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General Hospital Patient Report

Exploring Aboriginal people's experiences of hospital care in NSW

This qualitative study was conducted by the Sax Institute for the NSW Ministry of Health.

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We have used the term Aboriginal in this report to acknowledge Aboriginal and/or Torres Strait Islander peoples. The term is used to acknowledge the traditional custodians of lands in NSW and recognise the numerous nations, language groups and clans now residing in NSW.

Executive summary

Introduction

Improving patients' experiences of health care is a NSW Health priority. In 2019, the Bureau of Health Information (BHI) conducted census sampling of Aboriginal people for their Adult Admitted Patient Survey. This state-wide survey found differences in the experiences of hospital care reported by Aboriginal and non-Aboriginal patients, with Aboriginal patients significantly less likely to report being treated with respect and dignity. The Aboriginal Patient Experience Survey Project Advisory Committee subsequently recommended a qualitative study be conducted to further explore Aboriginal people's experiences of care in NSW public hospitals, and specifically the issue of cultural safety.

Purpose of this report

The Sax Institute was engaged by the NSW Ministry of Health to conduct this study. This report presents the study findings for Aboriginal patients in hospital settings (excluding maternity care), including implications for improving cultural safety and overall patient experience for Aboriginal patients in NSW public hospitals. Findings about Aboriginal patients' experiences of hospital-based maternity care are reported elsewhere such as The insights series - Aboriginal people's experience of hospital care undertaken by the NSW Bureau of Health Information. The qualitative study findings will be triangulated with the NSW Adult Admitted Patient Survey findings to provide a comprehensive story about Aboriginal peoples' experiences of hospital care in NSW.

Methods

An advisory committee with Aboriginal majority membership guided all aspects of the study. Three NSW local health districts (LHDs) and four Aboriginal Community Controlled Health Services (ACCHSs) participated in this study. The three LHDS were Murrumbidgee (MLHD), Illawarra Shoalhaven (ISLHD), and Western Sydney (WSLHD). The four ACCHSs were Riverina Medical and Dental Aboriginal Corporation (RivMed), Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation (Waminda), Illawarra Aboriginal Medical Service (IAMS), and Greater Western Aboriginal Health Service (GWAHS). Recruitment was coordinated through the LHDs and ACCHSs in each geographical area. The study took a decolonising, Indigenist approach (1), with all interviews and focus groups conducted by a team of experienced Aboriginal researchers, who also played a key role in data analysis, interpretation, and reporting.

Findings

Thirty-nine patients and staff participated in this study. In-depth qualitative interviews were conducted with Aboriginal people who had been admitted to hospital within the last 5 years (n=23 participants), LHD staff who worked closely with Aboriginal patients (n=3 participants), and two in-depth qualitative interviews and four focus groups (n=11) were held with staff across the four participating ACCHSs (n=13 participants). The study findings suggest that several important elements contribute to **cultural safety** for Aboriginal people during a hospital stay. These included feeling **welcomed, respected, comfortable, supported, and empowered**. Throughout the hospital journey (from admission to time on the ward, through to discharge and follow-up care), the extent to which Aboriginal patients experienced these elements of cultural safety was influenced by a range of views and interactions with the hospital, as well as hospital processes, practices and policies.

Most of the participants in this study had experienced previous negative or traumatic encounters, including racism or discrimination, in the hospital system or when dealing with other government

departments, either personally or through a family member, resulting in a fear of the hospital system. Data from this study suggest that while Aboriginal people's experiences of hospital care have improved overall in recent years, covert racism still exists. Hospital staff and how they interact and communicate with Aboriginal patients has a substantial impact on patient experiences, their health and wellbeing and cultural safety. Access to support from Aboriginal staff was also said to play a key role in improved cultural safety. Resourcing constraints were thought to be driving long waits and rushed interactions with hospital staff at times, as well as contributing to instances of perceived premature discharge. Improved communication with primary care providers was considered important for continuity of care post-discharge. Policies and environments that enabled and supported family and friends visiting Aboriginal patients in hospital impacted how comfortable and supported Aboriginal patients and their families felt in hospital. Study participants identified several priority areas to improve the hospital experience for Aboriginal people.

Proposed recommendations

1. Strengthen efforts to address racism and unconscious bias, with a zero-tolerance approach to racism. This may include creating accountability in the system for racism, teaching and celebrating allyship, ensuring cultural safety is built in to how NSW Health does business, and enhancing "respecting the difference" training for NSW Health staff to include cultural immersion programs and decolonisation training to support the delivery of culturally responsive care.
2. Review policies, procedures and systems for measuring, reporting and addressing racism.
3. Expand Aboriginal Health roles in hospitals across all LHDs and enable patient-nominated supports (e.g. ACCHSs), to support Aboriginal patients in hospital, and care coordination from hospitals back into the community.
4. Ensure culturally safe policies and environments which enable and support families attending hospitals are developed, implemented and monitored.
5. Ensure provision of cultural rooms and spaces that are accessible to Aboriginal patients and their visitors and ensure usage guidelines are adequately communicated to encourage their use.
6. Continue to improve communication with primary care providers for enhanced discharge planning (to ensure continuity of care for Aboriginal patients, including pragmatic considerations such as transport home); and support linkage to specialist and other outpatient services post discharge.

Background

Patient experience encompasses all aspects of a patient's care and treatment, including how they feel and respond to their experience (2). Positive patient experiences are associated with better health outcomes, clinical effectiveness, and increased patient safety (2). There is increasing recognition of the importance of patient perspectives and experiences of their healthcare in informing and improving healthcare (3). Ensuring positive patient experience is a core priority for NSW Health. The first strategic objective in *Future Health,* NSW Health's overarching roadmap, is "*Patients and carers have positive experiences and outcomes that matter*", with key objective 1.2 to "*Bring kindness and compassion into the delivery of personalised and culturally safe care*" (4). In 2020, NSW Health launched the *Elevating the Human Experience Strategy* and conducted extensive consultation with patients, families, carers, and health service providers to inform a *Guide to Action* (2).

NSW Health has made specific commitments to cultural respect and safety for Aboriginal people by upholding cultural protocols and practices and implementing agreed actions that support the delivery of services and programs to Aboriginal people in NSW (5). The *NSW Aboriginal Health Plan 2024–2034*, developed in partnership with the Aboriginal Health and Medical Research Council of NSW (AHMRC), also emphasises the importance of culturally safe work environments and health service provision (6).

The Bureau of Health Information (BHI) conducted census sampling of Aboriginal people for their Adult Admitted Patient Survey in 2019 (7). Every adult who identified as Aboriginal, and was admitted to a NSW public hospital, was invited to provide feedback on their experiences. Most Aboriginal patients admitted to hospital reflected positively on their overall care, particularly if they had access to support from an Aboriginal Hospital Liaison Officer. However, Aboriginal patients were significantly less likely than non-Aboriginal patients to report a positive experience across several key areas. For example, Aboriginal patients were significantly less likely to say that they were 'always' treated with respect and dignity, that their cultural beliefs were respected, or that their family members were given the 'right amount' of information about their condition or treatment. The Aboriginal Patient Experience Survey Project Advisory Committee subsequently recommended a qualitative study to be conducted to further explore Aboriginal people's experiences of care in NSW public hospitals, and specifically the issue of cultural safety.

While some Australian studies about the experiences of Aboriginal patients in hospital settings exist (8), these are limited in terms of number or quality of completed studies, and primarily focus on a particular health issue. In one study of 10 Aboriginal cardiac patients in a Melbourne hospital, researchers found that although most participants had positive experiences of their cardiac care, hospitalisation was often challenging because of a sense of dislocation and disorientation, and experiences of racism (9). Although there is a growing evidence base about the importance of cultural safety for Aboriginal patients in the health system, few published studies explore Aboriginal people's experiences of hospitalisation, except in the context of their experience of care for a specific health issue (10).

This qualitative study has been conducted to improve understandings of Aboriginal people's perspectives and experiences of care in public hospitals in urban and rural parts of NSW. The experiences of Aboriginal maternity patients were also explored through this study and are described in a separate report (10).

Study aim

The study aim was to develop a detailed understanding of Aboriginal people's experiences and perceptions of public hospital care in NSW.

Objectives

The objectives of the study were to explore in the context of admitted patient care:

I. Aboriginal patients' experiences of, and views about, the quality and safety of their care
II. Aboriginal patients' experiences of feeling culturally safe (or culturally unsafe) while receiving care[1]
III. What a culturally safe service looks like to Aboriginal patients
IV. How the quality and cultural safety of care influences the health of Aboriginal patients, including their health-seeking and self-management behaviours
V. Aboriginal patients' experiences of reporting incidents of discrimination in a service and of receiving support following such incidents, as well as their views about actions taken by the facility to address the problem
VI. Aboriginal patients and health staff suggestions for improving care for Aboriginal people in NSW.

Research team, ethics and governance

An advisory committee guided all aspects of this study, including the recommendations from the findings of the study. The committee was chaired by the Executive Director of the Centre for Aboriginal Health, NSW Ministry of Health and included senior Aboriginal academics, the Directors of Aboriginal Health in participating local health districts (LHDs), CEOs of participating Aboriginal Community Controlled Health Services (ACCHS),, representatives of relevant Branches of the NSW Ministry of Health, and the Aboriginal Health and Medical Research Council of NSW (AH&MRC). A smaller project management team consisting of key staff of the Centre for Epidemiology and Evidence, Centre for Aboriginal Health, and Health and Social Policy Branch was developed to support the study and facilitate input from the advisory committee. The Aboriginal Health Program at the Sax Institute was engaged to conduct the study. All interviews were conducted by experienced Aboriginal researchers (CC, JN, SS and MC) and the team was led by the Sax Institute's Senior Adviser, Aboriginal Health SB. DK was responsible for the project management of the study, the themes were jointly developed by CC, DK and JN.

Ethical approval for this study was provided by the AH&MRC Ethics Committee (1836/21). The research was carried out in accordance with the AH&MRC of NSW Ethics Committee guidelines for research with Aboriginal peoples (11). Ethical approval was also provided by the Joint University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (2021/ETH10941). Site Specific Approvals were also obtained from each participating LHD.

[1] Cultural safety is a philosophy of practice concerning how a health professional does something, not what they do. Its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing standardised care regardless of difference, to care that takes account of peoples' unique needs (11).

