Mercy Health

Care first

Nangnak Wan Myeek Community Consultation Report

February 2012

Nangnak Wan Myeek – "Nurture, care and look after me and mine"

Acknowledgements

Mercy Hospital for Women would like to thank the Office of Aboriginal and Torres Strait Islander Health (OATSIH) whose funding enabled the establishment of the Nangnak Wan Myeek program. This funding was also used to conduct a community consultation project so that people who require – and provide – culturally specific health services could inform the program plan.

This report summarises the information gathered during the consultation process – and the ways in which Mercy Hospital for Women has responded to the issues raised by project participants. These participants include patients who gave birth to an Aboriginal or Torres Strait Islander child in 2009, members of Aboriginal organisations and mainstream organisations around Victoria and staff of Mercy Hospital for Women.

The thoughts and opinions of all participants have been objectively reflected in this report. At times participants contributed not only from a professional perspective but also from a personal perspective, which involved discussions that were often of a sensitive nature. We thank you all sincerely.

We acknowledge the following key project staff: Program Manager Joanne Borg; Community Liaison Officer, Kellie Hunter-Loughron; Project Officer, Jessica Brooks; Social Worker, Olivia Kerr; Aboriginal Engagement Officer, Michelle Donovan; and Social Work Manager, Jane Middleton. We also acknowledge the work of two student volunteers, Renata Spiller and Bonnie Dawson who provided support during the development of this report and thank Penny Smith, Project Officer for her contribution.

Finally, we would like to acknowledge the support and dedication of the Children's Protection Society, the Victorian Aboriginal Health Service and Banyule Community Health Service. We look forward to continuing to work together to improve the health of Aboriginal and Torres Strait Islander mothers and babies.

Contents

Our commitment to Indigenous healthcare

As a Catholic provider of care, Mercy Health is committed to delivering services with compassion, dignity, justice and prudence. It is essential that we continually strive to improve the way we care for and improve the lives of those in need.

The community consultation component of the New Directions program (known as “Nangnak Wan Myeek”) is a key example of how we are obtaining essential information about how we can better care for Aboriginal and Torres Strait Islander people. Projects such as this are essential in assisting us to provide high quality care for all people regardless of culture, race or religion.

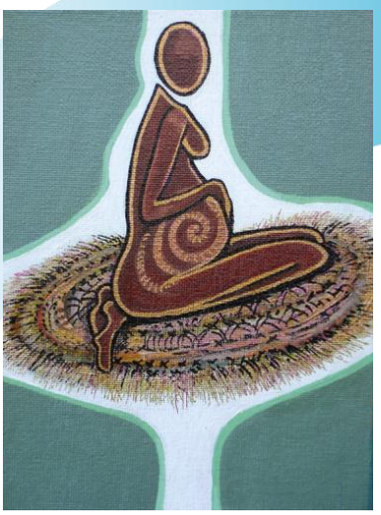
This report presents the key findings of the New Directions “Nangnak Wan Myeek” community consultation project conducted in 2009-10 and advises on the project outcomes to date. The report contains a number of views from a range of people and it is important to note that these may not always necessarily reflect the views of the Mercy Health organisation. It is however essential in a project like this that the views of those involved in the consultation are acknowledged and transcribed in an open and honest manner.

We extend our sincere thanks and appreciation to our project team, and our project partners, for their work in the program. The consultation process has given our organisation important insights into community expectations regarding culturally specific and mainstream heath service delivery. This information will be essential in assisting us plan for future delivery of healthcare services to our communities.

On behalf of Mercy Hospital for Women and the management team of Mercy Public Hospitals Inc we are pleased to commend this report.

Dr Linda Mellors
Executive Director
Mercy Hospital for Women

Mr Stephen Cornelissen
Chief Executive Officer
Mercy Health



Executive summary

For nearly 20 years Mercy Hospital for Women has been providing culturally specific services to Aboriginal and Torres Strait Islander mothers and babies. In 1984, Mercy Hospital for Women was one of the first Victorian hospitals to employ an Aboriginal Hospital Liaison Officer to support women and families before, during and after the birth of their babies.

Through our ongoing commitment to Aboriginal and Torres Strait Islander people, extensive work is being done to provide appropriate services within the hospital, within the community and across referral networks.

The hospital offers a full range of tertiary maternity care services, including standard care, shared care with a general practitioner, team midwifery, midwives clinic and the Family Birth Centre. Women also have access to a number of support services such as specialist obstetric and midwifery care for high risk pregnancies and parent and antenatal education.

In April 2009, the hospital received funding from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) under the “New Directions: An Equal Start in Life for Indigenous Children” initiative, which aims to improve the health of Aboriginal and Torres Strait Islander children from
0-8 years of age.

The New Directions funding guidelines outline five priority areas:

1. Access to antenatal care for women pregnant with an Aboriginal child.
2. Standard information about baby care for mothers of Aboriginal children.
3. Practical advice and assistance with breastfeeding, nutrition and parenting skills for mothers of Aboriginal children.
4. Monitoring of Aboriginal children’s weight gain, immunisation status, infections and early developmental milestones by a dedicated primary healthcare service.
5. Testing, early detection and timely treatment of Aboriginal children’s hearing, sight, speech and other development issues before starting school.

The funding was provided to develop a new program to enhance service delivery for Aboriginal families, reduce the mortality rates for Aboriginal children under five and improve their school readiness. The program was named “Nangnak Wan Myeek” by Auntie Joy Murphy, Aboriginal elder, which in Wurundjeri language means “nurture, care for and look after me and mine”.

In order to better understand the needs and experience of Aboriginal and Torres Strait Islander mothers and babies, a consultation project was undertaken to inform the development of the program plan.

The project commenced in December 2009 and consisted of a file audit of Mercy Hospital for Women patients who gave birth to an Aboriginal or Torres Strait Islander child during 2009 and extensive consultation with past Mercy Hospital for Women patients, hospital employees and staff from external stakeholder organisations.

A number of key themes emerged from the consultations and file audit, which are outlined in this report.

Key theme

Providing culturally appropriate services ("cultural safety")

Opportunities to improve the identification and understanding of Aboriginal and Torres Strait Islander patients were noted.

