

## **Consultation on the draft National Safety and Quality Health Service Standards (second edition) User guide for health service organisations providing care for patients from migrant and refugee backgrounds**

The Australian Commission on Safety and Quality in Health Care (the Commission) is seeking feedback on the draft *National Safety and Quality Health Service (NSQHS) Standards User guide for health service organisations providing care for patients from migrant and refugee backgrounds* (the user guide).

This user guide provides information for health service organisations on recommended approaches to delivering culturally responsive-care that is safe and of high quality to patients from migrant and refugee backgrounds. It contains practical strategies and examples for improving care for people from migrant and refugee backgrounds.

### ***Target audience***

This resource is for health service organisations implementing the NSQHS Standards (second edition).

### ***Consultation dates***

Consultation on this resource will run until **Friday, 15 May 2020**.

### ***Consultation questions***

You are invited to provide feedback on the whole resource, or alternatively, specific components of the resource that are important to you.

Included below are questions to guide your feedback. You can answer all, some or none of the questions in your feedback.

1. **Language:** How could we improve the language, terminology and glossary used in the resource so that they are more appropriate and applicable to the context of your organisation?
2. **Usability:** How could we make the content in this resource more applicable and easier to use to implement the NSQHS Standards (second edition)? For example, changes to the length, layout, and level of detail of the content.
3. **Clarification:** Does any of the content in this resource require further clarification or rewording? Please provide suggestions for these changes.
4. **Gaps and duplication:** Are there any gaps in the content and how should they be addressed? Is there any unnecessarily duplicated content that could be removed?
5. **Additional functionality:** What additional functionality would be helpful in an interactive online resource or as separate resources? For example: links between actions; links to other resources; one-page factsheets; or infographics.
6. **Other feedback:** Please provide any other feedback you have on this resource.

## **Submitting your feedback**

When providing feedback, please reference the specific resource, Standard and/or action.

Our preferred method for receiving your feedback is by [online survey](#). Alternatively, feedback can be provided by:

- Email: [NSQHSstandards@safetyandquality.gov.au](mailto:NSQHSstandards@safetyandquality.gov.au)
- Mail: NSQHS Standards Resources  
GPO Box 5480  
Sydney NSW 2001
- Fax: (02) 9126 3613

Please do not submit your feedback as tracked changes to a copy of the resource, due to difficulties in analysing feedback provided in this way.

## **Our contact details**

If you have any questions in relation to this consultation process please contact the Commission on 1800 304 056 or [NSQHSstandards@safetyandquality.gov.au](mailto:NSQHSstandards@safetyandquality.gov.au).

AUSTRALIAN COMMISSION  
ON SAFETY AND QUALITY IN HEALTH CARE



MIGRANT & REFUGEE  
HEALTH PARTNERSHIP

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**National Safety and Quality Health Service  
Standards**

# **User guide for health service organisations providing care for patients from migrant and refugee backgrounds**

**CONSULTATION DRAFT**

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# Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, consumers, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health care. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. Importantly, the NSQHS Standards provide a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The second edition of the NSQHS Standards embeds person-centred care and addresses the needs of people who may be at greater risk of harm. This includes patients from migrant and refugee backgrounds who may experience communication barriers leading to harm<sup>1</sup> and poorer health outcomes.<sup>2</sup>

Australia is a highly diverse, multicultural nation, nearly half of all Australians being overseas-born or having one or both parents born overseas. It is essential that health service organisations deliver safe and high-quality care to everyone in the Australian community. However, people from migrant and refugee backgrounds may be at greater risk of harm. This is consistent with the principle that health is a fundamental human right for all, and vulnerable population groups require particular attention to ensure equitable access to health care.

Provision of care that respects and is sensitive to different cultures and ethnic backgrounds is essential to the implementation of person-centred health care.<sup>3</sup> Such care is characterised by exploration, empathy, and responsiveness to people's needs, values, and preferences.<sup>4</sup> When working with people from migrant and refugee backgrounds it is important to recognise the social, economic, cultural and behavioural factors influencing health, both at individual and population levels.<sup>5</sup>

The Commission collaborated with the Migrant and Refugee Health Partnership<sup>i</sup> to develop this *User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds* (the user guide).

## Purpose of this user guide

This user guide provides information for health service organisations on recommended approaches to delivering culturally responsive-care that is safe and of high quality to patients from migrant and refugee backgrounds. It contains practical strategies and examples for improving care for people from migrant and refugee backgrounds.

All actions in the NSQHS Standards apply to patients from migrant and refugee backgrounds. However additional strategies may be required to address the specific risks faced by people from migrant and refugee backgrounds.

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<sup>i</sup> Migrant and Refugee Health Partnership is a national collaboration, auspiced by Migration Council Australia, bringing together clinicians, community and government to develop a consistent, minimum standard policy framework to address barriers to accessing health care for migrants and refugees.