Methods

Qualitative research methodology was used to gather rich data about Aboriginal people's experiences of hospital care in NSW. Interviews and focus groups were conducted with Aboriginal people who were in hospital or had recently been in hospital, Aboriginal LHD staff, and ACCHS staff. The interviews and focus groups were semi-structured and incorporated elements of research yarning methodology (12).

Aboriginal researchers were involved throughout the process, including data collection, analysis and interpretation of findings.

This research drew on the following aspects of Indigenous standpoint theory:

- Having Aboriginal researchers doing the 'researching' with Aboriginal people and involved throughout study design, conduct, analysis and reporting, as described by Smith (13) and Moreton-Robinson (14)
- Privileging Indigenous voices (15).

Setting

Three NSW LHDs were chosen for this study: Murrumbidgee (MLHD), Illawarra Shoalhaven (ISLHD) and Western Sydney (WSLHD). These LHDs were selected with consideration of the size of their Aboriginal populations, and the geographical spread of metropolitan, regional, and rural areas. In each LHD a lead hospital was nominated, through which data collection was coordinated: Wagga Wagga Base Hospital (MLHD), Wollongong Hospital (ISLHD) and Westmead Hospital (WSLHD). Other patients who attended other hospitals within the LHD were also invited for interview. Four ACCHSs located within the geographical boundaries of these three LHDs were key partners in the research: Riverina Medical and Dental Aboriginal Corporation (RivMed); Illawarra Aboriginal Medical Service (IAMS); Waminda South Coast Women's Health and Welfare Aboriginal Corporation (Waminda); and Greater Western Aboriginal Health Service (GWAHS).

Inclusion/exclusion criteria

Patients

Inclusion criteria: Patients who were Aboriginal and/or Torres Strait Islander, were aged 18 years and above, were recently discharged following a hospital admission (preferably in the last 12 months, but any time up to 5 years post-discharge), were able to speak English, were mentally and physically able to participate, and were able to provide informed consent. Where the participant was unable to read English, family members could provide support by reading the consent and participant information sheet to the participant. Patients who discharged against medical advice were eligible to be part of the study.

Exclusion criteria: Patients admitted with a primary or secondary diagnosis related to a mental health condition were not eligible to participate.

Staff - ACCHS and LHD

ACCHS staff inclusion criteria: Staff who were Aboriginal and/or Torres Strait Islander, were aged 18 years and above, had worked at the ACCHS for at least 3 months, and had a role where they provided health or social services to Aboriginal community members.

LHD staff inclusion criteria: The Aboriginal Hospital Liaison Officers (AHLO), Aboriginal Health Workers (AHWs) and affiliated staff (e.g., Aboriginal Chronic Care Nurses) who worked closely with Aboriginal patients in the public hospital system in each participating LHD.

Participant recruitment

Patients

Purposive, maximum variation sampling was used to identify Aboriginal community members who were recently discharged following a hospital admission (preferably in the last 12 months, but any time up to 5 years post-discharge). ACCHS and LHD staff aimed to recruit patients with varied characteristics (e.g., age, sex, reason for admission, experience during their hospital stay – negative/positive). Approximately 50% of patients were recruited via the ACCHSs and 50% via hospital recruitment. In the ACCHS setting, staff with good knowledge of their community invited Aboriginal community members who they felt would be willing and able to talk about their hospital experience. In the LHD setting, recruitment was conducted with the assistance of the Director, Aboriginal Health; Aboriginal Health Team Leader; AHLOs or an AHW who support admitted Aboriginal patients at each hospital. These staff used their existing relationships with community and patients to identify the most suitable patients for interview. The ACCHS/LHD staff contacted suitable patients, explained the purpose of the study, and invited the patient to participate. If the participant gave consent, the ACCHS/LHD staff either scheduled a time for the patient to be interviewed by the Sax Institute Aboriginal researchers or their details were passed to the Sax Institute Aboriginal researchers to schedule the interview. Four patients either declined to participate or did not respond to the invite when contacted by the Sax Institute team. No participants withdrew consent. Preliminary analysis was conducted once 50% of data collection was completed, which informed case selection and further exploration of emerging themes for the remaining 50% of data collection.

Staff - ACCHS and LHD

ACCHS CEOs (or delegated staff member with good knowledge of ACCHS staff) identified and invited staff members who were most appropriate to be involved in a focus group to discuss Aboriginal community members' experiences in hospital settings. Four staff (two LHD and two ACCHS) were contacted for focus group/interviews but did not respond. It was requested that the staff have varied sociodemographic characteristics (e.g., age, sex) where possible. In each LHD, staff were invited for interviews by the Sax Institute Aboriginal researchers, following consultation with the Director, Aboriginal Health.

Data collection

Interviews and focus groups were conducted by experienced Aboriginal researchers who followed the key domains of the semi-structured interview guides (Appendix 2).

Patient interviews

Participants provided voluntary informed consent prior to the interviews. Interviews were conducted face to face or via telephone. A level of flexibility and pragmatism was required to facilitate patient engagement; hence telephone interviews were used where requested by the participant. Participants recruited via the ACCHS were interviewed either at the ACCHS, at their home or via phone. Patients recruited through the hospitals were interviewed in an Aboriginal cultural room, a local health service or community area, at the interviewee's home, or via phone. Family members who were present

during the hospital stay were able to be part of the interview, following consent from the patient and the family member. Most interviews were conducted one-on-one, with three interviews held with two people. All patient participants received a $50 gift card intended to acknowledge their time and contribute to costs incurred through their participation in the research. Where requested by the patient, an AHLO, AHW or ACCHS staff member was present during the interview.

LHD staff interviews

Voluntary informed consent to take part in the interviews was sought from LHD staff by the interview team prior to the commencement of each interview. Interviews were held in a meeting room at the hospital where the staff member was employed, or via Teams. Interviews were audio-recorded with the participants' consent.

ACCHS staff focus groups and interviews

Voluntary informed consent to take part in interviews or focus groups was sought from ACCHS staff by the research team prior to the commencement of each interview or focus group, which were held at each of the four participating ACCHSs. Focus groups were audio recorded with the participants' consent. Where interviews or focus groups covered both hospital and maternity patient care, data has been included in this report where it relates to general patient experiences.

Data analysis

All focus groups and interviews were audio recorded, transcribed by a professional transcriber, and checked by the interviewer for errors. Confidentiality of collected information was strictly maintained. All records were saved using a unique study code. Raw data was saved on a secure drive, re-identifiable by the research team only. Identifiers were saved on a separate secure drive from the data itself to maintain data security. Data collected for the study will be destroyed 5 years post-publication.

A proportion of early transcripts were coded independently by two researchers (one Aboriginal). Emerging themes were shared with the wider group, which included Aboriginal researchers, to compare their preliminary coding and agree on a coding frame that captured the breadth of views and experiences in the data. Using NVivo, this coding frame was applied to further transcripts and revised iteratively in response to further data. The Aboriginal advisory committee reviewed early findings after 50% of data collection was complete.

Analysis and write-up followed the qualitative description approach (16, 17) which aims to represent data in a way that most stakeholders (participants, community members, clinicians and any others who know the phenomenon) would agree is accurate, i.e. descriptively valid, staying close to participants' direct experiences and summarising the data in participants' everyday language with minimal interpretation (16). This method is considered especially appropriate for research with minority groups where findings will be used to address healthcare barriers (18).

Findings

A total of 39 people were interviewed, comprised of 23 patients and 16 staff (three LHD and 13 ACCHS staff) (Appendix 1). Seventeen patients were interviewed face to face, and six by phone. All three LHD staff were interviewed individually. Eleven ACCHS staff were interviewed as part of four focus groups / in-depth interviews and two were interviewed separately. Participant characteristics are described in Appendix 1. Fourteen female and nine male patients participated, with ages ranging from 19 to 78 years. The interviews and focus groups were held between April 2022 and July 2023. The average duration of interviews was 46 minutes, and the average duration of focus groups was 75 minutes. In one case the interview was conducted with the daughter of the participant, as the participant was non-verbal. The terms 'patients' and 'participants' are used interchangeably throughout the report.

Participants spoke of their most recent hospital stay, but also often gave recounts of previous hospital stays which fell inside the study period of up to five years post-admission. Patients received care from one or more hospitals. **Patients spoke of their hospital journeys in their entirety: from existing held beliefs, to onset of illness, to arrival at hospital/Emergency Department (ED), time on the ward, discharge, and after care.** Patients described elements of care that made them feel *comfortable* and *respected* in hospital. The data also highlighted the critical importance of patients feeling *welcomed* and *supported* during their hospital stay and that these elements led to positive, *culturally safe*, hospital experiences that left patients *empowered* to manage their health into the future. The perceived quality of clinical care the patient received also played a significant role in overall hospital experiences.

From the analysis of the interview data, four themes emerged as the driving factors behind whether Aboriginal patients had positive, culturally safe hospital experiences, described as feeling welcomed, respected, comfortable, supported, and empowered during their hospital stay. These themes provide important insights into changes that can be made to improve hospital care for Aboriginal patients.

- **Pre-existing views about hospitals** - the range of views shaped by culture, family and friends, and previous healthcare experiences
- **People** – what, how and who matters. The key role of Aboriginal staff and communication in providing welcoming, supportive, and respectful, culturally safe care
- **Processes, practices and policies –** how the hospital system contributes to Aboriginal patients feeling comfortable, supported, and empowered as well as the affecting the quality of clinical care provided.
- **Places –** the environmental factors that impact how comfortable and supported Aboriginal patients and their families feel in hospital.

Pre-existing views about hospitals

Many patients noted that previous negative hospital experiences had resulted in them holding significant fear of hospitals. This included personal experiences, and the experiences of family, friends, and community members. These views ranged from perceived failures by hospital staff and systems that resulted in permanent injury or death, to experiences of racism and discrimination. Several participants noted that Aboriginal people historically believe that the hospital *'is where you go to die' (male hospital patient, LHD).* Negative experiences with government institutions outside of Health, (e.g., Police) were also often cited as a reason for institutional mistrust. This combination of historical and recent experiences created a lack of trust amongst many participants that their medical

concerns would be appropriately dealt with, or that they would be treated with respect and listened to during their stay. This view was particularly common in older patients.