These include:

- Enhancing the processes and systems at Mercy Hospital for Women which give patients the opportunity to identify as Aboriginal and/or Torres Strait Islander
- Improving systems to ensure all staff are aware of the role of the Aboriginal Hospital Liaison Officer (AHLO) and that all patients identifying as Aboriginal and Torres Strait Islander are offered a service by the Aboriginal Women & Family Support Unit
- Providing cultural awareness training for staff to improve their understanding of Aboriginal history and the health issues experienced by Aboriginal clients
- Recognising barriers to patients attending appointments. Examples identified by Aboriginal and Torres Strait Islander participants include transport difficulties, parking expenses and long appointment waiting times.

Project outcomes to date

Staff orientation: During orientation, all new staff are provided with an overview of the Aboriginal Women & Family Support Unit and the Nangnak Wan Myeek program. They also receive some brief cultural awareness training.

Patient identification: Administration staff and managers have been trained in the importance of identifying Aboriginal and Torres Strait Islander clients. Posters and brochures encouraging clients to identify if they are Aboriginal or Torres Strait Islander are prominently displayed in reception areas.

Systems for recording and reporting on the number of Aboriginal and Torres Strait Islander clients have been improved, including the development of a procedure and data report for identifying whether the father of a baby is Aboriginal or Torres Strait Islander. Staff are able to run quick reports to extract inpatient and outpatient lists of Aboriginal and Torres Strait Islander patients to improve opportunities to offer services during attendance at Mercy Hospital for Women.

Cultural awareness training: A cultural awareness training program was initiated in 2011 so that staff can deliver respectful and appropriate services to patients. By the end of 2011 all Mercy Health O'Connell Family Centre staff received cultural awareness training.

An extensive cultural awareness training program for frontline staff and senior staff at Mercy Hospital for Women is planned for 2011-12. It is anticipated that a minimum of 240 managers and staff will receive training during this time.

Key theme

Improving antenatal care

The Aboriginal and Torres Strait Islander patients consulted were generally very positive about the antenatal care they received at Mercy Hospital for Women. The Transitions Clinic, which supports marginalised clients in their maternity care, is attracting an increasing number of Aboriginal and Torres Strait Islanders and achieves higher than state average birth weights of Aboriginal and Torres Strait Islander babies.

Opportunities to improve antenatal services include:

- Providing clearer information about the range of antenatal services available at the point of referral, including information for women who are referred through shared care arrangements
- Recognising and responding to the stigmatism some Aboriginal and Torres Strait Islander women felt by being associated with a clinic that treats people with addiction issues
- Streamlining communication processes between local health services and Mercy Hospital for Women when women or their babies are transferred from rural hospitals
- Increasing education by:
    - Providing more culturally specific information regarding pregnancy and the early years of childhood
    - Developing a strategy to address the low levels of attendance at antenatal classes

Project outcomes to date

- In 2011-12, the model of care for maternity services will be reviewed, ensuring that all women are provided with clearer explanations and choices about the services offered
- An Aboriginal name for the Transitions Clinic (“Nangnak Baban Murrup”, which means “Nurturing Mother’s spirit”) was chosen and launched in 2011
- A strategy for improving antenatal education will be developed in 2011-12

Key theme

Improving postnatal care

The need for follow up support after women are discharged from hospital was raised as a strong issue: particularly with postnatal depression and breastfeeding, but also with follow up on referrals to other services.

Project outcomes to date

- Nangnak Wan Myeek will provide coordination of postnatal care to ensure women are linked to appropriate services on discharge. This will include transport to key follow up services for mothers and babies, home visits and linkage to services

such as the Victorian Aboriginal Health Service, maternal and child health services, general practitioners and community health services.

- Brokerage funding is available to support mothers with breastfeeding and purchase of essential nursery items
- Partnerships with the Victorian Aboriginal Health Service, Mercy Health O'Connell Family Centre, Banyule Community Health Service and the Children's Protection Society will continue to be developed and strengthened to improve antenatal and postnatal care
- A mothers group is being established to provide short term support to Aboriginal and Torres Strait Islander mothers with opportunistic health promotion and parenting support and linkages to other services
- Vulnerable women will be supported through the development of an "Adopt an Auntie" program that will work with Aboriginal elders as volunteers to mentor young mothers with significant support needs
- Transport is available to clients who have difficulty attending appointments. Other strategies to improve access to services are currently being developed.

Rural transfers home are provided for mothers who have been transferred to Mercy Hospital for Women. Additional support is also provided to these mothers while they and their babies are inpatients.

Project structure and process

The project was made up of two distinct parts: a file audit of Mercy Hospital for Women patients who gave birth to an Aboriginal or Torres Strait Islander child during 2009 and community consultation with past Mercy Hospital for Women patients, hospital employees and staff from external stakeholder organisations.

The file audit

An audit of 100 patient files was undertaken to:

- Analyse trends in both the mother's and baby's patient histories
- Review statistics on specific models of care
- Inform the questions to be asked in the consultation phase of the project

Patient records of 50 Aboriginal and Torres Strait Islander babies born at Mercy Hospital for Women in 2009 were randomly selected as well as the patient record of their respective mothers.

The consultation process (Appendix 1)

Over a three month period approximately 150 project participants were consulted, including:

- Staff from 37 external organisations
- 42 Mercy Hospital for Women employees
- 17 patients of Mercy Hospital for Women who gave birth to an Aboriginal and/or Torres Strait Islander child in 2009

In collaboration with the Cooperative Research Centre for Aboriginal Health and approved by the Mercy Health Human Research Ethics Committee, three separate questionnaires with similar themes were developed for the three target groups.

All participants were given an information and consent form, and a media consent form where applicable. Patients were first asked to complete a demographic sheet, and were then asked the questions.

Past patients

All women who had given birth to an Aboriginal and/or Torres Strait Islander baby in 2009 were identified and their records retrieved. Eighty six past patients were contacted and invited to take part in the consultation phase. Of these, 21 agreed to take part and 17 were consulted. Four of the 21 patients cancelled.

Mercy Hospital for Women employees

Forty two employees were consulted who worked in areas that were relevant to families in the antenatal or postnatal phase. The majority of consultations were individual meetings and two focus groups were held.

External stakeholders

Stakeholders from 37 external organisations were consulted, including the Victorian Aboriginal Health Service, a range of Koori maternity services, local councils, local community health services, the Children's Protection Society and a number of rural and urban hospitals.