The examples provided in this user guide are not exhaustive or mandatory. The user guide supplements existing resources published by the Commission to support implementation of the NSQHS Standards. These include:

- Guide for Hospitals
- Guide for Multi-Purpose Services and Small Hospitals
- Guide for Day Procedure Services
- User Guide for Aboriginal and Torres Strait Islander Health
- User Guide for Acute and Community Health Service Organisations that Provide Care for Children
- National Model Clinical Governance Framework
- User Guide for Governing Bodies

These resources are available on the Commission's website at <https://www.safetyandquality.gov.au/>

# Clinical Governance Standard

## **Intention of this standard:**

To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Understanding the diversity of patients from migrant and refugee backgrounds is essential for planning and delivering culturally responsive care, managing risks, and improving the safety and quality of care for all patients.

Migration- and ethnicity-related factors are significant social determinants of health.<sup>6</sup> Cultural considerations, which may be influenced by ethnicity, religion, sexual orientation, gender, socio-economic factors, disability or age<sup>7</sup>, pre-migration experiences, migration status, spiritual beliefs, social stigma and experience of trauma<sup>8</sup>, should be considered when planning care<sup>9, 10</sup>, as they may impact on a patient's:

- Understanding and acceptance of health information
- Understanding of health and illness
- Access to health care
- Response to healthcare interventions.<sup>7, 11</sup>

Benefits for health service organisations include:

- Positively impact on the patient's experience of care
- Improve trust<sup>2</sup>
- Reduce a patient's anxiety and apprehension about accessing health care<sup>12</sup>  
Improve effective communication
- Lead to the patient's satisfaction with, and adherence to health advice<sup>13</sup>
- Result in safer use of medicines<sup>14</sup>
- Improve processes for obtaining consent<sup>15</sup>
- Contribute to better health outcomes.<sup>2</sup>

## **Diversity and high-risk groups**

Action 1.15 states:

The health service organisation:

- a. Identifies the diversity of the consumers using its services
- b. Identifies groups of patients using its services who are at higher risk of harm
- c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Planning for and delivering care should include consideration of the specific needs associated with people from migrant and refugee backgrounds who use healthcare services, to ensure risks and barriers to safe, high quality care are identified and managed.

## Suggested strategies

### *Data collection*

Health service organisations that systematically collect patient demographic data on migrant and refugee patient populations can generate information to assess, anticipate and mitigate barriers to accessing care and risks of harm for patients.

Data collection for patients from migrant and refugee backgrounds, including general demographic information and their migration and social history, can be used to ensure that the patient's needs and preferences are incorporated in their care.<sup>16</sup> It can also be used to: analyse levels of service utilisation and identify patient tendencies to seek treatment at later and more acute stages of care.

The following minimum data set should be collected routinely:

- Country of birth
- Need for interpreter
- Preferred language
- Previous interaction with the healthcare system
- Ethnicity/Ancestry.

*Country of birth* is an important data item that may provide an insight into a patient's migration history.

*Need for interpreter* includes spoken language interpreter, an Auslan interpreter or a deaf interpreter and should extend to a patient's preferences for language and gender. This data item helps establish the patient's requirements for assistance in interpreting spoken information or translating written information.

*Preferred language* includes language spoken at home, Auslan or another sign language. It may not relate to country of birth and may be a language other than English even where the patient can speak English.

*Previous interaction with the healthcare system* may be dependent on the number of years a person has been in Australia and their health needs.

*Ethnicity/Ancestry* is often a more relevant identity characteristic than country of birth, particularly for people with complex migration history, as it is more closely related to cultural background and more likely to influence a patient's health beliefs and preferences. Patients from some ethnic groups may have a preference for gender concordance or discordance<sup>17</sup> with a clinician or an interpreter, or a preference for their family's participation in decision-making. Privacy and confidentiality may be a patient's concern if the clinician or the interpreter is from the same community as the patient, or there may be a perceived bias if the clinician or the interpreter are from an ethnic group which is or has been in conflict with the patient's ethnic group.<sup>18</sup>

In addition to these data items, information on a patient's migration history is important when planning service delivery. Patients from refugee and asylum seeker backgrounds, as well as other migrants with refugee-like experiences often have a complex migration history, including transiting through a number of countries, detention centres or refugee camps. They have frequently experienced traumatic events and separation of family units, have undergone hardship during their journeys of escape, and may have symptoms of post-traumatic stress disorder.<sup>19, 20</sup>

Documenting information that supports an understanding of migration history enables it to be shared among healthcare providers so that the patient is not required to repeat the information multiple times and potentially be re-traumatised. Migration history includes:

- Migration pathway, including whether the patient was a migrant (such as family migrant, international student, skilled migrant), refugee or asylum seeker
- For refugees and asylum seekers, whether their experience included:
  - Refugee camps
  - Detention centres
  - Community detention
  - Countries of transit can provide insight into the need for screening for potential diseases or conditions which are specific to certain areas of the world.

Two further data items that can have a significant impact on health care preferences and outcomes and could be collected from patients and collated for use in planning health services are:

- Religious affiliation
- Use of complementary and alternative medical practices.<sup>21</sup>

### *Understand the diversity of the local community*

Australian Bureau of Statistics census data can be used to understand the diversity of the local community and identify the proportion of people from different migrant and refugee groups that access the services. State and territory multicultural organisations may be able to assist in understanding the local multicultural community and provide support in educating the workforce.

