

National Safety and Quality Health Service Standards

User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds

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Introduction

The National Safety and Quality Health Service Standards

The National Safety and Quality Health Service (NSQHS) Standards¹ were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, all state and territory governments, the private sector, clinical experts, consumers, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health care. They provide a quality assurance mechanism, which tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. Importantly, the NSQHS Standards provide a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The *NSQHS Standards User Guide for Health Service Organisations Providing Care to People from Migrant and Refugee Backgrounds* (the User Guide) aims to support health service organisations to implement the NSQHS Standards and provide safe and high-quality care that meets the needs of people from migrant and refugee backgrounds.

This User Guide focuses on five actions from the NSQHS standards where specific efforts are required to meet the health care needs of people from migrant and refugee backgrounds (see **Table 1**). Other actions in the NSQHS Standards where some additional attention may be required to ensure safe, high quality and culturally responsive care are discussed in (**Attachment 1**).

The NSQHS Standards require organisations to consider the diversity of consumers and high-risk groups in the planning and delivery of care and services (Action 1.15). In addition, the Australian Charter of Healthcare Rights (the Charter)², sets out seven rights and principles that people can expect when accessing health care in Australia. This includes the right for people to have their culture, identity, beliefs and choices

recognised and respected. Organisations are required to adopt a charter of rights that aligns with the Charter (Action 2.3). To successfully implement these actions organisations need to understand the characteristics of their patient population. This will involve identifying groups within the catchment population which may be at greater risk of harm, or those who are more likely to have a poor experience of health care because of their medical background, age, gender, social, economic or geographic circumstances, cultural background, religion, preferred language, or sexuality.

The NSQHS Standards require organisations to embed person-centred care (see **Box 1**) into their processes. This is care that is respectful of, and responsive to, the preferences, needs and values of the individual.³ The principles of person-centred care provide an opportunity to address the health inequities facing groups, such as migrants and refugees. To deliver person-centred care, requires organisations to understand the cultural background of their patient population³ and implement culturally responsive and person-centred safety and quality systems.

Culturally responsive healthcare (see **Box 2**) supports equitable access and delivery of high quality health care.^{4,5} The four interrelated dimensions of cultural responsiveness are: systemic, organisational, professional and individual. To be effective, individual or professional cultural responsiveness should be underpinned by systemic and organisational commitment and capacity.⁶

Health service organisations are encouraged to assess and improve their cultural responsiveness⁷ and foster a culture where migrants and refugees feel welcomed⁸, supported and genuinely engaged with programs and services.⁹ Improving health systems should be undertaken in collaboration with migrant and refugee communities.



Table 1: Actions where specific strategies are required to ensure safe, high quality and culturally responsive care is provided to people from migrant and refugee backgrounds.

Standard	Criterion	Item	Action
 Clinical Governance	<u>Patient safety and quality systems</u>	Diversity and high-risk groups	1.15
	<u>Clinical performance and effectiveness</u>	Quality and safety training	1.20
 Partnering with Consumers	<u>Health literacy</u>	Communication that supports effective partnerships	2.8
	<u>Partnering with consumers in organisational design and governance</u>	Partnerships in healthcare governance planning, design, measurement and evaluation	2.11
 Comprehensive Care	<u>Developing the comprehensive care plan</u>	Developing the comprehensive care plan	5.13

The Commission collaborated with the Migrant and Refugee Health Partnership* in developing this User Guide.

Box 1: Person-centred care³

Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers.

Key dimensions include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, access to care, and partnerships with patients, carers and family in the design and delivery of care.

Person-centred care is the foundation for achieving safe, high-quality care. Focusing on effective delivery of person-centred care will enable healthcare organisations to be successful in achieving better outcomes for their patients, better experience for their patients and workforce, and better value care.

To achieve person-centred care, commitment across all areas of the organisation is needed – from the board, executive, senior managers, clinicians, volunteers and non-clinical workforce. Everyone has a role and responsibility to ensure care delivery is responsive, integrated, coordinated, safe and effective.

Members of the governing body have a key strategic role in leading, monitoring and ensuring organisational accountability for the delivery of person-centred care.

Managers of healthcare organisations play a critical role in leading and coordinating the workforce, as well as implementing well designed systems and strategies to achieve effective person-centred care.

* The Migrant and Refugee Health Partnership is a national body, established in 2016 and auspiced by Migration Council Australia, that brings health care providers and the community together to improve health access, experience and outcomes for migrants and refugees.

Box 2: Cultural responsiveness^{6,7}

Cultural responsiveness offers a framework through which service delivery to clients from culturally and linguistically diverse backgrounds is improved.

Cultural responsiveness requires an organisation-wide approach to planning, implementing and evaluating services for clients of culturally and linguistically diverse backgrounds.

Meaningful consultation and participation strategies need to be embedded in the core business of the organisation.

Policies and systems need to guide the actions of the board, management, staff, volunteers and students, in order to ensure a consistent and responsive approach.

By improving cultural responsiveness, organisations strengthen their service delivery (access and appropriateness) to people from migrant and refugee communities.

Cultural responsiveness is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.

To become more culturally competent, a system needs to:

- Value diversity
- Have the capacity for cultural self-assessment
- Be conscious of the dynamics that occur when cultures interact
- Institutionalise cultural knowledge
- Adapt service delivery so that it reflects an understanding of the diversity between and within cultures.

How to use this guide

This User Guide is intended to support organisations to consider and include the specific needs of people from migrant and refugee backgrounds. It is part of a **range of guides** designed to assist health service organisations align their patient safety and quality improvement programs through using the framework of the NSQHS Standards.

This User Guide identifies actions from the NSQHS Standards that require special consideration to ensure care is safe, of high quality and culturally responsive.

The User Guide provides suggestions on how organisations may approach planning, implementing and evaluating services for migrants and refugees. It also contains suggested strategies and examples of supporting evidence that can be used to demonstrate compliance with the NSQHS Standards.

The suggested strategies in this User Guide are not mandatory, nor are the supporting evidence exhaustive. Strategies implemented by organisations should be tailored to their local context in order to be meaningful, useful and relevant to the organisation's governance structure, workforce and consumers.

Terminology

This document uses the terms 'patient' and 'consumer' interchangeably to describe a person receiving care from a health service organisation.

It is acknowledged that people from migrant and refugee backgrounds may be unfamiliar with the term 'consumer'; however, this is the standard definition used within the NSQHS Standards to describe a person who has used, or may potentially use, health services, or is a carer for a patient using health services.

A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.¹⁰ 'Patient' is used when referring to an individual who is receiving care in a health service organisation.

The provision of 'language services' is defined as measures taken to assist people who have limited ability to communicate in English. Language services may include:¹¹

- Provision of interpreters either face-to-face or via telephone or video conference
- Translation of documents from English into community languages and vice versa, in plain English, the use of story boards and international signposting
- Employment of, and access to, multilingual staff
- Use of culturally appropriate, multilingual information and educational material
- Use of AUSLAN language services.

The resources and tools included in this User Guide are not exhaustive. They supplement existing resources published by the Commission to support implementation of the NSQHS Standards, that can be located [here](#).

Why focus on migrant and refugee populations?

Australia is a culturally and linguistically diverse population that continues to grow in diversity of language, culture, religion and country of origin. Migrants and refugees come from a wide range of social, political and economic backgrounds, and may have different experiences, customs, traditions and beliefs in relation to health and illness.⁸

The health and wellbeing of migrants and refugees can be affected by a range of physical and psychosocial factors both prior to and following arrival in Australia.¹² Poor health and complex health needs can occur pre-arrival due to limited access to appropriate health care, exposure to trauma and torture¹³, prolonged detention, social isolation as well as housing, food and financial insecurity.^{14,15} Upon arrival, physical and mental health can be further impacted by past trauma and post-migration stress¹⁶, discrimination¹⁷, language barriers, precarious visa status, limited availability of funds, circumscribed access to housing, work and education, family separation, lack of community support and loneliness.¹⁸

Access to health care is a basic human right.¹⁹ At the individual level, migrants and refugees should receive healthcare that is accessible, timely, high quality and evidence-based. However, migrants and refugees often have little knowledge of health care services in Australia and may experience increased difficulty navigating the healthcare system as well as major barriers in accessing and engaging with healthcare services and understanding health information.²⁰ As a result, migrant and refugee populations often underutilise health care services and are frequently underrepresented in health care research²¹ and evidence-based practice protocols.²² Limited English language skills, a lack of perceived cultural safety at an organisational level⁸, influence of cultural and personal characteristics of clinicians²³, cost²⁴ and discrimination¹², can also negatively impact the health outcomes of these groups. These barriers are complex and inter-related²⁰ and can result in disparities leading to lower quality health care, poorer outcomes, disempowerment and loss of autonomy.²⁵



Clinical Governance Standard

The Clinical Governance Standard requires leaders of a health service organisation to be responsible to the community for the continuous improvement of the safety and quality of their services, and ensure health services are person centred, safe and effective.

Action 1.15: Diversity and high-risk groups

The health service organisation:

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

The collection of accurate and comprehensive data on migrant and refugee populations has been identified as a key tool to measure and monitor health outcomes. It is required to identify population health needs, inform health policy and program development.²⁴ Organisations need to understand the diversity of the local community if services are to be culturally responsive.⁶

Understanding the patterns of service uptake and health needs is an integral part of service planning and essential to meet the needs of migrant and refugee populations.

Systematically collecting patient demographic data on migrant and refugee patient populations can generate information to assess, anticipate and mitigate barriers to accessing care and risks of harm for patients.⁶

Community-level data generated from public forums, surveys, or focus groups with consumers and leaders in the community can be used to compare patient and population data. In this way, organisations can identify sections of the population that may not be accessing services or not accessing services early, resulting in more complex and extensive health interventions.

External agencies such as the Australian Bureau of Statistics and the Department of Home Affairs can provide data regarding the diversity of the local community that may assist with service planning and determining the proportion of migrant and refugees from the locale accessing the service.

Key demographic information collected from migrant and refugee populations:

- **Country of birth:** this is one of several factors that may influence culture, language and ethnicity.²⁶ Preferred language cannot be assumed based upon a person's country of birth, as many countries have multiple languages and dialects.
- **Language preference:** this helps establish the patient's requirements for assistance in interpreting spoken or translating written information. Patients should be asked which language and dialect they speak and be provided with information about access to interpreting services.
- **Migration history:** this can be an important determinant of current needs and presenting issues. This information may be useful when screening for risk and developing an integrated care plan (Action 5.1). People from refugee and refugee-like backgrounds in particular, often have a complex migration history, including transiting through several countries and periods of time in detention centres or refugee camps. They have frequently experienced traumatic events, family separations and hardship during their migration journey, and may have symptoms of posttraumatic stress disorder.^{15,27}

Migration history can include:

- Migration pathway including time spent in
 - refugee camps
 - detention centres
 - community detention
- Countries of transit which highlight requirements for additional screening for country specific infectious diseases¹⁵
- Visa type
- Sources of post-migration stress: social and family circumstances, housing conditions, food and financial security, access to education, employment and training opportunities.⁸

The benefits for health service organisations collecting demographic data on patients from migrant and refugee backgrounds include:

- Improved access and equity for all groups in the health service catchment
- Identification of risks for patient groups and planning to mitigate risks and prevent adverse events
- Better planning for language services and therefore more effective informed consent processes, greater patient involvement in care planning, adherence to health advice and satisfaction with care.

Reflective questions

1. How does the health service organisation identify groups of people from migrant and refugee backgrounds accessing care, or those in the catchment population that require care?
2. How are the risks for these groups identified, recorded and addressed?
3. How does planning for services and care delivery address the needs of patients from migrant and refugee background?
4. How are services for migrants and refugees equitably delivered?
5. How are services for migrants and refugees assessed for potential improvements?

