hospitals nominated were offered the opportunity to participate by completing an expression of interest questionnaire which requested the following information:

- level of partnership with the local Aboriginal community and any outcomes that have been achieved through this partnership
- any Aboriginal health initiatives supporting better interaction with Aboriginal people and/or their communities that had been developed, including how they may have involved local community support and how long have these initiatives had been in place

- any systematic monitoring and/or evaluation processes that had been established for the above initiatives
- organisation support for these initiatives, through funding, encouraging networking and information sharing, establishment of regular meetings etc.
- identified clinical champions and/or executive sponsors to support these particular health initiatives
- details of these initiatives impact on practices in more than one department across your organisation.

The hospitals that responded were then assessed by the project team and five hospitals were selected. These hospitals clearly had achieved significant success in the development of their services to the Aboriginal community and had something to offer the project. They were also willing to share this information. The sites selected were:

1. Maitland Hospital (Yorke & Lower North Health Service, South Australia)
2. Goulburn Valley Health (Shepparton, Victoria)
3. Royal Adelaide Hospital (South Australia)
4. St Vincent's Hospital (Melbourne, Victoria)
5. Royal Children's Hospital (Melbourne, Victoria)

To collect information, a site visit to each hospital was undertaken. Aboriginal and non-Aboriginal researchers met with a wide range of hospital staff. Each site visit included the analysis of documentation and policies provided to the team as well as notes taken from meetings. At the conclusion of these visits all team members, Aboriginal and non-Aboriginal, discussed and finalised the key themes that emerged from each case study.

Second round case studies - trial of the Quality Improvement Framework (Toolkit)

The information gathered from the first round of case studies was used to generate a quality improvement framework or toolkit to guide a CQI process using relevant resources under each stage of the process. The draft toolkit was then trialled at five hospitals with only four completing the trial. Sites included:

1. Derby Hospital (WA)
2. Royal Brisbane and Women's Hospital (QLD)
3. Campbelltown Hospital (NSW)
4. Mater Hospital (QLD)
5. Katherine Hospital (NT) withdraw from the project after the initial visit

Aboriginal staff training in CQI

Aboriginal staff involved in the second round of case studies to trial the toolkit were offered training to provide them with a greater understanding of the quality improvement process. The two units delivered at Certificate IV level were 'Manage quality of organisation's service delivery outcomes' and 'Develop and implement policy'. Each site was encouraged to send two staff so there was support when returning to the

workplace, utilisation of the training and engaging with the project. As some sites did not have more than one Aboriginal staff member available to attend, jurisdictional staff chose another Aboriginal staff member from another hospital. A total of 10 Aboriginal staff participated.

Round Table meeting

The ICHP project has focused on continuous quality improvement in hospitals and how they can improve their cultural sensitivity and imbed a process of cultural reform into their quality improvement processes. The project has supported an ongoing reform strategy to ensure sustainability of improvements regarding Aboriginal health in line with the key responsibility of each state and territory jurisdiction. The Cooperative Research Centre for Aboriginal Health (CRAH) which funds the ICHP has as one of the key planks underpinning their work is doing research that can support sustainable improvements in Aboriginal and Torres Strait Islander health.

Therefore, as the ICHP had come to the end of the research phase it was important to examine about how the lessons learnt could be embedded in practice as widely as possible. Therefore a Round Table meeting was convened in Melbourne on the 15th October 2009 with senior political and policy staff from federal, state and territory governments along with staff of the Australian Council Healthcare Standards (ACHS), to present the projects findings and secondly to develop ideas around how these findings can be used as a catalyst for change in practice as widely as possible.

Outcomes

First round case studies

The first round of case studies indicated that hospitals that were considered to be successfully addressing the issues of their Aboriginal and Torres Strait Islander patients shared the following essential characteristics: strong partnerships with Aboriginal communities, enabling state and federal policy environments, leadership by hospital Boards, Chief Executive Officer/General Manager's and key clinical staff, strategic policies within their hospitals, structural and resource supports and commitment to supporting the Aboriginal workforce.

a) Strong partnerships with Aboriginal communities

It was clear that generating strong partnerships with Aboriginal communities was the foundation for any attempt to improve services to Aboriginal people and required commitment, time and resources. Consultations with various Aboriginal communities, organisations and leaders, conducted by Aboriginal staff from most of the hospitals, usually resulted in the development of formal agreements. These formal agreements provided a mechanism for ongoing relationships and information sharing. They also articulated specific goals, specified improvements in services and incorporated accountability requirements.

Strategies for maintaining a dialogue with the Aboriginal community also included a range of other activities such as the establishment of an Aboriginal Health Advisory Council and other advisory committees, and the hospital providing shared care, community based and outreach services, in particular, to Aboriginal communities and some primary care services. The variations between the hospitals in the case studies seemed to be more related to specific internal and local factors (staffing and resources) and organisations (capacity to participate in consultations) rather than whether they were large or small or rural or city based.

b) Enabling state and federal policy environments

Some of the hospitals were operating within, and clearly influenced by specific state and federal policies that aimed to improve the health of Aboriginal and Torres Strait Islander patients. At the national level hospitals are required to implement initiatives to achieve specific Aboriginal health outcomes as outlined in the Health Care agreements negotiated at the Council of Australian Governments (COAG).

All of the hospitals in the case studies referred to the national Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 and indicated that they had undertaken a range of activities related to the framework. Senior staff at one of the hospitals were also attempting to implement the National Health and Medical Research Council’s guide, ‘Cultural Competency in health: A guide for policy, partnerships and participation’.

At the state level Victorian hospitals had been implementing the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) policy that guides hospitals in improving their partnerships with Aboriginal communities. This policy supports, for example, the creation of health outcomes agreements with local Aboriginal communities that have been developed by rural hospitals.

In South Australia, the Department of Health established Aboriginal Health Advisory Councils (AHACs). These regional committees were initially established to provide advice to hospital boards. After boards were disbanded, AHACs were maintained to advise hospitals on regional issues. The Aboriginal Health Council of South Australia (AHCSA) recognised their importance and invited a representative to sit on the AHCSA’s Board of Management to provide advice to the South Australian government on Aboriginal health issues. In South Australia, the state government supports AHACs and one regional hospital has used this structure effectively to gain feedback from the community.

It is important to note that in some cases the policy requirements and associated funding had been most influential in enabling some hospitals to address the issue of the health of their Aboriginal patients. In Victoria for example, hospitals have used the funding that is targeted for Aboriginal patients through the ICAP policy to employ Aboriginal staff to fulfil key policy directives. For other hospitals the ICAP policy was a welcome support to work that had been already been initiated by key hospital staff and or other Aboriginal organisations.

c) Leadership by hospital Boards, Chief Executive Officer/General Managers and key clinical staff

It was no surprise that all the hospitals, regardless of size or location, had Board members, Chief Executive Officer/General Managers and clinical staff who exhibited leadership in relation to improving services to Aboriginal patients. Their formal responsibilities for effecting cultural and organisational change and improvements to Aboriginal health, were acknowledged by the hospital Boards in a range of ways including; allocating portfolios and resources, mandating targets, agreements and regular reports. Some also undertook cultural awareness training and, or, were participants of particular implementation committees.

d) Strategic policies within their hospitals

All the hospitals had generated a number of internal strategic policies aimed at improving the health of Aboriginal patients. Nearly all the hospitals had produced documents, such as, vision and mission statements which incorporated explicit value statements regarding the hospital's commitment to caring for Aboriginal people. All had a range of change management strategies that were often implemented via their quality improvement mechanisms. The five hospitals had developed new Aboriginal health frameworks, action plans, key performance measures, training, protocols, guidelines and models of care. Three had also monitored and reviewed these. Frameworks linked to quality improvement mechanisms that included action plans, with clear, achievable aims and allocated personnel, were the most effective.

All of the hospitals had policies that required some staff to attend cultural awareness training that was usually delivered by Aboriginal people. One hospital had incorporated the attendance at cultural awareness training into all position descriptions. Some of the hospitals exhibited a more complex understanding of the dimensions of cultural change, usually those that had been involved in change over a longer period. They considered cultural awareness to be a multi-faceted ongoing process of information exchange, debate and review of practice rather than something that could be accomplished as a result of a one off training session.

As part of their ongoing commitment to an improved understanding of and relationship with Aboriginal communities, some hospitals had policies that facilitated Aboriginal ceremonies and events occurring within the hospital. Again this achievement seemed to be related to the quality and extent of the established relationship rather than the size or location of the hospital.

e) Structural and resource supports

Not surprisingly, structural and resource supports seemed to be essential if the hospital was to focus on improving Aboriginal patients' health. Some of the hospitals linked their initiatives to quality improvement mechanisms, such as the Quality and Safety Committee, in part to formally identify support staff and resources. All had established a formal Aboriginal Hospital Liaison Officer or an Aboriginal Health Liaison Worker role. Some had a specific Aboriginal and Torres Strait Islander Steering Committee and an Aboriginal and Torres Strait Islander unit or an Aboriginal health team. All had increased or reallocated funding for Aboriginal staff. It is important to note that some hospitals undertook these initiatives with specific additional funds and others reprioritised funds within their ongoing budgets.

Additional resources had been provided by some hospitals for the purchase of Aboriginal artwork, posters and resources and particular rooms and spaces for Aboriginal people within the hospital area had been identified. In addition, some hospitals had arranged funding to allow hospital staff to provide services in the Aboriginal community. Most hospitals used internal newsletters and bulletins to inform staff of particular events, goals and progress.

f) Commitment to supporting the Aboriginal workforce.

Finally, the importance of policies, resources and practices that support the Aboriginal workforce in hospitals cannot be over estimated. Key findings from the case studies indicate that essential factors include: targets set for increasing the Aboriginal workforce; well articulated role statements for Aboriginal Hospital Liaison Officers and all Aboriginal staff; the establishment of Aboriginal teams rather than sole workers; Aboriginal staff employed in mainstream positions not just Aboriginal Hospital Liaison Officer roles; time allocations for Aboriginal workers to maintain relationships with community organisations, visit Aboriginal patients and fulfil their community responsibilities; clearly defined lines of accountability; and supportive senior management staff who are committed to the cultural change program. Several hospitals reinforced the point that improving outcomes for Aboriginal patients is the responsibility of all hospital staff not just the Aboriginal workers.