Strategies may be required to reach vulnerable communities not accessing services. Engaging ethno-specific or multicultural community organisations; religious organisations, migrant and refugee settlement organisations may be of assistance in reaching groups that are hard to access.

### *Planning and care delivery of culturally responsive care*

Culturally responsive care is respectful of migrant and refugee patients' cultural and linguistic needs, takes into consideration their health beliefs and healthcare issues, and is free from discrimination.<sup>16</sup> Initiatives that can support culturally responsive practice include:

- Actively increase the diversity of the workforce to reflect the diversity in the patient population and catchment area<sup>22</sup>
- Engage a bicultural or bilingual workforce<sup>23</sup> and advertise to patients and consumers the languages spoken by the workforce
- Use universally agreed signage whenever possible
- Provide access to spaces that accommodate patients' religious and spiritual needs
- Include cultural and religious considerations when addressing a patient's nutritional needs, for example vegetarian, halal or kosher options
- Where possible, accommodate patients in single gender wards. However, if this is not possible all patients involved should be informed
- Where possible, provide capacity for choice of gender for clinician or interpreters
- Create an inclusive and welcoming environment by using symbols, visuals and other displays that celebrate diversity

- Develop cultural protocols and display in waiting areas, consulting rooms and pre-admission documentation
- Provide access to resources that are appropriate to the health literacy and cultural needs of patients<sup>6</sup>, translated, or in plain English.<sup>16</sup>

## Examples of supporting evidence

- Strategic or business plans that identify and reflect the diversity of the patient population
- Consumer information that is available in different formats and languages that reflect the diversity of the patient population
- Healthcare records that capture relevant data items related to personal, migration history
- Agreements or formalised arrangements for accessing interpreters and reports on interpreter use and access
- Examples of human resource strategies to facilitate workforce diversity.

## Safety and quality training

Action 1.20 states:

The health service organisations uses its training system to:

- a. Assess the competency and training needs of its workforce
- b. Implement a mandatory training program to meet its requirements arising from these standards
- c. Provide access to training to meet its safety and quality training needs
- d. Monitor the workforce's participation in training

## Suggested strategies

### Workforce Training

Cultural responsiveness training can increase the cultural competence of the workforce and in turn can increase patient satisfaction and participation.<sup>13</sup> Regular reviews of the workforce's cultural responsiveness will ensure the identification of individual skills gaps, as well as organisational training needs.

Options to assess training requirements include:

- Recording attendance of the workforce at cultural responsiveness training sessions
- Surveying the workforce to determine self-identified knowledge gaps
- Analysing consumer feedback related to cultural safety
- Analysing incident reports and trends related to cultural responsiveness
- Prioritising training for the workforce that interacts most frequently with consumers from migrant and refugee backgrounds.

As a minimum, information about basic cultural responsiveness should be incorporated into mandatory training and orientation programs. Access to further resources and guidance should be easily available to all members of the workforce.

Training and resources for the workforce should:

- Encourage self-reflection on how an individual's personal and cultural beliefs influence interaction with others
- Promote cultural understanding by providing information on the cultural and linguistic diversity of the catchment population and access to best practice guidance on cultural and religious factors that influence the delivery of care
- Demonstrate how an individual's understanding and approach to health care can be influenced by factors such as language and communication, gender, pre-migration experiences, refugee-like experiences and trauma, cultural and religious beliefs, health beliefs, and family and community context.

Workforce participation in such training programs and uptake of resources and guidance should be monitored.

Health service organisations should evaluate the effectiveness of their training, including thorough analysis of feedback from the workforce and consumers. This evaluation can examine whether the training has enhanced cultural responsiveness in communication, improved awareness, increased use of interpreters, and improved the service delivery to patients from migrant and refugee backgrounds.

## Examples of supporting evidence

- Training documents on diversity and cultural awareness
- Audit results of compliance with policies on cultural responsiveness when working with patients and consumers from migrant and refugee backgrounds
- Audit of uptake of the training and the resources
- Reviews and evaluation reports of cultural awareness training programs
- Feedback from the workforce about their cultural training needs.

## Tools and resources

### Cultural responsiveness

- The Centre for Culture, Ethnicity & Health reference guides to improving the cultural responsiveness of health services:
  - Cultural competence in organisational values: [https://www.ceh.org.au/wp-content/uploads/2016/05/CC2\\_Cultural-competence-in-organisational-values.pdf](https://www.ceh.org.au/wp-content/uploads/2016/05/CC2_Cultural-competence-in-organisational-values.pdf)
  - Cultural competence in governance: <https://www.ceh.org.au/cultural-competence-governance/>
  - Cultural competence in staff development: <https://www.ceh.org.au/cultural-competence-in-staff-development/>
  - Cultural competence in services and interventions: <https://www.ceh.org.au/cultural-competence-in-services-and-interventions/>
- The *Cultural Competence Organisational Review Tool (CORE)*, [https://www.ceh.org.au/use-the-cultural-competence-review-tool-core/?sf\\_action=get\\_data&sf\\_data=all&\\_sft\\_category=cultural-competence](https://www.ceh.org.au/use-the-cultural-competence-review-tool-core/?sf_action=get_data&sf_data=all&_sft_category=cultural-competence)
- National Health and Medical Research Council, *Cultural Competency in Health: A guide for policy, partnerships and participation*, <https://www.nhmrc.gov.au/about-us/publications/cultural-competency-health>

