



Diagnostic Report: Understanding contributing factors for Take-Own-Leave in NSW Health organisations

Clinical Excellence Commission and NSW Centre for Aboriginal Health

May 2020



CLINICAL
EXCELLENCE
COMMISSION

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- Photographs taken at Broken Hill (FWLHD) and Orange Health Service (WNSWLHD) with permission.

Executive Summary

Respond to Take-Own-Leave episodes as clinical incidents and identify contributing factors is part of New South Wales (NSW) Health's Strategic Priority 2.1 and forms part of the Clinical Excellence Commission's (CEC) key deliverables under the NSW Health Performance Agreement 2019-20. In partnership with the NSW Centre for Aboriginal Health (CAH) the CEC have used a Human Centred Design approach (see Appendix 1) to build an understanding of the contributing factors for the occurrence of Take-Own-Leave in NSW Health Services.

This report captures the findings of the 'Diagnostic' phase. In this phase we applied the notion 'that any effort to improve a system, its processes, or its products and services must begin with customers and the people doing the work' (Kachirskaia, Mate & Neuwirth, 2018) and as such, we undertook broad consultations with the NSW Health workforce, consumers and industry representatives and an extensive literature review.

Take-Own-Leave is when an admitted or non-admitted patient leaves a hospital or healthcare setting before their treating physician/healthcare team has authorised discharge. In New South Wales, it may include patients who discharge against medical advice (DAMA), did not wait or left at own risk. Take-Own-Leave can lead to post-operative complications, increased morbidity and mortality, re-admission and increased healthcare expenditure. The DAMA rates for Aboriginal people are two and a half times that of non-Aboriginal people (2.3% / 0.9%) and incomplete ED attendances about one and a half times (8.6% / 5.9%) more (NSW Health Aboriginal Health Dashboard, 2020). This rate has remained unchanged over the past 5 years (Centre for Epidemiology and Evidence and Centre for Aboriginal Health, 2019).

Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.

As defined in NACCHO's Constitution as amended 9 March 2006 also from the National Aboriginal Health Strategy (NAHS) 1989
www.naccho.org.au

Take-Own-Leave displays the attributes of a 'wicked problem'. It is socially complex and multi-factorial with contributing factors that have many inter-dependencies related to the system, organisation, community and individual. The Aboriginal concept of health as total well-being of community and a whole of life view is a source of further complexity for addressing Take-Own-Leave within the medical model of health services (Mokak & Smith, 2018).

Throughout the consultation process the issue of cultural safety, which is how we provide care to Aboriginal patients, and what it means for the health service to be culturally aware and sensitive, were inextricably linked. The consultations and literature suggest that improvements may be gained through the cultivation of a safety culture, the building of a capability for improvement at a local level, the consolidation of associated measurement and reporting and clearer role expectations and accountability for Take-Own-leave.

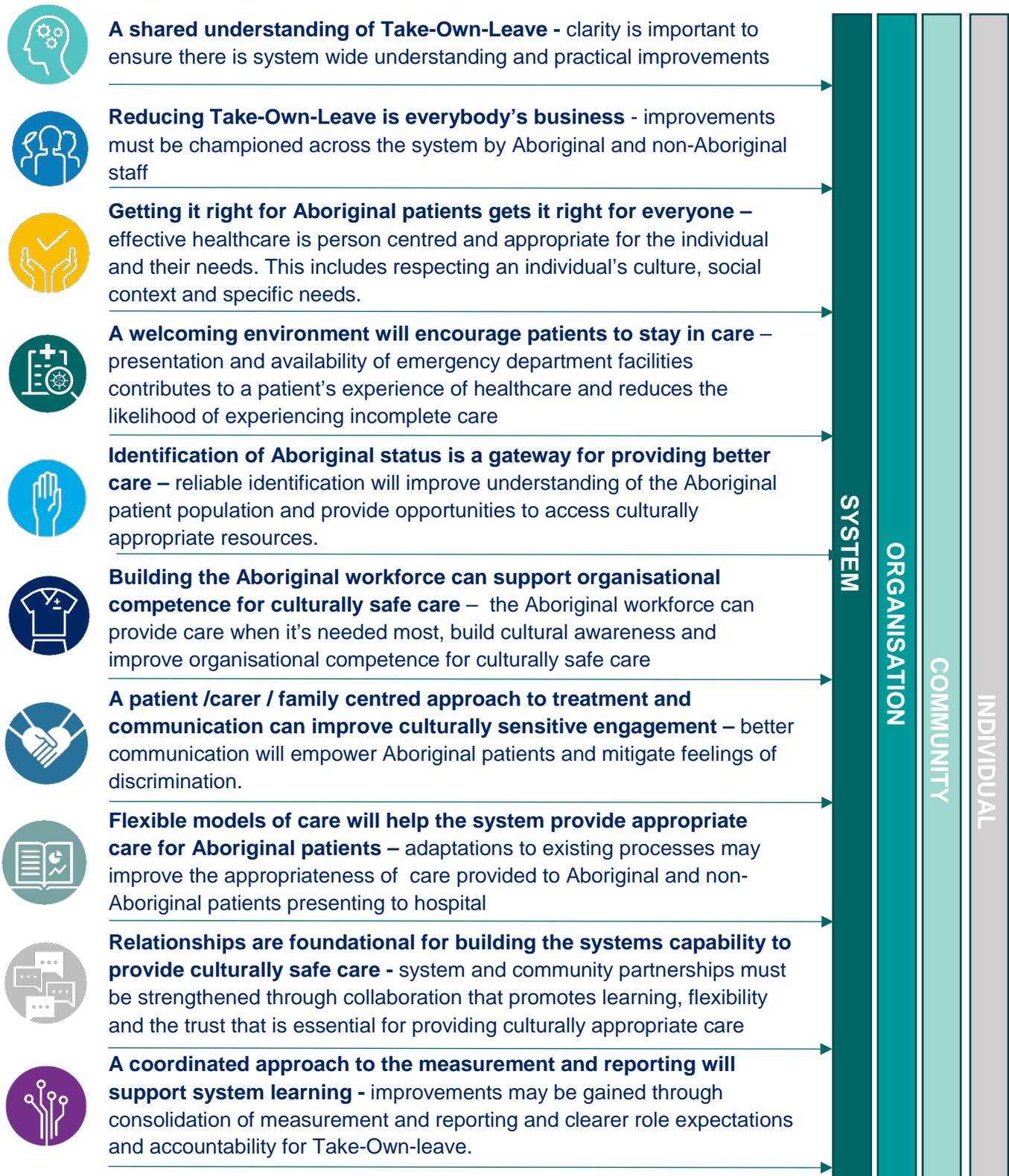
Our diagnostics have identified ten key themes for consideration and four levels of responsibility for further development of an approach for responding to Take-Own-Leave that may support initiatives to reduce harm and improve care of Aboriginal people in hospitals across New South Wales.

The findings from our diagnostics are supportive of the NSW Aboriginal Health Plan 2013-2023: Mid-Term Evaluation report (2019) recommendations that the next steps include a focus on building trust; ensuring integrated planning and service delivery; strengthening of the Aboriginal workforce; providing culturally safe work environments and services; and strengthening performance monitoring.

The CEC and CAH Take-Own-Leave project team

Summary of Findings

Through the consultation process and literature review ten main themes that could provide a basis for further programs of work were identified. Each theme links to all four levels of responsibility for action: the system, the organisation, the community and the individual.



Introduction

Patients who Take-Own-Leave including discharge against medical advice, left at own risk and did not wait, are susceptible to higher readmission rates as well as multiple admissions, a higher associated morbidity and mortality rates and increased healthcare expenditure (Shaw, 2016).

An Indigenous Australian is 6-19 times more likely than their non-Indigenous counterpart to experience incomplete care and being an Indigenous Australian is the highest predictor of the risk of experiencing incomplete care (Shaw, 2016). In 2016, 216,176 Aboriginal people resided in NSW, representing 2.9% of the total NSW population and 33.3% of the Aboriginal population in Australia (Australian Bureau of Statistics., 2017).

In 2019, NSW Health services treated 842,910 identified Aboriginal patients. Of those, 19,794 or 2.35% did not complete their care. While the gap for Aboriginal (2.5-2.6%) and non-Aboriginal patients (-1%) who discharge against medical advice remains, the rate of discharge against medical advice amongst both populations has remained stable over the past 5 years (Centre for Epidemiology and Evidence and Centre for Aboriginal Health, 2019).