Consultation findings

Asking the identification question

To ensure the health status of the population is accurately recorded, the question “Do you identify as Aboriginal and/or Torres Strait Islander?” needs to be asked of all patients presenting to health services.

At present, Aboriginal and Torres Strait Islander people are under identified in health service statistics nation-wide. By not being given the option to identify as Aboriginal and/or Torres Strait Islander, patients may miss the opportunity to access information and services specific to their needs. This has further implications for service providers in regard to policy development and the ability to measure the effectiveness of health services in meeting the needs of Aboriginal and Torres Strait Islander patients.

From a funding perspective, under identification affects the extent to which hospitals receive the additional 30 per cent WIES supplement for every Aboriginal and Torres Strait Islander inpatient, which is determined through hospital identification records. This funding is used to provide culturally appropriate support for mothers, babies and families. Under identification also creates difficulties in determining the accuracy of current available data and, as a result, Aboriginal and Torres Strait Islander patient services and health outcomes.

During the consultation, patients and staff were asked about the process of identification at Mercy Hospital for Women. The lack of a clear and consistent approach to identification and referral to the Aboriginal Women & Family Support Unit was identified.

Summary of feedback:

- Patients are generally comfortable identifying but have some concerns about the outcome of identification
- The majority of patients only identify on paper and are not asked verbally
- The identification question is not routinely asked by all staff; some staff do not ask the identification question because they believe it is already on the patient’s file or does not relate to the care provided
- Even though the identification of the father and baby is important in the provision of appropriate care, the question is not necessarily asked
- Aboriginal and Torres Strait Islander mothers who go through the general outpatient clinics at Mercy Hospital for Women (ie are not referred to the Transitions Clinic) may not have contact with the Aboriginal Hospital Liaison Officer
- Staff and patient education is seen as key to improving the process of asking the identification question

“It’s a nice surprise when you get asked, as often you don’t.”
Patient

In general, staff believe they know if someone is Aboriginal and/or Torres Strait Islander because it should be written on the patient record. However, it was identified that a large number of staff are not looking in either the patient file or on the patient database to find this information and rely on other factors, such as physical attributes, to inform identification.

> ***"I suppose we're not that good at looking in the history itself and looking at what's ticked in terms of if someone is Aboriginal. I know I saw someone a few weeks ago who, if she hadn't come in with her partner, I would have had no idea she was carrying an Aboriginal baby. Her partner was very clearly Aboriginal but she didn't look Aboriginal at all."*** *Mercy Hospital for Women employee*

At the time of the consultation there was no process for identifying whether the father of the baby was Aboriginal or Torres Strait Islander. Not identifying fathers is an issue as appropriate services may not be offered. These include linking to external services such as the Victorian Aboriginal Health Service or internal services such as the Aboriginal Women & Family Support Unit or partner services such as the Children's Protection Society's "I'm An Aboriginal Dad" program.

Some Aboriginal and Torres Strait Islander people articulated that their reluctance to identify within the hospital was due to fears about potential child protection involvement based on the identification of their Aboriginality. This may relate to the significant number of Aboriginal and Torres Strait Islander children currently in out-of-home care. As of 30 June 2009, these children numbered 10,512 across Australia[1]. This number is nine times the rate of non Aboriginal and Torres Strait Islander children and has significantly increased over the previous decade.

> ***"I don't feel comfortable when asked. I'm not sure how I will be treated if I do identify or what will happen, you know, around DHS stuff."*** *Patient*

> ***"I am a bit paranoid about what services they will make me access. I don't want to just access Aboriginal specific services, I want mainstream."*** *Patient*

Patients were asked if their Aboriginality was taken into account when they were a patient at Mercy Hospital for Women. Three said yes but one qualified this by saying she did not like being associated with high risk clients, five responded that they were treated like everyone else and that was fine, and two said no.

Not all staff were aware of the role of the Aboriginal Women & Family Support Unit, how they could make a referral or when it would be appropriate to do so. Responses from the patients surveyed indicated a range of views about whether identification

[1] Steve Larkins, SNAICC newsletter ,May 2010, pg 7

should result in a changed service response. This highlights the importance of an individual approach, where additional support is offered but may not be needed.

Role of the Aboriginal Women & Family Support Unit

Consultation with service providers indicated that the Aboriginal Women & Family Support Unit provides an important contact for external services. Clients indicated that they had received support from the Aboriginal Hospital Liaison Officers on a range of issues, including attending appointments, parking, providing transport, supplying train tickets, directions on where to go, social support and advocacy.

Recommendation

That training is provided to staff, and information is provided to patients, on how the identification question can improve identification of Aboriginal and Torres Strait Islander patients, prevent misconceptions and dispel fears or myths.

That information is provided to staff on how to make a referral to the Aboriginal Women & Family Support Unit and the services provided.

> ***"...the AHLO (Aboriginal Hospital Liaison Officer) was really nice. It was good to be able to go into her office. I liked going to Mercy Hospital for Women. It was a happy time for me and my nan to spend time together on a day out. There were also other young mums there that I knew."*** *Patient*

Cultural safety

During the consultation employees and patients were asked about cultural safety at Mercy Hospital for Women.

"(Cultural safety is) an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening."[2]

Cultural safety can only occur when differences in culture are recognised and respected and these differences are incorporated into health service delivery.[3]

A staff member articulated her idea of cultural safety in the following way:

> ***"It's about providing a service to the wider community, making the hospital culturally appropriate, welcoming and friendly. It's about flying the flag – things like having a family room are important, a space with relevant information and a place to make a cuppa. It's about having an understanding about Aboriginal people. It's about improving access and being able to ring the***

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[2] Williams R, Cultural Safety - What Does It Mean for Our Work Practice?

[3] Dowd, T & A Eckerman, Cultural Danger or Cultural Safety, 1992

patient up and they be comfortable with that. It's also about supporting the patient to work with mainstream services and be comfortable within that contact." *Mercy Hospital for Women employee*

The majority of Mercy Hospital for Women employees expressed the view that the hospital is "culturally safe" and employees name the presence of the Aboriginal Women & Family Support Unit as a key reason why. The unit was seen as a very positive and integral part of the hospital.

However, among some staff a referral to the Aboriginal Women & Family Support Unit is the only action seen necessary to provide culturally safe care. This places the responsibility to respond to the cultural needs of a patient solely on the unit.