- State of Victoria (Department of Health), *Cultural Responsiveness Framework: Guidelines for Victorian health services*, 2009, <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services>
- Queensland Health, *Five Cross Cultural Capabilities for Clinical Staff*, [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0034/382696/ccc-clinical.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0034/382696/ccc-clinical.pdf)
- Queensland Health, *Five Cross Cultural Capabilities for Non-Clinical Staff*, [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0020/386012/ccc-non-clinical.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0020/386012/ccc-non-clinical.pdf)
- The Lewin Group for the U.S. Department of Health and Human Services, *Indicators of Cultural Competence in Health Care Delivery Organizations: An organizational cultural competence Assessment profile*, <https://www.hrsa.gov/sites/default/files/culturalcompetence/healthdlvr.pdf>

### **Multicultural affairs agencies by state or territory**

- Multicultural NSW, [www.multicultural.nsw.gov.au](http://www.multicultural.nsw.gov.au)
- Victorian Multicultural Commission, [www.multicultural.vic.gov.au](http://www.multicultural.vic.gov.au)
- Department of Local Government, Racing and Multicultural Affairs (QLD), <http://www.dlgrma.qld.gov.au/multicultural-affairs/multicultural-affairs.html>
- Multicultural SA, <https://dpc.sa.gov.au/responsibilities/multicultural-affairs>
- Office of Multicultural Interests (WA), [www.omi.wa.gov.au](http://www.omi.wa.gov.au)
- Department of Premier and Cabinet (TAS), <http://www.multicultural.tas.gov.au>
- Office of Multicultural Affairs (NT), <https://nt.gov.au/community/multicultural-communities>
- Office of Multicultural Affairs (ACT) <http://www.communityservices.act.gov.au/multicultural>

# Partnering with Consumers Standard

## Intention of this standard:

To create an organisation in which there are mutually valuable outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

Language is among the most serious obstacles to the delivery of safe and high quality care.<sup>6</sup> <sup>24</sup> More than one fifth (21 per cent) of Australians speak a language other than English at home, and more than three per cent of Australians say they speak English poorly or not at all.<sup>25</sup> Proficiency in English is worse among older populations, with more than five per cent of adults 65 years or older reporting limited or no proficiency in English.

Effective communication is essential to providing safe and quality care. It is linked to the person's satisfaction, adherence to clinical instructions, and health outcomes.<sup>26-29</sup>

Conversely, ineffective communication can result in limited, delayed, inefficient care,<sup>30-33</sup> leading to more costly treatment and intervention, as well as negatively impacting the person's understanding of, and trust in, the healthcare system at large.

People with limited English proficiency are recognised to have poorer health outcomes<sup>34</sup> and substandard contacts with healthcare providers. They tend to have limited access to care and preventative services<sup>35, 36</sup>, and are at risk of severe adverse outcomes during or after hospital admission.<sup>15</sup> Further, people with poor English language skills can have difficulty interrogating and understanding complex health concepts that require a sophisticated understanding of language.

In particular, health service organisations should recognise and address language barriers when:

- Assessing a patient's *capacity* to understand, retain and believe the information about the treatment options; and their ability to weigh the information to reach a decision and to communicate that decision<sup>37</sup>
- Obtaining *consent* which may not be valid if it is obtained through third parties, including the patient's family members or workers with bilingual skills facilitating interpretation<sup>38</sup> or where language barriers exist
- Communicating complex instructions.

## Communication that supports effective partnerships

Action 2.8 states:

The health service organisations uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community.

## Suggested strategies

### Access to interpreters

It is the responsibility of health service organisations to ensure an interpreter is engaged when required, and the necessary contractual or other arrangements are in place with an appropriate language service provider to enable this to occur.

Engaging interpreters for patients from migrant and refugee backgrounds with limited or no English proficiency is best practice<sup>39</sup> and can:

- Decrease communication errors<sup>40</sup>
- Increase patient comprehension<sup>40</sup>
- Improve the delivery of person-centred care in healthcare settings<sup>41, 42</sup>
- Reduce unnecessary tests and treatments
- Improve clinical outcomes<sup>40</sup>
- Raise the quality of care to the same level as that for consumers without language barriers<sup>40</sup>
- Improve patient satisfaction and understanding of self-care and follow-up plans, reduced errors and better treatment adherence<sup>33, 40, 43</sup>
- Increase satisfaction of healthcare providers.<sup>43</sup>

While it is important to provide access to interpreters throughout patient care, it is essential that interpreters are engaged when:

- Obtaining informed consent, including assessing the patient's understanding of the information provided to allow them to consent to a treatment or procedure
- Starting or changing the dose of high-risk medications or medications that have a narrow therapeutic range, carry high risks for the patients if taken incorrectly, or require particular care in communicating with patients<sup>44</sup>
- Starting a medication that requires the use of a therapeutic device that needs to be explained by the clinician
- Patients are taking multiple medications or multiple daily doses, or their doses have been changed by other clinicians, or in another health service organisation.