> *Like [deidentified] Hospital, my uncle was 23, he went in there with really bad chest pain though and she goes yeah, you've got indigestion. Gave him a couple of antacid tablets. Walked down to the bus stop, heart attacked killed him. Twenty-three years old he was, and he died out the front of [deidentified] Hospital in the bus stop. Yeah, so I don't - I think sometimes they just don't listen.*
>
> *Female hospital patient, LHD*

> *I've already got a bit of a thing with the hospital. Family members here haven't had the best time. My mum was put in and they mocked and teased her…She got really sick. I ended up signing her out and taking her home because she was safer at home with me. She absolutely hated it. She does not come here for anything, even with [serious illness], she won't come here [the hospital] for anything. I thought she was being a bit thingy because she was having treatment and I come and sat in the room with her one day for about six hours or something, just to see. I thought maybe she was just thinking that way. Yeah, but it wasn't. It was just terrible, absolutely terrible.*
>
> *Female hospital patient, LHD*

Some staff participants re-iterated that patients, in particular older patients, are often impacted by previous negative experiences and trauma when dealing with government institutions and this fear regularly prevented Aboriginal patients from going to hospital. Staff noted that these patients often sought care from the local ACCHS, even when emergency care is required. Staff also highlighted that where hospitals are built on land where traumatic events at the hands of colonisers have occurred, or where they are named after people who have committed crimes against Aboriginal peoples (and therefore perpetuate historical trauma), Aboriginal patients are often unwilling to visit them.

> *It is that ingraining in your head that you - it's the same with when you go into a shop - you feel different. People might not think it, but you think it and it's just… [Look at] the security guard, he's watching me. Even when police are behind me, I still feel that…nervous. It's that I'm scared of, I know I'm not doing anything wrong. But I feel it. You see it in your older ones, your older patients.*
>
> *Staff, LHD*

> *It's just treatment of Aboriginal people and think – the issue that we face today is that we have …palliative care at [de-identified] Hospital, and Health continue to ask why Community won't utilise that space. Why our poor families won't go over there to die. [Too many] memories...*
>
> *Staff, ACCHS*

At the LHD level staff told of work that is being done to break down the barriers of institutional mistrust that exist.

> *Elders said to me, please don't do an assessment. Just go out there and sit with people and make the connection and develop the trust because you have to understand, Health [hospital system] were really vital in stealing our kids. So we want you to go out there, just talk to them and get to know the family and them. So that's what I've done.*

Staff, LHD

People – what, how and who matters

What - Covert racism and discrimination still exists

While participants felt there had been systemic improvements in cultural safety over time, they said that covert racism by individuals in the hospital system still existed.

> *I remember years ago when you're going into the bloody hospital you've got a lot just sitting there and staring at you…. what are you doing in here? This is not a bloody hospital for you ...But now a lot of them just turn and give you a nod and say hello, things like that.*
>
> *Male hospital patient, LHD*

> *It's changed but you still get your individuals. I think the setting has changed, there's more Aboriginal stuff around the place to go to, an Aboriginal room now you know where the health workers can meet you know and things like that, but you still going to get your individual person that's going to be racist.*
>
> *Female hospital patient, LHD.*

Several patients reported experiencing racism or discrimination during their hospital stay. Where it was experienced, patients often described **covert** racism in the form of **stereotyping, with assumptions being made regarding the use of drugs or alcohol, not being treated respectfully or not listened to.** Some described occasions where their non-Aboriginal partner was listened to more readily than themselves by hospital staff. Some participants noted that instances of racism and discrimination are more likely to occur when there are no other Aboriginal people around to witness it.

> *They wouldn't believe me that I didn't drink, and they kept asking, sorry (crying). Yeah, that I drank and whatever else. And I haven't drank for years and years... And it got to the stage that I said to my husband, you're going to have to tell them, because he's white. That was all the way through, so A and E and even up into the wards. And it was all the time.*
>
> *Female hospital patient, LHD*

> *I think they stereotype Aboriginals and I think that – it's horrible.*
>
> *Female hospital patient, LHD*

> *You have to be a Koori to experience it. How do I put this? They always do it so that there's no witnesses.*
>
> *Male hospital patient, LHD*

Others described **body language** of non-Aboriginal hospital workers as revealing how the staff members feel about them.

> *I'm a colour code, I have a feeling in my gut. You get the white man's bloody body language, and it tells you a story 10 times stronger than any words that come out of here [their mouth].*
>
> *Male hospital patient, LHD.*

Some participants reported feeling **inferior or ignored** or perceived that they did not receive care as readily as non-Aboriginal patients in the hospital at the same time.

I feel like every single person that wasn't Indigenous in that hospital or wasn't of colour, was treated straight away. The nurses were probably friendlier to them, than people who weren't, like, any other culture. I think that there was an Islander man as well. I feel like him and mum were the two worst ones. That weren't treated as quick. I would speak to his daughter as well. She would say they didn't treat him straight away as well. She felt like her dad was worse, because they didn't treat him as well.

Family member of hospital patient, LHD

I remember sitting there with an Aboriginal lady over there before and seeing how she got treated and they treated me different because they thought I was white. And we'd been in the same amount of time, same sort of things, she was like nearly in tears because nobody cared about her. I ended up saying something for her because she obviously is not the kind of person that's going to talk, like speak up to people. They're just left sitting longer. They're just not cared for the same way. Overall I just don't think they're getting the same care. Or maybe the nurses aren't equipped to care the same way. I don't know.

Female hospital patient, LHD

Several participants were undecided as to whether the perceived negative treatment they received was racially based or because staff were busy.

I don't feel different, but sometimes I think people treat you different. I'm proud of who I am. Sometimes I don't know whether it's paranoia, that you get paranoid that you're being treated different. I don't know because this last time it was. I know they were busy, they were hectic, but it was sort of like I felt I was inferior this time.

Female hospital patient, LHD

Some patients felt a **lack of awareness amongst non-Aboriginal hospital staff of Aboriginal culture** (including the role of family and community and perceptions and practices around death) and past trauma experienced by Aboriginal people led to the provision of culturally unsafe care.

I think a lot of medical professionals tend to treat us like we're some sort of machine, removed from our culture. They might not realise that many other cultures they don't do it that way. I guess the basic thing that I'm saying is that there is a monumental ignorance of medical staff about cultural difference.

Male hospital patient, LHD

I feel like when you're dealing with grief and loss, I feel there's no understanding about cultural respect. I mean it's not just this hospital... I think it's that lack of understanding about cultural respect and values and how we support one another in grief and loss.

Staff, ACCHS

Where experiences of **racism or discrimination** occurred, it impacted participants' overall stay in hospital and often future health seeking behaviour as well. Most commonly, patients would report an **unwillingness to return to the hospita**l where it occurred, and sometimes hospitals more broadly, resulting in the patient seeking care at other health providers (often local ACCHS) or going to a hospital further away to avoid the hospital where the incident occurred.

Aboriginal staff also reported instances of discrimination against Aboriginal patients, most commonly in the form of judgement and biases.

We have clients that go in there and they are looked upon as if, oh they're only looking for painkillers, or they're druggos

Staff, ACCHS

Staff participants supported the view of patients, that while there have been improvements over time, some individual staff members in the hospitals continue to be racist and felt that some smaller hospitals were less culturally safe. At times racial stereotyping was perceived to materially affect accurate clinical diagnoses and treatment.

> *We get so many patients from [de-identified] Hospital that really do not feel like they've been heard. So then when they come to [our hospital], they feel safe because they feel like they're being heard… one of our most recent, where they were treating her for alcohol withdrawal for five days, but really she had…encephalitis. Basically, we had to get the infection doctor to come in. Once he said, I don't think that she has alcohol withdrawal, the family broke down and they were crying and they - that was the first time that they had actually felt heard.*

Staff, LHD

Staff participants described strategies that are underway in their respective hospitals to improve cultural safety but also felt that more needed to be done. In one LHD, staff described the Aunty Jean's program, which is a community-orientated program to support Aboriginal people with/or at risk of chronic illness, run through the hospital. Clients already knew hospital staff before admission, and this improved their relationship with the hospital and made inroads towards decreasing hospital-related fear. This was particularly true for older people.

One insightful comment came from a ACCHS staff member, who suggested that a commitment to cultural safety needs to be top down and permeate through the whole organisation, and that any consultation processes should include Aboriginal people.

> *If you're privileged enough not to know what racism is, or you're blind to it, you do a cultural immersion, you open your eyes to it, you can't unsee it. It's up to you as an individual – not just day-to-day at work, it's in your life as well. It's an opportunity to open a door and walk the walk. That's the start of the journey that we've had – that's because you have someone like [de-identified senior hospital leader], who will sit alongside us, wants feedback, wants to improve services. I think at that high level, that there is that investment. Middle management, not as much, and then trickles down. Correct me if I'm wrong, but that's where I can see the difference. Also, for us, it's about the work that we do to make sure we're on every advisory, or make sure we have input. Making sure we hold people accountable. Giving back feedback to improve the outcomes for Aboriginal people. It's because of that investment. You can certainly see, if it was mandatory, it'd be different but at the moment you still only have to do respecting the difference online training, which is useless... You need to immerse yourself and really try to understand what it is like walking in our footsteps, so you can be aware of those biased assumptions.*

Staff, ACCHS

How – The way staff communicate with Aboriginal patients matters

Participants explained that the manner of communication by staff at the hospital significantly affected their hospital experiences. A key element of communication mentioned by participants in this study

was staff demeanour. Several patients noted feeling comfortable asking questions of hospital staff, while others reported feeling shy, and were hesitant to ask questions.

Where staff communicated in a manner that **was kind, friendly, and caring,** participants reported feeling **welcome, comfortable, and respected**.

