

**Australian Commission on Safety and Quality in Health Care
Migrant and Refugee Women's Health Partnership**

Workshop

**Development of a NSQHS Standards user guide for health service organisations:
migrant and refugee health**

Melbourne, 6 November 2017

OUTCOMES DOCUMENT

Prepared by the Migrant and Refugee Women's Health Partnership (MRWHP) Secretariat

Background

The Migrant and Refugee Women's Health Partnership in collaboration with the Australian Commission on Safety and Quality in Health Care has commenced a project to use the National Safety and Quality Health Service (NSQHS) Standards (2nd ed.) to improve health care provided to migrants and refugees.

The project will consult on safety and quality issues that typically affect migrants and refugees when accessing health care, and will discuss with stakeholders what good care would look like. In order to analyse the available information on safety and quality issues and good practice, a workshop was convened on 6 November 2017 bringing together key relevant stakeholders. The issues will then be mapped to the NSQHS Standards (2nd ed.) and supplemented by a literature scan of relevant evidence-based strategies for safety and quality in health care for migrants and refugees.

The user guide will aim to provide health services with practical examples of best practice care for migrants and refugees, linking this to the NSQHS Standards (2nd ed.), and will be recommended to health services and accrediting agencies when implementing the NSQHS Standards (2nd ed.).

National Safety and Quality Health Service Standards (2nd ed.)

The participants were given an overview of the NSQHS Standards (2nd ed.) and discussed the purpose of developing the user guide.

The appropriateness of terminology was raised, noting that the term 'migrant' and 'refugee' may not be applicable to individuals after a number of years since settlement, with it being agreed that no matter how long an individual has been in Australia, the same standard needs to apply in terms of health care.

It was noted that the user guide title should not imply that there might be services that do not provide care to migrants and refugees.

The participants raised the issue of acute deterioration in Standard 8, as acute deterioration in a chronic condition may be different to that in a health care scenario.

The framing of cognitive impairment was raised in the context of patients with disability, rather than limited to dementia and delirium, and the possibility of addressing this through the user guide.

Safety and quality issues typically experienced by migrants and refugees when accessing health services

Safety and quality issues were identified at the (1) referral/entry, (2) screening, (3) assessment, (4) planning, (5) delivery, and (6) exit stages, with a further category for (7) other issues.

(1) Referral/entry

- Utilisation of interpreting services:
 - Identification of a patient's requirement of an interpreter.
 - Inappropriate interpreter engagement, with certain mixed messages regarding the engagement of carers being noted.
- Cross-cultural considerations.
- Literacy, particularly health system literacy, such as the location of services and timing of appointments. There was agreement that it is reasonable for a health service to assist in the provision of such literacy, in view of significant savings for the system.
- Particular issues relevant to non-permanent residents (with not eligibility for Medicare card):
 - The lack of funding for health care for this group, with the consequent problems of late presentation and early discharge.
 - The move to electronic records will likely miss this vulnerable group.
- The lack of policy and procedure within health service organisations on migrants and refugees.
- Limited or inconsistent collection of information, specifically regarding:
 - Country of origin, with country of birth and ethnicity often being discordant.
 - Language spoken at home.
 - The need for an interpreter, and in which language.
- Limited patient identifiers, with refugee status noted as being particularly difficult.
- The importance of communication, particularly regarding:
 - Informing patients of appointments and strategies.
 - Giving time for patients to ask questions.
 - Allowing the patient to start with their story, as they do not always know how to express what is wrong.
- Clinician bias reducing informed consent.

- Cognitive impairment may result in language and understanding of Australian culture being lost.
- A lack of training for clinicians in how to engage and deal with migrant and refugee groups.
- Insufficient linkage between the community and the health system.

(2) Screening

- Time poor clinicians failing to properly provide patient centred care.
- Poor management of expectations throughout the healthcare journey.
- Additional complexity in view of family relationships and influences.
- Issues surrounding documentation, and the fact that something may be lost and not repeated.

(3) Assessment

- Particular issues surrounding confidentiality:
 - If it is what the patient wants, it may be appropriate to include the family in the patient's health care decisions.
 - There may be increased difficulty in ensuring confidentiality when engaged interpreters come from the same small, tightly knit communities.
- No education of the migrant and refugee community about the role of interpreters.
- The need to recognise the circumstances of the person in front of the clinician even in asking very standard questions, e.g. whether the patient has recently been overseas.
- Instances of clinicians making assumptions in the screening process, including:
 - That a patient's misunderstanding is necessarily a literacy or language issue.
 - That, when a patient has been in Australia for a long time, screening has already occurred.
- Cognitive impairment assessment can be difficult, with there being a need to take the background of a patient into account.
- The sharing of medication, because it "worked for someone else".