Quality of care is compromised when patients with limited English proficiency require interpreting assistance but do not receive it.<sup>33</sup> Failure to engage interpreters, or the inappropriate engagement of personally involved individuals, including family members, to facilitate interpretation can lead to risks of harm.<sup>15</sup> They include:

- Inappropriate clinical decisions due to communication errors<sup>33</sup> related to the lack of interpreting skills, subject matter knowledge and specialised medical terminology
- Possibility of information being withheld or distorted because of family relationships; in view of potential family, domestic or intimate partner violence situations; or due to the emotional and sensitive nature of the health issue
- Compromising confidentiality
- Potential emotional distress to the patient or family members.

Importantly, engaging minors to facilitate interpretation poses a number of ethical dilemmas as it undermines the parent's authority. This may affect family dynamics and imposes potentially dangerous emotional responsibilities on minors.<sup>45</sup>

While web-based translation applications are becoming more prevalent and continuously improving, they have not yet been proven to provide safe and accurate translation in complex health settings.<sup>46</sup> The confidentiality of web-based translation tools is undetermined

and unregulated. Given the risks, use of these applications should be infrequent and limited to low-risk situations until an interpreter is engaged. The use of these applications should be set out in organisational policies and procedures.

Interpreters can be engaged either in person or via telephone, depending on circumstances. Engaging interpreters over telephone may be necessary in regional and remote areas.

Patients from migrant and refugee backgrounds may prefer phone interpreting services, even when an interpreter is available in person, to:

- Address confidentiality concerns if it is likely that the interpreter is from the same small and tight-knit community<sup>47</sup>
- Discuss sensitive topics, such as mental or sexual health, particularly if the available on-site interpreter is of the opposite gender.

Policies and procedures on accessing and using interpreting services should address the following areas:

- Assessing the need for an interpreter based on the patient's request or their capacity to express and understand healthcare information in English
- Assessing the need for an Auslan interpreter or a deaf interpreter
- Procedures for engaging an interpreter (including code numbers if required) at no cost to the patient
- Access to speakerphone or hands-free telephones when working with telephone interpreters
- Access to resources to support the workforce working with interpreters to effectively communicate with patients and consumers
- Collecting and documenting patient preferences for interpreters, such as language and gender
- Protocol when an interpreter is not available or a patient refuses an interpreter despite being assessed as requiring interpreting assistance
- Eliminating the reliance on families and carers, especially minors, to facilitate interpretation
- Routinely collecting data on the use of interpreters, as well as failure to engage an interpreter when the need for one is identified. Information on the reason an interpreter was not engaged should be recorded to inform health service organisations about any issues that are arising regularly.

### **Provide clear signage to support communication**

Signage is the first point of communication with patients and consumers entering a health service organisation. Signage that supports communication with patients from migrant and refugee background includes:

- National interpreter symbol that signifies that patients and consumers can request an interpreter, and that interpreting services are available
- An indication of languages spoken by the frontline workforce.

### **Use of communication tools**

In addition to engaging interpreters, health service organisations can utilise a variety of communication tools to enable patients from migrant and refugee backgrounds to actively participate in their care. Different communication tools may help address different barriers to communication. For example:

- Technology familiar to patients, such as a mobile application can be used to set up an appointment instead of a letter in English sent by mail.
- Establish a directory of evidence-based or best practice resources, visual and written aids, pictograms, online tools and websites for the workforce to provide to patients and consumers in plain English or in languages other than English.<sup>16</sup>

It is important not to rely exclusively on written material, as patients and consumers from migrant and refugee backgrounds may have limited literacy and numeracy in English or in their first language.<sup>48</sup> Pictogram instructions for medicines use can be misinterpreted by patients with low literacy<sup>49</sup>, especially in cross-cultural settings.

In the absence of evidence-based or best practice and culturally appropriate information, health service organisations may be required to develop these resources. Co-designing with consumers from migrant and refugee backgrounds will ensure that the resources are tailored and relevant.

## Examples of supporting evidence

- Protocol for assessing the need for an interpreter
- Training documents about cultural awareness and diversity
- Consumer and carer information packages or resources that are culturally appropriate, and are available in different languages and accessible formats
- Policies, procedures or protocols for assessing decision-making capacity, obtaining informed consent and communicating complex instructions for patients with language discordance
- Signage or information provided to consumers informing them of the availability of interpreting assistance
- Use of the National Interpreter Symbol
- Material informing consumers of their right to access interpreting assistance
- Agreements or contractual arrangements with an interpreting service provider(s)
- Policies and procedures for working with interpreters
- Reports on interpreter use and access
- Resources available to clinicians to address health literacy barriers for people of migrant and refugee backgrounds.