> *They didn't treat you like a nobody. They came in and talked to you as if they knew you. They kind of got to know you. So they knew what was going on, if you know what I mean? They were like a friend.*
>
> *Female hospital patient, LHD*

> *Just very helpful... they were always coming in and asking if you needed another blanket and just if I asked for something, they get it. And just always coming in and asking if I needed a drink, if I was hungry, you know basic stuff, but just all the time. They were concerned because I wasn't really eating much. They were trying to make sure I was OK. And it wasn't like forcing either they was making me take my own time sort of thing, but just really checking up on me. Yes, it was good.*
>
> *Female hospital patient, LHD*

> *Every other time I've been in the hospital I've gone to the vascular ward, that's a brilliant ward the vascular. The most, how would you describe them? Caring people and looking after you. They didn't let you wait for anything or if you wanted a cup of tea they'd go and get you a cup of tea instead of you walking down there and getting it. But that vascular ward it's brilliant, a brilliant ward, I love going in there.*
>
> *Male hospital patient, LHD*

Participants also reported that when staff took the time to **explain things well, give clear directions and consultation, patients felt empowered to manage the next steps in their care pathway.**

> *The doctors, they kept me up to date and made sure I understood everything that was going on with my health. If I wasn't sure of it, I'd ask him again, and he'd always come back with an answer and give me the right answer and break it down to what was wrong with me.*
>
> *Male hospital patient, LHD*

> *The doctor explained it in layman's terms how she was going to do it, how she was going to [do the surgery] and no problem. Well when she done the job and my wife seen that she was very, very happy, she explained it in layman's terms.*
>
> *Male hospital patient, LHD*

> *The doctor was really good at kind of telling me – he said, okay, this is best. …You probably should go back to your doctor and have a chat. It could be a diet. It could be something else. Yeah, he was really helpful in giving me kind of feedback to the next path. He sat – he was really nice. Actually sat down and read all my charts to me and said, look, your levels are good. This is really good. This is really good. He was just really nice [laughs]*
>
> *Female hospital patient, LHD*

Participants also valued when staff made efforts to check they were comfortable and **took the time to sit and chat with them**. Patients noted appreciating when staff **followed up**, including information sharing with other relevant providers in the health care pathway (general practitioners, chemists, other

specialists). Some also described feeling confident in their care if they were known to hospital staff and were recognised at the hospital.

> *Well, when I finally got up to the ward it was good because they've got a new doctor now for old people. They've got a geriatrician, a special doctor, and he's got a real good way about him, he does – he's only very young… he's very nice to talk to and he explains everything. Oh, he's beautiful... His whole team… Because you know how you've got the main doctor and they bring in, they might have three or four young'uns that trail in behind them when they're coming around doing the rounds, yeah him and the whole team. They'd already let the chemist know though, so the chemist was looking after that side, they'd already faxed everything they had to through to my chemist.*
>
> *Female hospital patient, LHD*

Where patients received communication that was perceived to be **rushed, uncaring, or not well explained** (either not enough information or too much jargon), they felt powerless, undervalued, disrespected, and ashamed to ask questions.

> *Because I kept asking him, what's that for? You get the answer, but it still doesn't - I don't understand how they talk*.
>
> *Female hospital patient, LHD.*

> *But in the end, it ended up being the growth… which they didn't tell me about for - I was in there for five days and I didn't know there was a growth in there until they told me that I had to have surgery. And I said, well, what am I having surgery for? They said, oh, you've got a growth in there, didn't they tell you? No, you didn't tell me.*
>
> *Female hospital patient, LHD*

> *The last visit I had with my chest pain at [de-identified] Hospital, I wasn't keen on the nurses, they were just hurry up, get in and out sort of thing and check you and that, and if you had to ask a question they didn't want to answer you, just oh, I don't know, you'd have to - well, you know. Okay, all right then, no worries.*
>
> *Female hospital patient, LHD*

When participants felt ignored or not listened to, patient experiences were also compromised. Participants reported instances where staff delivered information **without tact and empathy,** or where they felt staff considered them a hassle **resulting in the patient feeling anxious and hesitant to return to the hospital**.

> *One nurse snapped and she said, you're only here waiting for a bed anyway... It was the way she looked at me and spoke as if you're in transit and you're not supposed to be getting fed, well how long are you going to keep me in transit for, three days and then feed me?*
>
> *Female hospital patient, LHD*

Several participants reported **mixed experiences** during and across their hospital stay/s, perceiving that some staff communicated with them well and others poorly.

> *I felt safe in the hospital. I felt cared for by the nurses. They were brilliant. If that doctor wasn't there, it would have been not a bad stay. It would have been all right. It would have been good. It was only that doctor out of the whole lot.*

Female hospital patient, LHD.

A few participants expressed frustration at needing to **re-tell their health story**, feeling **disrespected**, perceiving that the staff member hadn't taken the time to read their patient record, and feeling like they were not being listened to.

Several participants also thought **more rigorous cultural awareness training was needed for non-Aboriginal staff** to be more culturally aware, have greater cultural sensitivity, and understanding of Aboriginal culture and practices, especially around death and dying.

> *All their staff, I think they need to be put through that [cultural immersion] because it's like our schools, we've got teachers that have no idea what happened to our people. When I go in and talk about all this stuff and the Stolen Generation and the referendum and all these sorts of things, we had no rights, all that, the teachers are like, wow, we didn't know this.*

Female hospital patient, LHD

Who – Aboriginal staff are important for cultural safety

Having Aboriginal staff at the hospitals was considered to be the most important factor in ensuring cultural safety for Aboriginal patients. All patients, whether they had a good, average, or poor experience, felt Aboriginal staff were key to a culturally safe hospital experience. There were several reasons patients gave when articulating why having Aboriginal staff in the hospital provided them with a positive, culturally safe experiences.

Patients appreciated that the Aboriginal staff recognised them and **really took the time to listen**. Participants also described **trusting** Aboriginal staff, finding them more attentive, and feeling more comfortable to speak with them about their concerns. Participants expressed that having that person checking on them and there to listen and talk to them **improved their hospital stay**, and in some cases their **health outcomes**. Several participants expressed how they felt **safer** when receiving care by Aboriginal nurses or doctors, with many expressing a desire to see more Aboriginal nurses or doctors in NSW public hospitals.

For Aboriginal people, it's important to see that face, just to know that that face is going to be there

Female hospital patient, LHD.

I think that the [Aboriginal] nurse listened to me in a different way from any other nurse might have done

Male hospital patient, LHD.

I honestly only feel comfortable and safe when the Aboriginal health workers visit, that's my chance to feel – let them know how I'm going or whatever. I wouldn't really talk to other people

Female hospital patient, LHD.

> *I prefer Koori background, so that they can understand some of the problems that occur with the system… the system seems to generate a tendency of breaking up family relationships. It's so important for the Koori civilisation to have their own relations come and visit them.*

Male hospital patient, LHD

> *I mean it was nice to see one bloke pass who was the Indigenous person. He stopped and looked at me and he said, how are you going aunt? How long you been waiting? Well that felt*

all nice. It was the nicest thing someone could say to me…That's another thing too, recognising your own people. Even though I didn't have an identity thing on me, he knew straight away who we are. You can be taken for anybody else, but our people seem to know who we really are.

Female hospital patient, LHD

Then a young Aboriginal nurse came into the ward and my whole situation changed because she was bright and interested. I mean she made the big difference because she'd come in, she'd be happy, nothing was too much trouble. If I was struggling with something she'd say, I got that, I got that. Yeah, she was amazing. She made all the difference in my recovery in the hospital then.

Female hospital patient, LHD

Patients also spoke of the **important role AHLOs played** in supporting them during their time in hospital. AHLOs were perceived as providing **culturally specific support** which helped **overcome fear and loneliness.** Patients noted that AHLOs gave them much needed support during and after their hospital stay, through **assisting with communication**, advocating for their needs and providing logistical support. In some locations post-discharge care was also provided by the AHLOs.

I think it's hard when you explain to our Elders what you've got to do because they get scared, especially our Elders. Aunty [de-identified] gets terrified when the doctors tell her that she's got to have a test or something done… they need to have an Aboriginal person with them when they do it, I'm sorry, I reckon. I think having someone there, your own mob, it sort of makes you feel a bit more comfortable because they have that understanding of our culture and our people as well. I really do think you need that, an Aboriginal person there when they're explained to.

Female hospital patient, LHD

I thought I was listening, but I wasn't listening. It is really, I believe, beneficial to have someone with you asking the other questions that you don't think of cause you're emotionally affected. When it's yourself sitting there, you're not thinking the same, and it's just a different line of thinking that you're going down. It's so narrow, where that person with you is looking outside those blinkers.

Female hospital patient, LHD

Staff participants also noted that some patients do not get access to AHLOs due to their limited numbers. Patients may feel disappointed and frustrated when they don't receive a visit from the AHLO, particularly if there were issues that they felt were not being addressed at the hospital.

There are times when Aboriginal people have asked staff to get the ALO to come down and it hasn't happened and people get very disappointed, I guess, because they have an issue that they wanted to be addressed and it doesn't happen... I know there's only one AHLO at [de-identified] Hospital and that's a horrendously big hospital.

Staff, LHD

Several patients perceived that the current AHLOs are stretched with often only one or two positions at each large hospital, along with substantial periods where AHLO positions are unfilled. They also reported the need for AHLOs to be available **all hours**, with many Aboriginal people attending hospital at night-time, and **across all parts of the hospital**, from ED triage, up to the wards, and on all floors.

Processes, practices and policies

Staffing and bed numbers

Many participants described situations where they felt that **understaffing** and **limited numbers of beds** had resulted in lengthy wait times (e.g. on admission and waiting for discharge), patients feeling unwelcome, including feelings of being shuffled and discharged too early.

> *I just think nurses are rushed, that's why I think they rush around and - I don't think they mean to do it… but I think they're just too busy so they're rushing and that's why they hurt you, like they're in such a hurry they've got to get from patient to patient. They're overworked, I understand that, and I think they're tired because they work long hours too.*
>
> *Female hospital patient, LHD*

Patients reported instances of long wait times; including excessive ED wait times during which time no food or drinks were provided. These long waits led patients to want to **leave the hospital without obtaining care and others reported not wanting to return to the hospital, even when they needed to.**

> *I'd been in there for five hours or six hours or something… I was frustrated at this point [laughs] and I was like I'm just going to go, because it was all a bit too much*
>
> *Female hospital patient, LHD.*

> *Every hour they kept checking on me and checking blood pressure and all that. But every time they said, oh, it shouldn't be too long, shouldn't be too long, [every hour], but that hour went to 17 hours. I didn't get a bed till then, and that was pretty pathetic, I thought. I was tired, and I couldn't sleep. I couldn't sleep on the floor, I ended up falling asleep on the chairs… I was stressed and cranky. It was a long time to wait… I was lucky I had company, otherwise, I would have went.*
>
> *Male hospital patient, LHD*

> *But you know what, sometimes I've had chest pain, I can't be bothered going to the hospital because I think I'll just sit there and wait for hours, you know what I mean, and I just don't go.*
>
> *Female hospital patient, LHD*

> *One of our [Aboriginal] community going in there, walking into a packed waiting room where there's so many people in there, they're not going to wait… They'll just walk out. They won't even bother. They'd rather go home and be really, really, really sick and just deal with whatever happens however they can.*
>
> *Staff, ACCHS*

> *We might send them in from home, but they might go in to the emergency department and they [ED staff] are trying to send them home the same day even though they're really sick because they don't have capacity. They don't have the beds and then people complain, I laid in the emergency department for six days like and nobody did nothing for me.*
>
> *Staff, LHD*

Some participants suggested that **staffing levels and lack of beds resulted in mistakes**, poorer quality of care, life-long disability and even death. At one site it was suggested that patients, especially Aboriginal patients as they are less likely to voice their concerns, were regularly being ignored.