The Bureau of Health Information (2016) *'Patient Perspectives – Hospital care for Aboriginal people'* found that there were 'gaps' in experiences of care between Aboriginal and non-Aboriginal patients. It also found that there were differences in Aboriginal patients' experiences of care across the state.

The Australian Commission on Safety and Quality in Health Care (ACSQHC, 2015) suggests that episodes of incomplete care may be an indication of 'how safe, welcome and understood an Indigenous person feels and an indirect indicator of the extent to which services respond to an Indigenous patient's needs'.

Both the systematic review by Shaw (2016) and research conducted by the Australian Health Ministers' Advisory Council (2016) suggest that the contributing factors for occurrence of incomplete care include experiences of racism, distrust of the health system, a lack of culturally safe institutions, miscommunication and misunderstandings, feelings of isolation and loneliness, family and social obligations as well as sex, age group, remoteness of hospital, state/territory of hospital and remoteness of usual residence. Furthermore, intergenerational trauma and the socio economic disadvantage experienced by a large proportion of the Aboriginal patient population significantly impacts the occurrence of incomplete care (Shaw, 2016).

“If a health service can see where in a healthcare journey Indigenous people are having difficulty, they can adjust the way the service is delivered to reduce these problems.”

Vital Signs: The state of safety and quality in Australian healthcare, ACSQHC, 2015

Our Approach

For the purposes of the consultations Take-Own-Leave was used as an 'umbrella term' for when a patient chooses to leave the health facility prior to commencing or completing treatment. It included: did not wait (DNW), abscond or go missing, self-discharge, leave at their own risk (LOR), away/absent without leave (AWOL) or discharge against medical advice (DAMA).

Using a Human Centred Design process, based on the Design Council framework (2019) this work was approached with the aim of building an understanding of the contributing factors for the occurrence of Take-Own-Leave in New South Wales (NSW) Health Services.

This report captures the findings of the initial 'Discovery' phase. In this phase we applied the notion 'that any effort to improve a system, its processes, or its products and services must begin with customers and the people doing the work' (Kachirskaia, Mate & Neuwirth, 2018). As such, we included broad consultation with the NSW Health workforce, consumers and industry representatives and an extensive literature review.

Activities undertaken by the CEC and CAH teams included:

- Literature review including both peer review and grey literature
- Consultations with a range of clinicians and providers in NSW public health facilities
- Consultations with other national bodies undertaking this work
- Consultations with industry bodies involved in care of Aboriginal patients
- Onsite visits to Far West Local Health District and Western NSW Local Health District.

The consultations focused on clinician and expert perspectives about the contributing factors for Take-Own-Leave and how they would like to improve the provision of care for Aboriginal peoples. A core set of questions were used to guide the conversations – see Appendix 2.

The literature review sought to build a foundational understanding of the evidence and associated concepts related to the occurrence of Take-Own-Leave and to validate and expand on the consultations.

Throughout the report we have included a number of case studies which are intended to provide some practical examples of work being done or best practice around Take-Own-Leave. They are not included as endorsements or the best solution to the problem but as examples that we were introduced to through this process, which may support services in developing their own local solutions.

Recognising Cultural Safety

Throughout the consultation process the issue of cultural safety, which is how we provide care to Aboriginal patients, and what it means for the health service to be culturally aware and sensitive, were inextricably linked.

While we acknowledge there are many definitions of cultural safety it can be described as the outcome of care that reflects cultural awareness and an ability to exercise cultural sensitivity at a system, organisation and individual level (Australian Indigenous Doctors' Association, 2018; Oxfam Australia, 2019; Dwyer, O'Donnell & Kelly, 2016; Lavery, McDermott & Calma, 2017; Mbuji et al. 2017, Prentice, Blair & O'Mullan, 2016). Cultural safety is the accumulation and application of the knowledge of Aboriginal values, and the principles and norms that enables the delivery of optimal health care for Aboriginal peoples. It is seen as the recipient's own experience and cannot be defined by the caregiver (Australian Indigenous Doctors' Association, 2018; Australian Health Practitioner Regulatory Authority, 2018; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)).

It aims to overcome the cultural power imbalances of places, people and policies by enabling equity and appropriateness of care (Australian Indigenous Doctors' Association, 2018; Dwyer, O'Donnell & Kelly, 2016) through an indigenous-led model of care (Lavery, McDermott & Calma, 2017) and respect for cultural identity and diversity (Dwyer et al. 2016). More broadly, the NSW Health mandatory Aboriginal cultural training for all staff, *Respecting the Difference*, includes an online and a face to face module.

The model of cultural safety below demonstrates the stages through which an organisation and individual can achieve cultural safety.



Figure 1. Model of Cultural Safety: Adapted from AIDA, 2013, Oxfam Australia, 2019, Dwyer et al. 2016, Lavery, McDermott & Calma, 2017, Mbuji et al. 2017, Prentice, Blair & O'Mullan, 2016

The Centre for Epidemiology and Evidence and CAH (2019) suggests that NSW Health activities aiming to foster greater cultural safety have contributed to reduced incomplete

emergency department visits (from 10.1% in 2010–11 to 7.3% in 2016–17) and a stable rate (2.5–2.6%) of discharge from hospital against medical advice in Aboriginal peoples in NSW.

A range of opportunities exist to build competence for culturally safe care at the system, organisation, community and individual level. Our findings support that this issue should be a key consideration and an area for further support and exploration for any work related to Take-Own-Leave.

“We have to start doing things differently if we want things to change and that starts with bringing the care back into our work”

Director Aboriginal Health



NSW CENTRE FOR ABORIGINAL HEALTH

Aboriginal Cultural Engagement Self-Assessment Audit Tool

The NSW Health Services Aboriginal Cultural Engagement Self-Assessment Audit Tool aims to enable health services to adopt a measured approach to improving cultural safety. The Audit Tool also supports implementation of the Aboriginal specific actions of the National Safety and Quality Health Service Standards and accreditation of NSW Health Services against the Standards. Along with the Audit Tool the CAH is developing a broader program of work in relation to cultural safety that aims to consolidate Ministry wide opportunities to improve cultural safety as an enabling factor in the reduction of Take-Own-Leave events.

The audit tool is available <https://www.health.nsw.gov.au/aboriginal/Pages/cultural-engagement-tool.aspx>



ANTI-DISCRIMINATION COMMISSION QUEENSLAND

Institutional racism audit for health services (2019)

A matrix tool has been developed to measure progress towards the elimination of institutional racism over time in health services in Queensland. It has been trialled across 16 health and hospital services.

The matrix tool has five criteria that is believed to contribute to institutional racism:

1. Inclusion in governance
2. Policy implementation
3. Service delivery
4. Employment
5. Financial accountability levels

The understanding gained from this tool may help to improve the experience of care for Aboriginals and reduce the occurrence of Take-Own-Leave

Bourke, Marrie & Marrie (2019) *Transforming institutional racism at an Australian hospital*

Interdependent levels of responsibility

Within the NSW Health system, four levels of responsibility help to conceptualise Take-Own-Leave and to explore the contributing factors and opportunities for intervention from a whole of systems perspective. They include the system, the organisation, the community and the individual.

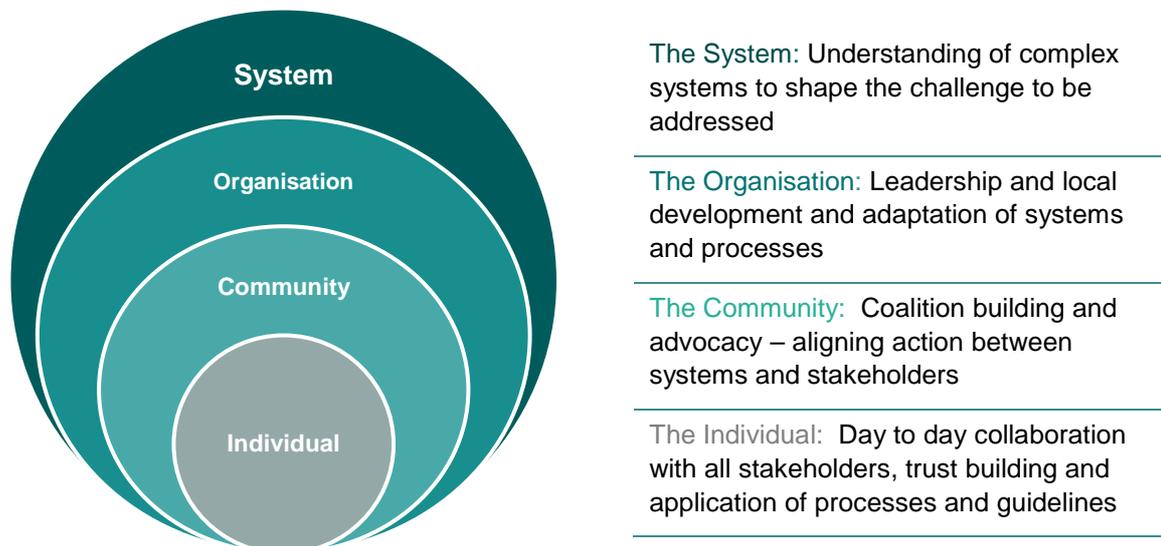


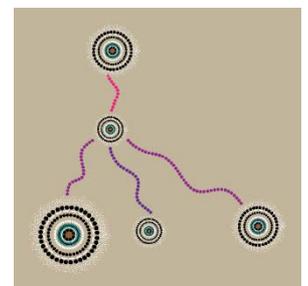
Figure 2: Four levels of responsibility for leadership for change