Suggested strategies for improvement

- Adopt a whole-organisation approach to the elimination of institutional discrimination and the development of cultural responsiveness
- Develop systems to review the cultural responsiveness of the organisation
- Engage with the local community as well as the bicultural or bilingual workforce²⁸ in planning services
- Conduct community needs assessments
- Monitor at-risk groups and take actions to manage risks
- Implement targeted, outreach approaches to improve access and provide migrants and refugees with information about health and the health system
- Identify and develop programs to target communities underutilising or not accessing services
- Develop systems for collecting and using migrant and refugee demographic data to evaluate and guide service development and improvement
- Analyse data from different sources and stratify by various factors to identify disparities in health outcomes for migrants and refugees
- Analyse routinely collected data sets such as the use of interpreters, bilingual staff²⁹, consultation times and frequency, adverse events involving migrant and refugee patients
- Use the data to
 - develop a supportive infrastructure for cultural responsiveness
 - evaluate services and use the findings to implement quality improvement initiatives
 - report to the highest levels of governance, patients and community members
- Develop systems to enhance privacy and trust in the data collection process²⁴ by discussing confidentiality²⁰ and determining who will have access to the data and how the information will be stored, accessed, used and reported.

Examples of supporting evidence

- Strategic or business plans that include strategies that reflect the diversity of the patient population
- Routinely produced reports highlighting demographic data and needs assessment of local populations
- Reports of quality assurance activities undertaken where gaps have been highlighted in the data
- Consumer information that is available in different formats and languages that reflect the diversity of the patient population
- Healthcare records that capture relevant data items related to migration history
- Agreements or formalised arrangements for accessing interpreters and reports on interpreter engagement and access
- Data on health care interpreter use, relative to the patient population and catchment area
- Policies on use of interpreting services and audit reports of interpreter usage
- Examples of human resource strategies to facilitate workforce diversity
- Annual reporting on workforce diversity relative to the patient population and catchment area.

Tools and resources

Data on culturally and linguistically diverse communities

- The Centre for Culture, Ethnicity & Health provides links to relevant data sources at: <https://disability.ceh.org.au/find-resources-and-information-on-cald-communities/>

Human resource strategies to facilitate workforce diversity

The Centre for Culture, Ethnicity & Health documents for facilitating workforce diversity:

- Recruiting bilingual staff: <https://www.ceh.org.au/resource-hub/recruiting-bilingual-staff/>
- Managing bilingual staff: <https://www.ceh.org.au/resource-hub/managing-bilingual-staff/>
- Bilingual Staff Research Project Report (2008): <https://www.ceh.org.au/wp-content/uploads/2018/08/CEH-Bilingual-Staff-Research-Project-Report.pdf>

Action 1.20: Safety and quality training

The health service organisation uses its training system to:

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

People from migrant and refugee backgrounds report experiencing discrimination in a range of ways that include incivility, threats and physical assault as well as unequal access to resources.¹⁷ These experiences of discrimination are associated with negative impacts on health; however, they often go underreported due to shame, social desirability, fear of potential negative consequences, the 'politeness principle' and discourses of gratitude.^{30,31} Discrimination (and lack of recourse), can result in lower levels of trust, control, hope and belonging which can impact integration with the health system and a sense of safety.

For people from refugee and refugee-like backgrounds, this is of particular importance given the likelihood of previous experiences of trauma and threats to personal security.²⁵ Professional development activities aimed at improving the cultural responsiveness of health service organisations and the workforce are recognised as an essential strategy to improve outcomes for consumers, carers and communities as well as health care providers.³²

Reflective questions

1. How does the organisation assess cultural responsiveness and develop training programs for the workforce?
2. How is training tailored to address the needs of migrant and refugee populations?
3. How does the organisation assess and incorporate feedback from consumers and the workforce to improve culturally responsive training?
4. How is participation in training and the effectiveness of training monitored, evaluated, and reported by the organisation?
5. Are members of the local population involved in the development of training programs?

Suggested strategies for improvement

- Establish systems to identify, develop, evaluate and monitor the cultural responsiveness capabilities of members of the workforce
- Analyse incident reports and trends related to cultural responsiveness
- Seek and analyse consumer feedback related to organisation-wide cultural responsiveness
- Provide access to best practice guidance on cultural and religious factors that influence the delivery of care
- Develop policies, position descriptions and key performance indicators that include and define cultural responsiveness
- Incorporate information about cultural responsiveness into workforce orientation programs and mandatory training. Include the following topics in workforce training
 - migrant and refugee pathways and impacts upon health²¹
 - prejudice, social inclusion
 - improving cultural responsiveness
 - addressing stigma and discrimination²⁴
 - reflective practice effective communication
 - use of interpreters
- Promote cultural understanding by providing information on the cultural and linguistic diversity of the catchment population
- Engage state and territory multicultural organisations to assist in understanding the local community and provide support in educating the workforce
- Seek feedback from the workforce to identify skill deficits and develop training programs and resources in response²⁴
- Where required, prioritise training for those members of the workforce that frequently work with migrant and refugee populations
- Record attendance and evaluate workforce cultural responsiveness training.

Examples of supporting evidence

- Training documents on cultural responsiveness
- Records of workforce participation in cultural responsiveness training
- Evaluation reports of cultural responsiveness training programs
- Feedback from the workforce about their cultural training needs
- Audit results of compliance with policies on cultural responsiveness
- Policies and guidelines referencing organisational cultural responsiveness
- Feedback from clients and the community on the cultural responsiveness of the organisation
- Consumer and community engagement and review of cultural awareness training
- Collaboration and memorandums of understanding with external services to provide education and support to the workforce.

Tools and resources

Cultural responsiveness

- The Centre for Culture, Ethnicity & Health reference guides to improving the cultural responsiveness of health services
 - Cultural competence in organisational values, https://www.ceh.org.au/wp-content/uploads/2016/05/CC2_Cultural-competence-in-organisational-values.pdf
 - Cultural competence in governance, <https://www.ceh.org.au/cultural-competence-governance/>
 - Cultural competence in staff development, <https://www.ceh.org.au/cultural-competence-in-staff-development/>
 - Cultural competence in services and interventions, <https://www.ceh.org.au/cultural-competence-in-services-and-interventions/>
- The *Cultural Competence Organisational Review Tool (CORE)*, https://www.ceh.org.au/use-the-cultural-competence-review-tool-core/?sf_action=get_data&sf_data=all&_sft_category=cultural-competence
- National Health and Medical Research Council, *Cultural Competency in Health: A guide for policy, partnerships and participation*, <https://www.nhmrc.gov.au/about-us/publications/cultural-competency-health>
- State of Victoria (Department of Health), *Cultural Responsiveness Framework: Guidelines for Victorian health services*, 2009, <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services>
- Queensland Health, *Five Cross Cultural Capabilities for Clinical Staff*, https://www.health.qld.gov.au/_data/assets/pdf_file/0034/382696/ccc-clinical.pdf
- Queensland Health, *Five Cross Cultural Capabilities for Non-Clinical Staff*, https://www.health.qld.gov.au/_data/assets/pdf_file/0020/386012/ccc-non-clinical.pdf

Multicultural affairs agencies by state or territory

- Multicultural NSW, www.multicultural.nsw.gov.au
- Victorian Multicultural Commission, www.multicultural.vic.gov.au
- Department of Children, Youth Justice and Multicultural Affairs (Qld), <https://www.cyjma.qld.gov.au/multicultural-affairs>
- Department of Premier and Cabinet, South Australia, <https://dpc.sa.gov.au/responsibilities/multicultural-affairs>
- Office of Multicultural Interests (WA), <https://www.omi.wa.gov.au>
- Department of Premier and Cabinet (Tas), <http://www.multicultural.tas.gov.au>
- Office of Multicultural Affairs (NT), <https://nt.gov.au/community/multicultural-communities>
- Office for Multicultural Affairs (ACT), <http://www.communityservices.act.gov.au/multicultural>



Partnering with Consumers Standard

The Partnering with Consumers Standard requires leaders of a health service organisation to develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Action 2.8: Communication that supports effective partnerships

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

Health literacy

Almost 60 per cent of the general adult population have low individual health literacy.³³⁻³⁵ This affects a person's capacity to make decisions and manage their health needs. More than one in five (21 per cent) of Australians speak a language other than English at home and almost four per cent of Australians say they speak English poorly or not at all.³³ Proficiency in English is worse among older populations, with more than five per cent of adults aged 65 years or older reporting limited or no proficiency in English.³⁶ Amongst migrant and refugee populations, 41 per cent of those aged over 60 years report they cannot understand English at all, and a further 40 per cent report they cannot understand English well.³⁷ For older people, low individual health literacy is associated with poorer health status and higher risk of premature death.³⁴

Levels of English language proficiency vary widely amongst migrant and refugee populations and while language proficiency has been shown to improve over time³⁷, low individual health literacy is associated with poorer health outcomes, higher rates of hospitalisation and emergency care with higher rates of adverse outcomes.⁶ Health literacy barriers are increased for people who speak a language other than English, and this one of the greatest obstacles to the delivery of safe and high quality health care.^{21,38}

Communication barriers, due to limited English language proficiency, are one of the major issues migrants and refugees face when accessing health care services.³⁹ It increases the risk of medication errors⁴⁰, adverse events⁴¹, unnecessary tests and treatments and higher hospital readmission rates, resulting in poorer quality of care and worse health outcomes overall.^{34,42}

Poor communication between health care providers and patients is a serious organisational risk and safety concern⁴³, and a common root cause of adverse events. It also contributes to over 70 per cent of allegations of malpractice.⁴⁴ Failure to provide interpreter services has been identified as a primary factor in one in forty malpractice claims.⁴⁵

While a person may speak some conversational English, this may not be sufficient to meet the demands of a clinical interaction.²¹ People often overstate their language skills due to embarrassment and fear of stigma.⁴⁴ Effective communication is essential for the provision of safe, high quality care. It is linked to reduced errors, improved health outcomes and patient satisfaction, increased comprehension and adherence to clinical instructions.⁴⁶⁻⁴⁹ Conversely, ineffective communication can result in limited, delayed, inefficient care⁵⁰⁻⁵³, leading to more costly treatment and intervention, as well as negatively impacting the person's understanding of, and trust in, the healthcare system.

Interpreters

Research has highlighted the lack of access to and underuse⁵⁴ of interpreters and culturally appropriate resources for migrant and refugee populations.^{20,31} Health service organisations have a duty of care to communicate effectively, in particular when obtaining informed consent.⁴⁵ Communication is one of the seven rights in the Australian Charter of Healthcare Rights.² The charter states patients have the right to receive clear information about their condition, the possible benefits and risks of different tests and treatments, to be able to give informed consent⁵⁵, and the right to be given assistance where required to help understand and use health information. Working with interpreters is one strategy to ensure that this right is upheld.

Interpreters can be engaged either in person, via telephone or videoconference, depending upon the local circumstances. Engaging interpreters over videoconference or telephone may be a necessity in rural and remote communities, and may be of preference to an individual where confidential²⁹ or sensitive topics such as mental or sexual health, or family and intimate partner violence¹⁵ are being discussed.^{8,24} Failure to engage interpreters, or the inappropriate engagement of family members, or bilingual staff⁵⁶ to facilitate interpretation can lead to risks of harm.⁵⁷

There is a view that people prefer having family or friends interpreting in health consultations. However, the majority of patients prefer that interpreters be engaged to facilitate a basic and thorough understanding; ensure essential information is not missed; reduce anxiety; enable privacy; and reduce embarrassment around private or serious health issues.²⁹

Family members should not routinely be used as interpreters.⁵⁸ The role of family and carers in supporting and advocating for patients is distinctly separate from the role of interpreter.²⁹ The role of an interpreter is to interpret everything that is said, and not add, modify or exclude information.⁴⁴ Family members may not possess the language proficiency to communicate complex information or interpret specialised medical terminology and inappropriate clinical decisions may inadvertently be made due to communication errors.⁵³ Information may be withheld or distorted because of family discord, or due to the emotional and sensitive nature of the health issue³², which could cause emotional distress to both the patient and family members.⁵⁹ Privacy, confidentiality or safety could be compromised in situations of family or domestic violence.¹⁵

Minors should not be engaged to facilitate interpretation as the burden of being asked to attend appointments to interpret for family members can impact school attendance²⁹, affect family dynamics and expose them to sensitive medical, personal and potentially distressing information.⁶⁰

Bilingual workforce

It is increasingly common for health service organisations to employ a bilingual workforce or peer educators specifically for their language skills.⁶ On occasions, members of the workforce who speak a language other than English are used in an informal capacity to provide language assistance. 'Ad hoc' use of bilingual members of the workforce is not without risk²⁹, has been associated with increased translation errors and omissions.⁵³ Their role should be limited to perform 'simple communication' such as to obtain basic information such as demographic details.⁴⁴ Simple communication should be viewed as communication where the outcome has limited risk of adverse effects for both the person with limited English language proficiency and the organisation. Bilingual staff should not be asked to communicate information that is legally binding, or that puts at risk either the organisation or the person with limited English language proficiency.⁶¹ This role should only be performed by an interpreter.⁶²

Reflective questions

1. How does the organisation identify clients that require support with communication?
2. How does the organisation identify the language needs and preferences of migrants and refugees and tailor communication provision?
3. How does the organisation ensure interpreters are available when they are needed?
4. How is health information provided to consumers?
5. How does the organisation engage its migrant and refugee consumers in developing and reviewing health communications?
6. How does the organisation know the information is provided in a way that meets the needs of migrant and refugee populations?