> *They might go in to the emergency department and they're trying to send them home the same day even though they're really sick because they don't have capacity… I believe that it's because of lack of resources in the hospital system. I really believe that. They're just after beds all the time because you go in to emergency department and every single bit of equipment, like chair, whatever, everything is always taken with somebody and they're all waiting for a bed to go up. There's just no way to do it. I know it's a new hospital and they've got more beds but they're full.*
>
> *Staff, LHD*

Some patients reported that there were **insufficient numbers of Aboriginal staff**.

> *I just don't think there's enough support there and they have no one after hours, no Aboriginal worker after hours, which I think is really important for our people*
>
> *Female hospital patient, LHD.*

> *I reckon they need more Aboriginal health workers to work shift work at night. Because I know that there's Indigenous people in this community that go to the hospital after hours, at night, and there's just no support there for Indigenous people. It's mainly just non-Indigenous nurses and stuff. I reckon they need Aboriginal health workers, and they need more Aboriginal nurses just to work down in that section [ED]. It needs to be 24/7, half the night, they haven't got that support, and they've got no family in town. They've got no contact till in the morning, till the health worker comes around. Their phone can be flat from sitting there all day, then they've got no communication to their families. But they might need that support at night too.*
>
> *Male hospital patient, LHD*

Patients and staff also discussed the **need for the hospital and other staff to support, respect and consult with Aboriginal staff** so that they stay in the hospital system. Some participants noted the high burnout of AHLOs and AHWs due to the **heavy workload**. Some AHLOs noted the need for **additional training** due the broad scope of care they are required to provide.

> *Even now it's like, sometimes we get asked when we go into a room, who are you? Where are you from? We all have that New South Wales logo on, but we are kind of are on edge straight away. It is how they make you feel sometimes. They make you feel like you're not even a health professional yourself.*
>
> *Staff, LHD*

> *[Previous Aboriginal health worker] goes you've seen how many times I was abused at the community working base meeting. It's me on my own doing all the hospitals. She goes you can't do it; she goes it's impossible, she goes I burnt out, that's why I got out.*
>
> *Female hospital patient, LHD*

A few staff participants discussed instances where hospital staff had sought out the assistance of the AHLO. This was seen as positive, as they were proactively taking steps to understand the needs of Aboriginal patients in order to provide them the best possible care.

It's really good when people come to us and ask for help. Like today, we had a doctor that come in from ED. It's like, thank you for actually asking us how you can deal with your patients better. He was actually the first doctor since I've been here that has gone out of his way to meet with us to have that conversation.

Staff, LHD

Another perceived benefit of more Aboriginal staff included **teaching non-Aboriginal staff** about Aboriginal culture.

See the other nurses would see the Aboriginal nurses and they'd intertwine and talk and they wouldn't be just doing white people and Aboriginal people, they'd be doing both lots and be intertwining. The white nurses can be learning [off the] Aboriginal nurses and vice versa. I think it'd be a very, very good idea because of the way they'd meet and greet and work together.

Male hospital patient, LHD

Clinical care practices

In line with the recruitment strategy for the study, participants reported varying levels of satisfaction with the clinical care they received during their hospital stay. Many participants reported that the **overall clinical care they received was good**, even if they had concerns with other aspects of their stay.

Well, I felt that they were looking after me. I got good care even though those kind of operations, they leave you in lots of pain and stuff, but I did feel I had good care

Female hospital patient, LHD.

Brilliant - brilliant, yeah. You only had to ask or anything, they saw that I was struggling, they come so - because I was like - being in that glass room, they just look at me and they could tell and they'd walk straight in so that was good.

Female hospital patient, LHD

Some participants reported experiencing significant physical pain that they felt could have been avoided. This was perceived to be because of **mistakes in their care and miscommunication** across the clinical care team, or significant delays in receiving care or treatment. Patients who reported these experiences felt less satisfied with their clinical care, with some reporting very poor outcomes from the care provided. Where perceived poor clinical care was received, this impacted patients' willingness to present to that hospital in the future.

I got really angry because they had to put [de-identified medication] into my body and that was through the cannula. They just put it in and walked away. It's absolutely excruciating, I couldn't stand it, I was screaming, pressing the buzzer, yelling, and they finally come back and whipped it out. And they said, oh yeah, sorry, I forgot to tell you that it's painful on that speed, so we'll slow the speed down. Then walked away again. Four times they did it and I just told them, I'm not doing it anymore. And I felt like they just didn't care.

Female hospital patient, LHD

[After the ED team sent me home the night before] the Doctor rung me first thing in the morning, and I said to him… I'm so unwell. That's when he said, why did you go home? We hadn't even got your results back, your bloods are out. I said, because I was sent home. They just couldn't work out what was wrong with me, and they couldn't get my blood pressure back up. Ended up being [de-identified medical condition]. So, it wasn't a very nice experience.

Female hospital patient, LHD

Visitor policies

Many of the study participants had their hospital stay in 2020-2021 and were therefore impacted by visitor restrictions to control the spread of COVID-19. Some participants relayed stories of **isolation,** missing their family and the support they provided during their hospital stays due to visitor policies.

I was a bit emotional. It was just hard. And during COVID, you just want people to be there like your family. But it was just hard because of the restrictions

Female hospital patient, LHD.

Some participants highlighted the need to support patients who are feeling isolated to communicate with families.

They should be able to... set something up, … even like FaceTime or something... because…not many people go in there that have credit or phones and stuff… especially like elderly people… And in the COVID ward, like they will not let you out them doors. No one can come in and it's just it's pretty hard and it is sad. You sit in there and you just looking at four walls and you don't know what to do. Looking at the window, you just wish you can go home.

Female hospital patient, LHD

Others highlighted the importance of **large kinship networks** that are significant in Aboriginal culture and the lives of Aboriginal people. These larger kinship networks mean that there may be more people wanting to visit, particularly if there is **sorry business**, and some participants felt that these larger groups of visitors were not welcomed or accommodated by hospital visitor policies.

Being in a regional hospital, I don't think that's good enough. People travel here and all that, and especially when they have restrictions… Aboriginal people have so many family members that want to go and visit and can't do any of that. It's really hard.

Female hospital patient, LHD.

Some patients stressed the importance of support people from their ACCHS to their hospital experience. The local ACCHSs sometimes have a staff member who attends with clients, Elders in particular. One participant told of how her support person was asked to 'move away' and how upset this made her feel.

My dear friend [de-identified], she comes to support Elders like ourselves in these places, they don't like to leave us. Then she stayed all the way through to quarter to five in the afternoon. She was told by a lady that worked there, I don't think she was a nurse, I think she worked on the window [triage]… she was told, could you please move away from this area and go and sit down in the waiting room, this lady [de-identified] was shocked… We don't like to see someone treat our people like that …being embarrassed… for something they didn't do wrong.

Female hospital patient, LHD

Discharge processes

Discharge experiences were variable across participants. Where the discharge process provided **adequate information** upon discharge, patients felt empowered to manage their care at home**. Follow-up care was highly valued** but not always provided. For example, having a contact number to call once they are home, having a staff member contact them post-discharge, or technology to support ongoing healthcare. Some staff participants told us of processes and practices they had put in place to improve the discharge process for Aboriginal patients.

> *Yeah, they sent me home with medications and I was on like a health care [plan] where they would call me every day and just check up and you had to do my stats at home. Once I was discharged and I just told them that I wasn't coping, and then they set up a Zoom call with one of my ..., specialists and stuff, and they admitted me again straight away. So it was good.*
>
> *Female hospital patient, LHD*

> *Then I found that a lot of [Aboriginal] people were going home really sick and needed to have some help. So I got permission to start following up on the discharged clients from hospital. So I've continued it ever since and I do that.*
>
> *Staff, LHD*

When the next steps were not explained well in the discharge process, or where follow up care was not coordinated patients felt less confident about managing their care once they were home.

> *They did give me a discharge summary, but they don't explain it to me and I can't read it*
>
> *Male hospital patient, LHD.*

> *When we got home from the hospital, we had no assistance at all. We were just left on our own. We didn't get to see a speech or a physio or anything for a few weeks when mum got home.*
> *Relative of female hospital patient, LHD*

Some patients felt **pushed out too soon** or without receiving adequate treatment**.**

> *I thought it was a bit, I don't know what would you say? Pushy, to get me out the bed… Then they're wheeling me out, get down to the car and the wife in the car, I still got the bloody thing in my arm [the cannula].*
>
> *Male hospital patient, LHD*

> *They don't seem to treat them. We had a gentleman who is very precious to us here and we wouldn't have sent him to hospital if we didn't have to. They kept discharging him. He had a sodium of 120 [severe hyponatremia].*
>
> *Staff, ACCHS*

> *I feel like they always want to get you in and out… When I had my heart surgery I stayed in one night or two nights, they couldn't wait to get rid of me then either. Am I that bad? I don't whinge or complain.*
>
> *Female hospital patient, LHD*

Others reported what they considered **delays in discharge processes**.

> *I was sitting there until four o'clock, and then on top of that you've got to wait, once the doctor has seen you, then you've got to wait for the meds, so, it's just ongoing.*

Female hospital patient, LHD.

A small number of participants discussed wanting to **discharge themselves early, or actually discharging against medical advice**.

> *I actually discharged myself from the hospital … I had to argue with them to get out, I hate hospitals … I couldn't see the sense of just lying there different from lying at home*
>
> *Female hospital patient, LHD*

Participants were asked about **transport** to go home after discharge, and arrangements at home. Most participants told us they were picked up by family, and in some cases, ACCHSs were assisting with transport home from hospital.

Some participants said that they felt a service was needed for those that do not have any family to collect them, and potentially an AHLO to support discharge, especially in the early hours of the morning.

> *I've heard a lot of Elders over the years complaining about [deidentified] Hospital and them being released in early hours of the morning, and not being even - the people don't even make sure that they've got someone to come pick them up. So if they were being released from the ward at one o'clock in the morning, if there was an Aboriginal face there, they would be asking them, hey, uncle, have you got someone at home?*
>
> *Female hospital patient, LHD*

Many participants received their usual primary care from the local ACCHS. Many reported that information was not being provided readily back to the ACCHS to support ongoing care. Others reported specialists not receiving referrals from their hospital visits, subsequently delaying further treatment. Several ACCHS staff also highlighted the need for improved information to be provided back to the ACCHS so they could provide continuity of care. Some called for a more automated system that would see information flowing back to the ACCHS where patients identified as an ACCHS client.