Structural racism is the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources and a key determinant of population health. *Bailey et al. 2017*

System

Institutional barriers impact on the system's capability to deliver safe and quality care for Aboriginal peoples

There are many factors that influence making significant improvements in the experience of care by Aboriginal patients. From the system level leadership for reducing Take-Own-Leave, improving Aboriginal representation in the workforce and appointing Aboriginal and non-Aboriginal system champions are essential. Leadership that facilitates sustainable health care models for Aboriginal patients is likely to lead to continued improvement and narrowing of the gap between Aboriginal and non-Aboriginal health outcomes (Prentice, Blair & O'Mullan, 2016; Young et al. 2017).

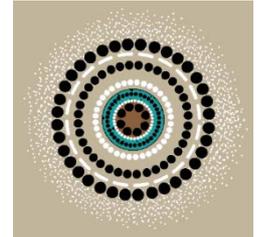


Institutional racism is the structure, policies and practices of an institution that leads to indirect or unintentional outcome disparity within ethnic or racial minority groups. It may be responsible for 46% of the discrepancy in health outcomes for Aboriginal peoples. *Bourke et al. 2019.*

Organisation

An organisational approach to building cultural safety should improve the safety, quality, equity and experience of Aboriginal peoples in care

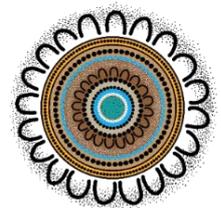
There is significant variability in the reports of Aboriginal patients' experience of care (Bureau of Health Information, 2016) and the percentage of patients who discharge against medical advice across the Local Health Districts of NSW (Centre for Aboriginal Health, 2019). This demonstrates the role organisations play and the responsibility they have in ensuring their facility is one where patients feel 'safe, welcome and understood' during their episode of care (Australian Commission on Safety and Quality in Health Care, 2015). For Aboriginal patients this includes the facilities' organisational competence to practice culturally safe care (Dwyer et al. 2016).



Community

The cultivation of community connections may improve feelings of trust and our ability to provide culturally appropriate care

The systems capability to create 'meaningful, accountable and equitable long-term relationships' with local communities is vital for improving the safety and quality of care provided by hospitals to Aboriginal patients (Prentice, Blair & O'Mullan, 2016). Connections with the community help to strengthen Aboriginal identity through self-determination, community control, and sharing of their story and heritage (Oxfam Australia, 2019; Mokak, & Smith, 2018) and aligns closely with the Aboriginal concept of health (NACCHO's Constitution, 2006).

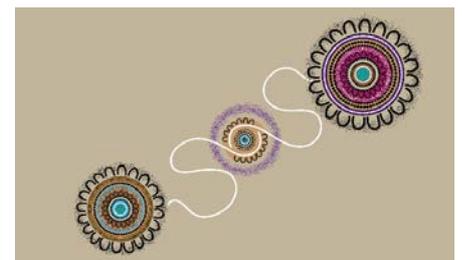


Interpersonal racism is perceived as unfair treatment as experienced by individuals. *Bailey et al. 2017*

Individual

Cultural awareness, cultural sensitivity and health literacy is essential for improving outcomes of care

Individuals may be constrained by the system in their ability to provide or engage with appropriate care that improves their health outcomes. Cultural awareness and sensitivity of the workforce is fundamental to the practice of culturally safe care and staff must be willing and able to engage in these practices. A patient's ability to understand their condition, the process of care and their role in their health outcomes is essential for reducing the occurrence of and poor outcomes associated with incomplete medical care.



Themes for further action

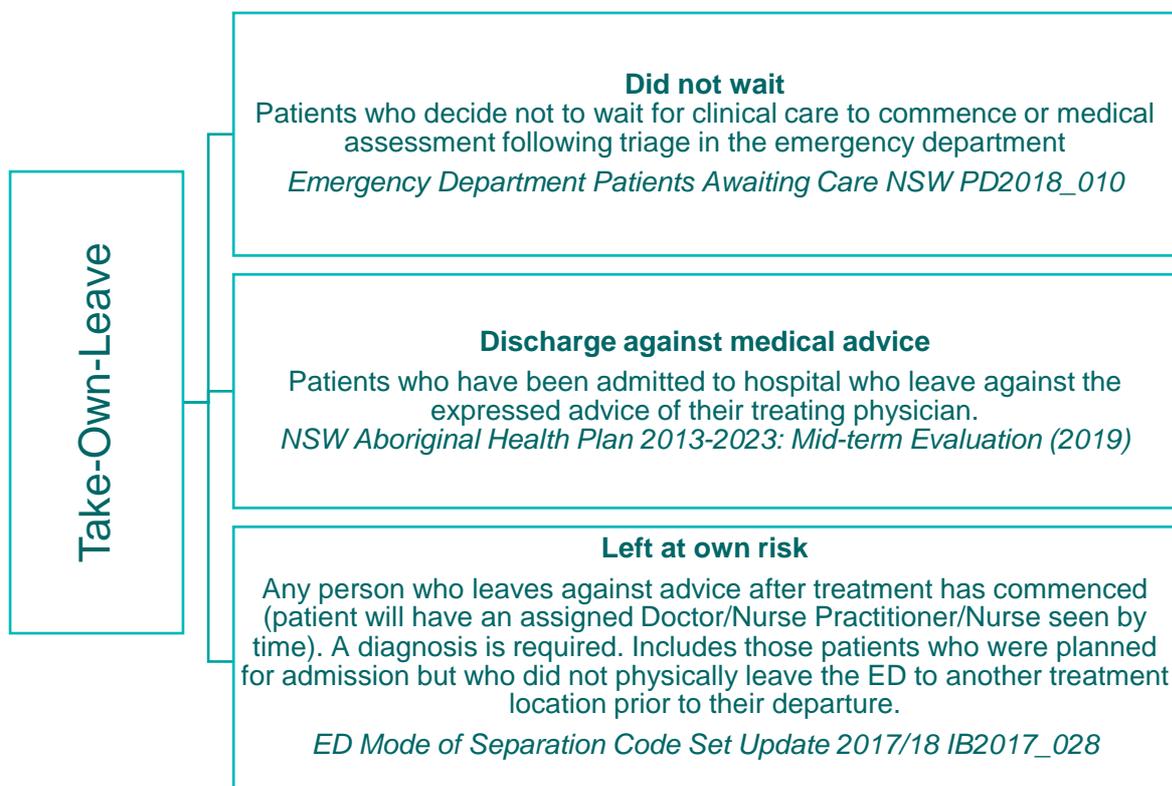


A shared understanding of Take-Own-Leave

A shared understanding of the definition of Take-Own-Leave is important to provide a common language for discussion, measurement, culture-building and practical improvements.

Consultations and literature review identified a number of terms associated with the occurrence of incomplete care. Most consultation groups referred to *discharge against medical advice*, *did not wait* and *left at own risk* when discussing Take-Own-Leave. Having clarity of definition is important to ensure there is system wide understanding of the term and that practical improvements address the specifics of the contributing factors for Take-Own-Leave. While discharge against medical advice may have similar contributing factors, the Aboriginality of patients is unique to Take-Own-Leave. Therefore, it may be appropriate to consider Take-Own-Leave as an 'umbrella term' for describing the occurrence of incomplete medical treatment across the patient journey and implies that efforts to reduce the occurrence of Take-Own-Leave will impact rates of *discharge against medical advice*, *left at own risk* and *did not wait*.