Second round case studies

Outcomes from the trial of the toolkit were positive with hospital staff highlighting that a CQI framework and package of credible information focused on culturally appropriate, responsive care is a useful resource.

The trial highlighted the need for briefing sessions or training for executive and other senior non-Aboriginal staff on the significance of culturally sensitive practice and its relationship to patient outcomes, as well as how to apply and use the toolkit.

Many of the sites undertook their trial of the toolkit with the limited involvement of Safety and Quality staff. The trial of the toolkit was established under the assumption that the Safety and Quality staff would engage readily but this proved to be inaccurate. The trial sites emphasised the key task of the Safety and Quality units which is on fulfilling the Australian Council of Healthcare Standards (ACHS) accreditation requirements and their function is controlled by senior management. These units appear to have limited capacity to influence change with their primary task to fulfil the reporting requirements of the EQiP which currently focuses primarily on clinical parameters.

The resources provided in the toolkit from other successful hospital projects were seen as useful especially the Royal Adelaide Hospital Action Plan which addressed all aspect of the hospital's business. However, even more information was requested additional information on how initiatives were implemented. This including requests for detailed examples of the complete CQI cycle to provide insight on how to implement a project successfully and how challenges were overcome as well as for patient stories to provide staff with more insight into the challenges faced by Aboriginal people engaging with hospital care.

In addition, it was also noted by trial participants that they required the support of the ICHP team members in order to implement their projects and trial the toolkit. Key informants indicated that the initial team visit to outline how to use the toolkit, follow-up email and phone support, and final visit to collect feedback, were all crucial to providing the necessary focus and support to ensure the projects were successfully progressed.

Aboriginal staff training on CQI

Feedback from the second round of case studies emphasised the value and importance of training provided to Aboriginal staff as part of this trial. Participants noted that the training: highlighted the key work that Aboriginal staff currently undertake; provided a mechanism for systematically addressing issues within a CQI process that involved staff from across their organisation; and provided assistance to both Aboriginal and non-Aboriginal staff to engage in the quality improvement activities effectively.

Round Table meeting

The engagement of the ICHP team with high level jurisdictional staff involved in acute policy monitoring and development was a useful process that enabled the exploration of options to develop the findings from the project. Participants acknowledged that the toolkit developed by the ICHP bridges the gap between policy and health standards, and is a practical way to operationalise policy into action. The need for the finalised toolkit to be integrated with relevant jurisdictional policies was also emphasised.

The most significant outcome from the Round Table was the agreement by the Cooperative Research Centre for Aboriginal Health to work with the Australian Council of Healthcare Standards (ACHS) to further develop specific standards for Aboriginal patient care as part of its review process for EQuIP4. The inclusion of specific standards on Aboriginal patient care has been seen by many stakeholders as a key component to ensure that the acute healthcare sector engages systematically to improve their services to the Aboriginal community. Other outcomes included recognition of the need for further implementation work and ongoing support for hospitals to ensure the wider successful uptake of the ICHP toolkit including: infrastructure support (resources); access to mentors; and access to education and training.

Conclusion

As has been highlighted, the emerging themes of workforce, partnerships, quality objectives, executive and board sponsorship, clinical champions and accreditation are all part of a comprehensive policy approach that will assist hospitals in improving the health outcomes for Aboriginal patients and communities.

The ICHP has provided hospitals with a culturally appropriate quality improvement process along with a set of tools and guidelines to ensure a sustainable change in the way they approach Aboriginal health. The capacity of hospitals to respond more effectively to Aboriginal patients is increased by making Aboriginal health a quality issue. This will not only build the capacity of hospitals to improve their response to the Aboriginal community but also improve their effectiveness in engaging with a range of other patients with complex needs.

The capacity of Aboriginal staff and communities to engage in a meaningful and effective way with hospital reform is also increased by this process. The ICHP has increased the involvement and effectiveness of non-Aboriginal clinical staff by engaging them in projects that require them to work alongside Aboriginal staff and Aboriginal communities to improve hospital service delivery to Aboriginal patients.

The potential to set in place a process for continuous quality improvement for cultural reform in hospitals has been increased by the ICHP which provides a systematic approach for local communities to develop strategies in partnership with the hospital in their area. This process will take time but will build the capacity and sustainability of both hospitals and their local communities to make a difference in Aboriginal health.

In conclusion hospitals need senior management to support this work as a priority and to ensure Aboriginal staff are trained to facilitate the process. It is recommended that further research is undertaken to build the evidence that supports the involvement of the quality units within hospitals to ensure learnings are adopted across the organisation in a systemic way. Finally, the inclusion of an Aboriginal patient care specific standard in the ACHS EQuIP accreditation system, is seen as a key driver to assist this change.

Annotated Bibliography

Introduction

This annotated bibliography is a component of the ICHP and is a companion to the Literature Review which can be found in Chapter Two of this report. This appendix is separated into sections entitled:

- Cultural Safety
- Quality Improvement
- Evaluation, monitoring and accreditation
- Cultural Frameworks

Cultural Safety

This section includes articles that discuss cultural safety/security issues, highlight the need for cultural safety in acute health care settings, highlight the adverse outcomes if a hospital is unsafe and also articles discussing cultural practice within the clinical setting between patients and staff and between Aboriginal and non-Aboriginal staff. The author wishes to acknowledge that several of these summaries were sourced from the ICAP Resources Project 2008 compiled by Angela Clarke, Sean Ewen, Nicole Waddell and Sonia Posenelli as part of the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Resources project (2008) published by Department of Human Services, Victorian state government.

1. **Scrimgeour and Scrimgeour (2008)**. Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature, *Cooperative Research Centre for Aboriginal Health, Discussion Paper Series: No. 5*.

This literature review discusses the findings from a study on access and attitudes to health care by Torres Strait Islanders living in urban centres on mainland Australia. They highlight that in general Torres Strait Islanders are not comfortable seeking medical treatment and delayed accessing any health service. They highlight that one of the barriers to health care access by Aboriginal and Torres Strait Islander people living in urban areas is the poor performance of the health system in meeting the needs of those with complex and multiple health conditions. The review highlights that this problem is not just confined to Aboriginal and Torres Strait Islander people but includes newly arrived refugees and people living with HIV as other examples of groups with complex health problems who present challenges for the health care system. The authors argue that there is evidence that a fee-for-service primary medical care policy does not deal well with the complex health problems with which many Aboriginal and Torres Strait Islander people present keeping in mind that complex health problems occur with greater frequency within the Aboriginal population. Further this failure of the primary care system probably contributes to the higher rate of admission for Aboriginal and Torres Strait Islander people to hospital with ambulatory-sensitive conditions. The paper then goes on to explain the challenges facing the acute health system in responding to those with complex needs and the need to negotiate many speciality areas.

Most used Aboriginal Community Controlled Health Services, followed by private medical services and hospital outpatient services and the most common reason given for the choice of type of service was convenience, access, quality of the relationship and trust of the medical staff

2. **Gruen R.L, Tesimale L, Kong K, Clarke M, Jacobs S, Jacobs O, Chenia F, Van Iersel E & O'Brien M (2007).** The surgical care of Indigenous Australians: a structured orientation program, *ANZ Journal of Surgery*, Nov 77 (11): 925-9

The authors consider some of the issues of surgery and Indigenous health. They also consider how the nature of public discourse affects the perception of opportunities, what the main challenges are and how the profession can tackle them. They end by describing a program developed by the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Obstetricians and Gynecologists to promote effective surgical care of Indigenous people, especially those living in rural and remote areas.

3. **Nangala T.B, Nangala G.M & McCoy B (2008).** Who Makes Decisions for the Unconscious Aboriginal Patient? *Aboriginal and Islander Health Worker Journal*; Volume 32, Issue 1; Jan/Feb, 6-8.

In those cases where a person remains unconscious and critically ill, the person or people that a clinic or hospital might consult are not necessarily the same people that desert people might consider as appropriate. In this paper, the authors have described how particular kinship relationships can identify those who have primary responsibility to make decisions at this time. Establishing and supporting such a protocol can avoid upset and recriminations. More importantly, it will respect and reinforce those desert values that strengthen kinship relationships as well as social responsibilities.

4. **Sinnott M.J & Wittmann B., (2001).** An introduction to Indigenous health and culture: the first tier of the three tiered plan, *Australian Journal of Rural Health v.9 no.3 June*, 116-120

The objective of this Queensland study was to prepare new doctors with an awareness of cultural and health issues to facilitate positive experiences with Indigenous patients. Results indicated that this active intervention improved the awareness of doctors and was seen as beneficial by Indigenous hospital liaison officers. In conclusion, it appears that this first tier one has been successful and is to be a formal component of intern orientations in Queensland public hospitals but further initiatives in Indigenous health and culture targeting medical staff (eg. tiers two and three) are needed.

5. **Tanner L, Agius K & Darbyshire P (2005).** Sometime they run away, that's how scared they feel: the pediatric hospitalisation experiences of Indigenous families from remote areas of Australia, *Contemporary Nurse v.18 no.1 Dec 2004 - no.2 Jan 2005: Special Issue: Advances in Indigenous Health Care: 3-17*

Hospitalisation can be a traumatic experience for any child and family but the experience can be significantly more so for Indigenous parents and children from remote areas of Australia. This paper reports on a study and presents the participating families' depictions of their experiences of 'coming down' and 'being in hospital', where they revealed the extent and effects of marked culture shock. The significant cultural differences between staff and Indigenous families contributed to the parents' sense

of fear, powerlessness and isolation from their child, home community and culture. For these families this isolation was not merely geographic but intricately linked to their health and wellbeing.

6. **Author Unknown (2005)** The Role of Diversity Health Co-ordinator in the St George Hospital and Community Health Service, Sydney, presented at *Respecting Culture and Diversity: Innovations in Healthcare Delivery*, June

This presentation looks at the establishment of 5 Diversity Health Co-ordinator (DHC) positions at major Area hospitals in 2000 to promote culturally competent care. Based in clinical settings, the DHC role directly addresses strategic areas of need including access and equity, organisational workforce development, health promotion, communication and language services and research and evaluation. The DHC is well positioned to coordinate hospital-wide diversity health activities that transcend organisational boundaries such as nurses/doctors and medicine/surgery, resulting in broader more effective implementation.