(4) Planning

- The fact that multidisciplinary care planning often fails to include the carer, interpreter, and patient.
- A lack of understanding of patients that their doctor is not all-knowing.

- While family meetings can be important for inclusion and collective decision-making, they may only have limited time allocated to them, or interpreters may miss important information.
- A failure of clinicians to recognise that their own cultural background impacts on their interactions.
- Clinicians do not recognise their own cultural background that impacts on their interactions.
- The delivery of care that is tailored to the system, and not particular needs, i.e. newly arrived refugees may enter the system at a later stage.
- The need for medications to be culturally and medically appropriate.

(5) Delivery

- Inadequate access of women to antenatal care, with women not attending or not being able to attend appropriate antenatal care sessions impacting on the ability to deliver safe care.
- Information being lost as patients move across the system.
- The absence of active ways for clinicians to ask for feedback, and the consequent failure of clinicians to clarify a patient's understanding *along* their journey.
- Delays in access to services when there is uncertainty as to whether informed consent has been given.

(6) Exit

- The need to ensure communication with other agencies.
- Feedback not being collected from migrants and refugees, and therefore not being used in improvement.
- There is no requirement for cultural understanding in health service accountabilities.
- Clinicians often take short cuts with information. For example, there is limited provision of information for patients about what an issue was, what resulted, or what a test showed.
- Readmission is often the result of a lack of future planning.
- The need to ensure that patients trust clinicians enough to give feedback, and are not in fear of retaliation, e.g. being 'sent back'.
- There is a lack of summary of care for patients, with there being a need to make referrals clear with explanation of who care is being transferred to, and what to expect next.

(7) Other

- There should be better clinical understanding of the distinctions of migrants and refugees.

- The importance of trauma-informed care.
- The need for workforce understanding of cross cultural considerations, and a shared understanding of what we want in an improved, culturally responsive system. This is particularly important to:
 - Understand migrant and refugee health-seeking behaviour.
 - Make appropriate follow-ups.
 - Negotiate health beliefs through skilled communication.
- Gender considerations, with women often preferring female clinicians and interpreters, and men sometimes distrusting women.
- The importance of recognising demographic variables.
- Issues relating to assumptions:
 - Assumptions of being applied to all patients.
 - Unconscious bias being evident in assumptions around disability, with consequent issues around informed consent.
- The role, access to and funding of interpreters needing to be improved.
- The need to avoid the exclusion of migrant and refugee communities in consultation and planning processes.
- The need to expand evidence bases beyond traditional audiences, often excluding cultural (as well as age and gender) diversity.
- The limited resources available for support in the private sector.

Safe and quality care for migrants and refugees

Participants identified factors that would provide safe and high quality care for migrants and refugees at the (1) entry, (2) planning, (3) delivery, (4) exit, with a further category for (5) other issues.

(1) Entry

- A clear partnership between governance and consumers.
- Communication between the clinician's and the patient:
 - An effort made by the clinician to explain to the patient their health issue and the pathway.
 - The clinician sets expectations for the patient and state their rights.
 - Information should be delivered in a format that is understood and trusted, and which gives the patient the opportunity for control.
- The use of interpreter services:

- Interpreters should be present whenever they are required throughout the patient's health journey, and be recognised as part of the health care team.
 - The use of interpreter services should not be affected by budget restrictions.
 - The interpreter should be in the correct language and have the appropriate level of health care understanding.
 - A person with language needs should be identified, and that should be noted in all documentation forms and electronic systems.
 - It should be understood that the interpreter can be a source of information about cultural norms, and may assist in obtaining culturally informed consent.
 - There should be a consistency of engaging same interpreter for the same patient, as far as possible, in order to build an effective relationship.
 - The patient should be provided with an interpreter of their preferred gender.
 - Everyone involved in the provision of health care should know the phone number to access interpreter services, as per the health service organisation arrangements.
- Care should be tailored to patient goals and preferences. However, when these are not compatible with the health service organisation, this should be explained.
 - Data relating to migrants and refugees should be collected, particularly with regard to:
 - Date of birth, noting that refugees may be assigned the same date of birth and there are risks of misidentification associated with this.
 - Interpreter requirement.
 - Preferred language.
 - Year of arrival.
 - The indicators should be nationally agreed upon and used by health service organisations.
 - Cultural competence training should be provided to both clinical and non-clinical staff within a health service organisation. This is particularly important for front of house staff, as the first point of contact.
 - There should be informed financial consent for unfunded patients.

(2) Planning

- Health literacy:
 - Health literacy information should be produced by experts and be in simple, plain English, with consumers being able to provide feedback.
 - It is important for the community to be engaged, with recognition that health is interpreted differently in different cultures and that community involvement can make patients more likely to trust messages.
 - Health literacy cannot simply be 'dumbed down' information, as it needs to address complex questions.
 - Information should be delivered in multiple forms, recognising the flawed presumption that people can read in their own language.
- The preference of a patient for including substitute or other decision makers should be identified.