> *Unfortunately, there doesn't seem to be very much discharge planning done from hospitals anymore. Years ago, they'd have discharge planners that had to refer people to appropriate services and programs but that doesn't appear to happen very often now. People are referred for wounds but when you get to chronic illnesses and people who have got cancer or who are palliative, it doesn't seem to happen that often.*
>
> *Staff, LHD*

> *She said, we haven't received it yet. I ring here [the hospital] and I say, Dr [de-identified] wrote a report referral for me for Dr [de-identified] in Sydney. I said, can you check it's been sent? She's like, I'll have a look. She come back and she said, no, it's still here. This is why he didn't ring me when he was supposed to, when he said he would. I said, look, send it now because everything depends on this referral.*
>
> *Female hospital patient, LHD*

> *I think there could be improvement. Because we probably don't know anything about the client for up to 48 hours. Sometimes it's a phone call from the client needing to come in to get medication and then when we look in their file, they've got a GPMP [General Practitioner Medical Plan]. Care plans are out of date, like how is there any - it's like get them in, get them*

out. Like we don't want to deal with them, we'll just release them over to [de-identified ACCHS], but how are we supposed to care for that client when they've done all the care during their stay, and we've got no handover.

Staff, ACCHS

At times we're even calling the wards, finding out how patients are going, figuring out a rough estimate of when they could be getting discharged, because we do not receive discharge summaries. It is rare. It is very rare that we received discharge summaries. Yet they give us a massive list of things that we must be following up on.

Staff, ACCHS

Feedback and consultation processes

Participants described their experiences with various feedback and consultation processes related to their hospital stays. Feedback mechanisms included hospital patient surveys, verbal feedback, complaints processes through letters, online forms or emails. Consultation processes included consultation with Boards, advisory groups and consultations sessions.

Some study participants reported receiving the hospital patient survey to complete and some did not. Most participants did not value surveys as a way of providing feedback; some felt that the surveys are '*too time consuming. You're not well anyhow, you're not 100 percent' (Female hospital patient, LHD).* A few participants noted that many Elders cannot read and write so a **written survey was not appropriate** for them. One person reported finding the survey text prompts a nuisance. The **preference for most was to give verbal feedback to a trusted Aboriginal person** (AHW, AHLO). Several participants felt that the interview process in this study had been cathartic for them, particularly if they had a negative experience, they were able to 'get it off their chest'.

Some participants discussed a reluctance to question or criticise any actions of hospital staff, expecting they would have a mark next to their name and be penalised with poorer care in the future.

They keep quiet, they think oh what's the point in causing a problem here? Because you don't know whether you're going to get black-banned

Male hospital patient, LHD

Like back how they used to be treated, back in the days. We get a lot of people that won't put … through complaints because they think that there's going to be backlash or repercussions on what they've spoken up about. When we say, no, we need to let the nursing staff know that they didn't whatever. They don't want us to say anything. It's the same old thing, never question authority.

Staff, LHD

A few participants shared stories where they had written letters of complaint following perceived poor treatment, which had been followed up with apologies from departments in most cases. Some younger patients reported using webforms and email to submit complaints, which in many cases had resulted in contact from the relevant bodies.

I sent it in, and it went to the hospital manager of the hospital, that's where all the complaints go. I was lucky they actually looked at it, and then the director for the …Care Centre actually rang me and apologised that I had that experience.

Female hospital patient, LHD

Participants noted **increased consultation** with the Aboriginal community, via Boards, advisory groups and consultation sessions, which they appreciated and felt were driving improvements in hospital care for Aboriginal patients.

> *I think some of the changes maybe where I see improvement is I also sit on the [de-identified] Hospital advisory committee. So that was new, and I think I see that as an improvement that they're actually consulting with us about things that happen in the hospital or anything that happens within health. So that's a big improvement for me.*

Female hospital patient, LHD

Places

Participants expressed the importance of having a **cultural room**, where family can meet in larger numbers, make food and be present for sick family members. Such a room provides privacy and an opportunity to connect with other Aboriginal people which can build strength during difficult times.

> *I come from a big family, and when our father was in hospital sick, then we all converged on [de-identified] Hospital, and we were everywhere. He had [a big family]. We were all there because he was very sick, we didn't know - he was critical and we didn't know if he was going to pull through, but we were all there. We were laying around the hospital wherever we could get a seat or that kind of stuff because that's just the way most Aboriginal families are… We've been advocating for that with this new [de-identified] Hospital to get family room and stuff like that.*

Female hospital patient, LHD

> *Being in a cultural space it makes you feel more at home. It's like when I was at the university, if I was having a bad day and I'd go for a walk and run into another Aboriginal on campus, it used to just give me that – I don't know, it builds up your strength a bit, and I think – well that's how I always find it.*

Female hospital patient, LHD

Patients reported that two of the included hospitals had designated cultural rooms. One had a cultural room located on an upper level and required special access to be provided. This was considered difficult when the AHLO was not on shift. One cultural room was included in a new hospital build and was located on the ground floor. At the time of data collection, artwork had recently been installed so the room could be easily found. Participants felt there needed to be some more promotion of it, to ensure that everyone knew that it was there for use and the process for accessing it.

> *I've even heard people say to me, oh, they're not very friendly when you go to that room either…I think the AHLO sits in there, but… he doesn't work 24/7. So if he's not there, I don't know how people get access to the room. I think they've got to go on and ask somebody... I don't know who they have to talk to about getting into there. But yeah, I have heard some people say it wasn't easy.. It's not accessible. It should have been something that maybe was on the ground floor.*

Female hospital patient, LHD

They've got a spot there where families can go outside and sit down, they've got a barbeque there, if they've got someone really sick in [de-identified] hospital, that's where they can go. Because they're the ones saying we're don't want to be getting stared at from standing around outside. So, they've got something for the Kooris.

Male hospital patient, LHD

Some participants suggested that **Aboriginal artwork** in the hospital made them feel more welcome and others mentioned the need for spaces to be warmer (less clinical looking). In some cases, local Indigenous artwork was particularly valued.

For me it makes a big difference, but I've always believed that if you're going to display any kind of artwork, then you should really make sure you've got it from the local artist. So it's very important for me that when I look at that artwork and I always look, doesn't matter where I am, I always look to see what the name is…Because it's part of my community…It's important for me because it makes me feel a little bit safer because that artwork's there and my community has actually put it there or consented to have their artwork there.

Female hospital patient, LHD

Discussion

This qualitative study is the first study to provide rich insights into the lived experiences of Aboriginal people receiving inpatient care across multiple NSW public hospitals. It has documented a wide range of positive and negative experiences and key contextual factors that make a difference to Aboriginal peoples' experiences of care while in hospital. Findings from this study are largely consistent with quantitative BHI survey findings and the small number of existing qualitative studies conducted in Australia, which have documented similar areas of concern and priority for Aboriginal people.

Many participants in this study had experienced previous negative or traumatic encounters, including racism or discrimination. This was in the hospital system or when dealing with government departments, either personally or through a family member, resulting in a fear of the hospital system. Historical instances of racism towards the Aboriginal community also continued to negatively influence the view Aboriginal patients have of hospitals, particularly for older patients. This finding is consistent with other studies, where Aboriginal patients have reported lack of trust based on past experiences (19, 20). Data from this study suggest that while there have been improvements over time, covert racism still exists. Hospital staff and how they interact and communicate with Aboriginal patients had the biggest impact on patient experiences. Access to support from Aboriginal staff was also said to play a key role in improving cultural safety. Resourcing constraints were thought to be driving long waits and rushed interactions with hospital staff. This was also reported to contribute to instances of perceived premature discharge. Improved communication with primary care providers was considered important for continuity of care post-discharge. Study participants identified several priority areas to improve Aboriginal hospital patient experience, which are listed in the recommendations below.

Study strengths and limitations

The study has several strengths. It adopted an Indigenist research approach, was led and conducted by Aboriginal researchers, used culturally appropriate yarning methodology, was guided by an

advisory committee with strong representation from senior Aboriginal stakeholders, and privileged Aboriginal voices throughout. An Indigenist research approach can improve both the quality of data collected and the relevance and utility of its findings (21). Rigorous research methods were used; interviews were recorded and transcribed verbatim, data were analysed systematically using an appropriate approach, and findings were reported transparently, with extensive inclusion of quote data to substantiate thematic findings. Maximum variation sampling ensured that the experiences of people from a range of geographic locations, ages, genders, and perspectives were heard. It enabled the documentation of negative experiences of care and provided examples of what good practice looks like. While the purpose of qualitative research is not to answer questions of prevalence or generalisability, the BHI state-wide NSW Patient Survey Program has established significant quantitative differences in the experiences of public hospital care for Aboriginal and non-Aboriginal patients (7). The findings in the current qualitative study complement and contextualise these findings and hold learnings to inform improvement. A limitation of the study was that many of the study participants had their hospital stay in 2020-2021 and were therefore impacted by visitor restrictions to control the spread of COVID-19, creating a different hospital experience to that of those outside of the COVID-19 restrictions.

Proposed recommendations

1. **Strengthen efforts to address racism and unconscious bias, with a zero-tolerance approach to racism. This may include creating accountability in the system for racism, teaching and celebrating allyship, ensuring cultural safety is built in to how NSW Health does business and enhancing "respecting the difference" training for NSW Health staff to include cultural immersion programs and decolonisation training to support the delivery of culturally responsive care.**
2. **Review policies, procedures and systems for measuring, reporting and addressing racism.**
3. **Expand Aboriginal Health roles in hospitals across all LHDs to support care coordination from hospitals back into the community**
4. **Ensure culturally safe policies and environments which enable and support families attending hospitals are developed, implemented and monitored**
5. **Ensure provision of cultural rooms and spaces that are accessible to Aboriginal patients and their visitors, and ensure usage guidelines are adequately communicated to encourage their use**
6. **Continue to improve communication with primary care providers and discharge planning to improve continuity of care for Aboriginal patients, including pragmatic considerations such as transport home**

Recommendation 1: Strengthen efforts to address racism and unconscious bias, with a zero-tolerance approach to racism. This may include creating accountability in the system for racism, teaching and celebrating allyship, ensuring cultural safety is built in to how NSW Health does business, and enhancing "respecting the difference" training for NSW Health staff to include cultural immersion programs and decolonisation training to support the delivery of culturally responsive care.