The DHC assess the needs of the Culturally and Linguistic Diverse (CALD) clients through community consultants, focus groups and interviews, identifying barriers and enablers to optimal health service provision. These findings are addressed through a wide range of activities including research, staff education and training. The DHC takes a proactive role in initiating changes to policies, procedures and standards of practice. The DHC also develops and implements a three-year Diversity Health strategic plan that documents the significant executive level commitment to ongoing organisational change.

7. **Coffin, J. (2007).** Rising to the Challenge in Aboriginal Health by Creating Cultural Security, *Aboriginal & Islander Health Worker Journal*, May/June, Vol 31 – Number 3

This paper differentiates between cultural security, safety and awareness, to demonstrate their importance in a health service context and to give practical strategies for achieving and sustaining culturally secure services. Improved cultural awareness does not lead to improved health outcomes and Coffin argues that hospitals need to adopt practices and policies that recognise cultural security as mandatory. The first step needs to be to honestly placing ones' organisation on the scale and moving forward from there. The Aboriginal community needs to be clearer about defining what it wants, be more united in voicing these areas and health services needs to listen. The paper outlines a cultural security scale ranging from awareness → brokerage → safety → protocol → security → sustainability. Two key elements:

Brokerage – involves respect and two way communication where both parties are equally informed and important; it must be developed with the Aboriginal community; faith and trust need to be built. One of the largest parts of brokerage is listening and yarning.

Protocols – formalise the fact that in an Aboriginal context, health care delivery and programs need to be done with Elders and key stakeholders within the particular community. Communities become partners in an equitable, culturally secure provision of service. Cultural awareness alone is not enough.

8. **Wilson D (2003)**. The nurse's role in improving Indigenous health. *Contemporary Nurse*, Oct, 15 (3): 232-40

The health status of Indigenous peoples is a global concern with mortality and hospitalisation data indicating that the health of Indigenous groups falls below that of other ethnic groups within their countries. The preliminary findings of a grounded theory research project undertaken with a group of 23 New Zealand Maori women about their health priorities and 'mainstream' health service needs provide the foundation for an exploration of issues impacting on the health status of Indigenous people. The role that nursing and nurses have in improving access and use of health services by Indigenous people is discussed. Strategies are suggested that nurses can utilise within their practice when working with local Indigenous groups.

9. **Weaver H.N (1998)**. Teaching Cultural Competence: Application of Experiential Learning Techniques in *Journal of Teaching in Social Work* Vol. 17(1/2)

The article focuses on experiential learning, direct participation in activities combined with personal observations and reflections, as a major source of learning (Laubscher 1994; Saddington 1992; Tate, 1992), learning for 'understanding'. Self reflection and exposure to different types of people are critical in the development of cultural competence. Two experiential learning techniques are discussed in depth. Firstly a buddy system and journal (can include any activity which allows partners or buddies from different cultures to talk with each other) and keeping a journal to evaluate learning. Secondly were interactions in cultural communities by attending events and celebrations, spending time in a neighborhood and examining feelings, reactions and behaviors.

10. **Magnusen S, Norem K, Jones N.K, McCrary J.C, Gentry J (2000)**. The Triad Model as a Cross Cultural Training Intervention for Supervisors in *The Clinical Supervisor*, Vol. 19(2)

The paper features a description of an experiential exercise (Triad Model, Pederson 1994) designed to increase sensitivity of supervisors-in-training to the subtle ways cultural experiences affect interactions between supervisors and supervisees. The authors found readiness to engage in discussions about cultural differences was lacking in this limited enquiry. They drew a primary conclusion endorsing the importance of training supervisors to recognise and address cultural issues (Fong and Lease, 1997; Fukuyama, 1994; Steward et al., 1998). They also encouraged supervisors to adopt a process of continuous and intentional efforts toward a process of cultural self awareness and examination.

11. **Leong T.L & Wagner N.S (????)**. Cross cultural counseling supervision: What do we know? What do we need to know? *Counselor Education and supervision*, 34, 117-131

The article provides a critical review of the theoretical and empirical literature on cross-cultural counseling supervision. Conclusions include that much remains untested. It seems empirically safe to conclude that:

1. Race can have a profound influence on the supervisory process, particularly in terms of trainees' expectations for supervisor characteristics like empathy, respect and congruence;

2. Race can influence a trainee's perception of supervisor liking

Recommendations include encouraging researchers to focus on supervisory relationship factors and elements of the interaction between supervisors and supervisees as well as isolated characteristics of both participants (including interactions between personality dynamics and cultural dynamics); consider implications at an organisational/institutional level; encourage diverse practicum and internship placements.

12. **Larkin C & Buckskin M (1995)** Aboriginal Liaison Officers: breaking down the barriers in *Aboriginal & Islander Health Worker Journal* Vol. 19, No. 6, Nov/Dec

The article describes the experience of a social work manager in the Australian Capital Territory (ACT) who worked with several social workers at Woden Valley Hospital ACT in an action research project exploring issues of racism. They worked also with two Aboriginal women who shared their experiences and understanding. Their deliberations led to their advocating for the appointment of an Aboriginal Hospital Liaison Officer (AHLO). The Aboriginal women subsequently became a support group for the AHLO (Mary Buckskin). The AHLO noted in the article that she was supervised by the social work manager – showing that commitment starts at the top.

The AHLO role is described as different to social workers – it involved contact with lots of wards and it was sporadic. The group worked together and with the hospital's medical committee, with local health service workers and consumers to present a Grand Round hypothetical.

The article highlights the importance of an open and supportive working environment and staff working to change themselves and their institutions to break down barriers.

13. **Sherwood J, Costello M, Congoo E, Cohen T, Duval T, Gibbs G, Kelaher B, Kelly T, Marshall C, Tabuai & G Winsor J (1999)** Indigenous Management Model in *Aboriginal and Islander Health Worker Journal* Vol. 23 No. 5, 1999

A group of BHSc (Aboriginal Health and Community Development) students from the Yoorang Gorang Centre for Indigenous Health Studies, University of Sydney were unable to identify through their research efforts an Indigenous management theory. They worked together to define a management model that they felt would sit well in their communities.

The group identified, through 'intense negotiation', the essential skills that are needed when managing 'the mob'. Considering past, present and future models the group identified policies and procedures and cultural values and beliefs impacting on quality assurance, communication /line management, ethics and law, 'managing our mob', professional development and training.

14. **Weick A, Rapp C, Sullivan W.O, Kishardt S, Saleeby D (1989)**. A strengths perspective for social work practice in *Social Work*, 34, 350-354 *The Strengths Perspective In Social Work Practice*. New York Longman Publishing.

The 'Strengths Perspective' is an approach which draws on principles and methods to create opportunities for professional knowledge building. The article by Weick et al. is a benchmark article

which coined the term ‘strengths perspective’. This perspective promotes a mindset which is to approach people with a greater concern for their strengths and competencies and to mutually discover how these personal resources can be applied. It encourages engaging people as equals and giving positive feedback. It reflects an approach to building relationships and resiliency.

Saleeby (1997) outlined the core ideas of the strengths perspective including empowerment, membership, regeneration, healing within, synergy, dialogue and collaboration. The dialogue includes empathy, identification with and inclusion of the other person. Strengths include what people have learned about themselves and others and their world; personal qualities; traits and virtues people possess; what people know about the world around them; the talent people have; cultural, personal stories and lore; pride; the community.

15. **Briskman L (Ed.) (2007).** Social work with Indigenous communities. *Federation Press*, chapter on confronting complicity and moving on.

This chapter promotes the value of critical social work practice. In this framework the social worker is a partner in action rather than an outside expert. It is important to recognise the limitations of our knowledge and not to reinforce patterns of domination. We need to incorporate Indigenous voices, affirming Aboriginal knowledge and expertise, while not totally discarding professional expertise. Indigenous knowledge is not less relevant. Social workers need to avoid taking a defensive stance when hearing critiques of past and present practice, maintain their commitment to social justice and human rights and be willing to challenge current social and power relationships.

This approach is a necessary precursor to effective engagement with Indigenous peoples. It is necessary to go through personally confronting experiences, accepting the position of learner and engaging with uncertainty and discomfort. A useful first step is to recognise Aboriginal co-workers as mentors and decision makers. This can assist in breaking down traditional hierarchies of supervision (Zubrzycki and Bennett 2006) creating more reciprocal relationships.

16. **Tesoriero F (2006).** Personal Growth Towards Intercultural Competence Through an International Field Education Program in *Australian Social Work* Vol. 59, No. 2, June.

This excellent article discusses an international field education programme at the University of South Australia. Of interest is the conceptualisation of the programme within a developmental framework identifying stages of personal growth from ethnocentrism to ‘interculturality’ or intercultural sensitivity. The framework, alongside the use of a clear ethical perspective and the reflective practice process, is a useful resource to identify the level of sophistication of cross cultural competence. Important models (Bennett 1993 and Fook 1996) are discussed. Milton Bennett’s (1993) model of Intercultural sensitivity derives from a review of concepts in the field of intercultural communication. People move through a process of personal growth, from a position of ethnocentrism to one of ‘ethno-relativism.’ The process is one of stages of increasingly sophisticated recognition and acceptance of difference, with a radical shift from an absolutist view of the world to a more contextual view that accommodates ambiguity of meaning and competently engages with those who are different.

Fook's (1996) approach to reflective practice promotes questions which include interrogating one's experience and accounts of them in terms of: emerging themes and patterns; one's feelings, thoughts, actions, interpretations and explanations of an event; the underlying assumptions and where these assumptions derive from; gaps and biases in the explanations; cultural positions etc. This reflective interrogation of one's practice experiences, when used in conjunction with human-rights based approaches such as empowerment and anti-oppressive practice, builds knowledge and fosters personal change.