The Australian Commission on Safety and Quality in Health Care will be presenting a consensus statement for Take-Own-Leave in early 2020 which may have implications for this body of work.





Reducing Take-Own-Leave as everybody's business

The majority of people consulted stated that initiatives to reduce Take-Own-Leave requires system and organisation-wide buy in and distributed accountability because Aboriginal health treatment and outcomes is the responsibility of all members of the NSW Health workforce. Aboriginal Health Units alone do not have the influence or resources to lead and sustain activities related to reducing rates of Take-Own-Leave and the overall improvement of Aboriginal health treatment.

The conversations engaged in through the consultations touched on the use of network champions (Aboriginal and non-Aboriginal) across the system to build the mindset of 'everybody's business' and accountability for 'doing the right thing' with regard to the appropriate treatment of Aboriginal patients in care. It was felt that this requires strong executive sponsorship in order to promote, advocate and suitably resource the commitment to initiatives. Support may include a commitment to workforce and education, the upgrading of facilities and sponsoring partnerships. Doing so may assist in creating safe, trusting and caring relationships with patients, the health services and the application of best practice in Aboriginal health.

"In a mainstream operational role I can make more of a difference than I could in a senior management role because I can make an immediate impact on patient experience"

Health Service Manager



WESTERN NEW SOUTH WALES LHD (WNSWLHD) CONSULTATION

Strategy – Improving Aboriginal Health Strategy 2018-2023

WNSWLHD has made a real commitment to strengthening the Aboriginal leadership throughout their organisation.

The Strategy was developed in partnership, via extensive consultation, with Aboriginal communities, Aboriginal Community Controlled Health Services, Aboriginal Staff, the broader workforce as well as the Executive Leadership Team and Board.

The strategy approaches the improvement of Aboriginal Health through four pillars:

1. Environment – improving our district's culture
2. Empowerment – strengthening our workforce
3. Connection – strengthening partnerships
4. Innovation – creating solutions

This Aboriginal Health Strategy focuses on improving the health and wellbeing of their Aboriginal population by setting realistic goals that focus on improving the environments they deliver services to, the way they deliver these services and by strengthening their Aboriginal workforce.



Getting it right for Aboriginal patients gets it right for everyone

Initiatives to address Take-Own-Leave present an opportunity for the system to be better equipped to provide appropriate care for all patients regardless of Aboriginality. Moreover, many of the initiatives that may reduce the occurrence of Take-Own-Leave have the potential to positively impact on all patients.

The CEC's (2019a) person-centred care approach focuses on building relationships with patients, families and carers based on being respectful and responsive to individual patient preferences, needs and values. Person-centred care emphasises the importance of the patient, family and/or carer being partners in care teams in order to improve the quality and safety of care and health outcomes. Consultations supported the notion that patient-centred care approaches can reduce the occurrence of Take-Own-Leave as well as improve the safety, quality and outcomes of care for patients.



MINISTRY OF HEALTH - *Improving the Emergency Department (ED) Patient Experience Pilot (Blacktown, Lismore, Liverpool and Nepean hospitals)*

The Improving Patient Experience in the Emergency Department (ED) pilot aimed to improve peoples' experience by creating an environment that makes patients, carers and their families feel welcomed, safe, cared-for and empowered. It was tested in four EDs at Blacktown, Lismore, Liverpool and Nepean using four specific strategies:

Strategies

1. Patient Experience Manager (PEM)

The PEM is a non-clinical role that is part of the waiting room team, whose main purpose is to communicate and build rapport with patients and their carers in the waiting room. The PEM works closely with clinical staff. NSW Health and Service NSW have worked collaboratively to design a training and mentoring program to support the introduction of PEMs

2. Multilingual digital patient information

A web application providing digital information regarding the ED process and discharge advice to patients and their carers

3. Patient experience development for staff

Immersive simulation workshops for nursing and clerical staff working in the front of house in the ED including reflective videos and an interactive online learning package

4. Enhancing waiting room facilities

New seating, phone chargers, water coolers, free patient Wi-Fi, improvements to parent rooms and child friendly areas

Result

- 30% improvement in patient satisfaction
- a decrease in the number of patient complaints
- an increase in the number of compliments



A welcoming environment can affect and encourage patients to stay in care

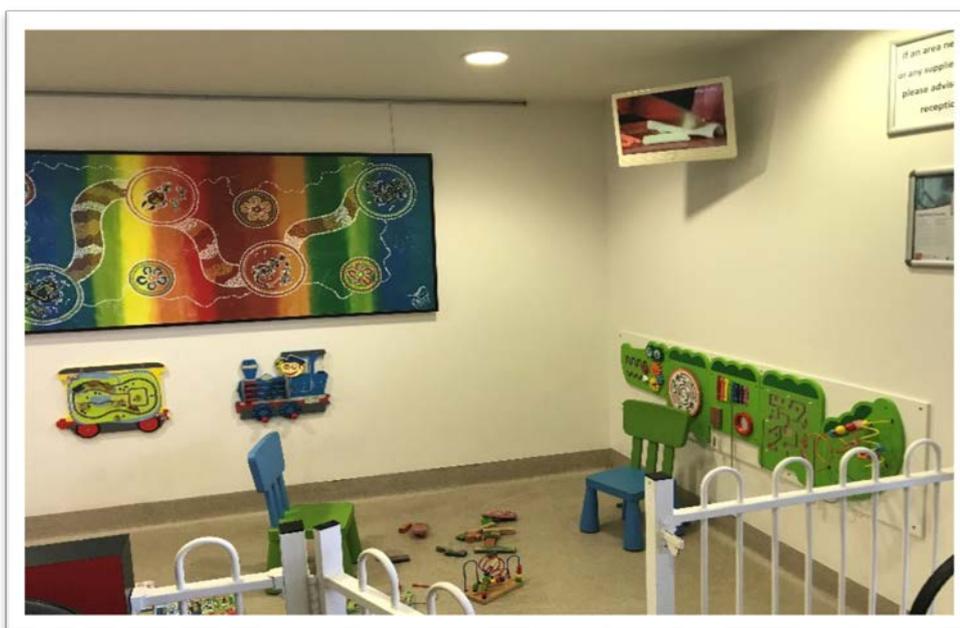
The cultural identification of the service directly impacts on cultural safety and the presentation of the facility and emergency department can be the first indication of how welcome a patient is within the service. Minor and/or major adaptations to the hospital environment can have a positive impact on the patient's experience of care and their likelihood of leaving before completing treatment.

A clear message throughout consultations was that 'first impressions last' and Lavery et al. (2017) suggests that 'hospitals should endeavour to provide a more welcoming and comfortable environment for their Aboriginal and Torres Strait Islander patients.' A range of opportunities exist to improve the experience of patients, both Aboriginal and non-Aboriginal in the ED. Suggestions include:

- improving the comfortability of waiting room chairs
- better understanding of what to expect from the hospital experience including:
 - communicating clearly about triage categories and expected wait times
 - knowing where to go and what facilities are available for patients, carers and family
- size and privacy of waiting rooms
- access to water, phone charging facilities and free wi-fi
- areas for children to play
- a paging system that provides flexibility to leave the waiting room without missing the opportunity for treatment.

“We’ve taken the humanity out of the environment and we’re surprised that people don’t want to stay?”