Racism and negative experiences during hospitalisation were consistently communicated throughout study by Aboriginal participants. This was compounded by historical experiences and trauma of family and community members, which creates a collective mistrust in the health system.

Addressing racism and unconscious bias is important to build trust with Aboriginal people, and to build capabilities in staff to provide culturally appropriate care.

The interactions with staff in the hospital played the largest role in whether Aboriginal patients had a culturally safe experience in hospital. Patients and staff reported that while there have been improvements over time towards eliminating overt racism, covert or subtle racism still existed among individual staff in the hospital system. This was generally in the form of making assumptions (particularly around drug and alcohol use), stereotyping, or ignoring Aboriginal patients. Several patients reported that non-Aboriginal staff did not understand their cultural needs. Quantitative data collected in the Adult Admitted Patient Survey supports this finding, with lower ratings from Aboriginal compared with non-Aboriginal patients admitted to hospital for questions asking whether they were treated with respect and dignity, and whether their cultural beliefs were respected (7).

While cultural awareness training is available for all staff, additional ways to support non-Aboriginal staff's understanding of the cultural needs of Aboriginal people and communities is imperative. For example, a cultural immersion course to break down unconscious biases, ensure respectful and compassionate communication, and understanding of the cultural needs of Aboriginal patients. The training should provide education around previous trauma and the **importance of building relationships** to establish trust with Aboriginal patients.

Recommendation 2: Review policies, procedures and systems for measuring, reporting and addressing racism.

Participants in this study noted a preference to provide verbal feedback on their hospital experiences (rather than via an online or printed survey) to a trusted person, like an Aboriginal staff member. They also suggested the length of the survey, literacy issues and still being in recovery from their hospital stay prevent people from filling hospital surveys. This finding is supported by BHI data that shows a 17% response rate among Aboriginal patients (7).

Strengthened mechanisms that support Aboriginal people to provide feedback on their care may include ways to provide verbal feedback. Feedback may include any experiences of racism. Improving these mechanisms will ensure that experiences are heard, acted on, and lead to improved experiences for Aboriginal people. Further measures should be developed that report on institutional racism within the health system and measure access by First Nations people to culturally safe health services (22).

Recommendation 3: Expand Aboriginal Health roles in hospitals across all LHDs to support care coordination from hospitals back into the community

Aboriginal staff were overwhelmingly considered key to cultural safety and improved communication in the hospital for Aboriginal patients. AHLOs were highly valued by Aboriginal patients but were thought to be overstretched in some locations. AHLOs are typically only rostered during business hours, so cultural safety was deemed to be reduced after hours. Aboriginal nurses and doctors were also considered extremely valuable. This sentiment was reflected in work by Worrall-Cater et al, which highlighted the important role AHLOs play in the care of Aboriginal patients in hospital, with their connection to communities, understanding of culture, and the provision of follow up care (9). The 2021 BHI report 'Aboriginal people's experiences of hospital care', reiterated that Aboriginal patients who had the support of an Aboriginal Health Worker in hospital were more likely to give a 'very good'

overall rating of care and were more likely to report being able to speak to doctors and nurses when needed (7).

Further exploring ways to support the recruitment and retention of additional Aboriginal staff is vital. For example, through improving support for AHLOs and increased training pathways for doctors, nurses, allied health professionals and AHLOs

Good communication with primary care providers was seen as critical to allow the patient to manage their health condition on discharge, however this was often not occurring. Follow up by AHLOs was noted to be occurring at one LHD and this was seen as beneficial by patients.

Findings from this study suggest further investigation is needed into how the information exchange between the hospital and ACCHSs can be improved.

Recommendation 4: Ensure culturally safe policies and environments which enable and support families attending hospitals are developed, implemented and monitored

Support from family and friends is important for Aboriginal people in hospital, helping to address feelings of alienation, anxiety and to act as advocates for patients where required. Practical considerations such as visiting hours, space to accommodate larger groups of family and friends at the bedside or elsewhere on the ward were considered important to improving patient experience for Aboriginal people.

Recommendation 5: Ensure provision of cultural rooms and spaces that are accessible to Aboriginal patients and their visitors, and ensure usage guidelines are adequately communicated to encourage their use

A cultural room for family members to congregate at hospital was considered important. Other studies have confirmed the need for a space that is appropriate for Aboriginal families (9). While a number of the hospitals in our study did have a cultural room, some patients did not know that they existed, where the room was located, or how to access the room.

Recommendation 6: Continue to improve communication with primary care providers and discharge planning to improve continuity of care for Aboriginal patients, including pragmatic considerations such as transport home

An Aboriginal patients experience and outcomes doesn't end when they leave the hospital. It's vital that patients receive continuity of care through effective care transfers from tertiary to primary and secondary health sectors. Improvements in this area should be aimed at reducing re-hospitalisations, improved disease management and reduced recovery time (23). Transport home was also identified as an important factor and this should be considered as part of the transfer of care from the hospital to the home.

Conclusion

Participants in this study reported feeling that Aboriginal people's experiences of hospital care have generally improved overall in recent years. Aboriginal people admitted in NSW hospitals, however, still reported many negative experiences of care that had impacts on their health, wellbeing, and future willingness to engage with the health system. Systemic challenges such as covert racism and other factors including long wait times from admission through to discharge, rushed or compromised interactions with staff, a lack of access to Aboriginal staff, and breakdowns in communication with

hospital and primary care that impact patient experience and cultural safety were reported. Aboriginal patients described culturally safe care as feeling welcomed, respected, comfortable, supported and empowered. Six recommendations were proposed to improve the experience of culturally safe care for Aboriginal patients in NSW hospitals centring around efforts to minimise and respond to racism, fostering good staff interpersonal and clinical skills, improving access to Aboriginal staff, ongoing efforts to improve such as wait time and resourcing, improving continuity of care from hospital to primary care, acknowledging the value of support networks, and appreciating the impact of financial stress and how this affects patient experience (9). Redressing differences in perceived hospital care for Aboriginal and non-Aboriginal people is a priority for NSW Health, therefore implementing these recommendations is a crucial next step.

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Appendix 1 – Demographics

TABLE 1: Participant characteristics

Characteristics	n	%
Gender		
Male	9	39%
Female	14	61%
TOTAL	23	100%
Age (years)		
18-24	1	4%
25-34	2	9%
35-44	2	9%
45-54	2	9%
55-64	8	35%
65+	8	35%
Recruitment sites		
Murrumbidgee (RivMed and Wagga Wagga Base Hospital)	8	35%
Illawarra-Shoalhaven (IAMS, Waminda and Wollongong Hospital)	9	39%
Western Sydney (GWAHS and Westmead hospital)	6	26%
Most recent admission date		
Last 6 months	12	52%
6-12 months	5	22%
1-2 years	2	9%
2-5 years	4	17%

TABLE 2: Staff characteristics

Characteristics	n	%
Gender		
Male	2	13%
Female	14	88%
TOTAL	16	100%
Age (years)		
18-24	1	6%
25-34	5	31%
35-44	9	56%
45-54	1	6%
Recruitment sites		
Murrumbidgee (RivMed and Wagga Wagga Base Hospital)	6	38%
Illawarra-Shoalhaven (IAMS, Waminda and Wollongong Hospital)	8	50%
Western Sydney (GWAHS and Westmead Hospital)	2	13%
Participant type		
ACCHS staff	13	81%
LHD staff	3	19%

Appendix 2 – Interview guides

Interview guide – hospital patients

Introduction

Thank you for meeting with us today.

We are here to speak with you today about your experience of your recent hospital stay. This study aims to explore Aboriginal admitted patients' views on their hospital care, with a focus on cultural safety. We expect the interview will take approximately 45-60 minutes.

The Sax Institute is conducting this study on behalf of NSW Health, who will use the information to inform how to best provide hospital services for Aboriginal people.

We want you to know that the information that you provide will be kept secure and will not be passed onto any other person or organisation. This information will be combined with information from other participants and you will not be named or identifiable in anyway. If in your consent you have agreed that your information can be used, we will contact you again with the information we would like to use.

As we noted in the consent form that you signed earlier, this study is voluntary. You can choose to withdraw at any time. With your permission we would like to record the meeting. Is that ok with you? Do you have any questions about the interview or the data?

1. **We are interested to hear about your most recent hospital stay, perhaps we could start with you telling us about your hospital stay and what it was like, and then we'll ask some more detailed questions.**

Prompts:

- What was your initial impression of the hospital?
- What was it like to be in hospital?
- What words would you use to describe how you felt in hospital?

Thank you for that. We'll ask you some more questions about your hospital stay. You've already talked about some of the issues we are interested, but we'll ask a few more questions anyway in case there's anything more you can add.

Quality and appropriateness

2. **How did you find the communication by the hospital staff?** (*explore why/why not? Ask for further explanation or specific example)*

- Were you asked whether you are Aboriginal and/or Torres Strait Islander?
- How well was everything explained to you? Was it easy to understand?
- Did you feel that you could ask questions, or check on things?
- If you asked a question, or made suggestions or other comments, were you listened to?
- Were the staff respectful to you, and to you family?

3. **What did you think of the healthcare you received?** *(explore why/why not? Ask for further explanation or specific example)*

- Did you feel that you ask about any needs you had?
- Were your needs met?
- Were staff helpful you when you needed assistance?
- Did you feel comfortable in the location/setting where care was provided?
- Did you trust the staff?

4. **What was the discharge process like?** *(explore why/why not? Ask for further explanation or specific example)*

- Did you feel well enough to leave hospital?
- Did you feel confident about what to do once you were home?
- Were you able to get assistance with transport home from hospital?
- Did the hospital communicate with your family/friends to support your discharge?
- Were you contacted by your GP, ACCHS or NSW Health after you left hospital? If yes, can you tell us about that follow-up?

If the participant reports discharging themselves early, explore why they left, and prompt how they felt.

5. **Overall, how would you rate quality of the care you received?**

1. Very poor
2. Poor
3. Fair
4. Good
5. Very good

6. Excellent

Why?