17. **Yunupingu G & Calma T (2007).** Garma Festival

Messages from the Garma Festival 2007. At the festival Indigenous and non-Indigenous people told and shared stories about what works in health and why. The festival theme was: 'Enjoying it, learning it, sharing it.

Key messages included the importance of:

- Give and take
- Spreading the word and two way learning - we need to continue to promote partnership and learning from each other (Aboriginal and non- Aboriginal people). Dialogue and relationship building are cornerstones for re-writing the story of mainstream efforts in Aboriginal health care.

Tom Calma (Equal Opportunity Commissioner) said in his presentation at the Festival:

- Indigenous and western systems are parallel systems
- We need to respect and work with each other
- One size does not fit all
- It is important to acknowledge Aboriginal culture and systems This is key to the healing process
- We need to build on what we know and to build on respect

18. **Guidelines for Cultural Safety (March 2002).** The Treaty of Waitangi and Maori Health in Nursing and Midwifery Practice.

In 1990 the Nursing Council of New Zealand (NZ) incorporated cultural safety into its curriculum assessment process. The concept of cultural safety incorporates a broad definition that expresses the diversity that exists within cultural groups. It includes cultural groups that are as diverse as social, religious and gender groups and is in addition to ethnicity.

The NZ Nursing Council definition of cultural safety is the effective nursing or midwifery practice of a person or family of another culture, and is determined by that person or family.

Culture includes but is not restricted to:

- age or generation;
- gender;
- sexual orientation;
- occupation and socio-economic status;
- ethnic origin or migrant experience;
- religious or spiritual belief;
- disability.

The nurse or midwife delivering the nursing or midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. Cultural safety is an approach which recognises diversity and individuality.

Safe service is defined by those who receive the service. Implications include demonstrating flexibility in relationships and examination of one's own realities and attitudes.

Source: <http://www.nursingcouncil.org.nz/culturalsafety.pdf>

19. **Clarke A, Andrews S & Austin N in (2000)**, Looking after our own: supporting Aboriginal families through the hospital experience, *RCH Report*.

Consideration of how to define cultural safety is provided in an extract from the book written by Aboriginal Health Unit staff from the Royal Children's Hospital.

"There are many interpretations of cultural safety. Our interpretation developed here at the hospital when we began to sense the overwhelming need for families to feel at ease and safe. All our initiatives for the Koori program were set up to work toward making the hospital experience for our families as culturally affirming as possible.

It is the right of our families to be able to express and be proud of their culture. We, as Kooris, acknowledge that western culture is no more or less important than our own culture. We do not force or inflict our views on others and we ask that our families be afforded the same courtesy – without the expectation that they conform to non-Aboriginal ways".

20. **Houston S (2002)**. Aboriginal Cultural Security, Health Department of WA, Perth in *New Doctor*, 77, Winter.

Cultural security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.

21. **Richards J (2003).** Indian/non-Indian life expectancy: why the gap? *Inroads: A Journal of Opinion*, Winter-Spring

This article looks at the Aboriginal Canadians experience. Richards outlines that over the 20th century there was a dramatic shift of Aboriginal people from rural to city areas. Richards cites figures of 7% registered Aboriginal Canadians living in cities in 1951 to that of 50% in 1996 and argues that non-Aboriginal people undertook this change but nowhere as quickly. From an Aboriginal perspective this change has had a significant social impact.

22. **Thomson N (2005).** Cultural Respect and related concepts: a brief summary of the literature in *Australian Indigenous Health Bulletin*, Vol 5 No 4 Oct – Dec.

Quality Improvement

Articles in this section focus primarily in quality improvement in Indigenous health in hospitals both from Australia and elsewhere.

23. **Buetow S.A (2004).** New Zealand Maori quality improvement in health care: lessons from an ideal type, *International Journal for Quality in Health Care 2004; Volume 16, Number 5: pp. 417–422*

There is no single best approach to quality improvement. Quality improvement has been adapted from its predominantly Japanese origins to form distinct, hybrid systems embedded in national cultures. These systems have seldom been studied despite their potential internationally to inform the local management of health care organisations. This article suggests six lessons from an ‘ideal type’ of one such system, New Zealand Maori quality improvement in health care. Mapped against ‘mainstream’ concepts of quality improvement, the lessons are to: emulate the character of leaders in health care; encourage ‘cultural governance’; operate the health care organisation as a ‘family’; move forward with eyes on the past; foster spiritual health; and respect everything for itself. These lessons support a global struggle by Indigenous peoples to have their national cultures reflected in programmes to improve their health care, and have potential relevance to mainstream services. By increasing cultural competence, responsiveness to Indigenous health needs, and awareness of insights from another culture, the lessons reveal opportunities to improve quality by incorporating aspects of a Maori ideal type.

24. **Lawrence M (2007).** Nurse Led Research Improves Outcomes in Indigenous Health, *Australian Nursing Journal*, May 08 Vol. 15 No. 10

This study examined cardiac care for remote Indigenous patients coming to a major tertiary hospital. Evidence showed that there were significant numbers of Aboriginal patients who were not showing up for surgery or had their surgery cancelled due to being psychologically and clinically unprepared. The suggested intervention to improve health outcomes was the establishment of a remote area liaison cardiac nurse position to assist in preparing patients including ensuring all patients were dentally fit for surgery and using previous patients to tell of their experience in their own language. Over a 2 to 3 year period of the pilot program the new nursing position reduced the ‘no shows’ to zero.

25. **Fawkes S & Chiarenza A (2004).** Lessons for Australian healthcare services from an EU project on enhancing responsiveness by hospitals to culturally diverse populations, *Presentation on major findings from the Migrant Friendly Hospitals project*

The complex political, economic and social changes that characterise the beginnings of the 21st century are changing Australia's demographic profile in significant ways. As a consequence, healthcare services must now provide accessible care to migrants, travellers, temporary workers, refugees, and asylum seekers from all parts of the world who vary in the cultural norms and religious beliefs they observe, their ethnicity, legal status, social history and circumstances and expectations of healthcare services. While economic and legal issues arise for healthcare services from these movements of people, access and quality of care stand out as most significant challenges, in particular, the ways in which healthcare services respond in a systematic way to culture and diversity.

The challenge of responding effectively to cultural diversity is shared internationally. This presentation will outline major findings from a two-year pan-European project, supported by WHO, that investigated models of good practice in pilot hospitals that improve the quality of care in a culturally diverse environment. The Migrant Friendly Hospitals (MFH) Project examined approaches in a variety of areas for their effectiveness: addressing language barriers, delivering culturally adequate patient education, training staff for cultural competence and developing organisational policies that integrate cultural diversity. The project has spawned the MFH Taskforce, an ongoing model for international collaboration, research and leadership. This presentation will outline the MFH Taskforce model and discuss how Australian colleges envisage both contributing to the European work and taking up themes of the European work program in Australia.

Strategic plan of MFH Taskforce includes:

- Dissemination and development of the PFH project
- Information and communication
- Partnerships and international contacts
- Working groups and their activities
- Organisation and infrastructures
- Champions, change agents and enablers.

Literature review outlines that partnerships with migrant organisations are important for hospitals to improve quality of care. Definition of quality of care is “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”.

Improving the quality of health care encompasses six aims: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. The last aim, equity, is crucial. A health care system or institution is not providing quality care if it is not providing quality care to all its patients. Quality in terms of equity is thus a key issue in migrant and minority health care. It is also a political issue, because a national health care system is supposed to provide health care equally to all its citizens.

Finally a double recommendation, adapted from 'Quality and Culture – Joining the levers (Smith 2002): Frame migrant and minority health care issues as quality issues and Include migrant and minority health care issues in quality monitoring.

Cultural humility should be the desired goal in medical education, not cultural competence, as it promotes a life long commitment to self critique and self evaluation.

26. **Stamp G, Miller D, Coleman H, Milera A & Taylor J (2006).** 'They get a bit funny about going': transfer issues for rural and remote Australian Aboriginal people, *Rural and Remote Health v.6 no.3: article 536, Online*

In 2004 a project was conducted across Australia to investigate the experiences of people travelling to city hospitals from rural and remote areas and to improve their health outcomes. This current article examines issues for Aboriginal people and makes recommendations for improving their care. Three Aboriginal health workers were interviewed, and issues identified included travel costs and organisation, culturally inappropriate accommodation, privacy, and the lack of inclusion of families, which has a huge impact on willingness to attend services, support, and recovery. Possible strategies include liaison officers, improved communication, improved hospital transfers, and provision for families to gather.

27. **Clarke A, Austin N, Andrews S & Miller J (2000).** Your way, my way: improving access of Aboriginal children and their families to the Royal Children's Hospital, Melbourne, *Issues facing Australian families: human services respond in Frenchs Forest, NSW: Pearson Education Australia, Weeks W. and Quinn M. (eds.), 3rd ed., p355-364.*

Major changes in the direction and delivery of hospital services are described in this chapter which focuses on a model of service delivery at the Royal Children's Hospital, Melbourne which aims to improve access of Aboriginal children and their families. Issues discussed include: Third World health status; access by Aboriginal people to tertiary specialist hospitals; the traditional liaison officer model; barriers faced by Aboriginal families in hospitals; why hospitals need Kooris to work with Kooris; why organisations need to employ more than one Aboriginal staff member; bring about change; the Aboriginal Policy Advisory Committee; cultural change; and lessons which can be learned from the experience of facilitating change.

28. **Thomas D.P & Anderson I.P (2006).** Use of emergency departments by Aboriginal and Torres Strait Islander people. *Emergency Medicine Australia, Feb 18 (1): 68-76*

This report reviewed published Australian literature about ED care of Aboriginal and Torres Strait Islander peoples. Method: Six databases were searched electronically for articles about ED use by Indigenous people in Australia. This strategy was complemented by manual searches of two websites, Emergency Medicine (1994-2004) and three bibliographies. Results: Aboriginal and Torres Strait Islander peoples attend EDs about twice as often as other Australians. The waiting times of Indigenous patients are similar to, or slightly shorter than, those of non-Indigenous patients. However, more Indigenous than other patients choose to walk out before being seen, indicating possibly greater Indigenous dissatisfaction with ED care. Conclusions: Further conclusions of the present literature

review were limited by contradictory results in the few studies of reasonable quality and by general concerns about data quality, especially the poor (but slowly improving) identification of Indigenous people in routine ED data sets. Closer collaboration between ED staff and Indigenous hospital liaison staff, combined with regular monitoring of routinely collected ED data, have the potential to improve Indigenous ED care and so contribute to improvements in Indigenous health.