Suggested strategies for improvement

- Develop policies and position statements on health literacy
- Develop policies and processes for the engagement of interpreters, include guidance on
 - obtaining informed consent
 - the use of families and carers to interpret
 - situations where an interpreter is not available
 - situations where a patient refuses an interpreter
 - use of bilingual members of the workforce
- Develop policies for the use of web-based translation tools, noting that publication of web-based translation tools is unregulated and carries a high risk of miscommunication and should not be used in place of an interpreter or translator⁴⁴
- Establish systems to identify and engage Auslan, Deaf Relay or foreign sign language interpreters
- Routinely collect data on the use of interpreting services, compare the expected to actual demand for services as well as failures to engage an interpreter when needed
- Implement systems to identify and audit if client preferences for interpreter services are met
- Monitor the delivery of interpreting services, such as wait times, quality and safety of outcomes for individuals
- Audit health care records where an interpreter was required
- Monitor compliance with policies and procedures
- Provide training for the workforce in the use of interpreter services, evaluate training and seek feedback from the workforce to identify ongoing requirements for training
- Provide technology to support the use of video or telephone interpreter services such as access to speakerphone, hands-free telephones and video or web-based video equipment

- Develop and provide access to resources to support the workforce working with interpreters
- Develop job descriptions for the employment of bilingual members of the workforce
- Provide signage and information to consumers about available language services
- Provide signage to direct people to rooms for worship; or to indicate that specialised multicultural support services are available and how to access them⁶³
- Evaluate effectiveness of signage and information in the health service organisation
- Co-design, develop and evaluate culturally appropriate resources for the local population to support communication
- Establish a directory of evidence-based or best practice resources, visual and written aids, pictograms, online tools and websites for the workforce to provide to patients and consumers in plain English or in languages other than English⁶⁴ and mechanisms to ensure they remain current or are removed from the directory
- Seek feedback from consumers and the workforce on the use of interpreter services and locally developed resources
- Engage with the local community and key stakeholders to develop and evaluate the provision of language services.

Examples of supporting evidence

- Policies and position statements on health literacy and working with migrant and refugee populations
- Policies and procedures on supporting people with low English literacy to improve communication
- Policies and procedures on language support and the engagement of interpreters
- Agreements, contractual arrangements, invoices or schedules with interpreting service provider(s)
- Protocols for assessing the need for an interpreter and identifying patient preferences
- Policies, procedures or protocols for assessing decision-making capacity, obtaining informed consent and communicating complex instructions for patients with communication barriers
- Policies proving guidance on the use of family members/carers or bilingual members of the workforce acting as interpreters
- Policies and scope of practice for the engagement of bilingual members of the workforce
- Audit results of health care records on interpreter engagement
- Reports on improvement projects aimed at reducing barriers to health literacy for migrant and refugee populations
- Resources for consumers on accessing language services
- Resources available to clinicians to address health literacy barriers for people of migrant and refugee backgrounds
- Training documents on best practice for improving communication and engagement of interpreters
- Attendance records and evaluation reports on training for the workforce
- Reports from the incident management system or complaints register documenting occasions where adverse events occurred due to a failure in communication
- Feedback from consumers, families and carers on their experiences with language support and access to interpreter services
- Feedback from the workforce on language services and engagement of interpreters
- Evaluation of signage or information provided to consumers informing them of the availability of interpreting assistance
- Consumer and carer resources that have been developed and evaluated by the target population
- Use of the National Interpreter Symbols
- Memorandum of understanding or similar formal agreements with external organisations to support communication for migrant and refugee populations.

Tools and resources

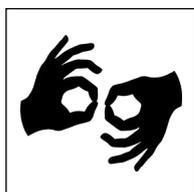
Assessing the need for language assistance

- ABC tool for assessing the need for an interpreter, NSW Health Western Sydney Local Health District, <https://www.wslhd.health.nsw.gov.au/Health-Care-Interpreter-Service-/HCIS-Publications>
- Government of Western Australia, Department of Health, https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Cultural%20diversity/PDF/11_ABCGuidelines.ashx
- Language identification cards, Queensland Health, https://www.health.qld.gov.au/_data/assets/pdf_file/0023/155813/language_id_crd.pdf
- The Centre for Culture, Ethnicity & Health has a comprehensive range of resources, tools and guides to support health practitioners communicate more effectively with consumers from culturally and linguistically diverse backgrounds. Topics include: Assessing the need for an Interpreter, Planning for Translations and Developing a Comprehensive Language Services Response. These resources are available at <https://www.ceh.org.au/resource-hub/>
- Queensland Health has developed a ward communication tool, <https://metrosouth.health.qld.gov.au/health-equity-and-access/culturally-and-linguistically-diverse-cald-people>
- The Health Equity and Access Unit has produced videos in multiple languages explaining the concept of informed consent and how consumers can effectively participate in decision making about their health care, <https://metrosouth.health.qld.gov.au/patients-and-visitors/your-time-in-hospital/informed-consent>
- Informed consent multicultural resources: The Health Equity and Access Unit has produced videos in multiple languages explaining the concept of informed consent, <https://metrosouth.health.qld.gov.au/health-equity-and-access/culturally-and-linguistically-diverse-cald-people/informed-consent>
- Working with interpreters and translators e-learning packages: The 'Working effectively with interpreters and translators' e-learning packages provide education for clinicians, interpreters and translators to develop collaborative inter-professional partnerships, <https://www.childrens.health.qld.gov.au/e-learning-package-working-with-interpreters-and-translators/>.

Medication safety

- *Easidose* is a prescribing aid to improve understanding of medicines information. Royal Australasian College of Physicians, <http://easidose.com>
- 'How to use medicines correctly' pamphlet, Centre for Culture, Ethnicity & Health, <https://www.ceh.org.au/resource-hub/how-to-use-medicines-correctly/>.

Signage



Left: National Interpreter symbol. Right: Certified Deaf Interpreters symbol.

- National Interpreter symbol can be downloaded from <https://immi.homeaffairs.gov.au/settling-in-australia/settle-in-australia/language-services/national-interpreter-symbol>
- Certified Deaf Interpreters symbol can be downloaded from <https://www.shutterstock.com/image-vector/sign-language-icondisabled-icon-web-application-526443427>.

Tailored communication tools

- NSW Refugee Health Service Appointment reminder translation tool, https://www.mhcs.health.nsw.gov.au/publications/appointment-reminder-translation-tool/create_an_appointment

- Centre for Culture, Ethnicity & Health on behalf of the Victorian Government Health Translations provides translated health information in many languages, <http://www.healthtranslations.vic.gov.au>
- Queensland Health has developed a ward communication tool, https://www.health.qld.gov.au/multicultural/support_tools/wct.

Guidance for working with interpreters

- Migrant and Refugee Health Partnership, Guide for Clinicians Working with Interpreters in Healthcare Settings, 2019, <https://culturaldiversityhealth.org.au/competency-standards-framework/>
- WA Health, System Language Services Policy Guidelines, 2017, <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Communications/mandatory/WA-Health-System-Language-Services-Policy>
- NSW Health, Policy Directive, Interpreters – *Standard Procedures for Working with Health Care Interpreters*, 2017, http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_044.pdf
- Centre for Culture, Ethnicity & Health, 'Interpreters: an Introduction' <https://www.ceh.org.au/resource-hub/interpreters-an-introduction/>
- Centre for Culture, Ethnicity & Health, 'Communicating via an Interpreter' <https://www.ceh.org.au/resource-hub/communicating-via-an-interpreter/>
- Centre for Culture, Ethnicity & Health, 'Booking and Briefing an Interpreter' <https://www.ceh.org.au/resource-hub/booking-and-briefing-an-interpreter/>
- Centre for Culture, Ethnicity & Health, 'Debriefing with an Interpreter' <https://www.ceh.org.au/resource-hub/debriefing-with-an-interpreter/>.

Action 2.11 Partnership in healthcare governance, planning, design, measurement and evaluation

The health service organisation:

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

Migrant and refugee populations may be reluctant to use health services due to a lack of understanding about facilities and services, fear and mistrust of authority³⁰, lack of institutional cultural responsiveness, or perceived racism.²²

Developing effective partnerships with consumers that are reflective of the diversity of the local community contributes to cultural responsiveness. Improving cultural responsiveness requires integration of culture into the delivery of health services.⁵⁶ This can be achieved by partnering with target populations, community development, capacity building and peer education.⁶ Partnering with multicultural organisations in planning, implementing and evaluating health care can lead to reductions in health inequalities. Engaging with people from migrant and refugee backgrounds can identify and address barriers²⁴, improve access to services and understanding of healthcare⁶⁵, and contribute to positive experiences of healthcare services.⁶⁶

To maximise the benefits from community engagement, it is important to talk to migrant and refugee populations and investigate which community stakeholders are best able to provide an informed and representative voice about the community needs.²¹ This may include community representatives,

religious or community leaders and multicultural organisations. Sustained reciprocal relationships require support and resources in order for migrants and refugee communities to participate fully in the development and evaluation of services.⁶

Feedback and complaints mechanisms are elements of the Australian Charter of Healthcare Rights² and are essential to developing and monitoring services. An individual's knowledge, language proficiency and cultural background can influence a person's willingness to provide feedback or make a complaint³¹ and how they prefer to express their feedback. To successfully interact with feedback and complaints mechanisms, migrants and refugees must be made aware that they can complain, be informed of the process and the rights and protections that are available to them.³⁰ Lack of trust, embarrassment, and fear of negative repercussions may prevent many migrants and refugees from providing feedback.³¹

Reflective questions

1. How does the organisation engage migrants and refugees in its governance processes?
2. How does the health service organisation evaluate and tailor service provision to reflect the needs and diversity of the local community?
3. How does the organisation enable migrants and refugees to provide feedback?
4. How does the organisation inform migrants and refugees about its complaints processes?

Suggested strategies for improvement

- Develop mechanisms to support migrant and refugee populations to understand the processes for providing feedback or making a complaint
- Provide culturally appropriate communication tools and language support to enable migrant and refugee patients, their family or carers to provide feedback or make a complaint
- Support migrants and refugees to provide feedback and submit complaints in their preferred language and by a variety of methods (anonymously, via a client advocate, online, in person, by phone, in writing)
- Collect data using a range of methods including
 - targeted individual or consumer group consultations
 - community forums
 - roundtables
 - targeted interviews
- Evaluate systems for the provision of feedback and complaints in collaboration with migrant and refugee communities
- Support consumers to understand and provide feedback on the clinical governance, function and evaluation of the health service organisation
- Use the findings from feedback and complaints systems to inform improvement initiatives
- Seek the views and experiences of patients from migrant and refugee backgrounds, their families and carers to inform workforce training and evaluation of healthcare services
- Establish community partnerships and support outreach efforts to create opportunities to connect with local communities
- Facilitate consumer access to information that allows consumers to fully participate in consultation processes such as
 - targeted surveys in relevant languages
 - individual consumer consultation and consumer focus groups
 - reporting to the community on consultation and survey outcomes
- Seek consumer input from community representatives, religious or community leaders and multicultural organisations

- Collaborate with other agencies and partners to identify and address issues relating to cultural responsiveness, through publicising good practices, sharing information, coordinating programs or collaborating on projects
- Establish formal and informal links with advocacy groups representing migrant and refugee populations.