Aboriginal Liaison Officer



Orange Health Service (WNSWLHD) Emergency Department children's play area

During the facility site visits we saw a number of interventions that have been implemented, including:

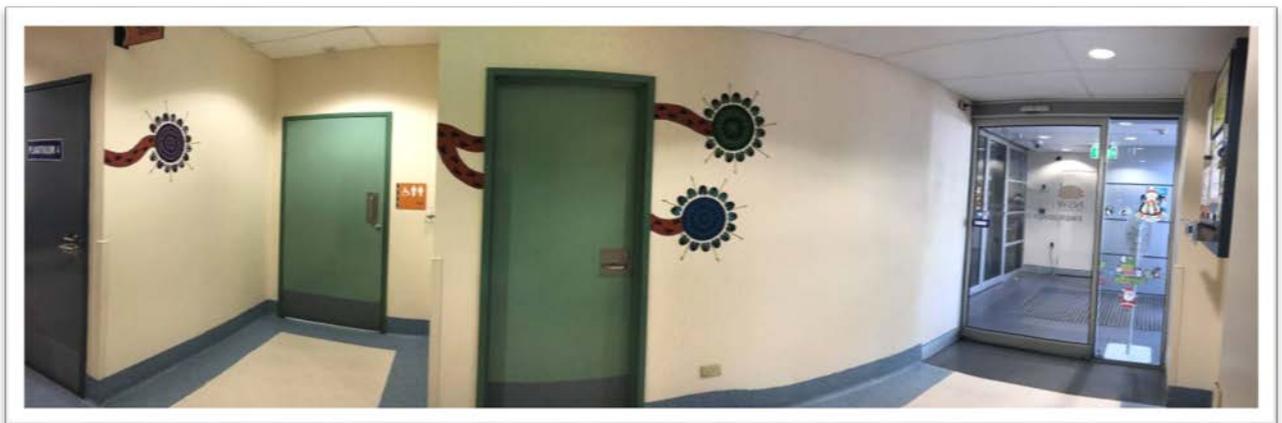
- signage in the local Aboriginal language
- Aboriginal artwork in public spaces
- Aboriginal community rooms
- Aboriginal gathering places



FAR WEST LOCAL HEALTH DISTRICT

Broken Hill Emergency Department Aboriginal Artwork - 'Triage'

The ED murals were painted by Aboriginal artist Corey Payne and partner Elisha Mangal. 'Triage' helps to explain how the triage system works from an Aboriginal perspective. The mural starts near the department's entrance with circles depicting community and linked by a path, with people on a path moving inwards to the waiting area. The main mural tells the story of what triage is, why people with different illnesses may have to wait different times and how the red chairs are for those who are waiting to see the Triage Nurse.





MURRUMBIDGEE LOCAL HEALTH DISTRICT

Project - Murrumbidgee LHD Internal Transformation Team – SMS MESSAGING

The Murrumbidgee LHD Internal Transformation Team are working with the LHD Aboriginal Health team to introduce SMS messaging to Aboriginal and Torres Strait islander patients who present to the ED or for planned admission.

The SMS would go to the patient's contact number outlining the support / advocacy services that are available within the LHD and linking them to appropriate service providers after leaving the health service. There will be an 'opt out' option. If the consumer does opt out then it would link them to the team that supports the 48 hr follow up services.

The team are working to "co design" this solution and then trial it in a number of localities in the LHD before rolling it out more broadly. The team are working with all key stakeholder groups and in partnership with the Ministry of Health

“Communicate in a way that makes patients feel like they belong. Tell the stories, not the illness.”

Director of Aboriginal Health



MID-NORTH COAST LOCAL HEALTH DISTRICT

Aboriginal Cultural and Wellness Centre (Maam Darruyaygamba) at Coffs Harbour Health Campus

Maam Darruyaygamba – A place of Wellbeing, at Coffs Harbour Health Campus provides culturally-tailored support, information and referral for Aboriginal patients, families and visitors. This collaborative project involved local Aboriginal Elders and Aboriginal staff in the layout and design of the centre and reached out to local Gumbaynggirr students whose artwork now adorns the entranceway to the building. It was officially opened in December 2018 and is located within the main hospital courtyard where it is easily accessible to patients, visitors and staff to provide culturally-tailored support, information and referral for Aboriginal patients, families and visitors



A patient /carer / family centred approach to treatment and communication can improve engagement

Consultations emphasised the important role families and carers play in supporting all aspects of the patient's care including discharge. Patients, families and carers who understand the condition, identify with the outcomes of care and feel empowered to enact are more likely to experience better health outcomes and less likely to Take-Own-Leave (Hibbard et al, 2005 cited in Consumers Health Forum of Australia, 2019; Machin et al. 2018; Shaw, 2016).

Building rapport with patients, families and carers including engaging in value-based conversations where they feel listened to and there is shared decision making can help build health literacy and empower patients, families and carers (Consumers Health Forum of Australia, 2019). The use of interpreters and service navigator roles, informative tools and resources, the use of plain language and asking clarifying questions may also improve patient health literacy and activation (Amery, 2017; Aboriginal Health Policy Directorate, 2018). Health services can support Aboriginal patient engagement through the use of plain language and culturally sensitive, patient-centred approaches to care (Hibbard et al, 2005 cited in Consumers Health Forum of Australia, 2019). At a system level, Machin, Goodwin & Warriner (2018) encourage the implementation of discharge procedures that promote patient-centred care by using communication to explore the patients' and relatives' rationale for wanting to leave and the opportunity to better understand patient needs, communicate compassion and modify care through the implementation of a mechanism to request leave. Further improvements may be facilitated through early intervention by the Aboriginal Health Worker/Practitioner.

Are you worried?

If you think someone is getting sicker and no one seems to be noticing, follow these steps

- 1** Tell the nurse or doctor your worries.
- 2** If they do not help you, ask the nurse in charge for a clinical review. This is when a nurse or doctor has to come to check you or the condition of the person you care for. This should happen within 30 minutes.
- 3** If you are still worried, make a R.E.A.C.H. call to the emergency team. You can use the bedside phone or ask for a ward phone. Your nurse will show you which ward phone to use or can help you make the call.

Your R.E.A.C.H. number is:

Phone

Hospital

Remember: Speak to your nurse or doctor first. They may be able to help with your worries.

NSW | CLINICAL EXCELLENCE COMMISSION | With your help together we can be a great team.

RE.A.C.H. was developed by the NSW Clinical Excellence Commission | 1 of 2



CLINICAL EXCELLENCE COMMISSION

Program – Person-centred care

The program supports LHDs across NSW to transform services, by including patients, family and carers as health team members and to champion consumer engagement with the aim of improving safety and quality in health care. It provides strategic advice, guidance, program materials, practical support and training.

The program has multiple resources that support and raise awareness of specific areas of patient-based care. These include:

- Health Literacy
- Patient & Family Activated Escalation (REACH)
- Carer Engagement (TOP 5)



Identification of a patient's Aboriginal status is a gateway to providing better care and follow up

A common and constant theme raised during the consultation was a lack of reliability in asking all patients the question *'Do you identify as Aboriginal or Torres Strait Islander?'* even though it is compulsory under NSW Health policy PD2012_042 - Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients.

Asking the question *'Do you identify as Aboriginal or Torres Strait Islander?'* is the first step for providing appropriate, safe and quality care for Aboriginal patients and improving the cultural safety of the service. Identification benefits patients by providing the system with an understanding of the Aboriginal representation within the New South Wales patient population which may then inform support for the provision of culturally appropriate resources and help the workforce intervene early should a risk of Take-Own-Leave be present (Shaw, 2016; Li, 2015).

"Identification can change a person's healthcare trajectory"

Aboriginal Health Clinical Nurse Consultant

The NSW Aboriginal Affairs group (2014) found six barriers to identification of Aboriginal patients in government services. They include:

- difficulty tracing identity;
- racism, discrimination and stereotyping;
- the type of government service or its physical location;
- concerns about cultural safety;
- the question and how it was asked; and
- the use and privacy of the information.

The consultations found the most common reasons for not asking the question were:

- a lack of comfort of staff in asking;
- a fear of causing offence; or
- a perception that 'the patient didn't look Aboriginal'.

Orange Health Service (WNSWLHD) Emergency Department Identification poster





NORTHERN SYDNEY LOCAL HEALTH DISTRICT (NSLHD)

Asking the question video (2019)

Asking the Question is a campaign developed by NSLHD Mental Health, Drug and Alcohol in full consultation with the NSLHD Aboriginal Health Unit and the Aboriginal community of NSLHD. It shows commitment and respect for First Nations Peoples and enables the provision of culturally appropriate care and treatment.

The animation has two key aims for the Aboriginal community:

- to increase the population of Aboriginal and Torres Strait Islander community utilising the services, and
- to encourage the Aboriginal and Torres Strait Islander community to self-identify.

The video also aims to encourage all NSLHD staff to understand the importance and the medical relevance of correct cultural identification of people presenting to services.

It is used in staff orientation and training as well as in public areas throughout the district and is complemented by additional resources including stickers and posters.

This video is available free to all health or other relevant services to draw upon and make minor changes with recognition of NSLHD as the original developer.

The animation aligns with the National Strategic Framework for Aboriginal and Torres Strait Islander Health.