"I see the AWFSU's role as to support the women and families, offer guidance and try to engage women into the hospital system. I get worried sometimes about what message this sends. It can sometimes seem the AHLO (Aboriginal Hospital Liasion Officer) is the putty between the hospital and the Aboriginal person. Who is the first person you call when there's trouble? The AHLO. This isn't good enough. We should be working in partnership with the AWFSU to learn how everyone can respond best to Aboriginal patients." *Mercy Hospital for Women employee*

Patients generally expressed the view that Mercy Hospital for Women is a culturally safe place. The reasons why patients felt culturally safe at Mercy Hospital for Women included:

- Continuity of care
- Support provided to them by the Aboriginal Women & Family Support Unit
- Provision of good care by staff
- Seeing other Aboriginal people in the waiting rooms
- Meeting women from a wide range of backgrounds

The reasons why patients felt culturally unsafe at Mercy Hospital for Women included:

- Negative staff attitudes
- Lack of communication between staff and patients
- Assumptions based on Aboriginality
- Gaps in understanding of culturally appropriate care
- Lack of acknowledgement of Aboriginality, eg when patients are not provided with the choice to contact the Aboriginal Hospital Liaison Officer if they so wish

Staff indicated a high level of interest in attending cultural awareness training and felt that this would lead to more sensitive and appropriate service delivery.

Topics suggested included Aboriginal culture, the definition of being Aboriginal or Torres Strait Islander, traditional birthing practices, beliefs about childbirth and child

rearing, culture, diet, lifestyle, family and community networks, the impact of the stolen generation on parenting and child protection issues, loss and grief.

Recommendation

That cultural awareness training is comprehensively provided for staff and managers at Mercy Hospital for Women.

Patient care in the antenatal phase

The consultation questions on antenatal care focused on the information received by women, attendance at antenatal appointments and antenatal parent education and feedback on their experiences attending Transitions Clinic.

Summary

- Patients were generally very positive about the antenatal care they received at Mercy Hospital for Women
- A low number of Aboriginal and Torres Strait Islander patients attend antenatal parent education classes
- Only 29 per cent of Aboriginal and Torres Strait Islander patients completed a birthing plan
- Staff believe more culturally specific information would be helpful, especially relating to pregnancy and the early years of parenting
- Patients felt overwhelmed by the quantity and complexity of written material and would prefer more visual aids, DVDs and personal contact
- Patient expectations that they would receive intensive education while on the ward may link back to the low rates of attendance at parent education classes for Aboriginal women

Provision of information to patients

A “Welcome Pack” is received by patients when they first arrange to have their antenatal care at Mercy Hospital for Women, which includes brochures and fact sheets about pregnancy, the hospital experience and the models of antenatal care provided. However, at the time of the consultation, the pack did not contain information about the Transitions Clinic or Aboriginal Women & Family Support Unit.

Birth plans

During their antenatal visits, patients are offered the chance to complete a birth plan. Only 29 per cent of patients consulted completed a birthing plan with the midwife during their antenatal care, although another 24 per cent were invited to develop a plan but chose not to. In the absence of a birthing plan, hospital policies may not be thoroughly discussed in the antenatal phase.

Attendance at antenatal appointments

In the 2009-10 financial year, Aboriginal and Torres Strait Islander identified patients had higher rates of non attendance (18 per cent) at Mercy Hospital for Women in comparison to their non Indigenous counterparts (8 per cent).

A number of strategies have been used by staff to respond to non attendance of patients. Mercy Hospital for Women staff interviewed responded that they generally followed up patients who did not attend through phone calls, letters and referrals. Mercy Hospital for Women staff also indicated that they are more likely to refer to the Aboriginal Hospital Liaison Officer than a social worker if an Aboriginal and/or Torres Strait Islander patient does not attend an appointment. Regular multidisciplinary meetings are held in a number of service areas within Mercy Hospital for Women to discuss complex patients and identify ways to support them. This includes looking at ways to support patients who have multiple occurrences of missed appointments as well as planning for their discharge.

Patients identified the following main reasons for not attending appointments:

- Access to transport
- Access to and cost of parking at the hospital
- Long waiting times
- Lack of access to child care

Staff and stakeholders viewed the following as the most significant barriers and gaps to access Mercy Hospital for Women:

- The hospital environment
- Inflexibility of appointments
- A lack of Aboriginal artwork
- A need for cultural awareness training at Mercy Hospital for Women
- A lack of effective communication between staff and patients
- Inaccurate identification of Aboriginal patients
- Lack of accessibility to transport
- Lack of knowledge of relevant services to assist with referrals
- Financial situation of clients
- Distance to health services
- Communication gaps between services

Suggestions from patients to address these barriers include:

- Transport assistance (24 per cent of responses)
- Parking assistance (24 per cent of responses)
- Reduced waiting times (12 per cent of responses)
- Provision of education while waiting for appointments (6 per cent)
- Text message reminders of appointment times (6 per cent)

Recommendation

That a range of strategies are developed in 2011-12 to respond to these barriers.

> ***"Would be good to do a little course while you're waiting for your appointment. More effective than reading a pamphlet."*** *Patient*

> ***"Information with pictures and DVDs are easier to understand as well as having someone to sit with and explain it. That would be better."*** *Patient*

Antenatal clinics

Aboriginal and Torres Strait Islander patients attended a range of clinics at Mercy Hospital for Women, with the largest proportion attending the Transitions Clinic.

Antenatal clinics attended at Mercy Hospital for Women:

- Transitions Clinic (41 per cent)
- Mainstream care (30 per cent)
- Family Birth Centre (6 per cent)
- Perinatal Unit (6 per cent)
- No antenatal care at Mercy Hospital for Women (18 per cent)

Transitions Clinic

The Transitions Clinic was established in 2000 to provide antenatal care that is specifically tailored to cater for the needs of three groups: young women, Aboriginal and Torres Strait Islander women, and women with a chemical dependency during their pregnancy. The clinic aims to provide a relaxed and friendly environment for Aboriginal and Torres Strait Islander women who may not feel comfortable in mainstream antenatal clinics. Clinic staff work closely with the Aboriginal Women & Family Support Unit and relevant Aboriginal health services to ensure quality of care.

Transitions Clinic has a shared care arrangement with VAHS, which sees mothers for most appointments while patients attend Mercy Hospital for Women for key appointments and the birth. Recently, the clinic for young mothers was transferred to the Ivanhoe site.