Experiences and perceptions of feeling culturally safe (or culturally unsafe):

6. **When accessing health care what kinds of things help make you feel comfortable and respected as an Aboriginal person?**
7. **Were you able to access an Aboriginal Health Worker/Liaison Officer? Can you describe what impact this had on your experience?**
8. **Can you describe any aspects of your hospital care that you particularly valued?**
9. **When you were in hospital did you feel you feel comfortable and respected as an Aboriginal person? Can you describe anything that made you feel uncomfortable?**
10. **Is there anything else that you think is important to ensure Aboriginal people to feel comfortable and respected in hospital?**

Experiences and perceptions of any incidents of discrimination:

11. **Did you experience any discrimination or racism during your hospital stay?**

- If so, can you tell me about your experience? Did you or anyone report the incident/s?
- If yes, did you feel supported? Was it followed up?
- If yes - were you satisfied? Why/Why not? If it wasn't followed up, what would you like to have seen done?
- If you didn't report, was there a reason why? What could be done to support people to report such instances?

Perceived impacts on health after the stay in hospital:

12. **Has your hospital stay impacted on your health in other ways (positive or negative)? Can you describe these impacts?**

Prompts: Has it affected your:

- willingness or ability to seek help for health concerns?
- self-management of any health conditions?
- social and emotional wellbeing?
- decisions on how you access health services?

Suggestions for improvement

13. **Do you have any suggestions on what hospitals could do to improve experiences for yourself and other Aboriginal people in the community?**

Experiences with hospital patient surveys (note: if run out of time, this question can be left)

14. **At the end of your stay, you may have been provided with a hospital patient survey to complete. Do you recall being provided with one of these surveys?**

If yes,

- Did you attempt to fill the hospital survey?
- How did you find the questions in the survey?
- Do you have any suggestions to improve the survey, or better ways of getting feedback from Aboriginal patients

Focus group guide – ACCHS staff

Introduction

We are here to speak with you today about your views of the care Aboriginal patients receive in NSW public hospitals and your experiences of working with local public hospitals (in your role in the ACCHS) and with a focus on cultural safety. We expect the focus group will take approximately 60-90 minutes to complete.

The Sax Institute is implementing this study on behalf of NSW Health, who will use the information to inform how to best provide hospital services for Aboriginal people.

We want to emphasise that the information that you provide will be kept secure and will not be passed onto any other person or organisation. This information will be combined with information from other participants and you will not be named or identifiable in anyway.

As we noted in the consent form that you signed earlier, this study is voluntary, and you can choose to leave the discussion at any time. With your permission we would like to record the meeting. Is that ok with you? Do you have any questions about the interview before we start?

Thank you for meeting with us today. There are two main areas we would like to explore in this focus group:

1 - your experiences working with local hospitals (during your role at the ACCHS)

2 – your perceptions of Aboriginal patient experiences at the hospitals (main focus)

Your experiences working with local public hospitals

1. **In your role at the ACCHS, can you tell us about your interactions with hospital staff?** *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)*
    - Do you feel everything you need to know is explained clearly?
    - Do you feel the communication with you, as an Aboriginal health worker is respectful?
    - How do your interactions with hospital staff influence the quality and continuity of care that you are able to provide to your patients?
    - How do you feel when you enter a local hospital or public maternity service? What are your first impressions?

1. **Do you have any suggestions for things the local public hospitals could do to improve the way they work with local ACCHS?**

Perceptions of the care Aboriginal patients receive at local hospitals (Hospital and maternity)

Quality and appropriateness

2.	**Can you tell us about the experiences of Aboriginal patients/clients that have been admitted to hospital?**
	How do you think Aboriginal patients find the communication by hospital staff? Do you have any examples that you can share? *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)* • Do you think everything is fully explained, in a way the patient can understand? • Do you think Aboriginal patients feel comfortable to ask questions? • When they ask questions, or make comments, do you think they feel listened to? • Do you think hospital staff are respectful to Aboriginal patients?
	What do you think of the healthcare Aboriginal patients receive? If you have any examples that you can share, that would be great. *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)* • Do you think the patients feel comfortable asking about their needs? • Do you think they feel that their needs are met? • Do you think Aboriginal patients can easily access staff to help them when they need assistance? • Do you think Aboriginal patients trust the staff at the hospital? • Have you heard if hospital staff are consistent and respectful when asking patients about their Aboriginal status?
3.	**What about leaving hospital? What are your views on the discharge processes?** *(for the sub-questions – prompt why/why not?)* • Do you think Aboriginal patients feel confident about what to do once they are home? • Are Aboriginal patients able to get assistance with transport home from hospital? • Does the hospital generally communicate with family members to support the Aboriginal patients' discharge? **Do you hear reports of patients discharging themselves early? If yes, why do you think they discharge early?**

Experiences and perceptions of feeling culturally safe (or culturally unsafe)):

4.	**When accessing health care what kinds of things do you think help make Aboriginal people feel comfortable and respected? Can you think of any specific examples?**
5.	**Can you think of any aspects of hospital care that are particularly valued by Aboriginal patients? Are there any specific examples you can share with us?**
6.	**Do you think Aboriginal patients feel comfortable and respected at the local hospitals? What sorts of things contribute to this? Can you think of any specific examples?**

7. **Is there anything else that you think is important to ensure Aboriginal patients feel comfortable and respected while in hospital?**

Experiences and perceptions of any incidents of discrimination:

8. **Have any of your patients experienced any discrimination or racism during their hospital stay? If so, can you tell me about their experience?**

Prompt: Does it seem like assumptions are made about Aboriginal patients' behaviours? Can you describe some of the assumptions that are made?

Do you know if anyone reported these incident/s?

- If yes, was the patient supported? Was it followed up? If it wasn't followed up, what would you like to have seen done?
- If no, was there a reason it was not reported? What could be done to support people to report such instances?

Perceived impacts on health after the stay in hospital:

9. **Do you think Aboriginal patients' experiences in hospital impact their health in broader (negative and positive) ways?**

Prompts

Are there any changes, positive or negative in patients:

- willingness or ability to seek help for health concerns?
- self-management of any health conditions?
- social and emotional wellbeing?
- decisions on how they access health services in the future?
- Misdiagnosis or mismanagement of a health issue – are there any examples of this and what impact did it have for the patient?

Suggestions for improvement

10. **Do you have any suggestions for things the local hospitals could do to improve patient experiences for Aboriginal people in your community?**

Interview guide – LHD staff

Introduction

Thank you for meeting with us today.

We are here to speak with you today about your experiences working in a NSW public hospital and your views of the care Aboriginal patients receive in these hospitals, with a focus on cultural safety. We expect the interview will take approximately 45 minutes to an hour to complete.

The Sax Institute is implementing this study on behalf of NSW Health. NSW Health will use the information to inform how to best provide hospital services for Aboriginal people.

We want to emphasise that the information that you provide will be kept secure and will not be passed onto any other person or organisation. This information will be combined with information from other participants and you will not be named or identifiable in anyway. If in your consent you have agreed that your information can be used, we will contact you again with the information we would like to use.

As we noted in the consent form that you signed earlier, this study is voluntary. You can choose to withdraw at any time. With your permission we would like to record the meeting. Is that ok with you? Do you have any questions about the interview or the data before we start?

We will now go onto the questions - there are two main parts to this interview:

1 - your experiences working in an NSW hospital

2 – your perceptions of Aboriginal patient experiences at the hospital where you work (main focus)

Your experiences working in a NSW public hospital

1. **We are interested in what it is like for you working at this hospital:** • How would you describe the culture? • What are your interactions with other staff like? • Do you feel the communication is respectful?
2. **Do you think Aboriginal staff feel comfortable and respected at the hospital where you work? What sorts of things contribute to this?**
3. **Is there anything else that you think is important to ensure Aboriginal staff to feel comfortable and respected in the hospital?**

Perceptions of the care Aboriginal patients receive at local hospitals (Hospital)

Quality and appropriateness

4. **How do you think Aboriginal patients find being admitted to NSW public hospitals?**

5. **How do you think Aboriginal patients find communication by hospital staff?** *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)*

- Do you think everything is explained properly (in a way the patient can understand)?
- Do you think Aboriginal patients feel like they can ask questions?
- When they ask questions, or other comments, do you think they feel listened to?
- Do you think hospital staff are respectful to Aboriginal patients?
- Do you feel that hospital staff are consistent and respectful when asking patients about their Aboriginal status?

6. **What do you think of the healthcare and support that Aboriginal patients receive in the hospital where you work?** *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)*

- Do you think Aboriginal patients feel comfortable to ask about their needs? Are they encouraged to ask any questions they may have?
- Do you think their needs, particularly any cultural needs are met?
- Do you think Aboriginal patients can easily access staff to help when they need assistance?
- Do you think Aboriginal patients feel respected?
- Do you think Aboriginal patients trust the staff at the hospital?

7. **What about leaving hospital? What are your views on the discharge processes?**

- Do you think Aboriginal patients leave the hospital feeling confident about what to do once they are home?
- Are Aboriginal patients able to get assistance with transport home from hospital?
- Do you know about how the hospital communicates with family members to support discharge?
- Do you have any suggestions on whether, and how the discharge process could be improved?

Experiences and perceptions of feeling culturally safe (or culturally unsafe):

8. **When accessing health care what kinds of things do you think help make Aboriginal people feel comfortable and respected? Can you think of any specific examples?**
9. **Can you think of any aspects of hospital care that are particularly valued by Aboriginal patients? Can you think of any specific examples?**

10. **Do you think Aboriginal patients feel comfortable and respected at the hospital where you work? What sorts of things contribute to this? Can you think of any specific examples?**

11. **Is there anything else that you think is important to ensure Aboriginal patients to feel comfortable and respected while in hospital?**

Experiences and perceptions of any incidents of discrimination:

12. **Can you please describe any experiences of discrimination/racism that have happened to Aboriginal patients at the hospital where you are employed?**

Prompt: Does it seem like assumptions are made about Aboriginal patients' behaviours? Can you describe some of the assumptions that are made?

- Do you know if anyone reported these incident/s?
- If yes, did the patient feel supported? Was it followed up? If it wasn't followed up, what would you like to have seen done?
- If no, was there a reason it was not reported? What could be done to support people to report such instances?

Perceived impacts on health after the stay in hospital:

13. **Do you think Aboriginal patients' experiences in hospital impact their health in broader (negative and positive) ways?**

Prompts are there any changes, positive or negative in patients

- willingness or ability to seek help for health concerns
- self-management of any health conditions
- social and emotional wellbeing
- their decision on how they access health services.

Suggestions for improvement

14. **Do you have any suggestions for things that NSW public hospitals could do to improve patient experiences for Aboriginal people?**