Examples of supporting evidence

- Policy documents that describe the process for involving consumers in partnerships to design, measure and evaluate health care
- A policy or framework that enables migrants and refugees to participate in feedback and complaints mechanisms
- Reports that detail consumer participation in activities to design, measure and evaluate health care, particularly including consumers from migrant and refugee backgrounds
- Membership of consumer advisory groups including representatives from migrant and refugee populations
- Training documents for members of consumer advisory groups
- Minutes of meetings where consumer participation is sought
- Reports on feedback and complaints provided by people from migrant and refugee backgrounds
- Communication tools and resources that have been developed and evaluated by migrant and refugee populations
- Reports on surveys and feedback from migrant and refugee populations
- Feedback tools that have been developed and evaluated by migrant and refugee populations
- Workforce training records and evaluation on supporting migrants and refugees to provide feedback and make complaints
- Analysis of feedback and complaints received from migrants and refugee populations and evidence of remediation taken to improve service provision
- Evidence of partnerships with migrant and refugee advocacy groups.

Tools and resources

Partnering with consumers

- *Health care providers' Guide to Engaging Multicultural Communities and Consumers*, Queensland Health, https://www.health.qld.gov.au/multicultural/support_tools/com-engage-guide.pdf
- Consumer Participation and Culturally and Linguistically Diverse Communities, Centre for Culture, Ethnicity & Health, <https://www.ceh.org.au/resource-hub/consumer-participation-and-culturally-and-linguistically-diverse-communities/>
- Consumer Participation in Service Planning and Decision Making, Centre for Culture Ethnicity & Health, <https://www.ceh.org.au/resource-hub/consumer-participation-in-service-planning-and-decision-making/>
- Supportive Systems for Health Literacy, Centre for Culture Ethnicity & Health, <https://www.ceh.org.au/resource-hub/supportive-systems-for-health-literacy/>
- Embrace Multicultural Mental Health, Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery, <https://www.embracementalhealth.org.au/service-providers/framework-landing>
- Correa-Velez I, Queensland University of Technology and Mater Centre for Integrated Care and Innovation, 2020, *Refugee Health and Wellbeing: A policy and action plan for Queensland, 2017–2020* <https://www.refugeehealthnetworkqld.org.au/publications/>.



Comprehensive Care Standard

The Comprehensive Care Standard requires leaders of a health service organisation to set up and maintain systems and processes to support clinicians to deliver comprehensive care. They must set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses these systems to deliver comprehensive care and manage risk.

Action 5.13 Developing the comprehensive care plan

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

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

The physical and mental health of migrants and refugees can be significantly affected by their experiences and migration path both prior to and post-arrival in Australia.^{12,14} People from refugee or refugee-like backgrounds can spend years displaced, experiencing insecure conditions, moving between countries or refugee camps with little access to health care. These experiences and conditions mean some will have significant health problems⁶⁷, and may have been exposed to traumatic experiences, including torture, violence and abuse.⁶⁸

The health needs of migrants and refugees will vary greatly depending upon a number of migration and ethnicity-linked health inequities.²¹ The health conditions and needs of newly arrived migrants and refugees may differ from those that have been in the country for some time. Therefore, when planning care, assessment and interventions need to be appropriately tailored and targeted.^{15,69}

Comprehensive care planning should consider the impact of settlement and social circumstances on healthcare including cultural influences, ethnicity, religion, spiritual beliefs, sexual orientation, gender, socio-economic factors, disability, age⁷⁰, pre- and post-migration experiences, social isolation and experiences of trauma and torture.⁷¹

While many health conditions will be the same across populations²⁴, people from migrant and refugee backgrounds may present with conditions or concerns that are unfamiliar to health care providers.¹⁵ Specific health risks for women can be associated with exposure to sexual violence and abuse, trafficking and risks surrounding pregnancy and childbirth, while men may be more exposed to accidents, physical stress and other health hazards in the workplace.²¹

Whilst migrants and refugees are influenced by the same social determinants of mental health as the general population, the nature of migration experiences, social conditions and post-migration stressors can result in a greater likelihood of a negative impact on mental health.¹⁴

Migrants and refugees affected by depression, post-traumatic stress disorder and other anxiety related mental health problems⁷² are less likely to access mental health services⁷³ and Medicare funded counselling services.²¹ These issues should be considered when screening for risk and planning comprehensive care.

The health beliefs and help-seeking behaviour of migrants and refugees may be a barrier to accessing healthcare. People's views about the nature of their problems, their threshold for seeking help and the forms of help they regard as appropriate, differ widely and they may not realise that they have a health problem, or that they can access, or need medical assistance.²¹ The threshold for treating problems is often much lower than in less affluent countries and migrants and refugees may have views on health that diverge strongly from those of (Western) health professionals.⁷⁴ Some migrants and refugees may find it difficult to provide a detailed medical history or repeat information due to cultural sensitivities, past trauma or fear of stigma. Migrants and refugees may also be reluctant to access services, because shame and fear or anxieties about confidentiality and negative reactions from health professionals or from within their own community.⁷⁵ In these circumstances, comprehensive care planning should adopt the principles of traumainformed approaches to care.⁷⁶

Failure of healthcare providers to understand and manage sociocultural variations in the health beliefs and needs of their patients may impede comprehensive care planning. Heightened anxiety, depression and lack of social support can also decrease the capacity of people to advocate for themselves. In developing the comprehensive care plan, it is important to recognise and understand how traditional health care practices, customs, beliefs, cultural, religious and social traditions can influence health, at both the individual and population level.⁷⁷ Dismissal of traditional practices can alienate patients and lead to tensions and abandonment of health services.⁷⁸ A challenge for health service organisations is how best to provide patient-centred, flexible care whilst ensuring safety is maintained.

The principles of person-centred care^{3,79} and shared decision making⁸⁰ are important strategies for supporting people from migrant and refugee backgrounds to have greater involvement in their care and achieve better outcomes.³ Shared decision making is about bringing together a consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person.⁸¹

Family and carers often play a vital role in the decision-making and care of patients from migrant and refugee backgrounds. The Australian Charter on Healthcare Rights gives patients the right to involve the people they want to in planning and making decisions about their care and treatment.² When health services, patients and families work in partnership the quality and safety of health care improves and patient and workforce satisfaction increases.⁷⁹

Reflective questions

1. What systems do clinicians use to screen for and minimise harm for people from migrant and refugee backgrounds?
2. What systems are implemented to integrate person-centred care and shared-decision making?
3. How does the organisation partner with migrants and refugees to identify their health needs and preferences?
4. How does the organisation support the workforce to provide culturally responsive care to people from migrant and refugee backgrounds?

Suggested strategies for improvement

- Develop and implement systems for workforce training in person-centred care and shared-decision making
- Develop policies and procedures for screening and managing risks specific to patients from migrant and refugee backgrounds
- Monitor compliance with policies and processes
- Develop systems and evaluate processes for involving families and carers in comprehensive care planning to the extent the patient chooses
- Adopt a universal precautions approach and the principles of trauma-informed care when developing the comprehensive care plan⁸²
- Provide an environment where effective shared decision-making can occur
- Implement processes that are culturally responsive to support patient preferences in developing the comprehensive care plans⁵⁸
- Support effective communication between the workforce and migrants and refugees
- Develop and implement evidence based culturally appropriate, decision support tools
- Provide culturally appropriate resources explaining patients' rights to privacy and confidentiality, shared decision making and care planning
- Support migrants and refugees in the development and evaluation of resources
- Provide support and referral pathways for the workforce providing trauma informed care to migrants and refugees.

Examples of supporting evidence

- Systems for the provision of person-centred care and shared decision making
- Procedures and protocols for inclusion of family members and carers in comprehensive care planning
- Policies and procedures for staff providing trauma informed care to access training and support
- Culturally appropriate decision support tools that have been evaluated by migrant and refugee populations

- Audit of the involvement of consumers and their families/carers in the development of comprehensive care plans
- Audit of the extent to which people's individual needs and preferences are integrated into the comprehensive care plan
- Reports of incidents and complaints where requests for families/carers to be involved in decision making and comprehensive care planning were not met
- Workforce training records and evaluation reports of trauma informed care training
- Memorandum of understanding and partnerships with specialist external multi-cultural organisations
- Reports of surveys and feedback from consumers and the workforce about the provision of person-centred care and shared decision making.

Tools and resources

- The Australian Commission on Safety and Quality in Health Care, *Implementing the Comprehensive Care Standard: Approaches to person-centred risk screening*, 2018, <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/implementing-comprehensive-care-standard-approaches-person-centered-screening>
- Wall. S, Santalucia. Y, Salem. M, Giacomini. D, McDonald. R and Bosnjak. F, 2011, Enhancing the lives of Older Refugees, Fairfield Council Older Refugee Working Committee, https://www.swslhd.health.nsw.gov.au/refugee/pdf/Enhancing_The_Lives_Of_Olde_Refugees.pdf
- National Ageing Research Institute and Curtin University, Dementia awareness for Culturally and Linguistically Diverse (CALD) communities, <https://movingpictures.org.au/the-project>
- The Centre for Cultural Diversity in Ageing provides links to resources on dementia, <http://www.culturaldiversity.com.au/>
- Advance Care Planning Australia has fact sheets and other resources available in 13 languages, <https://www.advancecareplanning.org.au/languages>
- Australia Government Department of Health, Aged Care Diversity Framework action plans, <https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans>.

Community health profiles

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

Comprehensive assessment and care

- Migrant and Refugee Health Partnership, Competency Standards Framework for Clinicians, *Culturally Responsive Clinical Practice: Working with people from migrant and refugee backgrounds*, 2019, <https://www.culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Culturally-responsive-clinical-practice-Working-with-people-from-migrant-and-refugee-backgrounds-Jan2019.pdf>
- Australian Refugee Health Practice Guide, Victorian Foundation, <http://refugeehealthguide.org.au>
- 'Cultural considerations in health assessment' tip sheet was developed by the Centre for Culture, Ethnicity & Health, https://www.ceh.org.au/wp-content/uploads/2017/07/CEH_TipSheet3_Mar2011_Web-002.pdf
- *Evidence-Based Clinical Guidelines for Immigrants and Refugees* (Pottie K, Greenaway C, Feightner J, et al. 2011; CMAJ), <http://www.cmaj.ca/content/cmaj/early/2011/07/26/cmaj.090313.full.pdf>
- Cultural Competence in Services and Interventions, Centre for Culture Ethnicity & Health, <https://www.ceh.org.au/resource-hub/cultural-competence-in-services-interventions/>.

Trauma-informed care

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

Specialised agencies that work with people from refugee backgrounds who are survivors of torture and trauma

- Association for Services to Torture and Trauma Survivors WA, www.asetts.org.au
- Companion House: Assisting Survivors of Torture and Trauma ACT, www.companionhouse.org.au
- Foundation House: Victorian Foundation for Survivors of Torture, www.foundationhouse.org.au
- Melaleuca: Torture and Trauma Survivors Service of the Northern Territory, www.melaleuca.org.au
- Migrant Resource Centre Tasmania's Phoenix Centre: Support for Survivors of Torture and Trauma, www.mrctas.org.au/phoenix-centre
- Queensland Program of Assistance to Survivors of Torture and Trauma, www.qpastt.org.au
- Survivors of Torture and Trauma Assistance and Rehabilitation Service South Australia, www.sttars.org.au
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, <https://www.startts.org.au/>.

Referrals

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

Appendix

It is mandatory for all hospitals and day procedure services to implement all of the relevant actions in the NSQHS Standards. For general implementation of strategies and actions, this User Guide should be read in conjunction with other relevant [Commission Guides and resources](#).

The following table provides additional information on actions where specific strategies may be required to ensure safe, high quality and culturally responsive care is provided to people from migrant and refugee backgrounds.