Overall, patients who attended Transitions Clinic had a positive response to the care they received. This was generally attributed to the continuity of care, which enabled relationships between patients and staff to be built, and the approachability of the staff. Patients appreciated visits from Transitions Clinic staff on the postnatal ward as well.

"I liked it because I saw the same doctor and things were explained really well to me. The midwife was really good, I felt comfortable with her." *Patient*

"I would go through the Transitions Clinic again as it's what I know and trust." *Patient*

Among the staff surveyed, there was a lack of understanding of the target groups for Transitions Clinic with a general assumption that patients need to be medically high risk with complex needs to attend. This perception may lead to incorrect assumptions by staff about the medical and social situation of Aboriginal and/or Torres Strait Islander patients. Likewise, if a woman has identified as Aboriginal and/or Torres Strait Islander but does not present with complex needs, incorrect assumptions may mean she is not given the option to attend the Transitions Clinic.

Fifty three per cent of patients responding to the survey were aware of the Transitions Clinic, but some patients who attended Transitions Clinic were automatically placed in the clinic without being given a choice by Mercy Hospital for Women staff. Generally it seems patients who are referred by the Victorian Aboriginal Health Service (a shared care arrangement with Mercy Hospital for Women) may not be given the option to attend other antenatal clinics.

"I am not sure why I was in Transitions Clinic. I don't understand the difference between outpatients and Transitions. VAHS never explained it either. Is that why I used to see all my cousins there?" *Patient*

Recommendations

- A better or clearer assessment process to determine appropriate referrals to Transitions Clinic
- Information about Transitions Clinic should be included in the Welcome Pack

Project outcome to date

The Aboriginal and Torres Strait Islander stream of the Transitions Clinic has been renamed with the Wurundjeri name "Nangnak Baban Murrup", which means "Nurturing Mother's spirit", to make the clinic more welcoming to Aboriginal patients.

Nangnak Baban Murrup and Transitions Clinic provide holistic care from a multidisciplinary team made up of an obstetric consultant, two antenatal midwives, an Aboriginal Hospital Liaison Officer, two social workers, a psychologist, psychiatrist and a paediatrician. The transitions component of the clinic is now only for referrals for women with a chemical dependency.

Antenatal parent education

Only three of the patients consulted attended antenatal parent education classes consistently. Without attending these sessions a woman may not feel adequately informed about baby care, which means education on the ward becomes imperative.

Patients generally feel that during their stay on the ward there is not enough information provided about baby care, in regard to what staff are doing with the babies and what mothers need to learn before they are discharged. This issue directly relates to the low number of Aboriginal women attending antenatal parent education.

Reasons given by patients for not attending parent education classes:

- The additional travel to the hospital
- The costs involved
- A reluctance to attend mainstream classes due to a fear of being judged and the nature of the mainstream information being given

Staff suggestions to enhance attendance at parent education include:

- Information sessions specifically for Aboriginal patients about what to expect at the classes
- The development of culturally specific parent education run by an appropriate facilitator in conjunction with Mercy Hospital for Women staff and/or the Victorian Aboriginal Health Service
- More promotion of the classes being free of charge for Aboriginal patients

Recommendations

Information about services specifically for Aboriginal and Torres Strait Islander patients should be included in the Welcome Pack and made available during antenatal care at different times, eg at the 28 week visit.

Some patients suggested that information about birth and parenting could be provided through educational DVDs, culturally relevant content and an emphasis on verbal rather than written information. Longer sessions with domiciliary midwives following discharge from hospital may also address this need.

Involving fathers in care

Service providers consulted were asked if they included fathers in the care of their babies. Three services consulted said that they did involve the fathers, but in a limited way, and would like to do more. Four services did not engage the fathers. There was a widespread view that more could be done to involve the fathers. The "I'm An Aboriginal Dad" program was seen as a good model.

At Mercy Hospital for Women there is a partnership with the Children's Protection Society which runs the "I'm An Aboriginal Dad" program. The Program Coordinator attends the Transitions Clinic where he meets with fathers on an informal basis. Staff from the Transitions Clinic also refer Aboriginal and/or Torres Strait Islander dads into the program.

Inpatient care

The general consensus about the care received at Mercy Hospital for Women was very positive, with patients appreciating the overall respect and support shown by staff. Eighty eight per cent of patients consulted would have another baby at Mercy Hospital for Women.

Patient feedback

"I was blown away by how friendly the staff were in the Family Birth Centre at Mercy Hospital for Women. It was such a relief to have people volunteering information, because there's so much to learn.

"I didn't have contact with the AHLO throughout my antenatal care. Actually, apart from telling the staff I was Aboriginal, it never came up again. I overwhelmingly felt that the staff were culturally safe though because they were able to provide a safe environment for everyone based on what you wanted as a pregnant woman. There was one woman who wanted to sing all through her labour and the staff were fine with that! My family and support people were able to be included in my antenatal care and during the birth, which was exactly what I wanted. There were no visitor restrictions and information was provided well in advance about where to get food, what's around, where to park, as well as information for my husband about the birth and planning.

"Pregnancy is not a medical condition – you are not sick. My wishes were carried out. I perceive everyone as equal and see the birthing experience as another equality thing that every woman has a right to, regardless of her cultural identification."

As family is very important to Aboriginal and Torres Strait Islander people, it was noted a number of times that patients wanting to have more visitors than the policy allows did not understand or agree with the policy restricting the number of visitors. Patients would have liked to have been more fully informed about the restrictions on the number of people who can be present at the birth.

Patient feedback

Healthcare providers' assumptions about Aboriginality show how attitudes can be perpetuated within healthcare settings. This is demonstrated in this excerpt from one patient's experience at Mercy Hospital for Women.

"I had a really bad experience with one of the nurses after I had given birth. She questioned my Aboriginality by saying I didn't look Aboriginal and she kept asking me if I was keeping the baby or getting rid of him.

"She was so rude. She made me upset. She said, 'You can't wag a baby, like you wag school.' What she doesn't know is I haven't wagged a day of school in my whole life. She made me so upset. It felt like because she knew I was young and Aboriginal that I was going to be a bad mum. Not all the nurses were like that, though. There was one nurse during the birth, she was the best. She was young, not grumpy, so friendly, made me feel comfortable."

Rural transfers

Stakeholders from rural hospitals and health services were also consulted. They identified the need to improve communication between organisations when transfers between rural and metropolitan services were taking place.