<https://youtu.be/ON7OTJHQskE>



A greater representation of Aboriginal staff in the workforce may support the provision of culturally safe care

The Aboriginal workforce are a knowledge and relationship rich resource that can provide many benefits to NSW Health and the reduction of Take-Own-Leave. The system is key to building this resource through recruitment and professional development strategies and cultural immersion and advocacy opportunities. Furthermore, a greater representation of Aboriginal staff may aid in speaking up, championing initiatives throughout the system and organisation and strengthening relationships with the community.

The Good Health - Great Jobs: Aboriginal Workforce Strategic Framework 2016 – 2020 provides support for increased recruitment and retention of Aboriginal staff in acute care settings. Throughout the consultations participants suggested that role specialisation, benchmarking and standardisation of Aboriginal Health Workers and Practitioners' roles was required. Professional development pathways may also improve interest in positions, retention of Aboriginal staff, the capability of the staff member to provide clinical and cultural support to Aboriginal patients and integration with the clinical team.

“It takes effort, commitment and champions within an organisation, especially non Aboriginal leaders, to prioritise Aboriginal and Torres Strait Islander health”

Director of Aboriginal Health

In NSW Health there are 97 Aboriginal medical staff; 726 Aboriginal nursing staff; 105 Aboriginal Allied Health Professionals and approximately 380 Aboriginal Health Workers (AHWs) employed across a wide variety of roles (NSW Health, June 2016).

The Aboriginal Workforce Unit connect with a number of agencies /groups / organisations across the health sector to support their work. These include:

- Managers of Aboriginal Workforce Development
- Aboriginal Population Health Training Initiative (APHTI)
- Aboriginal Policy Pathways Program (APPP)
- NSW Aboriginal Mental Health Workforce Reference Group
- Aboriginal Workforce Strategic Steering Committee
- Aboriginal and Torres Strait Islander Health Workforce Working Group

Consultations suggested that more funding is needed for roles in remote/rural areas or those areas with a higher proportion of the Aboriginal population and uncovered an appetite to expand the award hours of Aboriginal Health Worker to match the 24 hour operating hours of the hospital. Other issues raised that may improve the ability of these roles to support patient care and raise community perceptions of these roles included the need to upskill non-clinical Aboriginal roles such as Aboriginal Liaison Officers and Health Workers to understand clinical language and charts and be involved in clinical rounding,

The Aboriginal workforce, clinical and non-clinical, may also help to improve the cultural identity of service (Li, 2017), build the cultural awareness and sensitivity of non-Aboriginal

workers and improve organisational competence for culturally safe care in areas such as women's and men's business.

It was reported through the consultations that Aboriginal Health Workers visit the hospital in their own time, after hours and on the weekend, to support staff and vulnerable patients which speaks to the dedicated staff within NSW Health.

“Patients sometimes feel comforted by simply having someone like them near them”

Aboriginal Health Worker



ST VINCENTS HOSPITAL

Project - Stay'n Deadly and Stay'n In

Aim

To decrease the number of Aboriginal patients who do not complete their treatment in the Emergency Department (ED)

Identified Issues

- Individuals who sleep in the ED without conditions are recorded due to fire safety and often leave without notification. These individuals are coded as 'Left at own risk' and 'incomplete treatment'.
- Wait times of greater than 63 minutes influence the numbers of people leaving before treatment is completed
- Lack of access to Aboriginal Health Workers after hours/on weekends
- Incorrect coding of Aboriginal patients when leaving the hospital due to risk of re-presentation - Treatment Complete is not documented in the patient's notes.
- Doctors report a lack development and support for treating Aboriginal Patients.

Interventions

- Staffing of Aboriginal Liaison Officers for afterhours presentation
- Aboriginal Flexi-Care clinic, an Aboriginal patient specific ED team, allows patients to present to ED and return to complete treatment at a time that is suitable to them.
- Training Package for the ED Doctors including coding education and a condensed course of Respecting the Difference.



Flexible models of care will support the system provide appropriate care

Person-centred care relies on the responsiveness of the system in which the treating team provides care and is the foundation for achieving safe, high quality care. There are significant gaps in experiences of care between Aboriginal and non-Aboriginal patients in rural and remote areas and across local health districts (Australian Health Ministers' Advisory Council, 2016; Bureau of Health Information, 2016) and flexibility may help these services to provide more appropriate care.

Throughout the consultations we were told of initiatives or models of care either in progress or commencing that aim to improve the patient's journey through the system as well as their experience of care and thereby aim to reduce the occurrence of Take-Own-Leave. They include:

- ACI Aboriginal Chronic Conditions Network. The Agency for Clinical Innovation identified that discharge planning must commence at the point of admission by setting expectations, improving transparency and enabling the transfer of care to the community where appropriate
- Hunter New England Local Health District implemented re-classification of triage category following observations during the patient's time in the waiting room. A modified fast tracking program, where lower triage patients are seen following the medical staff changeover, was also implemented
- A 48 hour follow-up call initiative, implemented across a range of districts, had variable effectiveness reported. Key findings of this work was that Aboriginal patients demonstrate greater compliance when the treating team lets them know to expect a call. This protocol, in response to discharge against medical advice, was also implemented by the Department of Health in Western Australia as part of their Take-Own-Leave strategy (2018) and its efficacy will be reported in early 2020.

Shaw (2016) suggests that facilities should consider how best to manage and the degree to which they manage women's and men's business, the fear of dying off country, the significance of areas where loved ones have passed and where conflicts or lateral violence exists between individuals. Rural and remote facilities experience the greatest gap in health outcomes and rates of discharge against medical advice and may need to consider how to cater for costly and long travel times, feelings of isolation, loss of connection to community and a fear of dying off country (Akter et al. 2019; Clinical Senate of Western Australia, 2018; Meiklejohn et al. 2016; Quigly et al. 2019).



WESTERN SYDNEY LOCAL HEALTH DISTRICT (WSLHD)

Emergency Department (ED) District Analysis – Patients who did not wait. 2016-2018

A review of district-wide Emergency Department (ED) data was undertaken by WSLHD for the period 2016-2018 for all patients who did not wait (DNW). The main findings included:

- The predominate time at both a district and facility level for DNW patients aged 0-64 years to leave occurred between 20:00 and 02:00 with the peak time around midnight
- There was an increase of patients who left before completing care if they presented to the ED between 1800 and 04:00
- Patients who did not wait or left against medical advice were less likely to have been referred to the ED by their GP and more likely to be attending the ED out of hours

As part of the review ED staff and those patients who were identified as *did not wait* were surveyed about their experience.

- Staff were asked why they thought patients would leave without completing treatment
- Patients were asked why they had left the ED before treatment was complete.

The main responses both patients and staff gave was the wait was too long with no idea how long the wait would be.

Suggestions for improvement included:

- communication in relation to providing information on wait times
- explanation of what triage categories mean
- how staff speak and interact with patients
- the comfort and environment of the ED

While this project did not distinguish for Aboriginality the highest percentage of patients who left before treatment was complete identified that Aboriginal was their preferred language. This type of review may be replicable at a local level to provide helpful information to develop and implement strategies that will improve care for all patients.



Relationships are foundational to building the system's capability to provide culturally safe care

Relationships between Local Health Districts and local communities (Aboriginal and non-Aboriginal) are foundational to improving the continuity of care and feelings of trust towards health care services, better supporting the socio-economic factors that contribute to Take-Own-Leave and gaining traction for change at a system level.

The University of Newcastle in their paper '48 Hour Follow Up Evaluation: Final Report' (2016) suggests that communication and collaboration between the districts should be encouraged and supported and partnerships between hospital services and primary health services strengthened to help improve patient outcomes of care. The Centre for Aboriginal Health, in conjunction with a range of literature, acknowledges the importance of improving the coordination between hospital and community care providers to allow more Aboriginal and Torres Strait Islander patients to receive care in their communities, including at discharge.

Consultations found that opportunities exist to build partnerships with:

- Education providers to build the Aboriginal representation and skills of the workforce
- Local community groups and facilities such as displaying artwork from the local gallery to strengthen links with the Aboriginal and non-Aboriginal community
- Aboriginal Medical Services and Aboriginal Community Controlled health services to promote the correct use of services and provide support for at risk patients
- Aboriginal providers to demonstrate support for the local community
- Community boards including Aboriginal groups to improve exposure and understanding of community needs and demonstrate support for the local community



MID-NORTH COAST LOCAL HEALTH DISTRICT

Wutu room at Kempsey Health Campus

The Wutu Room at Kempsey Health Campus was an integral part of the Hospital redevelopment in 2014-15. The Kempsey Hospital Aboriginal Advisory Committee, in collaboration with the Ngabu Bingayi Dunghutti Language Group, provided 4 potential names for the new gathering place which was put to a community vote.