- Clinicians should know where to access information about care for migrants and refugees.
- Health service organisations should know the diversity of their patient populations.
- There should be two-way communication, i.e. feedback received from migrants and refugees, and the community being informed of the follow-up and outcomes.
- Those in the workforce who are likely to work with migrants and refugees should be identified, to help them understand their role.
- There should be flexibility in models of care, in order to maximise the use of interpreter services and to manage the length of appointments.

(3) Delivery

- Trauma informed care should be central to the delivery of services.
- Quick procedures:
 - Trauma and gender issues still need to be recognised.
 - When there is need for quick information, it should still be provided in a culturally appropriate way.
 - Patients should be involved in making decisions, e.g. when undergoing an x-ray.
- Privacy during a procedure is very important for migrant and refugee communities.
- Wards may need to be single sex.

(4) Exit

- Patients should be given copies of all information.
- The patient should know and understand what is to happen next and why. The provision of this information may need to go beyond written communication.
- Clinicians need to know what services are available to refer the patient to.
- At the client handover, clinicians, when permission has been given, should communicate to the next provider the information that would be difficult for the patient to share again (trauma considerations).
- Patients should be given enough discharge medication, including equipment and dressings, to get them through to the next practitioner appointment.
- At exit, information related to migrants and refugees should be collected, ideally in language and with a culturally explicit Likert Scale.

(5) Other

- There should be evaluation of training relating to working with migrants and refugees.
- The areas of end-of-life, maternity, and sexual health are strongly culturally embedded.

- There may be cultural stigma surrounding cancer, sexual health, and end-of-life.
- The community should be linked in, in order to develop trust and support, and drive prevention of further health complications.
- Workforce diversity should be enhanced, beyond the inclusion of migrant and refugee volunteers.
- Welcoming environments:
 - Interfaith rooms.
 - Catering for religious practice, using relevant gowns, head coverings, etc.
 - Provision of food preferences.
- Benefits of tools:
 - There is an ABC tool for interpreter need.
 - There should be agreement as to what training should consist of.
 - There should be clear links to literacy information.

Relevant actions from the NSQHS Standards (2nd ed.)

Standards 1 and 2

- Actions 1.1-1.6 are directed at leadership at various levels. Key considerations include:
 - Financial business decisions could have an impact.
 - Communication is still considered a soft touch, but interpreters and cultural competency should be recognised as being equal to safety.
- It is necessary to recognise migrant and refugee considerations in each of actions 1.7-1.18.
- The importance of information collection, particularly in regards to patient satisfaction, was emphasised as a means of understanding the system and identifying risk profiles.
- In addressing feedback and complaints in actions 1.13 and 1.14, participants agreed that organisations need to have a broader evidence base in order to obtain a true reflection of patient experiences.
- Participants noted the recognition of diversity in action 1.15(a), in order to address the needs of consumers.
- In regards to the mention of electronic records in 1.16(d), participants noted that these may miss some relevant constituents, and that the action should include mention of demographic representation or the need to correctly verify the information.
- Several actions were noted as being relevant to the need for and provision of interpreters.
 - Regarding action 1.16(b), identification of interpreter need is essential to a complete healthcare record.

- It should be made clear that effective communication should be in a language that the patient understands.
- A provision should be included in action 1.23 to ensure that interpreters are appropriately credentialed.
- Provision of interpreter services was noted as constituting a safety issue under action 1.25.
- Action 1.26 was noted as including the ability to find an interpreter after hours.
- It was noted that action 1.27 could include tools and processes to assist clinicians in determining the need for engaging an interpreter.

Standards 3 & 5

- While migrants and refugees have specific risks around infectious diseases, the care in response to this shouldn't differ from that given to anyone else.
- Action 3.3: In partnering with consumers clinicians need to meet their information needs, which may necessitate an interpreter.
- Actions 3.6 & 3.7: Regarding the assessment of infection risks, the new arrivals screening process is not always complied with or understood.
- Actions 3.5, 3.8 and 3.13: Precautions relating to infectious diseases extend to interpreters, who do not have nationally consistent hygiene training.
- Actions 5.1 – 5.4: Training in competency care is relevant, with these actions including the roles and responsibilities of the interpreter in the team and the possible need to include family in information and decision-making.
- Identification of migrant or refugee status, whether a person speaks English, and their level of comprehension were are risks associated with comprehensive care.
- Monitoring the delivery and effectiveness of comprehensive care must be inclusive to all groups, and not just to those who can answer questions.
- Action 5.3: The implementation of this action should involve an understanding of what patient information needs and shared decision-making look like in different cultural groups.
- Action 5.4: Knowledge of how to refer and explain, were identified as being included in this action.
- Action 5.4(b): The settings that best meet patient needs may include the need for interpreters.
- Actions 5.7-5.13: The actions should recognise how screening, assessment, care planning, discharge, referrals and family involvement may look different depending on resources and awareness of migrant and refugee communities.
 - Action 5.7: Screening cannot be done without identifying the background of the patient.
 - Action 5.9: Documentation of clear advance care plans is particularly difficult for people from migrant and refugee backgrounds.
 - Action 5.12: Particular risks relating to a patient of migrant and refugee status should be documented.