## Tools and resources

### Assessing the need for language assistance

- ABC tool for assessing the need for an interpreter, NSW Health Western Sydney Local Health District, [https://ww2.health.wa.gov.au/~/\\_media/Files/Corporate/general%20documents/Cultural%20diversity/PDF/11\\_ABCGuidelines.ashx](https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Cultural%20diversity/PDF/11_ABCGuidelines.ashx)
- Language identification cards, Queensland Health, [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0023/155813/language\\_id\\_crd.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0023/155813/language_id_crd.pdf)

## Medication safety

- *Easidose* is a prescribing aid to improve understanding of medicines information. Royal Australasian College of Physicians, <http://easidose.com>

## Signage

- National Interpreter Symbol  The symbol can be downloaded from: <https://www.dss.gov.au/settlement-and-multicultural-affairs/programs-policy/settle-in-australia/help-with-english/national-interpreter-symbol>

## Tailored communication tools

- Appointment reminder translation tool. NSW Refugee Health Service, <https://www.swslhd.health.nsw.gov.au/refugee/appointment/>
- Health Translations provides information in many languages. Centre for Culture, Ethnicity & Health on behalf of the Victorian Government, <http://www.healthtranslations.vic.gov.au>
- Ward communication tools Queensland Health, [https://www.health.qld.gov.au/multicultural/support\\_tools/wct](https://www.health.qld.gov.au/multicultural/support_tools/wct)

## Guidance for working with interpreters

- Migrant and Refugee Health Partnership, Guide for Clinicians Working with Interpreters in Healthcare Settings, 2019, <https://www.culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf>
- WA Health, System Language Services Policy Guidelines, 2017, <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Communications/mandatory/WA-Health-System-Language-Services-Policy>
- NSW Health, Policy Directive, Interpreters - *Standard Procedures for Working with Health Care Interpreters*, 2017, [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017\\_044.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_044.pdf)

## Partnership in healthcare governance, planning, design, measurement and evaluation

Developing effective partnerships with consumers that are reflective of the diversity of the local community contributes to the cultural responsiveness of the organisation and care that is delivered.

The involvement of consumers from migrant and refugee backgrounds can contribute to the delivery of culturally responsive care and services that are more accessible and appropriate for this population.<sup>50</sup> Consumer engagement that is based on respect, finding common goals, and building trust contributes to positive health services.<sup>51</sup>

Action 2.11 states:

The health service organisation:

- a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care
- b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community.

### Suggested strategies

#### **Actively seek feedback from consumers from migrant and refugee backgrounds**

Consumers from migrant and refugee backgrounds should be encouraged to articulate their views and provide feedback. Factors that affect the capacity or willingness to provide feedback include:

- Language and literacy
- Health literacy
- Cultural norms
- Familiarity with feedback mechanisms (e.g. rating scales are not commonly used in some cultures)
- Understanding of the functions and processes of health service organisations.

These factors can be addressed by:

- Using tailored communication tools, such as translated resources
- Providing clear and easily accessible information about the intent and process for providing feedback
- Tailoring data collection methods, such as targeted individual or group consumer consultations
- Informing consumers of the outcome of feedback they provide.

## Examples of supporting evidence

- Reports on feedback and complaints provided by people from migrant and refugee backgrounds
- Policy documents that describe the process for involving consumers in partnerships to design, measure and evaluate health care
- Reports that detail consumer participation in activities to design, measure and evaluate health care, particularly including consumers from migrant and refugee backgrounds
- Communication tools and resources.

## Tools and resources

### Partnering with consumers

- *Health care providers' Guide to Engaging Multicultural Communities and Consumers*, Queensland Health, [https://www.health.qld.gov.au/multicultural/support\\_tools/com-engage-guide.pdf](https://www.health.qld.gov.au/multicultural/support_tools/com-engage-guide.pdf)
- Department of Public Health, Flinders University, and South Australian Community Health Research Unit, *Improving Health Services Through Consumer Participation: A resource guide for organisations* (Culturally appropriate approaches, p. 105), <http://healthissuescentre.org.au/images/uploads/resources/Improving-health-services-through-cp-resources-guide-for-orgs.pdf>

# Comprehensive Care Standard:

## Intention of this standard:

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Cultural and religious beliefs, as well as social context, influence a person's preference for care, especially for mental health care, at discharge and referral, and when planning end-of-life care.

Many people from migrant and refugee backgrounds come from collectivist communities in which healthcare decisions are shared decisions that involve family and community.<sup>52</sup>

When patients, their families, carers and sometimes community's cultural, religious beliefs, and preferences are included in the planning of their care, patients are more likely to adhere to plans for care.<sup>6</sup> Clinicians may require training in how to ask about a patient's beliefs, their preferences and social context, including their situation regarding family support and housing.