For example, rural Aboriginal health services may not find out that a patient has been transferred to a metropolitan hospital due to lack of communication from the local hospital. Likewise, metropolitan Aboriginal Hospital Liaison Officers may not know that a patient from a rural area has been admitted due to lack of communication both internally and from the local hospital.

This lack of communication can lead to inadequate service provision to the patient. Also, if a patient has been receiving the majority of their antenatal care at their rural Aboriginal health service, then that service may hold important information about the patient's health or social situation. Communication with the rural health service will enable more appropriate discharge planning for the family upon return to their local area.

Two of the patients consulted gave birth in a rural hospital and their babies were transferred to Mercy Hospital for Women's Neonatal Intensive Care Unit (NICU). Of these two families, neither was assisted with transport to Mercy Hospital for Women. One family found the transfer extremely challenging, particularly in regard to accessing services in Melbourne.

Patient feedback

"My baby was born at 28 weeks and he was transferred to Mercy Hospital for Women. I had to get directions on how to get to the hospital from an ambulance driver because we had no idea how to get there. It would have been good to have been provided with an information pack from the hospital with directions on how to get there and who to ask for when you arrive. I would have liked to know what to expect when I arrived. Even things like which floor to go to so you can see your baby. It was all so confusing, plus you have this really sick baby that you're scared about. It's already hard; you just need that support so badly.

"We got heaps of info when we arrived. We got a booklet from the Featherweight Club, train timetable and map of the local area. It would have been good to have this before we got there though."

Recommendations

- That formal handover processes are developed between rural hospitals and Mercy Hospital for Women to support admission to the hospital and discharge planning
- That information packs about Mercy Hospital for Women are developed and distributed to rural hospitals to be given to patients in the event of a rural transfer

Postnatal care

Although only a relatively small number of women were interviewed, their comments about the need for more postnatal support indicates a significant service gap.

The capacity of staff to follow up with the patient to put supports in place following discharge is limited, even with the knowledge that a patient has not engaged in services. Forty five per cent of staff interviewed refer patients to external services; however, communication about the outcome of referrals is often not provided.

The project's file audit identified that staff are not necessarily informed if a patient does not engage in a referral. Although the majority of patients consulted were linked into support services of some kind at the time of the consultation, 18 per cent of patients interviewed were not linked into any services and 65 per cent wanted to be linked into further services after the consultation.

Postnatal depression

Almost half of the patients consulted exhibited some signs of postnatal depression. This is a very high proportion compared to the general population's prevalence of postnatal depression (16 per cent). National data from BeyondBlue[4] suggests that being of Aboriginal and/or Torres Strait Islander descent significantly increases the risk of depression. Of the patients who experienced postnatal depression, only two had been referred to specific mental health services.

> ***"The way I felt when I came home was not normal – to want to throw your baby through the window. I needed someone to recognise how I was feeling. I felt let down by the service system. I had a vision of how it was going to be and it didn't pan out that way. It would have been good to have got further follow up from the hospital, to have someone checking in who might have picked up that I wasn't coping so well. I kind of needed someone to reassure me I was doing ok. It would be good to have someone to talk to on those off days."*** *Patient*

> ***"I would have liked some extra support when I left the hospital. It would be nice to know someone would be checking in with you, particularly for those who suffer from postnatal depression. Once the influx of visitors stops it can be very isolating."*** *Patient*

Breastfeeding

The majority of patients consulted breastfed for under two months, with only 24 per cent breastfeeding longer than this. This is consistent with findings from a study on a Melbourne Aboriginal community, which revealed that "although 98 per cent of mothers initiated breastfeeding, only 32 per cent were still breastfeeding at six

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[4] http://www.beyondblue.org.au Accessed Aug 2010

months"[5]. The study recommended that breastfeeding promotion to Aboriginal women needed to look at building on the individual's confidence and self esteem and also can be related back to a lack of uptake of parent education services[6].

There is a perception among some Mercy Hospital for Women staff that breastfeeding rates within the Aboriginal and Torres Strait Islander community are high. This incorrect perception could lead to less intensive breastfeeding education and support for Aboriginal and Torres Strait Islander women by Mercy Hospital for Women staff.

The difficulty of breastfeeding is the most common reason patients are unable to breastfeed for longer.

Other reasons include:

- Insufficient milk supply
- Formula is more convenient
- Shame or embarrassment about breastfeeding in public
- Other health issues

Postnatal services

Patients regarded postnatal services that provided social interaction and practical advice as the most beneficial to them.

They were asked their suggestions as to what an ideal service would look like for them. The most common responses were:

- A service run by Mercy Hospital for Women to provide extra support and follow up after discharge
- Having a "one stop shop" where patients can access a range of services relevant to their local area
- A phone line or support centre
- A service with a focus on the needs of Aboriginal families

> ***"A service that's easy to get to. I like VAHS and the services they offer. Some more follow up from the hospital. I would like someone to check on how I'm going not just the baby. Even if it's just social work or someone. Because if I'm struggling I want someone to ask me if I'm ok so I can tell them I'm not and get some help. You can just get home and breakdown. Even follow up phone calls when you get home: 'are you ok, are you stressed, how are you, do you need some help?'"*** *Patient*

[5] Holmes, Phillips, & Thorpe, 1997, p. 502

[6] Holmes et al, 1997

"Maybe a mums group that was suburb oriented so you could know there were other people out there. Even if it was just for Aboriginal women. I would like to meet other professional Aboriginal women." *Patient*

"Somewhere you could go and talk to people, like I did with social work during my pregnancy. It would have been good to have been able to take baby back to Mercy Hospital for Women every few months to see how baby is going." *Patient*

"More information about what services are out there. Not just Aboriginal services. Programs that are closer to home. Programs to stop you getting depression. Being stuck at home is depressing. It's usually a bit down the track when you realise you need the support. Cooking classes would be good. Something to get me out of the house. You want to get your child out there and learning. A toll free number that you can ring and find out what's going on. Something like the Maternal and Child Health Nurse line. I used that a few times." *Patient*

Summary

- Referrals to postnatal services do not always occur
- If there is a lack of engagement with patients following an external referral, there are not necessarily any specific procedures in place to be informed of this or to provide follow up
- The majority of patients would like to be linked in with more postnatal services
- The majority of patients breastfeed for less than two months
- Postnatal depression is a significant issue for Aboriginal and/or Torres Strait Islander patients