29. **Snell H, Dore T, Trim S, Wood C, Galler D, Salmond G, Oliff D, Powell I, Keene L**, National Health Committee (NZ) & Ministry of Health staff (NZ) (2001). Quality improvement developments in New Zealand, chapter from *Discussion paper: Quality Improvement Strategy for Public Hospitals September, p.8-10*

This chapter outlines hospital developments in New Zealand over recent times who have individually introduced quality improvement systems. One hospital has a “clinical governance” structure and continuous quality improvement measures such as measuring the time taken from admission to administration of medication for thrombolysis (clot dissolving) for heart attack victims. Intensive care units and renal units participate fully in Australasian quality assessment activities.

Many service providers have signed up to voluntary accreditation programmes where services undergo a regular assessment to evaluate the quality of services and participate in a process of continuing quality improvement. The current hospital licensing regime, which focuses on only some causes of safety risk and lacks clarity as to who is responsible for safe services, is to be replaced by a national safety standards regime through the Health and Disability (Safety) Bill. Under the new legislation, hospitals and aged care facilities will be required to undergo regular assessments in order to comply with recently developed Health & Disability Sector Standards. The Sector Standards are based on minimum safety measures and do not necessarily require continuing quality improvement however, providers may continue to sign up to voluntary accreditation programmes which include progressive quality improvement.

30. **Snell H, Dore T, Trim S, Wood C, Galler D, Salmond G, Oliff D, Powell I, Keene L**, National Health Committee (NZ) & Ministry of Health staff (NZ) (2001) Developing an all-encompassing quality improvement strategy, chapter from: *Discussion paper: Quality Improvement Strategy for Public Hospitals (New Zealand), September, p 10-12*

This chapter discusses the importance of developing an all-encompassing national strategy for improving quality. At this point there was no specific initiative aimed at fostering a culture of quality improvement within organisations. While better monitoring and reporting are needed, with a focus on quality, no monitoring system will pick up every fault, no matter how timely the spot check or hospital survey. To complement external monitoring systems, hospitals need to develop their own frameworks which draw together all local activity for minimising errors and improving quality into a single coherent programme. Furthermore, the highly complex nature of clinical care at the individual level calls for a bottom-up approach to planning and implementing quality improvement activities to complement organisational standards. Also support from clinicians is essential for any quality improvement plan to succeed and this support is unlikely unless the development of the plan involves clinicians themselves. Nor are strategies likely to succeed without cooperation and collaboration between clinicians, managers, government agencies and the patients.

This discussion paper's main purpose is to promote discussion on the best way to develop an overall strategy for improving quality services, pulling together and developing current initiatives where appropriate, and developing new measures where necessary. It is limited to hospital services because it is primarily written with reference to the Health and Disability Services (Safety) Bill, which relates initially only to hospital and residential aged care services, and because hospital services have attracted most public concern over quality and safety. The clinical governance model, introduced into the NHS in the UK, is used as a basis from which to develop the strategy, taking into account New Zealand conditions.

The paper recognises some of the weaknesses experienced in the implementation of the clinical governance model during its early development. It also recognises that the measurement of quality is a far from exact science and that, because of the very human nature of health service delivery, any strategy for quality improvement will be an uneven, evolutionary process.

31. **Mooney N, Bauman A, Westwood B, Kelaher B, Tibben B & Jalaludin B. (2005).** A Quantitative Evaluation of Aboriginal Cultural Awareness Training in an Urban Health Service, *Aboriginal and Islander Health Worker Journal July/August 2005, vol 29 – No.4, pg 23-30*

This study evaluated the impact of a half day Aboriginal Cultural Awareness Training program in an urban health service in NSW on non- Aboriginal health professionals' perceptions, familiarity, friendships, attitudes, knowledge and the health issues affecting Australian Aboriginal people. Results indicated there was a positive impact on familiarity and friendships with Aboriginal people and also an increase in knowledge regarding the complex nature of conditions effecting Aboriginal people The training did not have a major influence in changing peoples perceptions or attitudes and the authors concluded that to have a significant effect in changing beliefs and attitudes, resources could be better put to more systematic identifications of effective strategies.

32. **Westwood B, Atkinson N & Westwood G (2008).** Recognition of Cultural Awareness Training as a Core Component of Health Services, *Aboriginal & Islander Health Worker Journal, January/February, Vol 32 – Number 1*

Evaluation, monitoring and accreditation

The articles in this section have a focus on evaluation, monitoring of performance and accreditation.

33. **Renhard R & Anderson I (2002).** Aboriginal and Torres Strait Islander Accreditation Report, *Metropolitan Health and Aged Care Services Division of the Department of Human Services Victoria (DHS)*

This report gives a detailed analysis of the need for accurate data and the connection this has with CQI. It outlines that data accuracy regarding Aboriginal or Torres Strait Islander status is due to two general factors including:

- The effectiveness and consistency of administration practices and systems
- The preparedness of Aboriginal people to disclose their Indigenous status

This link between data accuracy and status disclosure leads to the need to develop culturally safe services which is closely aligned with the strength of relationship between health services and Aboriginal organisations and community. The report also outline the need to bring about organisational change requires an explicit accountability framework complimented by data collection and analysis (the data relating to the purpose of the framework). Therefore the level of effectiveness of developing strong relationships with Aboriginal organisations and community will be determined by the absence or presence of management systems.

As the relationship between acute health services and Aboriginal organisations develops and the feedback moves from celebrations and artwork to discussion about practices and outcomes, this will have a long term effect on the quality of service provided to the Aboriginal community. This report also includes a comprehensive literature review. This report is the precursor to the Developing a New Approach to Koori Hospital Liaison Services, Final Report 2004 by the same authors that is summarised in the Continuous Quality Improvement Tools, Processors and Guidelines section of this review.

34. **Hurst B, Taylor A, Bonnin R, Pirone C, Waters S & Keeler N (2001).** The South Australian Aboriginal & Torres Strait Islander Patient Evaluation of Hospital Services (PEHS), *Department of Health, Government of South Australia*.

One issue with this approach is how to ensure locally driven initiatives to respond to feedback is supported.

35. **Willis J, Bernard S, Posenelli S & Donnelly B (2006).** Mixing Oil and Water: The practical implication of policy to improve Aboriginal health outcomes for consumers, *Health Issues Journal, Spring*

The authors' review the national and Victorian policy contexts regarding Aboriginal health in relation to hospitals and then outline findings of an evaluation of an existing Aboriginal Hospital Liaison Officer program at St Vincent's Hospital in Melbourne with a focus on improving the quality of service provided to Aboriginal patients. Key outcomes included unrealistic expectations of Aboriginal staff, need to allow community agencies and extended family know what is happening (with patients consent), whole of health service response required to achieve success, partnership with Aboriginal community (including regular communication re staffing changes and advisory committee) and undertake ongoing quality improvement projects (medication and discharge planning tool trials).

36. **Mackenzie G & Currie B.J (1999).** Communication between hospitals and isolated Aboriginal Community Clinics, *Australian and New Zealand Journal of Public Health, Apr:23, 2, pg 204*

This study described the communication dynamics, identified problems and recommended changes to improve patient follow-up and communication between Royal Darwin Hospital and isolated Aboriginal community clinics in the Northern Territory. Staff were interviewed and an audit completed of discharge summaries. Results found that 18% of discharge summaries never arrived. Conclusions and outcomes from this study included the giving of discharge summaries to patients at

discharge, the appointment of an Aboriginal health worker within the hospital and a discharge manual produced for communities.

37. **Hill B (2005).** What do we Change and How: a Reflection on How a Community Health Centre Strategically Re-Thought Who their Community Was and How they could change services to meet their needs, *Presentation at Respecting Culture and Diversity: Innovations in Healthcare Delivery*

The presentation focuses on the process to change service delivery processes, noted the time taken to undertake this change and that this change involved major changes more broadly across the organisation. This included:

- Support from senior management
- Training and education of staff
- Changes to policies
- Changes to the role expectation of health professionals that has included changes to position descriptions
- Re-structuring program areas to promote more integrated services
- Reviewing agency goals to reflect commitment to marginalised populations; and
- Changes to how services are delivered

38. **Franks C & Beckmann K (1998).** A Qualitative Analysis of Patients Taking Their Own Leave from Alice Springs Hospital, *Aboriginal and Islander Health Worker Journal; Volume 26, Issue 4; July/Aug 2002; 3-8*

This qualitative study investigates the phenomenon- of patients taking their own leave (TOL) from Alice Springs Hospital in Central Australia and is the first substantial study of its kind in Australia. Interviews were conducted with a range of patients and relevant staff, and particular efforts were made to work closely and collaboratively with Aboriginal people from within Alice Springs and remote communities in Central Australia. Both staff and client interviewees identified similar factors that they believed led to TOL. These included cultural and language differences, family and social obligations, loneliness and social isolation from family, patients' belief that they were 'better' and that it was 'OK' to go home, and the desire for alcohol/alcohol withdrawal.

39. **Dartworth Medical School (2005)** American Indians and Alaska Native veterans have higher mortality rate after surgery than Caucasians, *Medical News Today, 1 June*

Contributing to growing literature on marked racial and ethnic disparities in US healthcare, a study led by Dartmouth Medical School has concluded that American Indians and Alaska Natives have a greater chance of death within 30 days of surgery and suffer more from several preoperative risks compared to Caucasian patients. The first Navajo woman surgeon in the U.S., Alvord notes that the health status of American Indians is generally lower than the total U.S. population, with a higher prevalence of diabetes and a shorter life expectancy.