## Developing the comprehensive care plan

Action 5.13 a, c, e, f states:

Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

- a. Addresses the significance and complexity of the patient's health issues and risks of harm
- c. Identifies the support people a patient wants involved in communications and decision-making about their care
- e. Includes a plan for referral to follow-up services, if appropriate and available
- f. Is consistent with best practice and evidence

[Note: b, d are deliberately omitted]

## Suggested strategies

### Screen for and address risks specific to patients from migrant and refugee backgrounds

Risks of harm for patients from migrant and refugee backgrounds are multi-faceted and include:

- Pre-migration environments, such as living in resource-poor locations, limited access to health care and screening, infectious diseases, nutritional deficiencies, anaemia, undiagnosed or untreated chronic illnesses, low immunisation rates

- Population-based risks, such as thalassaemia, diabetes mellitus, hepatitis<sup>53-55</sup>
- Settlement factors, such as mental health conditions<sup>19, 20</sup>
- Exposure to injury, such as female genital mutilation, trauma, exposure to war.

Identifying and addressing risk factors associated with a patient's migration or refugee-like experience requires a person-centred, risk-based approach rather than universal screening for selected conditions.<sup>39</sup> Investigations for clinical conditions should be tailored to an individual's risk factors, source and transit countries, migration and social history, and examination findings.<sup>39</sup>

However, a universal precaution approach to pre-migration trauma is recommended when caring for patients from refugee backgrounds.<sup>56</sup>

### **Trauma-informed care**

People from refugee backgrounds, including those seeking asylum and other migrants with refugee-like pre-migration experiences have often experienced traumatic events and losses<sup>57</sup>, have undergone hardship during their journeys to Australia, and may have symptoms of post-traumatic stress disorder. Refugees are three times as likely to have a mental disorder and twice as likely to have post-traumatic stress disorder compared with people born in Australia.<sup>58</sup> They may also experience communication issues, beyond language, requiring additional support.

Refugee-like experiences depend on:

- The country of origin
- The context of pre-arrival health care
- The degree of war, displacement, trauma and torture, and immigration detention experience
- Level of impoverishment and education<sup>7</sup>
- Current or past experiences of immigration detention
- Protection status (i.e. permanent or temporary).

There is a risk of re-traumatisation in the absence of trauma-informed approaches to care.<sup>59</sup> Trauma-informed care incorporates factors as person-centred communication and care, maintaining safe clinical environments, and knowing when to refer for trauma screening.

For some patients from migrant and refugee backgrounds, providing a comprehensive history can be traumatic and culturally difficult. This can mean they become reluctant to repeat the same sensitive information to numerous clinicians. To reduce unnecessary distress, it is important that the information is documented in a comprehensive, accurate and timely manner and available at clinical handover.<sup>20</sup>

### **Family and community support people**

Family can play a vital role in the care of patients from migrant and refugee backgrounds and clinicians may need to include family members in discussions about health-related issues and decisions.<sup>52, 60</sup> Obtaining consent may need to involve family members because, in some cultures, the family needs to agree to the procedure, or the older people may rely on family members for decision-making on their behalf.

### **Incorporate best practice and evidence**

A patient's clinical needs, risks and preference may differ from the cultural or religious group from which they come. Care should be guided by, but not rely entirely on information about high-risk patient groups. Actions in the Comprehensive Care Standard require care to be responsive to individual needs and preferences.

## Examples of supporting evidence

- Policies, procedures and protocols for providing care to patients from migrant and refugee backgrounds
- Clinical communication resources for patients from migrant and refugee backgrounds
- Audit of the involvement of support people in the development and use of care plans
- Procedures and protocols for communicating with family members and carers for patients from migrant and refugee backgrounds.

## Tools and resources

- The Australian Commission on Safety and Quality in Health Care, *Implementing the Comprehensive Care Standard: Approaches to person-centred risk screening*, 2018, <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/implementing-comprehensive-care-standard-approaches-person-centered-screening>

## Community health profiles

- *Multicultural Health – A Guide for Health Professionals*, Queensland Health, [https://www.health.qld.gov.au/multicultural/health\\_workers/cultdiver\\_guide](https://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide)
- Community profiles for health professionals, ACT Health, <https://www.health.act.gov.au/about-our-health-system/multicultural-health-act>
- Multicultural Clinical Support Resources: *Health Care Providers' Handbook on Sikh Patients; Health Care Providers' Handbook on Hindu Patients; and Health Care Providers' Handbook on Muslim Patients*, Queensland Health, [https://www.health.qld.gov.au/multicultural/support\\_tools/mcsr](https://www.health.qld.gov.au/multicultural/support_tools/mcsr)
- *Staying Healthy During Festivities Guides. Healthy Diwali – A Guide for Health Professionals; Managing Diabetes During Ramadan – A Guide for Health Professionals; Managing Diabetes During Yom Kippur – A Guide for Health Professionals*, ACT Health, <https://www.health.act.gov.au/about-our-health-system/multicultural-health-act>