Input from more than 200 Aboriginal people from across the Macleay Valley ensured a strong consumer voice in the project.

In the traditional language of the Dunghutti people Wutu translates to many, much, a lot, big mob. For the local Aboriginal people the establishment of the Wutu Room was a significant step in the spiritual rebuilding of the Health Campus to align with the physical redevelopment of the Hospital. This space provides a safe and culturally inclusive area for all people to gather in.



Having a coordinated approach to measurement and reporting of Take-Own-Leave will support system learning and change

An Incident is any unplanned event resulting in, or with the potential for, injury, damage or other loss. This includes a near miss. *NSW Health, 2019*

The strategic deliverable of responding to Take-Own-Leave as a clinical incident is one that needs consideration of what is hoped to be achieved and what can be gained by doing so. While there is system wide consensus that the occurrence of Take-Own-Leave is a significant departure from good care, the means by which it is recorded, alerted and resolved is not as unanimously supported.

Framing Take-Own-Leave as an incident suggests the occurrence of incomplete care is unplanned and has the potential to cause harm to a patient (NSW Health, 2019a) including injury, damage or other harm excluding psychological harm (ACSQHC, 2018). The literature does support the notion that the occurrence of Take-Own-Leave leads to poorer patient outcomes; however, the incident management policy and procedure and reporting system (NSW Health, 2019a) may not be the most appropriate mechanisms for learning about and mitigating the contributing factors for Take-Own-Leave.

Through the consultations it was suggested that learning about the contributing factors for Take-Own-Leave may be better enabled through a strong safety culture, consideration of why patients don't want to stay in care and what may be able to be done to reduce its occurrence. It was suggested that conversations should occur at the point of care and before the patient is leaving, at multi-disciplinary team rounding, team and directorate meetings and District Quality Accounts. Berwick & Bisognano (2019) reinforce that a culture of improvement has greater potential for positive change than a culture of measurement.

“Take-Own-Leave is a significant departure from good care. Making it an incident could push people further from having reasonable conversations about what you want to do about it”

Consultation participant

The Bureau for Health Information in collaboration with the Centre for Aboriginal Health, is currently developing a special purpose questionnaire that comprises questions of high relevance to the Aboriginal community and stakeholders and could provide an opportunity to gain a better understanding of the contributing factors for Take-Own-Leave.

The 2019 Mid-Term Evaluation: NSW Aboriginal Health Plan 2013-2023 (Centre for Epidemiology and Evidence and Centre for Aboriginal Health, 2019) suggests that improvements in the quality of reporting, particularly in the emergency department, may improve Aboriginal patients' health outcomes and is an important consideration for measuring the occurrence of Take-Own-Leave. Take-own-leave is currently reported and monitored through:

1. Aboriginal Health Dashboard – discharge against medical advice and incomplete ED attendances at LHD level
2. Systems Management Branch – added as KPI to each LHDs Quarterly Performance Review



NSW CENTRE FOR ABORIGINAL HEALTH

NSW Aboriginal Health Dashboards

The annual Dashboards provide a measure of performance for Local Health Districts and Specialty Health Networks across 20 key indicators relating to access and equity of health care for Aboriginal peoples. They provide a tool for the review and analysis of data to inform efforts to help drive change at a local level and improve health outcomes for Aboriginal peoples.

The Dashboards facilitate and support constructive data-driven conversations and collaborative efforts with local services, communities and with the Ministry of Health. These conversations enable system level identification and sharing of strategies to be put in place to address the occurrence of Take-Own-Leave.

Discharge against medical advice, under the domain of safety and quality of care, is included in the Dashboards.

NSW Aboriginal Health Dashboard Toolkit

The Toolkit accompanies the Dashboards and was developed to support Local Health Districts and Specialty Health Networks in the delivery of the best healthcare possible for Aboriginal peoples. The Toolkit is a guide to improving Aboriginal health across the key indicators in the Dashboards, including through the reduction of Take-Own-Leave events. It is informed by published evidence, expert opinion and information from health service consultations.

Health System Performance Report

The monthly Health System Performance Report is used in conjunction with a quarterly performance meeting and annual Dashboards, to more regularly identify, monitor and discuss performance concerns relating to the occurrence of Take-Own-Leave; Discharge against Medical Advice, Did not wait and Left at own risk.



NBMLHD, SWSLHD & WSLHD Partnership (2019)

The new Greater Western Sydney Health Partnership has brought together South Western Sydney, Nepean Blue Mountains and Western Sydney Local Health Districts to provide better health outcomes for its community. The joint initiative is driven by the three Local Health Districts to focus on future-proofing public hospitals and health services and thinking differently about the delivery of care. The partnership will work alongside existing working groups and agencies already committed to the region, as well as to co-create new opportunities for collaboration.

Conclusion

During this Diagnostic phase we have identified:

- key challenges in the provision of care to people who Take-Own-leave;
- ten key themes for further action;
- four levels of responsibility; and
- a range of examples of best practice across NSW Health in relation to Take-Own-Leave.

While we have consulted widely and have worked in partnership with the Centre for Aboriginal Health we acknowledge there may be some limitations to our findings notably that not all activities implemented across NSW Health were captured.

Next Steps

The NSW Aboriginal Health Plan 2013-2023: Mid-Term Evaluation report (2019) was released in May 2019. It recommends that there should be a strategic focus on building trust; ensuring integrated planning and service delivery; strengthening of the Aboriginal workforce; providing culturally safe work environments and services; and strengthening performance monitoring. Our work supports the above recommendations.

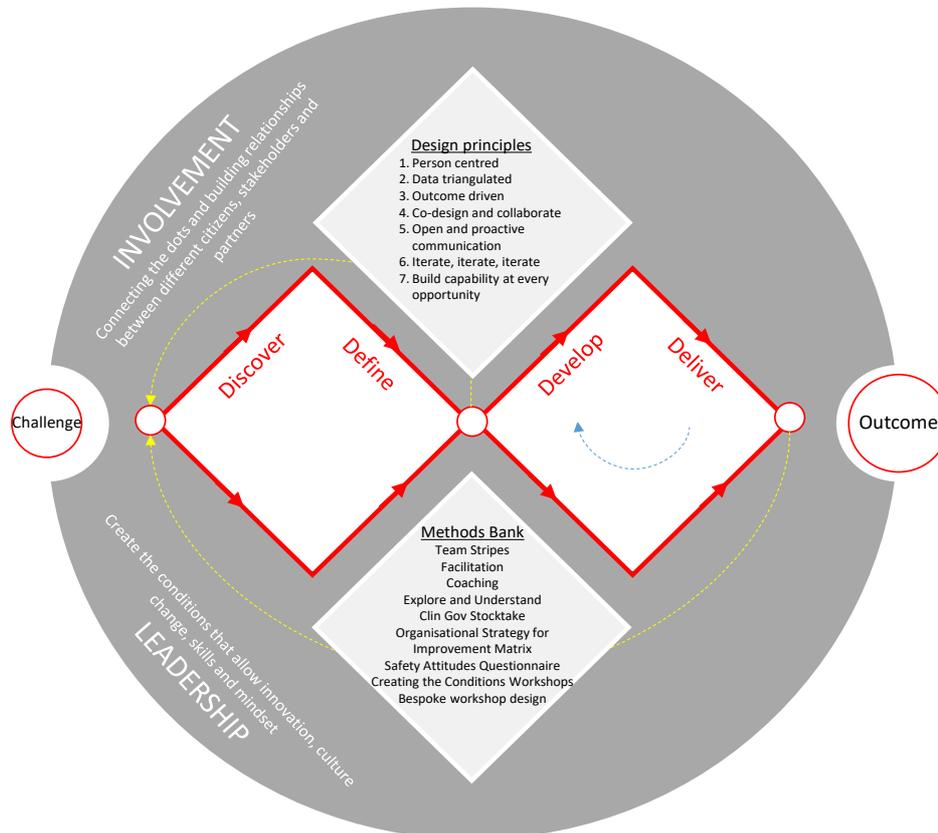
In light of the evaluation report and our work we would encourage the next phase be guided by what we have identified. The multi-factorial nature of Aboriginal health and the opportunities that exist in the short and long-term and for system, organisation, community and individual level interventions, must therefore be considered.