40. **Valery P.C, Coory M, Stirling J & Green A.C (2006). Cancer diagnosis, treatment, and survival in Indigenous and non-Indigenous Australians: a matched cohort study.** *The Lancet, London: Jun 3-Jun 9, Vol. 367, Issue 9525; pg. 1842*

This study assesses the differences in disease stage at cancer diagnosis, treatment, and survival between **Indigenous and non-Indigenous** populations in Queensland. Indigenous people diagnosed with cancer between 1997 and 2002 were identified through the cancer registry and compared with randomly selected non-Indigenous patients who were frequency-matched for age, sex, place of residence, cancer site, and year of diagnosis. Details were obtained of treatment from hospital medical records. Co-morbidities such as diabetes mellitus or chronic renal disease were more common in Indigenous patients. These individuals were less likely to have had treatment for cancer and waited longer for surgery than non-Indigenous patients. After adjustment for stage at diagnosis, treatment, and co-morbidities, non-Indigenous patients had better survival than Indigenous ones. Non-Indigenous cancer patients survive longer than Indigenous ones, even after adjustment for stage at diagnosis, cancer treatment, and greater co-morbidity in Indigenous cases. The authors believe that better understanding of cultural differences in attitudes to cancer and its treatment could translate into meaningful public-health and clinical interventions to improve cancer survival in Indigenous Australians.

Continuous quality improvement tools and processors

41. **Renhard R (2001).** The Evidence of Effectiveness for Quality Initiatives in Human Services: A Critical Review, *Prepared for the Quality in Services Flagship project.*

This review examines the evidence for the effectiveness of a range of quality initiatives. This review explores the two fundamental questions when operationalising quality. How do all stakeholders obtain an assurance that a certain level of quality is being delivered and how can quality be improved? The key findings were that quality initiatives, regardless of scope or focus, are more likely to be effective when used in an organisation or service that functions according to particular quality principles and practices. These include:

- The use of problem-solving approaches based on statistical analysis and relevant ‘soft’ data
- The focus of analytical processes is on underlying organisational processes and systems rather than blaming individuals
- The use of cross-functional employee teams in continuous improvement activities
- Employee empowerment to identify problems and opportunities for improved care and to take the necessary action
- An explicit focus on both internal and external consumers

The author outlines that the key determinant of success of a quality initiative is not the initiative itself but the nature of the organisation in which it is used.

In qualifying the results of this review the author highlights that even though there can be successes found in a ‘micro’ approach to quality, to address complex quality issues such as consumer satisfaction, one needs to take a wider approach. The other issue raised was that certain characteristics, if not present in a quality initiative, will limit its effectiveness even if introduced into an organisation that has adopted the necessary quality principles and practices. An example given was the development of standards that did not have general support from all key stakeholders involved in a system.

42. **Renhard R & Anderson I (2004).** Developing A New Approach to Koori Hospital Liaison Services, Final Report, *Metropolitan Health and Aged Care Services Division of the Department of Human Services Victoria (DHS)*

This report presents key guidelines designed to act as an accountability framework for Victorian acute health care providers focusing on relationships with Aboriginal organisations, culturally aware staff, discharge planning and primary care referrals.

43. **Bailie R.S, Si D, O’Donoghue L & Dowden M (2007).** Indigenous health: effective health services through continuous quality improvement, *Medical Journal of Australia*, 186(10):525-527.

This article outlines the ABCD research project which was an important influence on the Healthy for Life program funded by the Australian Federal government and operating in over 80 Aboriginal and Torres Strait Islander primary health care services. The article outlines the CQI approach which includes facilitating ongoing improvement by using objective data to analyse and improve processes, efficient and effective functioning of organisational systems, an ongoing cycle of gathering data on how well organisational systems are operating and developing and implementing improvements.

The authors give a brief overview of CQI research and where it has been used successfully including manufacturing, service and health care industries. Research in the business and manufacturing areas highlights leadership, people management and customer focus as key CQI components that predict performance. In the clinical area, CQI is most effective when focusing on: organisational priorities, good engagement of high level managers, the intervention is clearly formulated, the organisation is ready for change, there is a relationship of trust with practitioners, there are adequate information systems, and the external environment is supportive.

The authors then outline why CQI is well suited to Australian Aboriginal and Torres Strait Islander setting and to the principles of the Indigenous research and service delivery.

The participatory approach and the customer focus of CQI, and the combination of scientific and humanistic professional values, adhere to the principles and values of Aboriginal and Torres Strait islander peoples, as expressed in recent national statements on research and cultural respect. In these statements, the emphasis given to tackling underlying causes (eg. Human resource capacity and social conditions including unemployment), to capacity building (including specifically community capacity to understand and use data), and to improve outcomes is also central to CQI, as is the development of positive models and a

culture of self-evaluation rather than blame. CQI also provides a structure to refine and re-invigorate programs to promote sustainability.

Bailie Et Al pg 526

44. **Comino E.J, Titmuss A, Harris E, Craig P & Jackson P.L (2007).** Identification of Aboriginal infants at an urban hospital, *Journal of Pediatric Child Health, Sep; 43 (9): 623-6*

This study explored the accuracy of identification of Aboriginal infants at an urban hospital by using data from a number of sources and supplementing this with local health worker knowledge about the Aboriginal status of infants. This study highlighted the importance of systematically seeking information on the Aboriginal status of both parents by antenatal services; of providing opportunities for timely feedback on the data quality to maternity service providers; and ensuring that the data are used to inform development of culturally appropriate services. As a result of this study, services have implemented strategies to routinely identify infants with an Aboriginal father as well as those with an Aboriginal mother.

45. **Author Unknown (2008).** Return on Investment Paper 1: Creating Efficiency by Improving Patient Satisfaction, published in *Satisfaction Snapshot January 2008 Volume 7 Issue 1, p.2-3*

This article explores the many challenges that health care leaders face as a result of rising consumer expectations, new technology, growing competition, and scarce resources. Efficiency in the care process, a key component of managing increasing patient volumes, has become a focal point for many providers faced with the reality of doing more with less. Leading providers have found that there does not need to be a trade-off between efficiency and service and, in fact, excellent service can lead to improved efficiency. Health care organisations can identify inefficiencies through patient satisfaction initiatives and target improvement efforts in areas that negatively impact both patient satisfaction and efficiency. Focusing improvement efforts around the areas causing patient dissatisfaction can streamline processes to better meet the needs of patients while at the same time improve other key organisational measures. There is a quote in the article that emphasises that *“Patients are the best source of information about a hospital system’s communication, education, and pain management processes, and they are the only source of information about whether they were treated with dignity and respect. Their experiences often reveal how well a hospital system is operating and can stimulate important insights into the kinds of changes that are needed to close the chasm between the care provided and the care that should be provided.” Cleary 2003*

The article concludes that without strong and organisational patient satisfaction initiatives, providers will lack the critical information needed to improve efficiency and solve problems.

46. **Author Unknown (2008).** Return on Investment Paper 2: Increasing Profitability by Improving Patient Satisfaction, published in *Satisfaction Snapshot January 2008 Volume 7 Issue 1. p.4-6*

This article argues that there is substantial evidence to show that incorporating consistent satisfaction measurement, acting on patient feedback and developing leaders to elevate the priority in these areas improves patient loyalty, improves operational efficiency, improves the capacity to treat more patients, retains staff and ultimately provides increased financial returns. Patient

satisfaction measurement identifies opportunities to better meet the needs of patients. As hospitals successfully meet these needs, their patients continue to utilise hospital services, which boosts the overall volume and profitability of the organisation. Numerous studies confirm that highly satisfied patients are loyal patients. They are more likely to return to the same provider for future medical care if required and to refer other patients. Leading providers who have recognised the lifetime value of a satisfied patient are finding enhanced profitability to be among the resulting outcomes.

47. **Clarke A, Ewen S, Waddell N & Posenelli S (2008).** Improving Care for Aboriginal and Torres Strait Islander Patients – Resource Kit

The development of this kit was funded by the Department of Human Services in Victoria and provides a number of resources for hospital staff to assist in the implementation and ongoing successful management of an Aboriginal program. The kit includes:

- Orientation and information package for health service managers;
- Orientation and information package for Aboriginal hospital liaison officers;
- Cultural competency information package for health services;
- Appendices package;
- Literature review.

The process undertaken to develop these resources included gathering data and best practice resources from key stakeholders across Victoria. The report also included a number of recommendations that included the need to strengthen executive ‘buy-in’ by including KPIs for Aboriginal health in the DHS Statement of Priorities for the hospitals and training for non-Aboriginal staff on the management of Aboriginal staff.

48. **Hurley A (2003).** *Respect, Acknowledge, Listen: Practical protocols for working with Indigenous Community of Western Sydney*, Indigenous Program of Community Cultural Development NSW

These protocols provide some practical advice on working with Indigenous communities. They include:

Get to know your Indigenous community - Make appointments to meet community organisations, health services. You may have to organise meetings through other Indigenous people. Attend, participate in and support Indigenous events e.g. NAIDOC Week celebrations. Use Indigenous publications such as the Koori Mail, National Indigenous Times, ATSIC and ABC Message Stick websites.

Consult - Consultation should not be tokenistic. Negotiation needs to occur for equal relationships to develop. Focus on issues that are of interest and advantage to the Indigenous community. Seek a facilitator or chairperson who is impartial. When establishing a reference group or steering committee it is important to advertise an expression of interest to allow a broad representation. Take account of issues such as language. Responses such as silence do not necessarily mean acceptance.

Get permission - This includes the local community, Elders, traditional owners according to what is required. Copyright and moral rights are very important issues to be aware of.

Communicate - The communication process requires a variety of skills ie respect, good listening, patience, understanding, common language, confirmation, clarification and more. See Language (some good points to remember), Koori time reporting back and staying in touch.

Ethics and morals - Confidentiality and privacy are essential including traditional customs and stories may be given to you in trust and cannot be reproduced without permission. The integrity and trust you develop within an Indigenous community is vital and must be maintained. Acknowledgement and attribution of clans, Elders, traditional owners, information, ideas and research has to be written into any documentation and verbalized in speeches, talks and presentations. Any advertising, media releases, news articles etc concerning Indigenous people should only be made with the prior knowledge and agreement of the community concerned.