## Comprehensive assessment and care

- Migrant and Refugee Health Partnership, Competency Standards Framework for Clinicians, *Culturally Responsive Clinical Practice: Working with people from migrant and refugee backgrounds*, 2019, <https://www.culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Culturally-responsive-clinical-practice-Working-with-people-from-migrant-and-refugee-backgrounds-Jan2019.pdf>
- *Australian Refugee Health Practice Guide for Survivors of Torture*, Victorian Foundation, <http://refugeehealthguide.org.au>
- *Tipsheet on cultural considerations in health assessment* was developed by the Centre for Culture, Ethnicity and Health,

[https://www.ceh.org.au/wp-content/uploads/2017/07/CEH\\_TipSheet3\\_Mar2011\\_Web-002.pdf](https://www.ceh.org.au/wp-content/uploads/2017/07/CEH_TipSheet3_Mar2011_Web-002.pdf)

- *Evidence-Based Clinical Guidelines for Immigrants and Refugees* (Pottie K, Greenaway C, Feightner J, et al. 2011; CMAJ), <http://www.cmaj.ca/content/cmaj/early/2011/07/26/cmaj.090313.full.pdf>

## Trauma-informed care

- The Australian Commission on Safety and Quality in Health Care, *NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues*, 2018, <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-health-services-providing-care-people-mental-health-issues>
- *Trauma-Informed Care in Child/Family Welfare Services* (Wall L, Higgings D, Hunter K, Australian Institute of Family Studies. 2016; CFCA Paper No. 37), <https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services>

## Referrals

- A resource, titled *Tips for Making Referrals* was developed by the Victorian Foundation for Survivors of Torture, Forum of Australian Services for Survivors of Torture and Trauma, and the Refugee Health Network of Australia, <http://refugeehealthguide.org.au/tips-for-making-referrals/>

# Glossary

In this user guide:

**Clinician** means a healthcare provider, trained as a health practitioner, including registered and nonregistered practitioners. Clinicians may provide care with a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They may include: nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.<sup>61</sup>

**Cultural responsiveness** means the capacity of clinicians to provide care that is respectful of and relevant to, the health beliefs, health practices, cultural and linguistic needs of diverse patient populations and communities. It describes the capacity to respond to the healthcare issues of different communities.<sup>62, 63</sup>

**Diversity** means the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities. (Quality and Safety Standards 2<sup>nd</sup> ed)

**Health beliefs** means a person's beliefs and past experiences that affect the way they view health, causes of illness and treatment.<sup>64</sup>

**Health literacy** means skills, knowledge, motivation and capacity of an individual to access, understand, appraise and apply health-related information to make effective decisions about health and health care, and take appropriate actions.<sup>61</sup>

**Interpreter** means a practitioner, conveying spoken or signed information from one language into another language<sup>65</sup>, who has obtained certification issued by the National Accreditation Authority for Translators and Interpreters (NAATI) – the national body responsible for setting, maintaining and promoting standards for the translation and interpreting industry through its certification system for translators and interpreters – at one of the following levels:

- Certified Conference Interpreter
- Certified Specialist Interpreter (Health or Legal)
- Certified Interpreter
- Certified Provisional Interpreter
- Recognised Practising Interpreter (for some languages, in which NAATI certification is not available).

All NAATI credentialed interpreters are bound by the Australian Institute of Interpreters and Translators (AUSIT) code of ethics<sup>66</sup> or by the Australian Sign Language Interpreters' Association (ASLIA) code of ethics<sup>67</sup>, respectively, obliging them to maintain impartiality, objectivity and confidentiality.

**Patients from migrant backgrounds** means patients who are permanent migrants, including first generation (born overseas) and second generation (at least one parent born overseas) Australians, as well as temporary migrants. Patients from migrant backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

**Patients from refugee backgrounds** means patients with refugee-like experiences, including people who are humanitarian migrants granted permanent or temporary protection, asylum seekers, and permanent or temporary migrants.<sup>68</sup> Patients from refugee backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

**Preferred language** means a language most preferred by a person for communication.<sup>69</sup> Preferred language may not be related to country of birth<sup>64</sup>, and may be a language other than English, even where the person can speak fluent English.<sup>69</sup>

**Bicultural workforce** means professionals employed in a range of positions within an organisation, and able and willing to use their cultural skills and knowledge to facilitate communication between the organisation and communities with whom they share similar cultural experiences and understandings. Some professionals with bicultural skills are employed specifically for their cultural skills.<sup>70</sup>

**Bilingual workforce** means professionals employed in a range of positions within an organisation, who are not interpreters, but are able and willing to utilise their proficiency in languages other than English as an additional skill. Some professionals with bilingual skills are employed specifically for their proficiency in a language other than English.<sup>71</sup>

**Social determinants of health** means the circumstances in which people are born grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, including economics, social policies and politics.<sup>57</sup>

**Teach-back method** means a way for a clinician to confirm that the clinician explained to the person what they need to know in a manner that the person understands by asking them to teach back directions.<sup>72</sup>

**Trauma-informed care** means an organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for people who have experienced trauma; this also includes their families and carers, and service providers.<sup>73</sup>

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