Clinical Governance Standard

Item	Action required	Comments/Strategies
Governance and strategic leadership	1.01 The governing body:	<p>Consumers from migrant and refugee backgrounds face significant barriers in accessing and engaging with healthcare services.²⁰</p> <p>The highest level of organisational governance should:</p> <ul style="list-style-type: none"> ■ Seek information about the diversity and extent of the migrant and refugee population in its catchment area ■ Endorse and monitor safety and quality systems to support equitable access and consistent delivery of safe, high quality health care for migrants and refugees.
	a. provides leadership to promote a culture of safety and quality improvement	
	b. provides leadership to promote partnering with patients and consumers	
	c. sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community	
	d. endorses the organisation's clinical governance framework	
	e. ensures that roles and responsibilities are clearly defined for the governing body, executive management, clinicians and the workforce	
	f. monitors the action taken that result from the analysis of clinical incidents	
	g. reviews reports, and monitors the organisation's progress on safety and quality performance	

Item	Action required	Comments/Strategies
Policies and procedures	<p>1.07 The health service organisation uses a risk management approach to:</p> <ul style="list-style-type: none"> a. set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. monitor and take action to improve adherence to policies, procedures and protocols c. review compliance with legislation, regulation and jurisdictional requirements 	<p>The development of specific policies to improve cultural safety and equitable access can result in better health outcomes and reduced barriers and health inequalities among migrant and refugee populations.</p> <p>Organisational commitment can be demonstrated when policies and procedures for migrants and refugees are adopted alongside systems promoting implementation and evaluation.</p>
Incident management systems and open disclosure	<p>1.11 The health service organisation has organisation-wide incident management and investigation systems and:</p> <ul style="list-style-type: none"> a. supports the workforce to recognise and report incidents b. supports patients, carers and families to communicate concerns or incidents c. involves the workforce and consumers in the review of incidents d. provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. uses the information from the analysis of incidents to improve safety and quality f. incorporates risks identified in the analysis of incidents into the risk management system g. regularly reviews and takes action to improve the effectiveness of the incident management and investigation systems 	<p>Health service organisations need to foster a culture where consumers from migrant and refugee backgrounds feel supported and are encouraged to identify and report incidents so that opportunities for system improvements can be identified and acted upon.¹²</p> <p>Organisations should implement robust clinical governance safety and quality systems along with clear and formalised local processes for open disclosure.³⁵</p> <p>Incident reports and feedback related to cultural responsiveness need to be analysed to identify systemic issues affecting patients from migrant and refugee backgrounds.³⁰</p> <p>The involvement of migrant and refugee communities in the evaluation and remediation of this information is key.</p>

Item	Action required	Comments/Strategies
Incident management systems and open disclosure <i>continued</i>	1.12 The health service organisation: <ol style="list-style-type: none"> a. uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. monitors and takes action to improve the effectiveness of open disclosure processes 	<p>Organisations must develop and support an open disclosure framework, policies and procedures based on best practice principles and integrate these into the organisation's local clinical governance and quality improvement systems.</p> <p>Open disclosure processes should be implemented as part of routine practice and the workforce supported to conduct open disclosure that is culturally responsive and in a language consumers can understand.⁸³</p> <p>To ensure genuine engagement that is culturally appropriate, organisations should seek to understand the person's goals, needs and preferences with the process. Information should be discussed and provided to migrants and refugees using language and terminology that is easily understood, relevant and meaningful.</p> <p>Translated material and easy access to interpreters in the person's preferred language or communication style should be provided.</p>
Feedback and complaints management	1.13 The health service organisation: <ol style="list-style-type: none"> a. has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. uses this information to improve safety and quality systems 	<p>Feedback and complaints are essential elements of developing and monitoring service delivery. Ensure consumers from migrants and refugee backgrounds are afforded equal opportunity to provide frank, confidential feedback in their preferred language or communication style.³¹ Provide multiple methods and channels for feedback and complaints, including, telephone, voice, email or online.</p> <p>Client satisfaction and workforce surveys should include questions on access and satisfaction with language services. Inform the community of how their feedback was applied to quality improvement strategies.⁵⁴</p>

Item	Action required	Comments/Strategies
Feedback and complaints management <i>continued</i>	<p>1.14 The health service organisation has an organisation-wide complaints management system and:</p> <ul style="list-style-type: none"> a. encourages and supports patients, carers and families, and the workforce to report complaints b. involves the workforce and consumers in the review of complaints c. resolves complaints in a timely way d. provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. uses information from the analysis of complaints to inform improvements in safety and quality systems f. records the risks identified from the analysis of complaints in the risk management system g. regularly reviews and takes action to improve the effectiveness of the complaints management system 	<p>People from migrant and refugee backgrounds may be reluctant to complain due to previous adverse interactions with health systems, lack of trust and concerns that a complaint may result in the withdrawal of services or cause negative consequences for current or future health care.^{12,54}</p> <p>Complaints mechanisms must be accessible and culturally safe to the extent that migrants and refugees have confidence that the use of complaints processes will lead to just outcomes without negative consequences.²⁹</p>
Healthcare records	<p>1.16 The health service organisation has healthcare records systems that:</p> <ul style="list-style-type: none"> a. make the healthcare record available to clinicians at the point of care b. support the workforce to maintain accurate and complete healthcare records c. comply with security and privacy regulations d. support systematic audit of clinical information e. integrate multiple information systems, where they are used 	<p>To implement culturally responsive and person-centred safety and quality systems, it is essential to understand the diversity of healthcare consumers from migrant and refugee backgrounds and identify their characteristics.</p> <p>Systematic collection of patient demographic data and effective records management can generate information on the migrant and refugee patient population for use in the planning and delivery of care. This information can also be used to assess, anticipate and mitigate barriers to care, and risks of harm for people from migrant and refugee backgrounds.⁶</p> <p>Documenting information that supports an understanding of migration history enables it to be shared among healthcare providers so that the patient is not required to repeat the information multiple times and potentially be re-traumatised.</p>

Item	Action required	Comments/Strategies
Evidence-based care	<p>1.27 The health service organisation has processes that:</p> <ul style="list-style-type: none"> a. provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. support clinicians to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care 	<p>At the individual level, migrant and refugees should receive healthcare that is accessible, timely, high quality and evidence-based. However, migrant and refugee populations are often under represented within population health modelling and research.⁶</p> <p>Policies and procedures should be developed to foster cultural responsiveness, be based upon the best available evidence and an understanding of the local population and prevailing health conditions. They should be monitored and evaluated regularly to ensure an understanding of current and emerging health needs of migrant and refugee communities.</p> <p>To reduce barriers and improve knowledge and understanding, migrants and refugees should be involved in planning, implementation and evaluation of health programs.</p>
Safe environment	<p>1.31 The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose</p>	<p>Migrants and refugees often lack familiarity with the Australian healthcare systems and have difficulty accessing and navigating health organisations.</p> <p>Negotiating health systems demands a high level of health literacy. Organisations should adopt a plain English language policy and ensure signage and posters are reflective of the population being serviced, are easily understood by people whose additional language/s may include English.³⁴</p> <p>It is critical to create an environment which indicates to migrants and refugees that their presence in the service is welcomed and their needs are understood.⁷⁹</p>



Partnering with Consumers Standard

Item	Action required	Comments/Strategies
Healthcare rights and informed consent	2.03 The health service organisation has a charter of rights that is: <ul style="list-style-type: none"> a. consistent with the Australian Charter of Healthcare Rights b. easily accessible for patients, carers, families and consume 	<p>The Australian Charter of Healthcare Rights² describes the rights of patients and other people using the Australian healthcare system. These rights are essential to ensure that safe and high-quality care is provided to all people, in all health settings in Australia (including public and private hospitals).</p> <p>Health service organisations are expected to recognise the rights described in The Australian Charter of Healthcare Rights (or a similar set of healthcare rights) and provide information about these rights to consumers.</p> <p>The seven rights and principles are of particular importance to people from migrant and refugee backgrounds, and when implemented may elicit positive outcomes in the reduction of barriers, improvement of equitable access, shared decision making and provision of culturally responsive services for these patient populations.</p>
	2.04 The health service organisation ensures that its informed consent processes comply with legislation and best practice	<p>There is a clear link between culture, language and patient safety outcomes, with increased risks associated with inadequate communication and language barriers when gaining informed consent.⁵⁵</p> <p>Clients who are not able to communicate through written or spoken English must have access to interpreters or information in their preferred language in order to meet the legal requirements of informed consent.⁸⁴</p> <p>Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals and supports person-centred care. Good clinical practice involves ensuring that informed consent is validly obtained and appropriately timed.⁸⁵</p> <p>Obtaining consent may not be valid if it is obtained through third parties. Consider best practice guidelines when developing local policies relating to access to accredited interpreters, family members or workers with bilingual skills.</p> <p>Policies and procedures should include directions about the role of interpreters and family. Ensure informed consent forms are tested for readability and processes meet the standards for obtaining informed consent.</p>

Item	Action required	Comments/Strategies
Healthcare rights and informed consent <i>continued</i>	2.05 The health service organisation has processes to identify: <ol style="list-style-type: none"> a. the capacity of a patient to make decisions about their own care b. a substitute decision maker if a patient does not have the capacity to make decisions for themselves 	<p>Communication is fundamental to the provision of health care. Limited English language proficiency can adversely affect the communication process and infringe the rights of the consumer. Failure to provide culturally and linguistically appropriate health care information, or access to an interpreter could result in the patient being unable to give valid informed consent.⁴⁴</p> <p>Organisations should provide migrants and refugees with information in ways that are accessible to them and ensures they are able to make informed decisions and partner in their care.</p>
	2.06 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care	<p>Migrants and refugees can face major barriers in their understanding, engagement and access of healthcare services, these barriers are complex and inter-related and can result in disempowerment and loss of autonomy.²⁰</p> <p>Health information can be unnecessarily complex, the quality of consumer information materials scarce, culturally inappropriate, or not translated and access to interpreters inconsistent, undermining the capacity of migrants and refugees to actively participate in shared decision making.⁸⁶</p>
	2.07 The health service organisation supports the workforce to form partnerships with patients so that patients can be actively involved in their own care	<p>Migrants and refugees can face a particular set of challenges when it comes to accessing appropriate health care and can experience disparities leading to poorer outcomes and lower quality health care compared to other consumers.²⁵</p> <p>Discrimination, limited English language skills, unfamiliarity with the health care system, and a lack of cultural competency amongst the work force all have negative implications for the health outcomes of these groups.¹²</p> <p>To enhance cultural responsiveness within the organisation, provide the workforce with training, education and professional development opportunities to meet the language, cultural, and health literacy needs of migrants and refugees accessing the service.</p>

Item	Action required	Comments/Strategies
Communication that supports effective partnerships	2.09 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	<p>When communication barriers exist, the quality of care for clients diminishes and adverse health outcomes are increased. Effective communication is linked to improved consumer health outcomes, improved compliance and engagement with health care services.⁴⁵ Culturally appropriate resources should be developed in partnership with migrants and refugees.</p>
	2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: <ol style="list-style-type: none"> a. information is provided in a way that meets the needs of patients, carers, families and consumers b. information provided is easy to understand and use c. the clinical needs of patients are addressed while they are in the health service organisation d. information needs for ongoing care are provided at discharge 	<p>The importance of interpersonal communication between consumers and healthcare providers is well recognised.⁴⁵ Effective communication has been linked to improved consumer health outcomes and is closely associated with patient safety.⁸⁴</p> <p>Effective communication based on trust, understanding, empathy and cooperation is one of the most important contributors to consumer engagement, participation and adherence to healthcare plans.</p> <p>Implement mechanisms and systems to ensure the communication needs of migrants and refugees are met and resources are developed to support the use of interpreters and translated materials. Strategies for effective interpersonal communication include the use of decision support aids, shared decision-making processes, educative and recall strategies.³⁴</p>
Partnerships in healthcare governance planning, design, measurement and evaluation	2.14 The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	<p>Providing education and training is fundamental to any change process. High quality services to migrants and refugees rely on access to well-qualified, trained and supported staff who are able to deliver services in a culturally competent and sensitive manner. Training of the workforce should be tailored to meet the needs of the local population.²⁰</p> <p>Feedback and complaint mechanisms can reflect what is working well, and provide examples of good practice of cultural responsiveness and gaps where the needs of migrants and refugees are not being met. Implement strategies to collect and incorporate their feedback into training and education for the workforce.³⁰</p>