Correct procedures

Respect and acknowledgement are common procedures for working within Indigenous communities – e.g. Welcomes and Acknowledging Traditional Owners

What to call people – some Indigenous people prefer to be called Indigenous, others prefer Aboriginal. The same way that some people prefer Torres Strait Islander to Islander. Try and gauge how people want to be addressed.

Traditional welcome or welcome to country – mostly done at major events and meetings.

Paying people. - If an Indigenous person chooses to work with you in any capacity ie in giving a dance performance, giving a speech, a talk or traditional welcome, doing or participating in artwork or project, it is appropriate that they be paid for time, expertise and knowledge, just as it is for any other artist or professional.

Indigenous involvement – in working with the Indigenous community on Indigenous projects it is vital to have Indigenous involvement throughout.

Cross cultural training – protocols are a useful cross cultural tool.

www.ccdnsw.org/ccdnsw/pdf/protocols.pdf

49. **Waples-Crowe P & Pyett P (2005)**. *The making of a great relationship: A review of a healthy partnership between mainstream and Indigenous organisations*, Victorian Aboriginal Community Controlled Health Organisations (VACCHO).

This publication reports on the apparently successful partnership between mainstream and Aboriginal organisations involved in the Victorian Indigenous Blood Borne Virus/Injecting Drug Use Training Project. The review set out to discover what made for an effective working model of a working partnership between mainstream and Indigenous organisations – what makes for a healthy

relationship, what processes work, and what steps you may need to take in your organisation, whether it is an Aboriginal or a mainstream organisation.

This list of steps summarizes what was important in the collaborative process.

A long time frame – let the relationship grow at its own pace. Not a forced partnership but one built on trust. Get to know each other, work together formally and informally.

Building trust – mainstream organisations need to work with Indigenous organisations in their time frame and on their priorities, allowing the relationship to develop naturally.

Valuing each other – mutual respect, valuing what each can bring to the partnership, listening to each other and respecting different points of view.

Get educated – it is not up Aboriginal people to educate the mainstream about all things Aboriginal. Before planning a collaboration, mainstream organisations need to ensure that they have allowed time and allocated funding for cross-cultural training.

Good planning – a successful project is dependent on good planning, which should involve all the key stakeholders.

Useful product – a collaborative project is only as good as what is produced by it.

Community initiated

Identifying the partners and formalising partnerships – identify the partners. Even better, include the partners in a formal partnership arrangement such as a memorandum of understanding – this makes all of the partners equal and gives the partnership and the project a solid foundation.

Supportive work environments – to develop an Indigenous and mainstream collaborative project takes effort and time. For example mainstream organisations give time and support from their workplaces to make the commitment and the health service embraces opportunities to make the health service more Indigenous friendly, from the executive board down.

Cultural awareness – time to exchange ideas and values helps to build solid foundations. Cross cultural training at the beginning of any Indigenous/mainstream collaborative project is highly recommended.

50. **Satisfaction Snapshot (2008).** Research and experience has shown time and again: sharing results of customer satisfaction surveys will help you get the results you want, published in *Satisfaction Snapshot April, Volume 7 Issue 4*

Regularly providing information about customer satisfaction in a consistent manner will keep staff informed and connected to the process. The article provides a guide to focus on sharing patient/resident satisfaction information within healthcare organisations. The same strategies and tactics can be applied to the communication of any performance improvement data—including

quality data, employee satisfaction, doctor satisfaction, and anything where results depend upon the behaviours of the audience. This guide is designed to help with the basics of information sharing: identifying which staff should receive results and how often, deciding what types of results to share, and forming the best ways to share survey results with your staff. The article outlines that everyone should know about customer satisfaction. Everyone at the hospital contributes to patient/resident satisfaction. It's not just receptionists, nurses, aides, doctors, technicians, and other clinical staff who affect customer satisfaction; everyone has the potential to make an impact including:

- The information technology department member observed fixing a computer;
- The food services staff member who delivers or picks up a tray;
- Anyone who answers a phone call ;
- The environmental services personnel who clean patient/resident rooms, offices, and reception areas, mow the grass, collect rubbish, or wash windows;
- Anyone who walks around the facility and can be identified as a member of the organisation;
- Anyone who aids in the ability of frontline staff to do their job effectively;
- Doctor and nurses who provide clinical care must incorporate competent care, courtesy and compassion.

The article outlines that there is a big difference between measuring patient satisfaction and service quality as perceived by patients. With patient satisfaction, many staff think that it is only about those with direct patient contact that have a role to play. With service quality as viewed by patients, it is everyone's job. Since everyone at the hospital provides some kind of service that ultimately traces back to the patient, everyone needs to be involved.

51. **Bauert P.A (2005).** The Royal Darwin Hospital as a centre of excellence for clinical training in Aboriginal health: still a dream, *Medical Journal of Australia, Vol 182 – Number 10*

A key message from this article is that the goal to achieving the creation of a 'Centre of Excellence in Indigenous Health' requires strong leadership to overcome bureaucratic and financial obstacles. Paul Bauert highlights the low percentage of Aboriginal people employed within the hospital (less than 3%) compared to the high percentage of Aboriginal patients attending the service (at times up to 60%). Outlines a proposal for clinical excellence put together by clinicians at RDH. Barriers have been encountered including the argument that focus should be on the primary health area but Bauert counters with the point that many clinicians at RDH do specialist outreach work to communities and have gained extensive knowledge in both primary and tertiary areas. Other barriers include administrators focusing on access blockages, elective surgery and budget matters so future planning is left as a low priority. Also health bureaucrats feel it should already be core business for the hospital so no extra funds are forth coming.

Cultural Frameworks

52. **Orlandi (1992).** Cultural competence: an organizing framework

The author describes the Cultural Sophistication Matrix and identifies:

- the importance of getting (Indigenous) people involved
- the need to distinguish between important within-culture sub groups
- the importance of going beyond cultural competence

The Cultural Sophistication Framework

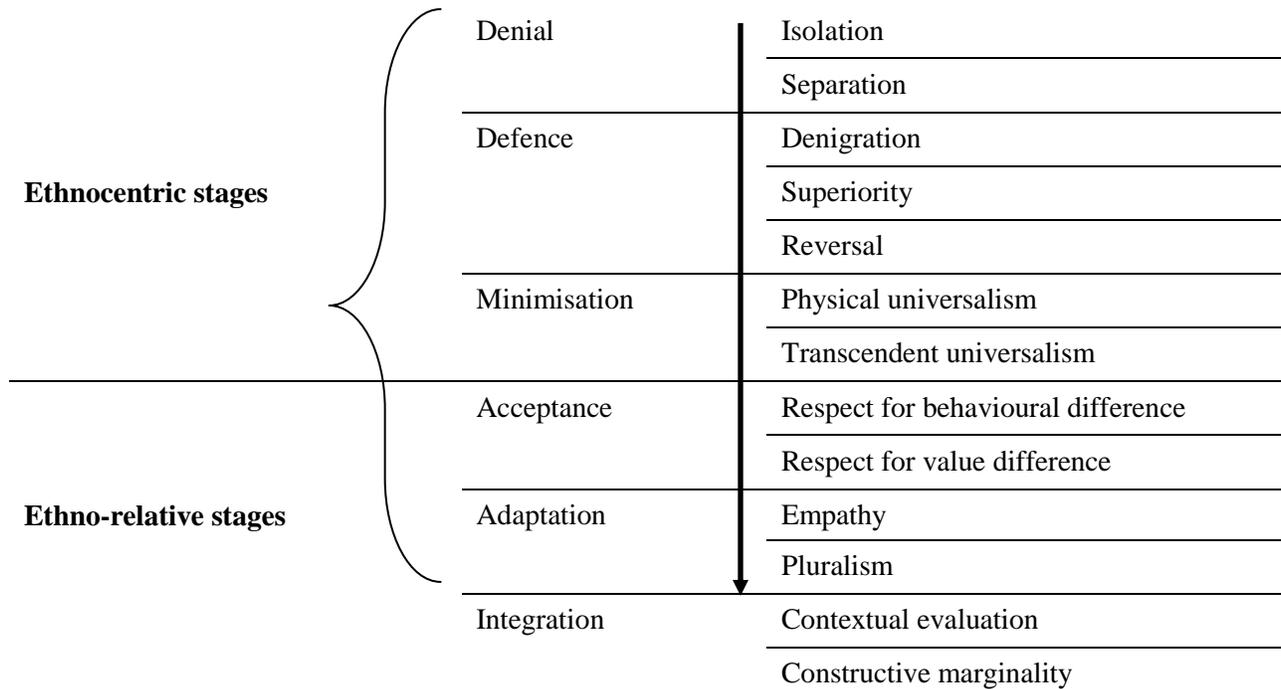
	Culturally Incompetent	Culturally Sensitive	Culturally Competent
Cognitive Dimension	Oblivious	Aware	Knowledgeable
Affective Dimension	Apathetic	Sympathetic	Committed to change
Skills Dimension	Unskilled	Lacking some skills	Highly skilled
Overall Effect	Destructive	Neutral	Constructive

The characterizations suggested by the cells of the matrix provide some useful distinctions. The intermediate category can be thought of as describing someone who is aware of the issues involved and is sympathetic to the needs created by a particular cultural problem but who lacks the necessary skills to do anything about it.

The approach has practical implications for the development and evaluation of training programs.

Source: Orlandi M, Cultural Competence for Evaluators: A Guide for Alcohol and other Drug Abuse Prevention Professionals Working with Ethnic / Racial Minorities. US Department of Health & Human Services, 1998.

53. **Bennett (1993).** Bennett’s model of intercultural sensitivity



Source: Tesoriero Frank, Personal growth towards intercultural competence through an international field education program in *Australian Social Work*, Vol. 59, No. 2, June 2006 pp. 126-140.

Ethnocentric stages

Denial

In this stage cultural difference is simply not considered, or where it is, there are only very wide categories for cultural difference, such as skin colour.

Isolation, separation

Isolation results in cultural differences not being experienced at all. With separation barriers are erected to maintain distance from the different and this is a slight development in intercultural sensitivity beyond isolation because it must acknowledge difference.

Defence

Defence is a position where, recognizing cultural differences, a person postures themselves so that they may counter the impact of those differences, which they see and experience as threatening. They create particular defences. Emphasizing commonality is a strategy to respond to defences.