- Action 5.14: The emphasis of the need for the workforce, patients, carers and families to work in partnership was noted as involving clinician's identification of what is required in the decision-making about a person's care.
 - Clinicians need to be willing to step outside the paradigm they are comfortable with, in order to not invalidate a patient's response to an issue or situation.
 - It may be difficult to establish, for example, whether a patient wants a person making decisions with them or not, as they may say what they have to in order to please the clinician or the family member.
- Actions 5.15 - 5.20: There needs to be more clinical education of what the meaning of comprehensive care at the end of life and decision making surrounding this is for different cultures, recognising the traditions embedded in those stages.
- Action 5.28: Inherent in meeting nutritional needs and requirements is the provision of culturally appropriate food.
- Action 5.29: Regarding the provision of services to patients with cognitive impairment or delirium, there should be recognition that people may revert back to their base in these situations and so more care should be taken for patients for whom English is not their first language. It was additionally noted that people may be misdiagnosed if culturally appropriate tools are not used.
- Action 5.25: There should be recognition that recent arrivals may have nothing at home to assist in the provision of services to promote safe mobility and manage the risks of falls.

Standards 4 & 6

- Action 4.3: Interpreters are relevant in partnering with consumers. Patient information needs must be met, and assumptions must not be made about patient understanding.
- Actions 4.5 & 4.6: Regarding medical reconciliation, it was noted that:
 - This process goes beyond medical history.
 - 'Best possible' is a minimum standard.
 - Time and research should be taken to identify medications from overseas.
 - NPS MedicineWise work may have relevant input.
 - Natural medicine and alternative medicines should be considered.
 - Cultural translations matter.
- The particular risks of taking medicine were noted, identifying the issues of sharing medicine and taking medicine as preventative.
- Action 6.1(b): Identification of the risks for particular population groups is an inherent part of managing the risks associated with clinical communication. This involves asking the right questions.
- Action 6.2(c): There need to be tools to report on the effectiveness and outcomes of implementing strategies to improve clinical communication and associated processes. There should also be consideration of what works well.

- Action 6.5: Identification and procedure matching may have complexities for the migrant and refugee cohort, as this group can have the same dates of birth, last names, and addresses.
- Action 6.7(b) and 6.8(b): Clinical handover requires indication on the handover sheet of interpreter and trauma awareness.
- Action 6.11: Interpreter refusal is relevant to the documentation of information.

Standards 7 & 8

- Standard 7: It includes the communication of safety of Australian blood services to migrants and refugees, in the case that they need a blood transfusion.
- Action 7.3: Health literacy and cultural symbolism and/or religious beliefs need to be taken into account in situations where blood is taken or given. The example of a patient refusing to receive blood during Ramadan was noted, with it being recommended that there needs to be:
 - Communication with the clinician to explain concerns.
 - A flexible health system to allow the procedure after breaking the fast, or before or after Ramadan if it is not an urgent procedure.
 - Provision of resources, such as including a religious elder or leader to share their point of view and explain that religion allows for blood transfusions for health reasons.
 - Active involvement of the patient in care and shared decision making.
- A reasonably detailed communication document should be developed in this regard.
- Standard 8: There is a need for adaptive models of care. For example, a large unit with primary and tertiary care in the same area will enhance the care for migrants and refugees, including late presentations for care (e.g. women showing up at 38 weeks of pregnancy).
- Interpreter engagement is a necessity in situations of acute deterioration more than at any other time.
 - A clinician will be unable to know if a patient is hallucinating or upset if they can not understand them (example of a patient being mistakenly thought to be suicidal, because no interpreter was engaged to clarify the situation).
 - At the very least, a telephone interpreter should be engaged to explain to the family what is happening.
- Action 8.3: Information needs and shared decision-making are relevant.
- Action 8.5: Trauma informed care and an understanding of a pos-traumatic stress response need to be emphasised in the processes for clinicians to recognise acute deterioration.
- Action 8.7: In directly escalating care, consideration needs to be given as to how well it is thought about and communicated to the migrant or refugee, and whether any assumptions are being made based on ethnicity.

ATTACHMENT

Participants

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