Medication Safety Standard

Item	Action required	Comments/Strategies
Partnering with consumers	<p>4.03 Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:</p> <ul style="list-style-type: none"> a. actively involve patients in their own care b. meet the patient's information needs c. share decision-making 	<p>For many patients from migrant and refugee backgrounds, the safe use of medicines is affected by language and communication barriers, cultural factors, financial barriers, limited health literacy and health system literacy.⁸⁷</p> <p>Cultural and religious beliefs about illness can have a significant influence upon medication adherence. This should be considered when providing information and advice on medications.⁸⁸</p> <p>Effective communication can improve patient safety, enhance adherence and decrease the risk of medication errors and adverse health outcomes.⁶ Organisations should ensure that interpreters are engaged when discussing medications.</p> <p>Implementing patient-centred systems and tailoring health care advice improves collaboration and partnerships between healthcare providers and consumers.³⁴ Ensuring the needs and preferences of consumers are met is vital to improving quality use of medicines and achieving better medication adherence.^{40,88}</p>
	<p>4.07 The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation</p>	<p>Migrants and refugees with limited English proficiency are at greater risk of medication related harm.⁸⁹ Simultaneous use of over the counter and traditional medicines has been reported among migrants and refugees.⁸⁹ However, concerns among migrant and refugee patients that health professionals do not favour combining Western and traditional medicines can lead to reluctance to disclosing complementary medications and people managing their medicines without advice from their doctor.⁹⁰ This can increase risk of drug interactions and other side effects.⁹¹</p> <p>The information that needs to be exchanged when taking a medication history goes well beyond which medications are being taken and dosage instructions.⁸⁷ Health service organisations should establish culturally responsive systems for the workforce to conduct and document a comprehensive best possible medical history.⁹²</p>

Item	Action required	Comments/Strategies
Partnering with consumers <i>continued</i>	4.11 The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	<p>Using plain language has been linked to both quality improvement in the delivery of person centred care, and reducing organisational risk through increasing informed consent and medication compliance.³⁴ This needs to be supported by an organisational commitment to clear communication, which should include a formalised plain language policy.</p> <p>Females over 50 years of age with low levels of English proficiency have been shown to experience additional barriers to accessing medications.⁹³ Greater adherence to medication regimes can be achieved where there are tailored education and implementation strategies that promote migrants' and refugees' understanding of their health and illnesses.⁹⁴</p> <p>Health service organisations should provide and support access to health literacy and interpersonal communication training for the workforce. Organisations should include training in communicating risk and understanding the impact of illness perceptions, cultural and other beliefs on patients' adherence to medication.⁹⁵ Organisations should implement appropriate strategies and apply tools to enhance communication, provide consumer education and improve medication adherence.^{87,40}</p> <p>Community engagement is essential to ensure the development and evaluation of safe and effective tools such as pictograms and translated resources.⁸⁷</p>
	4.12 The health service organisation has processes to: <ul style="list-style-type: none"> a. generate a current medicines list and the reasons for any changes b. distribute the current medicines list to receiving clinicians at transitions of care c. provide patients on discharge with a current medicines list and the reasons for any changes 	<p>Providing migrants and refugees with culturally appropriate information and advice upon discharge can enhance medication uptake and adherence.⁹⁶ Organisations should encourage migrants and refugees to work in partnership with their health care providers to improve transitions of care and accurately list all medications taken including Western and traditional medicines.⁹⁰</p> <p>Migrants and refugees can face varying costs for pharmaceuticals depending on their entitlements, and therefore access to, and continuity of, medications can be challenging. Optimising the use of medicines is a key element of the delivery of quality care to migrants and refugees. Collaboration between health care providers including pharmacists can enable quality use of medicines.⁸⁷ To support effective communication, both general practitioners and pharmacists have access to free interpreting services.</p>



Comprehensive Care Standard

Item	Action required	Comments/Strategies
<p>Screening of risk</p>	<p>5.10 Clinicians use relevant screening processes:</p> <ul style="list-style-type: none"> a. at presentation, during clinical examination and history taking, and when required during care b. to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm c. to identify social and other circumstances that may compound these risks 	<p>People from refugee and refugee-like backgrounds in particular may have experienced significant human rights violations, trauma, torture, gender-based violence, disruption of basic services, poverty, and extremely challenging living conditions. These circumstances place them at increased risk of complex physical and mental health conditions, including communicable and vaccine preventable diseases.¹⁵</p> <p>Identifying patients at high risk of harm and addressing any disparities associated with a person’s migrant or refugee background requires a person-centred, risk-based approach. Ensuring sensitivity and adopting a universal precautions approach to pre-migration trauma is recommended when screening patients from migrant and refugee backgrounds.⁵⁴</p>
<p>Clinical assessment</p>	<p>5.11 Clinicians comprehensively assess the conditions and risks identified through the screening process</p>	<p>The health and wellbeing of migrants and refugees are frequently affected by a range of psychosocial factors both prior to and following arrival in Australia.</p> <p>Effective partnerships require a focus on health literacy to ensure that consumers can adequately participate in screening and assessment processes. Systems should be implemented to support shared decision making and empower migrants and refugees to contribute to the assessment process, make effective decisions and take appropriate actions in relation to their health and health care.³⁴</p> <p>Family can play a vital role in the care of patients from migrant and refugee backgrounds. In partnership with the consumer, family members should be included in discussions about health related issues and decisions. However, they should not be used as substitute interpreters.⁴³</p>

Item	Action required	Comments/Strategies
Comprehensive care at the end of life	5.15 The health service organisation has processes to identify patients who are at the end of life that are consistent with the <i>National Consensus Statement: essential elements for safe and high-quality end-of-life care</i>	Migrants and refugees have reported cultural incompatibility of services, the inability to observe cultural practices and a lack of cultural sensitivity. ²³ Health service organisations need to be aware of cultural differences and requirements when a person is at the end of-life. This includes having an understanding of specific cultural and religious rites, rituals ceremonies and requirements.
	5.16 The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	Organisations should ensure migrants and refugees are provided with culturally appropriate, accessible information, advice and tools to engage with their family and healthcare providers to discuss, and make decisions about, their future care preferences that are consistent with the <i>National Consensus Statement: essential elements for safe and high-quality end-of-life care</i> . ⁹⁷
	5.17 The health service organisation has processes to ensure that current advance care plans: a. can be received from patients b. are documented in the patient's healthcare record	
	5.18 The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
	5.19 The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
	5.20 Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the <i>National Consensus Statement: essential elements for safe and high-quality end-of-life care</i>	

Item	Action required	Comments/Strategies
Nutrition and hydration	<p>5.28 The workforce uses the systems for preparation and distribution of food and fluids to:</p> <ul style="list-style-type: none"> a. meet patients' nutritional needs and requirements b. monitor the nutritional care of patients at risk c. identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. support patients who require assistance with eating and drinking 	<p>Prolonged food deprivation and inadequate access to nutritious food and clean water are common for many migrants and refugees. Post arrival vulnerabilities may remain with regard to food insecurity, poor access to healthy foods and consequent under-nutrition. Comprehensive care planning should include cultural and religious considerations when addressing a patient's nutritional needs.⁶</p> <p>The principles of healthy eating should be discussed with patients and their families, as they may have limited knowledge and access to information about healthy food options in Australia.¹⁵</p>
Predicting, preventing and managing self-harm and suicide	<p>5.31 The health service organisation has systems to support collaboration with patients, carers and families to:</p> <ul style="list-style-type: none"> a. identify when a patient is at risk of self-harm b. identify when a patient is at risk of suicide c. safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed <p>5.32 The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts</p>	<p>Many migrants and refugees will have been exposed to traumatic experiences, including torture. Consequently, their mental health can deteriorate over time due to exposure to new risks and the loss of protective factors in the country of origin, such as extended family support. Depression, post-traumatic stress disorder and other anxiety disorders are common.¹⁵</p> <p>Assessment of emotional wellbeing and mental health should occur as an integral part of health screening for migrants and refugees. Organisations need to implement processes to ensure the workforce can identify clients at risk of self-harm or suicide.</p> <p>There should be systems in place to enable the workforce to gain access to specialist mental health expertise to assess and manage a person with suicidal thoughts. Information and resources to increase awareness around mental health conditions and their treatment must be culturally appropriate and accessible to migrant and refugee populations.⁹⁸</p>



Communicating for Safety Standard

Item	Action required	Comments/Strategies
Clinical handover	<p>6.08 Clinicians use structured clinical handover processes that include:</p> <ul style="list-style-type: none"> a. preparing and scheduling clinical handover b. having the relevant information at clinical handover c. organising relevant clinicians and others to participate d. being aware of the patient's goals and preferences e. supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. ensuring that clinical handover results in the transfer of responsibility and accountability for care 	<p>Migrants and refugees are often being seen by a range of specialist services and may have difficulty understanding information about priorities, health issues and treatment options.</p> <p>This requires a coordinated approach to support people to understand and navigate unfamiliar health environments. Support from family can promote engagement with health services.</p> <p>When health services work in partnership with patients and families, the quality and safety of health care rise, cost decreases, and provider and patient satisfaction increase.</p> <p>Organisations should establish patient-centred approaches based on the principles of dignity and respect, sharing information, collaboration and partnerships. Cultural and familial traditions around caring and family must also be taken into consideration.</p> <p>The influence of traditional health beliefs among migrant and refugee populations should be recognised, as decisions around care can conflict with traditional cultural practices. Organisations should ensure that access to interpreters and resources in the person's preferred language is provided.</p> <p>Tailored health information is critical for consumers. Providing understandable and accessible health information for consumers can improve their knowledge, compliance, understanding and recall about their health and care.⁷⁹</p>

Item	Action required	Comments/Strategies
Communicating critical information	6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	<p>A range of pre- and post-arrival factors can contribute to migrants and refugees being unable to provide comprehensive and accurate details of their medical and social history. Fear and shame can contribute to people being unwilling to share culturally sensitive information.¹⁴</p> <p>Organisations should empower migrants, refugees and their families to ask questions and share critical information by providing appropriate support and privacy.</p> <p>Consumers and their families should be encouraged and supported to participate in care and shared decision-making at the level they choose by providing access to appropriate resources, language support and advocacy when required.³</p>



Recognising and Responding to Acute Deterioration Standard

Item	Action required	Comments/Strategies
Escalating care	8.07 The health service organisation has processes for patients, carers or families to directly escalate care	Organisations should ensure that migrants, refugees and their families know how to directly escalate care. A range of systems and strategies to support migrants and refugees to access appropriate resources and interpreters in a language of their choice is also critical.

Glossary

A full list of glossary definitions can be found in the [NSQHS Standards](#)

Term	Definition
bicultural workforce	Members of the workforce employed specifically for their cultural knowledge, often employed in a range of positions within an organisation and able to use their cultural skills and knowledge to facilitate communication between the organisation and communities with whom they share similar cultural experiences and understandings. ⁹⁹
bilingual workforce	Members of the workforce employed specifically for their proficiency in a language other than English. They can be employed in a range of positions within an organisation and are able to utilise their proficiency in languages other than English as an additional skill. However, they are not interpreters. ⁶¹
cultural responsiveness	A framework through which to improve service delivery to clients from culturally and linguistically diverse backgrounds. Cultural responsiveness requires an organisation-wide approach to planning, implementing and evaluating services for clients of culturally and linguistically diverse backgrounds and is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services. ^{6,32}
cultural and linguistic diversity	Refers to the wide range of cultural groups that make up the Australian population and Australian communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. ⁶
discrimination	When a person, or a group of people, is treated less favourably than another person or group because of their background or certain personal characteristics. ¹⁰⁰
diversity	The varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.
equitable health care	One in which all people have the same opportunity to develop and maintain their health, through fair and just access to resources for health. This does not mean that everyone receives the same level of care. Instead it means health care is provided relative to people's health status and needs. Equity in health is not the same as equality in health status. <i>Inequalities</i> in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. ⁶
health beliefs	A person's beliefs and past experiences that affect the way they view health, causes of illness and treatment. ¹⁰¹