Denigration, superiority

These are indicative responses to cultural differences where the person is defensive of the differences confronting him or her, where they either negatively evaluate what they see or take a slightly difference focus and positively evaluate their own cultural status.

Minimisation

This is the final way to preserve one's own world view as central and normal. Here cultural difference is acknowledged but not negatively valued, just somewhat lost within a focus on similarities. This position can be seen as akin to human sensitivity, respect and acceptance (e.g. we are all children of God). Moving beyond his stage requires a quantum leap to an appreciation of relativity and ambiguity.

Ethno-relative stages

These stages assume that cultures can be understood contextually. In the ethno-centric stages difference is experienced as threatening. In the ethno-relative stages difference is non-threatening. Cultural difference is more likely to be enjoyable and sought after. Here cultural differences are acknowledged and respected, considered inevitable and a preferred human condition.

Adaptation

The adaptive relativist nurtures a deep appreciation and respect for the integrity of cultures, including one's own culture, values and world view. Adaptation is not the assimilation of two world views into one melting pot. Nor is it a process of substituting one work view for another. Adaptation is an additional process. Culture is a process. It is not something one 'has', it is something one engages with.

Integration

Here empathy is central. It is achieved if one can imagine or comprehend the perspective of the other and imaginatively participate in it.

Reflective practice is dynamic, there is excitement in becoming culturally competent, in naming the personal and professional growth, the enjoyment of change and discovering one's own position in relation to difference. At the same time, there are ongoing challenges that emerge alongside the learning and discoveries.

54. **National Health and Medical Research Council (2006).** Four Dimensional Model

The guidelines outline a four dimensional model for increasing cultural competency in the health sector. Integral to the model is the need for:

- Capacity and conviction at systemic and organisational levels to direct, support and acknowledge culturally competent practice at an individual or professional level.
- Clear delineation of levels of responsibility and the interrelationship between these levels.

The model acknowledges four dimensions of cultural competency (based on Eisenbruch et al 2001):

- Systemic – effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behavior and practice at other levels. Policies support the active involvement of culturally diverse communities in matters concerning their health and environment.
- Organisational – the skills and resources required by cultural diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.
- Professional – overarching the other dimensions, this level of cultural competence is identified as an important component in education and professional development. It also results in specific professions developing cultural competence standards to guide the working lives of individuals.
- Individual – knowledge, attitudes and behaviours defining cultural competency behaviours are maximised and made more effective by existing within a supportive health organisation and wider health system. Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable health programs.

Source: Cultural Competency in Health: a guide for policy, partnership and participation – NH&MRC (2006). www.nhmrc.gov.au/publications/synopses/hp25syn.htm

55. Guidelines for delivering Indigenous content: CDAMS Indigenous Health Curriculum Framework (2004)

In 2002 the Committee of Deans of Australasian Medical Schools (CDAMS) partnered with the Office of Aboriginal and Torres Strait Islander Health (OATSIH), within the Commonwealth Department of Health and Ageing, to establish and implement the CDAMS Indigenous Health Curriculum Development Unit. The University of Melbourne through the VicHealth Koori Health Research and Community Development Unit hosted the project.

The purpose of this curriculum framework is to provide medical schools *with a set of guidelines for success* in developing and delivering Indigenous health content in core medical education. The document seeks to enunciate the basic components of a functional curriculum for delivering Indigenous health effectively.

Of relevance are the guiding principles which include for example that Aboriginal and Torres Strait Islander people have a diversity of cultures and this should be reflected in the design, delivery and evaluation of curricula; Indigenous views on health and wellbeing are both valid and critical to the delivery of culturally appropriate, and safe, medicine and health care; health outcomes are governed

more by the historical and social determinants of health, than with inherent Aboriginality; Aboriginal and Torres Strait Islander peoples require equity of access not only to mainstream services that are free of racism and other forms of discrimination, but also services which are specific and culturally appropriate. See p7 for additional information.

The material on suggested key subject areas that make up the learning about the health of Aboriginal and Torres Strait Islander peoples also lists the attributes and outcomes students might be expected to achieve as a result of the delivery of this content.

Key subject areas:

History; Culture, Self and Diversity; Indigenous Societies, Cultures and Medicines; Population Health; Models of Health Service Delivery; Clinical Presentations of Disease; Communication Skills; Working with Indigenous Peoples – Ethics, Protocols and Research. Includes recommendations on the delivery/formats - lectures, tutorials, case studies, self guided workbooks, multi media tools, talking circles where elders are empowered to share their experiences, reflective discussion, field visits, experiential learning camps, community visits, problem based learning scenarios, simulated patient training, community clinical placements. p 23.

Ten key pedagogical principles and approach are outlined along with strategies, examples and cautions for teaching and implementation approaches are outlined. These are worthy of close review.

Examples: Some of the principles include teaching from a strengths based perspective, including positive examples of successful programs in Indigenous Australia.

- Facilitate positive learning experiences and interactions with Aboriginal Australians based on real world contexts.
- Teach discrete compulsory subjects to lay a foundation. Indigenous people should be included in the design, delivery and evaluation, they are key developers and enhancers.
- Content should be locally accurate, partnerships will need to be developed.
- Teach Indigenous cultural safety/awareness separately to multicultural awareness – Indigenous Australians are the First Australians and their experience is distinct from the migrant experience.
- For further details see pp13-22 of the guidelines.

Source: CDAMS Indigenous Health Curriculum Framework – Project Steering Committee, Committee of Deans of Australian Medical Schools, August 2004.

The University of Melbourne, VicHealth Koori Health Research and Community Development Unit, Australian Government Office for Aboriginal and Torres Strait Islander Health.

Other

Articles in this section are more general in nature but are included as they highlight and reinforce the key elements required to bring about quality improvement processes in acute health care settings.

56. **McGrath P (2007)**. 'I don't want to die in that big city; this is my country here'. Research findings on Aboriginal people's preference to die at home, *Australian Journal of Rural Health v.15 no.4 Aug, 264-268*

This article presents findings from a two-year study on Indigenous palliative care conducted in the Northern Territory that explored and documented wishes in relation to place of death for rural and remote Aboriginal people. The findings provide a clear articulation of the wish of Aboriginal people from rural and remote areas to die at home connected to land and family. The strong wish to die at home informs the importance of building up local health and palliative care services and avoiding, where possible, the need for relocation for health care to the major metropolitan hospitals during end-of-life care.

57. **Salisbury, C (1998)**. A health service and Aboriginal and Torres Strait Islander partnership to develop and plan mental health services, *Australian Journal of Primary Health - Interchange v.4 no.4, 18-30*.

The aim of this study was to examine the effects of an action research partnership between the Tweed Valley Health Service (TVHS) and the Aboriginal and Torres Strait Islander community for the development and delivery of Aboriginal and Torres Strait Islander mental health services. This partnership was based upon Labonte's (1989) view of empowerment where it is suggested that to be empowered means to have increased capacity to define, analyse and act upon one's problems. It was proposed that the establishment of a 'partnership' based upon these principles would assist in operationalising Indigenous community participation in TVHS planning. To achieve this type of 'partnership', the health service had to be willing to enter the partnership and to give the authority to the Aboriginal and Torres Strait Islander Health Outcome Council to seek and trial solutions on Aboriginal and Torres Strait Islander mental health matters. Key outcomes were defined as the extent to which the re-organised services proved to be acceptable and utilised by the local Aboriginal and Torres Strait Islander population. Outcomes were operationalised through measures of service utilisation and consumer satisfaction with accessibility, process and outcomes. The study trialed participatory action research 'as a method for Indigenous participation in mental health service planning and development and concludes that it is a valid model for cross cultural research and health service development in a complex medical setting.

58. **Kofi O (2005)**. Western Region Health Centre Refugee/Newly Arrived Health Model, *Presentation at Respecting Culture and Diversity: Innovations in Healthcare Delivery*

This presentation highlighted the key issues in the development of the Refugee/newly arrived health model. This included the development of strong partnerships with relevant community organisations and health services, development of internal systems to ensure an integrated and co-ordinated

approach to the range of health and welfare needs of the new arrival refugees, development of internal and external capacity building strategies and the use of the community development model.

59. **Levin R & Herbert M (2004)**. The Experience of Urban Aboriginals with Health Care Services in Canada: Implications for Social Work Practice, *Social Work Visions from Around the Globe: Citizens, Methods and Approaches*, The Haworth Press Inc.
60. **Browne A.J (2007)**. Clinical encounters between nurses and First Nations women in a Western Canadian hospital, *Social Science & Medicine* 64, p. 2165-2176.
61. **Ingram S (2007)**. Defining the distinctive communication tools and styles to enable increased effectiveness in health education and promotion amongst Aboriginal people who use English as their everyday language: a literature review and web appraisal of evidence based practice, *Aboriginal & Islander Health Worker Journal*, March/April, Vol 31 – Number 2.
62. **Cultural Competency in Health: A guide for policy, partnerships and participation (2005)**. National government policy developed by the NHMRC

This policy focuses on culturally and linguistically diverse communities and therefore is not specifically targeted at Aboriginal communities. Some of the key messages in the policy include:

- Achieving culturally competent health care must include the development of relationships with the targeted communities
 - Is everyone's responsibility including community members
 - Acknowledgment that cultural competence at management levels affects the service culture of organisations
63. **Gracey M, Williams P and Smith P (2000)** Aboriginal deaths in Western Australia 1985- 89 and 1990-94 *Aust NZ J Public Health* 24:145-152.
 64. **McDermott R, Rowley K.G, Lee A.J, Knight S, O'Dea K (2000)** Increase in the prevalence of obesity and diabetes and decrease in plasma cholesterol in a central Australian Aboriginal community *Med J Aust* 172:480-484.
 65. **Rousham EK and Gracey M (1997)** Persistent growth faltering among Aboriginal infants and young children in north-west Australia: a retrospective study from 1969 to 1993 *Acta Paediatrica* 86 (1):26-50.
 66. **National Health Strategy (1992)** *Enough to make you sick: How income and environment affect health* National Health Strategy, Canberra.

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