We would encourage the report is used to facilitate partnership, action and evaluation that:

- is developed through a patient/carer/family centred lens
- is able to leverage existing statewide programs and relationships
- includes Aboriginal Elders and community organisations in planning and implementation
- engages all clinicians and staff
- engages statewide leader groups such as, Australian Indigenous Doctors' Association and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
- utilises existing NSW Health performance frameworks such as Safety and Quality Accounts, and relevant measures to monitor Take-Own-Leave data
- is based on developing, testing and evaluating and sharing best practice and evidence based strategies.

Appendix 1: Using a Human Centred (HCD) Approach

People, trust and data are the bedrock to effective change and delivering positive outcomes. The CEC Capability and Culture Directorate uses HCD, based on the [Design Council UK framework, 2019](#) with the intention of generating broader thinking and aligning of different data and information to better understand a situation, before focusing in with commitment to the work that needs to be done.



The first diamond – the diagnostic phase - places understanding above assumptions, focusing on a broad **discovery** in order to **define** the challenge.

The second diamond pays attention to different thinking to **develop** solutions before the organisational, team and individual commitment to **deliver**.

As a thinking and design process, success of the double-diamond sits in a background context of transformational leadership behaviours and high-levels of involvement with clinicians, patients, managers and executives. The approach is guided by consistent design principles and leverages off a methods bank of evidence-based and adaptable diagnostic tools, frameworks and resources.

Human Centred Design principles are supported by adaptable evidence based frameworks and tools, and are applied through a lens of positive enquiry, solutions focus, and change psychology.

Appendix 2: Interview questions

Consultations focused on clinician and expert perspectives about the contributing factors for Take-Own-Leave and how they would like to improve the provision of care for Aboriginal peoples. A core set of questions were used to guide the conversations:

1. What is your experience of Take-Own-Leave and what do you believe are the contributing factors for an episode of incomplete care?
2. What work have you been involved in that aims to reduce the occurrence of Take-Own-Leave?
3. What do you believe are the current challenges for reducing the occurrence of Take-Own-Leave?
4. What do you believe are the future challenges for reducing the occurrence of Take-Own-Leave?
5. If you could make one change that would reduce the occurrence of Take-Own-Leave what would you do?

Appendix 3: Policy guiding Aboriginal Health

A range of documents offer direction to NSW Health Services for the provision of healthcare to Aboriginal peoples. Some of those of relevance to Take-Own-Leave are outlined below.

NSW Aboriginal Health Plan 2013 – 2023

The plan identifies six strategic directions:

1. Building trust through partnerships
2. Implementing what works and building the evidence
3. Ensuring integrated planning and service delivery
4. Strengthening the Aboriginal workforce
5. Providing culturally safe workplaces and health services
6. Strengthening performance monitoring, management and accountability

Aboriginal Health Impact Statement PD2017_034

The Aboriginal Health Impact Statement (2017) provides direction for NSW Health organisations and staff to systematically apply an ‘Aboriginal health lens’ to all policies, programs and strategies. It suggests that three key components should be considered when developing policies, programs and strategies:

1. The health context for Aboriginal peoples
2. The potential impact of the policy, program or strategy on Aboriginal peoples including approaches to mitigate any potential undesired effects
3. Engagement with Aboriginal peoples

Aboriginal Cultural Activities Policy PD2019_025

This Policy Directive provides a summary of cultural activities including Welcome to Country, Acknowledgment of Country, displaying flags and smoking ceremonies. Engagement in Aboriginal cultural activities ensures Aboriginal values, strengths and differences are recognised, respected and celebrated. All NSW Health staff are required to adhere to this policy and incorporate Aboriginal cultural activities into their business.

National Safety and Quality Health Service standards for Aboriginal and Torres Strait Islander health V2 (ACSQHC, 2019)

There are six discrete actions in Version 2, these include:

- 2.13 The health service organisation works in *partnership with Aboriginal and Torres Strait Islander communities* to meet their healthcare needs
- 1.2 The governing body ensures that the organisation’s *safety and quality priorities address the specific health needs* of Aboriginal and Torres Strait Islander peoples
- 1.4 The health service organisation *implements and monitors strategies* to meet the organisation’s safety and quality priorities for Aboriginal and Torres Strait Islander peoples
- 1.21 The health service organisation has strategies to improve *the cultural awareness and cultural competency of the workforce* to meet the needs of its Aboriginal and Torres Strait Islander patients
- 1.33 The health service organisation demonstrates a *welcoming environment that recognises the importance of cultural beliefs and practices* of Aboriginal and Torres Strait Islander peoples
- 5.8 The health service organisation has *processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin*, and to record this information in administrative and clinical information systems

Aboriginal and Torres Strait Islander Health Performance Framework

The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was developed to support a comprehensive and coordinated effort across and beyond the health sector to address the complex and interrelated factors that contribute to health outcomes experienced by Aboriginal and Torres Strait Islander Australians. Within the framework cultural safety and discharge against medical advice are identified as key indicators of health system performance.

Cultural Respect Framework 2016 – 2026 for Aboriginal and Torres Strait Islander Health

The Cultural Respect Framework (Australian Health Ministers' Advisory Council, 2016) aims to ensure the health system is accessible, responsive and safe for Aboriginal peoples by respecting the inherent rights, cultures and traditions of Aboriginal peoples. It proposes six domains for the system wide improvement including:

1. Whole-of-organisation approach and commitment
2. Communication
3. Workforce development and training
4. Consumer participation and engagement
5. Stakeholder partnerships and collaboration
6. Data, planning, research and evaluation

Partnership Agreement on Closing the Gap 2019-2029

The Partnership Agreement on Closing the Gap 2019-2029 builds on the progress over the past 10 years under Closing the Gap and is a commitment to fundamentally change the way that governments and Aboriginal and Torres Strait Islander peoples work together in order to accelerate improved outcomes. The priority areas include:

- **Hospital and hospital-related care** to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management.
- **Patient experiences** to ensure access by Aboriginal and Torres Strait Islander peoples to comprehensive and co-ordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services.

Appendix 4: About the NSW Centre for Aboriginal Health (CAH) and the Clinical Excellence Commission (CEC)

The **CAH** works in partnership to build a culturally safe and responsive health system, where Aboriginal peoples have the same health outcomes as non-Aboriginal peoples. The Centre's role is to support the health system to better engage and listen to the needs and aspirations of Aboriginal peoples so that their health and wellbeing is improved. They do this by supporting the implementation of a range of policies, tools and resources including:

- The Aboriginal Health Impact Statement (AHIS) which supports careful consideration of the health needs of Aboriginal peoples at an early stage in the process of revising or developing policies, programs and strategies. The AHIS guides the systematic examination of health system barriers, enablers and linkages in relation to Aboriginal health to identify opportunities to improve access to healthcare and achieve equity for Aboriginal people. The AHIS supports NSW Health organisations to develop effective partnerships and strategies to meaningfully engage with Aboriginal stakeholders and communities.
- The Aboriginal Health Dashboard Toolkit synthesises published evidence, expert opinion and includes case studies to produce a guide to improving Aboriginal health across the key indicators in the Dashboards including DAMA and incomplete ED attendances.
- The Aboriginal Cultural Activities Policy provides information and guidance to support NSW Health staff in understanding, organising and engaging in Aboriginal cultural activities, including Welcome to Country.
- 'Communicating Positively' provides information and guidance on appropriate word usage when working with Aboriginal people and communities, and when developing policy and programs.
- the review and development of existing policies and guidelines to ensure the focus on Aboriginal people is prioritised such as Patient Discharge Documentation policy and the Emergency Department Patients Awaiting Care.

Established in 2004, the board-governed **CEC** is one of five pillars of the NSW health system. Pillar agencies provide specialist services and support to frontline health teams in hospitals and care settings. The role of the CEC is to lead, support and promote improved safety and quality in clinical care across the NSW health system through consultation and collaboration with clinicians, health consumers, other pillars and the NSW Ministry of Health.

The agency has two broad areas of responsibility:

- setting standards for safety, and monitoring clinical safety and quality processes and
- improving performance of individuals, teams and systems in prioritising safety.

Included in the CEC functions is identification of priorities for research about clinical quality and safety in health care and review and response to adverse clinical incidents arising in the NSW public health system. To improve performance of individuals, teams and systems, the CEC initiates and manages a range of programs in collaboration with local health districts and specialty health networks (LHDs/SHNs) to raise capability and support process improvements and safety culture in clinical teams. The CEC plays a leading role delivering the first priority of the NSW Ministry of Health: Patient Safety First.

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