Term	Definition
interpreter	<p>A professional, conveying spoken or signed information from one language into another language¹⁰², who has obtained certification issued by the National Accreditation Authority for Translators and Interpreters (NAATI) – the national body responsible for setting, maintaining and promoting standards for the translation and interpreting industry through its certification system for translators and interpreters – at one of the following levels:</p> <ul style="list-style-type: none"> ■ Certified Conference Interpreter ■ Certified Specialist Interpreter (Health or Legal) ■ Certified Interpreter ■ Certified Provisional Interpreter ■ Recognised Practising Interpreter (for some languages, in which NAATI certification is not available). <p>All NAATI credentialed interpreters are bound by the Australian Institute of Interpreters and Translators (AUSIT) code of ethics¹⁰³ or by the Australian Sign Language Interpreters' Association (ASLIA) code of ethics¹⁰⁴, respectively, obliging them to maintain impartiality, objectivity and confidentiality.</p>
limited English proficiency	<p>Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English well enough to understand and be understood without the aid of an interpreter, or translated resources.</p>
migrant	<p>There is no universally accepted definition of the term 'migrant'. It is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of 'personal convenience' and without intervention of any coercive external factors.¹⁰⁵</p>
new and emerging communities	<p>Are those which generally have small numbers in any one population centre, lack organised advocacy or social networks, have difficulty accessing government services and may require substantial assistance and time to settle effectively in Australia.⁶</p>
post-traumatic stress disorder	<p>Is a particular set of reactions that can develop in people who have been through a traumatic event which threatened their life or safety, or that of others around them. This could be a car or other serious accident, physical or sexual assault, war or torture, or disasters such as bushfires or floods. As a result, the person experiences feelings of intense fear, helplessness or horror.¹⁰⁶</p>
refugee	<p>Includes people who are humanitarian migrants granted permanent or temporary protection, asylum seekers, and permanent or temporary migrants.¹⁰⁷ Someone who, 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality, and is unable to, or owing to such fear, is unwilling to avail himself/herself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable or, owing to such fear, is unwilling to return to it'.¹⁰⁸</p>
refugee-like	<p>Is used to describe people who have been found to be refugees under the United Nations Refugee Convention, who hold an Australian or Humanitarian visa, and also people from refugee-like backgrounds who have entered under other migration streams including asylum seekers. 'Refugee-like' acknowledges that people may have had refugee experience in their countries of origin, but do not have formal refugee status.¹⁵</p>

Term	Definition
risk factors	Are characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder. ⁶
social determinants of health	The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, including economics, social policies and politics. ¹⁰⁹
stigma	A negative opinion or judgment that excludes, rejects, shames or devalues a person or group of people on the basis of a particular characteristic. Stigma may include self-stigma, social stigma and structural stigma. Stigma against people living with mental illness involves perceptions or representations of them as violent, unpredictable, dangerous, prone to criminality, incompetent, undeserving or weak in character. ¹¹⁰
trauma	Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. ¹¹¹
torture	Refers to any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from them or a third person information or a confession, punishing them for an act they or a third person has committed or is suspected of having committed, or intimidating or coercing them or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. ¹¹²
trauma-informed care	A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage. This can occur on two levels: trauma-specific interventions; and trauma-informed models of care. ⁷⁶

References

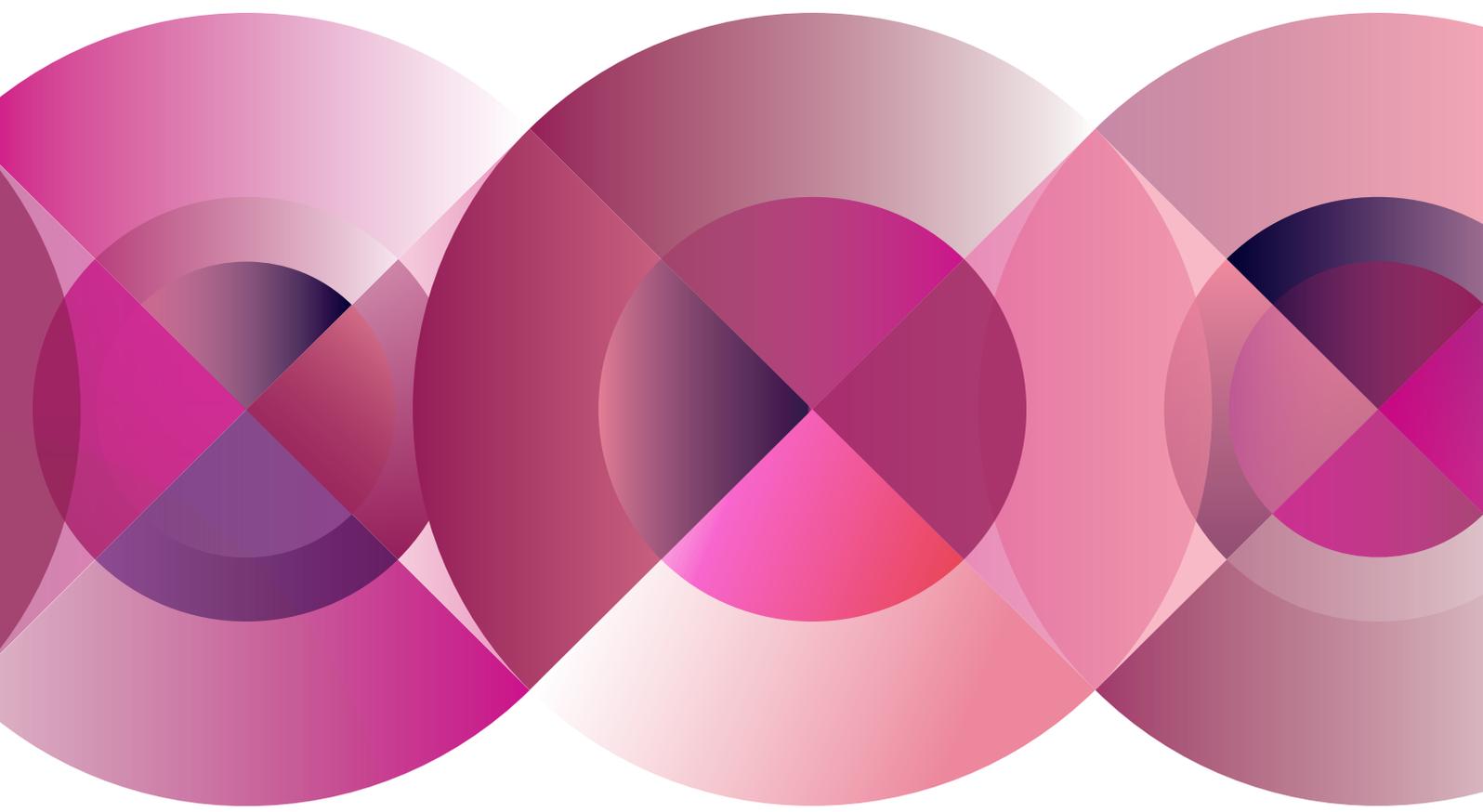
1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: 2017.
2. Australian Commission of Safety and Quality in Health Care. Australian Charter of Healthcare Rights. [Internet] Sydney: Australian Commission on Safety and Quality in Health Care; 2020 [cited 17 December 2020] Available from: <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights>.
3. Australian Commission on Safety and Quality in Health Care. Patient centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: ACSQHC, 2011.
4. Allotey P, Reidpath D. The health of refugees: public health perspectives from crisis to settlement: Oxford University Press; 2018.
5. Cross TL. Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. CASSP Technical Assistance Center: Georgetown University Child Development Center 1989.
6. National Health and Medical Research Council. Cultural Competency in Health: A guide for policy, partnerships and participation. Canberra: 2005.
7. The Lewin Group Inc. Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile,. In: Prepared for: The Health Resources and Services Administration U.S. Department of Health and Human Services, editor. 2002.
8. Fozdar F, Hartley L. Refugee resettlement in Australia: What we know and need to know. J Refugee Survey Quarterly. 2013;32(3):23–51.
9. Fozdar F, Banki S. Settling refugees in Australia: Achievements and challenges. International Journal of Migration Border Studies. 2017;3(1):43–66.
10. Consumers Health Forum of Australia. About Consumer Representation. [Internet] 2016 [cited 11 December 2020] Available from: <https://chf.org.au/representation>.
11. The Commonwealth of Australia. Multicultural Language Services Guidelines for Australian Government Agencies. Canberra 2013.
12. Ziersch A, Due C, Walsh M. Discrimination: a health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia. BMC public health. 2020;20(1):108.
13. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet. 2005;365(9467):1309–1314.
14. Hynie M. The social determinants of refugee mental health in the post-migration context: A critical review. The Canadian Journal of Psychiatry. 2018;63(5):297–303.
15. Chaves NJ, Paxton G, Biggs BA, Thambiran A, Smith M, Williams J, et al. Recommendations for Comprehensive Post-Arrival Health Assessment for People from Refugee-like Backgrounds. Surry Hills, NSW: Australasian Society for Infectious Diseases and Refugee Health Network of Australia, 2016.
16. Silove D, Ekblad S. How well do refugees adapt after resettlement in Western countries? Acta psychiatrica Scandinavica. 2002;106(6):401–402.
17. Fozdar F, Torezani S. Discrimination and well-being: Perceptions of refugees in Western Australia. J International Migration Review. 2008;42(1):30–63.
18. Fozdar F. The Golden Country': Ex-Yugoslav and African Refugee Experiences of Settlement and Depression. Journal of Ethnic Migration Studies. 2009;35(8):1335–1352.
19. National Health Medical Research Council. Cultural competency in health: A guide for policy, partnerships and participation: National Health and Medical Research Council; 2006.
20. Au M, Anandakumar AD, Preston R, Ray RA, Davis M. A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. International Health and Human Rights. 2019;19(1):22.
21. WHO Regional Office for Europe. How Health Systems can Address Health Inequities Linked to Migration and Ethnicity. Copenhagen: WHO Regional Office for Europe, 2010.
22. Smith L. The Health outcomes of migrants: A literautre review. Migration Council Australia, 2015.

23. Brooks LA, Bloomer MJ, Manias E. Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review. *Australian Critical Care*. 2019;32(6):516–523.
24. Cheng I-H, Advocat JR, Vasi S, Enticott J, Willey S, Wahidi S, et al. A rapid review of evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants: report to the World Health Organization. 2018.
25. Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. One size does not fit all: Meeting the health care needs of diverse populations. Oakbrook Terrace, IL: The Joint Commission 2008.
26. Minas H, Kakuma R, San Too L, Vayani H, Orapeleng S, Prasad-Ildes R, et al. Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *International journal of mental health systems*. 2013;7(1):23.
27. Bradby H, Humphris R, Newall D, Phillimore J. *Public Health Aspects of Migrant Health: A review of the evidence on health status for refugees and asylum seekers in the European Region*. Copenhagen: WHO Regional Office for Europe, 2015.
28. Henderson S, Kendall E, See L. The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: A systematic literature review. *Health & Social Care in the Community*,. 2011 May;19(3):225–249.
29. Vanstone R, Szwarc J, Casey S, Maloney M, Duell-Piening P. *Promoting the engagement of interpreters in Victorian health services: Victorian Foundation for Survivors of Torture*; 2013.
30. Federation of Ethnic Communities Councils of Australia. *Access and Equity to Feedback and Complains Mechanisms for Multicultural Communities*. Canberra: FECCA, 2011.
31. Niner S, Kokanovic R, Cuthbert D. *Displaced mothers: birth and resettlement, gratitude and complaint*. Taylor & Francis; 2013.
32. Victorian Government. *Cultural Responsiveness Framework: Guidelines for Victorian health services*. Melbourne, Victoria: Rural and Regional Health and Aged Care Services, 2009.
33. Australian Bureau of Statistics. 2024.0 – Census of Population and Housing: Australia Revealed, 2016. [Internet] 2017 [cited 17 December 2020] Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/2024.0>.
34. Australian Commission on Safety and Quality in Health Care. *Health literacy: Taking action to improve safety and quality*. Sydney: ACSQHC, 2015.
35. Australian Commission on Safety and Quality in Health Care. *Australian Open Disclosure Framework*. Sydney: ACSQHC; 2013.
36. Australian Bureau of Statistics. 2011.0 – Census of Population and Housing: Reflecting Australia – Stories from the Census. 2016.
37. Smart D, De Maio J, Riaseco P, Edwards B. *English skills, engagement in education, and entrance into employment of recently arrived humanitarian migrants*. Melbourne: Australian Institute of Family Studies, 2017.
38. Russell G, Harris M, Cheng I-H, et al. *Coordinated Primary Health Care for Refugees: A best practice framework for Australia*. Report to the Australian Primary Health Care Research Institute. Dandenong, Vic: 2013.
39. Australian Institute of Health and Welfare. *Australia's Health 2020*. Canberra: AIHW, 2020.
40. Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 4: Medication Safety*, October 2012. Sydney: 2012.
41. Rowse J, Anderson K, Phillips C, Chan B. *Critical Case Analysis of Adverse Events Associated with Failure to use Interpreters for Non-English Speaking Patients*. Australian National University Medical School: 2017. [Internet] Canberra: ANU Medical School; 2017 [cited 11 December 2020] Available from: <https://ausit.org/wp-content/uploads/2020/02/ANU-Critical-Case-Analysis.pdf>.
42. Phillips CB. Improving health outcomes for linguistically diverse patients. *The Medical Journal of Australia*. 2016;204(6):209–210.
43. Brophy-Williams S, Boylen S, Gill FJ, Wilson S, Cherian S. Use of professional interpreters for children and families with limited English proficiency: The intersection with quality and safety. *Journal of Paediatrics and Child Health*. 2020 (56):1201–1209.
44. Department of Health and Human Services (Victorian Government). *Language services policy*. Victoria State Government, 2017.
45. *Migrant & Refugee Health Partnership in collaboration with Inala Primary Care. Interpreter Engagement in General Practice in Australia*. ACT: 2020.