Recommendations

- The postnatal phase is a key area in which continuity of care for patients can be provided through the partnerships with organisations such as the Victorian Aboriginal Health Service, Banyule Community Health Service and Children's Protection Society. Banyule Community Health Service offers a wide range of health and support services for mothers and babies including paediatric services and parenting groups. In addition, Banyule Community Health Service has a GP service and a policy to prioritise Aboriginal and Torres Strait Islander clients and waive fees.
- Children's Protection Society offers services to children and parents, including a new early childcare centre, the "Mentoring Mum's" program, "I'm An Aboriginal Dad" and other child and family support services
- Further investigation is needed to identify how Nangnak Wan Myeek can work more closely with Mercy@Home and maternal and child health services to ensure Aboriginal and/or Torres Strait Islander babies and their parents get the best support

Conclusion

The file audit and community consultation undertaken for Nangnak Wan Myeek provide some important information and insights that will continue to shape the program. It is important that these findings are incorporated into a robust planning and evaluation framework that includes an understanding of the policy environment, the current health status of Aboriginal and Torres Strait Island people and the social determinants of these health issues.

This research is the starting point for ongoing dialogue with the Indigenous community, other services within Mercy Hospital for Women and service providers within the community. In order to develop the most effective program, it is important that we continue to develop, evaluate and re-shape our program in response to community need.

While there is room for improvement, the hospital and its staff are meeting the needs of many individuals. When asked if they would choose to have another baby at Mercy Hospital for Women, a few of the participants said:

> ***"Yes for sure. The experience was unbelievable. Out of all the hospitals, Mercy Hospital for Women beats them all. Everyone is really nice, supportive and lovely. I recommend the Mercy to everyone now."*** *Patient*

> ***"Absolutely. I feel they provide a great service and that it's a new building and that it's a women's hospital."*** *Patient*

> ***"Yes. I was treated with respect at the Mercy as a young mum. I felt discriminated against at my rural hospital. I felt really comfortable at Mercy Hospital for Women."*** *Patient*

By tapping into the strengths and resilience of the community and the willingness of everyone to contribute we can continue to work to close the gap in life expectancy for Aboriginal and Torres Strait Islanders.

Appendix 1

Research methods

File audit

Prior to the consultation phase a file audit of past patients was conducted. Fifty patient records were randomly selected from a list of Aboriginal babies born in 2009, as well as the 50 patient records of the respective mothers.

Information from the patient records was recorded in quantitative and qualitative measures. Statistical reports were created and key themes identified.

Consultation

The consultation was undertaken between November 2009 and April 2010 and is the umbrella term used to describe the development and implementation of consultations around the state.

Stakeholders

A stakeholder list was developed, which led to the identification of consultation participants.

Information sheets were developed specific to the three target groups – past patients, Mercy Hospital for Women staff and external stakeholders – in order to inform stakeholders of the project and consultation phase. All participants received a letter which outlined the consultation phase and that they had been identified as a possible participant.

In collaboration with the Cooperative Research Centre for Aboriginal Health, and with the approval of Mercy Health's Human Research Ethics Committee, three separate questionnaires with similar themes were developed for the three target groups.

A plan was developed to structure the consultations that recorded contact people, addresses, consultation dates, etc and keep track of any communication with the organisation.

All participants were given an information and consent form as well as a media consent form where applicable. Patients were asked to complete a demographic sheet and then were asked the questions.

External stakeholders

Stakeholders from 37 external organisations were consulted:

- Banyule City Council
- Banyule Community Health Service
- Bendigo District Aboriginal Cooperative
- Bunurong Medical Centre
- Centrelink

- Central Gippsland Aboriginal Health and Housing Cooperative
- Children's Protection Society
- Darebin City Council
- Darebin Community Health
- Dental Health Services Victoria
- DHS Northwest Region
- Diabetes Victoria
- Dianella Health
- Gippsland and East Gippsland Aboriginal Cooperative
- Gunditjmara Aboriginal Cooperative
- Mildura Aboriginal Cooperative
- Mungabareena Aboriginal Cooperative
- Njernda Aboriginal Cooperative
- Office of Child and Safety Commissioner
- Plenty Valley Community Health
- Robinvale New Directions (Murray Valley Aboriginal Cooperative)
- Royal Children's Hospital
- Royal Women's Hospital, Aboriginal Women's Business Unit
- Royal Women's Hospital, Women Alcohol and Drugs Clinic
- Rumbalara Aboriginal Cooperative
- Secretariat of National Aboriginal and Islander Child Care
- Southern Health
- St Vincent's Hospital
- Swan Hill and District Aboriginal Cooperative
- Swan Hill District Hospital
- Victorian Aboriginal Child Care Agency
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Aboriginal Health Service
- Wathaurong Aboriginal Cooperative
- Whittlesea City Council
- Wodonga District Hospital
- Yappera Children's Services Cooperative

Past patients

All women who were recorded as having given birth to an Aboriginal or Torres Strait Islander baby in 2009 were identified and their records retrieved. Eighty six past patients were contacted and offered the opportunity to take part in the consultation phase.

Of these 86:

- 12 patients were incorrectly identified as Aboriginal
- 9 patients' identification record stated "Question unable to be asked", but none of these women identified as Aboriginal and Torres Strait Islander when contacted
- 16 patients did not respond to phone calls
- 12 patients phones were disconnected
- 5 patients were in a situation where it was not appropriate to engage
- 11 patients did not want to be involved in consultations
- 21 patients agreed to take part in the consultation (4 patients cancelled)
- 17 patients were consulted

Patients received a $30 gift voucher for Kmart or Big W and follow up referrals were provided by a Social Worker or Aboriginal Community Liaison Officer where necessary based on issues raised during the consultation.

Mercy Hospital for Women staff

Staff who took part in the consultation worked in areas of Mercy Hospital for Women that were relevant to families in the antenatal or postnatal phase. Forty two members of staff were consulted, the majority during individual meetings. Two focus groups were also held.

Appendix 2

Questionnaire 1

Questions for Mercy Hospital for Women patient consultations.

PRE-ADMISSION

We would like to hear from you a little bit about your experience from when you found out you were pregnant. Is it ok if we ask you some questions?