46. Stewart M, Brown JB, Boon H, Galajda J, Meredith L, Sangster M. Evidence on patient-doctor communication. *Cancer Prev Control*. 1999 Feb;3(1):25–30.
47. Stewart MA. Effective physician-patient communication and health outcomes: A review. *CMAJ*. 1995 May 1;152(9):1423–1433.
48. Zolnieriek KB, Dimatteo MR. Physician communication and patient adherence to treatment: A meta-analysis. *Med Care*. 2009 Aug;47(8):826–834.
49. Tongue JR, Epps HR, Forese LL. Communication skills for patient-centered care: Research-based, easily learned techniques for medical interviews that benefit orthopaedic surgeons and their patients. *J Bone Joint Surg Am* 2005;87:652–658.
50. Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine*. 2005;20(9):800–806.
51. Radermacher H, Feldman S, Browning C. Mainstream versus ethno-specific community aged care services: It's not an 'either or'. *Australas J Ageing*. 2009 Jun;28(2):58–63.
52. Wilson C, Alam R, Latif S, Knighting K, Williamson S, Beaver K. Patient access to healthcare services and optimisation of self-management for ethnic minority populations living with diabetes: A systematic review. *Health and Social Care Community*. 2012;20(1):1–19.
53. Flores G. The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review*. 2005 Jun;62(3):255–299.
54. Federation of Ethnic Communities Councils of Australia. Opening the door to access and equity. FECCA Access and Equity Report 2011–2012. Prepared for the Australian Government Department of Immigration and Citizenship, 2012.
55. Snow H, Fleming, BR. Consent, capacity and the right to say no. *Medical Journal of Australia*. 2014;201(8):486–488.
56. Betancourt JR, Renfrew MR, Green AR, et al. Improving patient safety systems for patients with Limited English Proficiency – A guide for hospitals. [Internet] Rockville, MD: Agency for Healthcare Research and Quality; 2012 [cited 26 January 2020] Available from: <https://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf>.
57. Rowse J, Anderson K, Phillips C, Chan B. Critical Case Analysis of Adverse Events Associated with Failure to use Interpreters for Non-English Speaking Patients. Australian National University Medical School, 2017.
58. O'Reilly-de Brun M, MacFarlane A, de Brun T, et al. Involving migrants in the development of guidelines for communication in cross-cultural general practice consultations: A participatory learning and action research project. *BMJ Open*. 2015 Sep 21;5(9).
59. Victorian Government. Understanding Language Services [Internet] website 2019 [cited 21 December 2020] Available from: <https://www.vic.gov.au/guidelines-using-interpreting-services/understanding-language-services>.
60. Quan K, Lynch J. The High Costs of Language Barriers in Medical Malpractice. University of California School of Public Health, National Health Law Program, 2010.
61. Centre for Culture Ethnicity and Health. Managing Bilingual Staff. State Government Victoria; 2014.
62. Commonwealth of Australia. The Multicultural language services guidelines for Australian Government agencies,. Canberra: Department of Immigration and Citizenship, 2013.
63. Queensland Government. Multicultural Nurse Navigator breaks down barriers to health. [Internet] 2017 [cited 11 December 2020] Available from: <https://metrosouth.health.qld.gov.au/news/multicultural-nurse-navigator-breaks-down-barriers-to-health>.
64. The Royal Australian College of General Practitioners. Standards for General Practices. East Melbourne, Victoria RACGP, 2017.
65. Consumer Focus Collaboration. The Evidence Supporting Consumer Participation in Health. Consumer Focus Collaboration, 2001.
66. Peterson P, Sackey D, Correa-Velez I, Kay M. Building Trust: Delivering health care to newly arrived refugees. 2011.
67. Refugee Council of Australia. Settling in Australia: The challenges. [Internet] 26 December 2019 [cited 13 January 2021] Available from: <https://www.refugeecouncil.org.au/settlement-challenges/3/>.
68. Australian Institute of Health and Welfare Australia's Health 2020. Australia's Health 2018. Canberra: AIHW, 2018 Contract No.: Cat. no. AUS 222.
69. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ*. 2011 Sep 6;183(12):E824–925.

70. Australasian College for Emergency Medicine. Statement on Culturally Competent Care and Cultural Safety in Emergency Medicine. 2015.
71. Williams R. Cultural safety-What does it mean for our work practice? *Aust N Z J Public Health*. 1999;23(2): 213–215.
72. Shawyer F, Enticott JC, Block AA, Cheng I-H, Meadows GN. The mental health status of refugees and asylum seekers attending a refugee health clinic including comparisons with a matched sample of Australian-born residents. *Bmc Psychiatry*. 2017;17(1):76.
73. Australian Bureau of Statistics. Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications. [Internet]: Australian Bureau of Statistics; 2016 Available from: abs.gov.au
74. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine*. 1978;88(2):251–258.
75. Drummond PD, Mizan A, Brocx K, Wright B. Barriers to accessing health care services for West African refugee women living in Western Australia. *Health care for women international*. 2011;32(3):206–224.
76. Wall L, Higgins D, Hunter C. Trauma-Informed Care in Child/Family Welfare Services. Melbourne: Australian Institute of Family Studies, 2016.
77. Shawyer F, Enticott JC, Block AA, Cheng I-H, Meadows GN. The mental health status of refugees and asylum seekers attending a refugee health clinic including comparisons with a matched sample of Australian-born residents. *BMC Psychiatry*. 2017;17(76).
78. Henderson S, Kendall E. Reflecting on the tensions faced by a community-based multicultural health navigator service. *Australian Health Review*. 2014;38(5):584–588.
79. Institute for Patient- and Family-Centred Care. Advancing The Practice Of Patient- And Family-Centred Care In Hospitals. How to get Started. [Internet] Bethesda: IPFCC; 2017 [cited 25 March 2021].
80. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Social science medicine*. 1997;44(5):681–692.
81. Elwyn G, Frosch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley P, et al. Shared decision making: a model for clinical practice. *Journal of general internal medicine*. 2012;27(10):1361–1367.
82. The Victorian Foundation for Survivors of Torture. The Australian refugee health practice guide. Approach to patient care: Approach to consultation and management. Primary Care for People from Refugee Backgrounds. 2018.
83. Australian Commission on Safety and Quality in Health Care. Review: Implementation of the Australian Open Disclosure Framework – Final consultation report. Sydney: ACSQHC; 2020.
84. Johnstone M-J, Kanitsaki O. Culture, language, and patient safety: making the link. *International journal for quality in health care*. 2006;18(5):383–388.
85. Australian Commission on Safety and Quality in Health Care. Informed consent in health care. [Internet] Sydney: ACSQHC; 2020 [cited 15 January 2021] Available from: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/informed-consent-fact-sheet-clinicians>.
86. Nilsen ES, Myrhaug HT, Johansen M, Oliver S, Oxman AD. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. *Cochrane database of systematic reviews*. 2006 (3).
87. Kay M, Wijayanayaka S, Cook H, Hollingworth S. Understanding quality use of medicines in refugee communities in Australian primary care: a qualitative study. *British Journal of General Practice*. 2016;66(647):e397–e409.
88. Shahin W, Kennedy GA, Stupans I. The impact of personal and cultural beliefs on medication adherence of patients with chronic illnesses: a systematic review. *Patient preference and adherence*. 2019;13:1019.
89. Shahin W, Kennedy GA, Cockshaw W, Stupans I. The effect of acculturation and harm beliefs on medication adherence on Middle Eastern hypertensive refugees and migrants in Australia. *International Journal of Clinical Pharmacy*. 2021:1–10.
90. O'Callaghan C, Quine S. How older Vietnamese Australian women manage their medicines. *Journal of cross-cultural gerontology*. 2007;22(4):405–419.
91. Davis TC, Wolf MS, Bass PF, Middlebrooks M, Kennen E, Baker DW. Low literacy impairs comprehension of prescription drug warning labels. *Journal of General Internal Medicine*. 2006;21(8):847–851.
92. World Health Organization. The High 5s Project standard operating protocol-assuring medication accuracy at transitions in care: medication reconciliation. Geneva: WHO. 2014.
93. Aljadeeah S, Wirtz VJ, Nagel E. Barriers to Accessing Medicines among Syrian Asylum Seekers and Refugees in a German Federal State. *International Journal of Environmental Research and Public Health*. 2021;18(2):519.

94. Centre for Culture Ethnicity & Health. Health Literacy – Using the teach-back technique. [Internet] [cited 26 March 2021] Available from: <https://www.ceh.org.au/resource-hub/health-literacy-using-the-teach-back-technique/>.
95. Shahin W, Kennedy GA, Cockshaw W, Stupans I. The role of refugee and migrant migration status on medication adherence: Mediation through illness perceptions. *PloS one*. 2020;15(1):e0227326.
96. Yehekel A, Rawal S. Exploring the 'Patient experience' of individuals with limited English proficiency: a scoping review. *Journal of immigrant and minority health*. 2019;21(4):853–878.
97. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2015.
98. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards: User Guide for Health Services Providing Care for People with Mental Health Issues. Sydney: ACSQHC; 2018.
99. Centre for Multicultural Youth. Addressing the Strengths and Complexities of Bicultural Youth and Family Work – Consultation Report. Centre for Multicultural Youth, 2011.
100. Australian Human Rights Commission. Discrimination. [Internet] 2014 [cited 27 March 2021] Available from: <https://humanrights.gov.au/quick-guide/12030>.
101. Centre for Culture Ethnicity & Health. Cultural Considerations in Health Assessments. [Internet] [cited 1 November 2020] Available from: https://www.ceh.org.au/wp-content/uploads/2017/07/CEH_TipSheet3_Mar2011_Web-002.pdf.
102. Australian Institute of Interpreters and Translators. Interpreting: Getting it right. [Internet] [cited 1 March 2020] Available from: <https://www.tisnational.gov.au/en/Interpreters/Information-for-current-TIS-National-interpreters/Interpreter-support-and-resources>.
103. Australian Institute of Interpreters and Translators. AUSIT Code of Ethics and Code of Conduct. 2012.
104. Australian Sign Language Interpreters' Association. Code of Ethics and Guidelines for Professional Conduct. 2007.
105. UNHCR. Resettlement Handbook: Glossary. [Internet] Geneva: UNHCR; [cited 26 March 2021] Available from: <https://www.unhcr.org/en-au/protection/resettlement/3d46515d4/unhcr-resettlement-handbook-glossary.html?query=glossary>
106. Beyond Blue. Post-traumatic stress disorder (PTSD). [Internet]: Beyond Blue; 2020 [cited 27 March 2021] Available from: <https://www.beyondblue.org.au/the-facts/anxiety/types-of-anxiety/ptsd>.
107. Department of Health and Human Services Victorian Government. Refugee and Asylum Seeker Health Services: Guidelines for the community health program. Melbourne 2015.
108. UNHCR. The 1951 Convention and its 1967 Protocol. Geneva: UNHCR; 2011.
109. Australian Institute of Health and Welfare. Australia's Health 2016. Canberra: AIHW, 2016.
110. Commonwealth of Australia. The Fifth National Mental Health and Suicide Prevention Plan. 2017.
111. US Department of Health and Human Services. SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville: Substance Abuse and Mental Health Services Administration; 2014.
112. Burgers JH. The United Nations Convention against Torture: A handbook on the Convention against Torture and other cruel, inhuman, or degrading treatment or punishment: Martinus Nijhoff Publishers; 1988.



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