1. Why did you choose to have your baby at Mercy Hospital for Women?

2. When you booked in were you asked the question if you were A&TSI?

   If yes: When were you asked? Were you asked if your baby was A&TSI? Did you feel comfortable when asked?

   If no: Did you identify yourself and at what point? Did you feel comfortable when identifying?

3. What information were you provided with in the pre-admission phase? What form was it in? *(eg pamphlet, fact sheet, form)*

4. Was the information you received useful/easy?

   If no: What would have made it more useful/easy to understand?

ANTENATAL CARE

Now that we have heard a little bit about how you came to be a patient at Mercy Hospital for Women and your experience of booking in or attending your first appointment we would like to hear about some of your experiences during your pregnancy as a patient at Mercy Hospital for Women.

5. Which clinic did you attend for your antenatal care?

   Why did you go to this clinic?

6. What was your experience within this clinic?

7. Do you know what an AHLO is?

8. Were you made aware of the AHLO? Were you introduced?

   If yes: Did you find this supportive and what did she assist you with?

   If no: Would you have like to be supported by the AHLO and how?

9. Are you aware of the Transitions Clinic?

10. Were you given the option of attending the Transitions Clinic?

    If no: Would you have chosen to proceed with your ante-natal care in the T/C if offered?

11. If given the option of attending the Transitions Clinic, did you attend?

    If yes: Why?

    If no: Why not?

12. What is your understanding of cultural safety/appropriateness for Aboriginal patients?

13. Did you find your experience during your ante-natal care culturally safe?

    If yes: In what way?

    If no: Why not?

14. Do you have any suggestions as to how the outpatients area could improve its cultural safety?

15. If you identified yourself or your baby as ATSI do you feel that the health professionals working with you considered this throughout the duration of your ante-natal care?

16. What information were you provided with in the ante-natal phase? Did this include information about nutrition advice? What form was it in? *(eg pamphlet, fact sheet, form*)*If yes:* From whom did this information come from? *If no*: Do you feel you would have benefited from some information regarding nutrition?

17. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

18. Did you find it difficult to attend all of your required appointments?

    If yes: Why?

    If no: What made it easy for you to attend appointments?

19. Can you suggest what might make it easier to attend appointments at Mercy Hospital for Women?

20. If you missed an appointment, were you followed up by Mercy Hospital for Women?

    If yes: Who followed up?

21. Were you referred to any other service while receiving you ante-natal care?

22. Were you or your partner made aware of the IAAD program? Did your partner participate in the program?

23. Did you have an opportunity to complete a birthing plan specific to your birthing needs with your mid-wife?

    If yes: Did you feel that this was carried out during your labour?

    If no: Would have you taken this opportunity up to complete a birthing plan?

BIRTHING

Now that we have heard from you your experiences during your pregnancy care we'll now ask some questions about the day that you delivered your baby.

24. How did you get into hospital when you were in labour?

25. Did you have phone contact with the hospital prior to coming in?

    If yes: What was your experience?

    If no: Why not?

26. Did you find your experience during your birth culturally safe?

27. Do you have any suggestions about how the birthing experience for A&TSI women could be improved?

ADMISSION TO THE WARD

After your delivery you may have spent some time in the birthing suite prior to moving up to the Maternity ward on the 5th floor.

28. After you delivered your baby was your baby transferred to NICU/SCN?

    If yes: For how long? **(Go to Questionnaire 2)**

29. Were you asked the question if your baby was A&TSI?

    If yes: When were you asked? Did you feel comfortable when asked?

    If no: Did you identify and at what point? Did you feel comfortable when identifying?

30. How did you find the transition from the BSU to the Maternity Ward?

31. How long did you stay in hospital after you gave birth? Did you feel this was long enough?

32. Did you find your experience during your stay on the ward culturally safe?

    If yes: In what way?

    If no: Why not?

33. Do you have any suggestions as to how the ward could improve cultural safety?

34. What information were you provided with in the admission phase? What form was it in? *(eg pamphlet, fact sheet, form)*

35. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

36. Were you referred to any service while on the ward?

DISCHARGE

After your stay on the Maternity ward it is now time for you to leave the hospital with your baby. We are interested to hear about what planning was in place for you at the time of discharge.

37. What information were you provided with in the discharge phase? What form was it in? *(eg pamphlet, fact sheet)*

38. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

39. Were you visited by DOM mid-wives?

    If yes: Did you benefit from this service?

    If no: Why not?

40. Have you continued to see your Maternal Child Health Nurse since having your baby?

    If yes: Which service? Do you find this useful? What practical advice/support do they assist you with?

    If no: Why not?

41. What information were you provided with by the Maternal Child Health Nurse? What form was it in? *(eg pamphlet, fact sheet)*

42. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

43. Did Mercy Hospital for Women require any further follow up with you or your baby?

    If yes: What follow-up?

    If no: Why not

44. Did you find it difficult to attend your follow up appointments?

    If yes: Why?

    If no: What made it easy for you to attend follow up appointments?

45. Can you suggest what might make it easier for you to attend follow up appointments at Mercy Hospital for Women?

46. If you missed an appointment after discharge, were you followed up by Mercy Hospital for Women?

    If yes: Who followed up?

47. Did you continue to breastfeed your baby for after discharge? If yes, for how long? *Between 1-2 weeks. 2-4 weeks. 1-2 months. 2-3 months. 3-6 months. More.*

    If under 3 months can you tell us why you stopped breast feeding?

48. Would you choose Mercy Hospital for Women to have another baby?

    If yes: Why?

    If no: Why not?

49. Has your child seen a paediatrician for follow-up?

    If yes: Where?

    If no: Why not?

50. Is your child immunised?

    If yes: Where was this done?

    If no: Why not?

    (If applicable)

    Are your other children immunised?

    If yes: Where was this done?

    If no: Why not?

51. What services do you use with your baby now? How do you find these services? What practical advice/support do they assist you with? Is the information easy to understand?

52. Hypothetically, if you imagine the ideal service for you and your baby can you tell us what that might look like?

53. Were there any other services you might want to be connected with or introduced to?

Would you like to raise any other issues for us to consider that haven't been discussed today?

Appendix 3

Questionnaire 2

Questions for mothers of babies that were transferred to Mercy Hospital for Women NICU after delivering at Mercy Hospital for Women.

Please note: Complete Questionnaire 1 first and begin this questionnaire, if relevant, after question 29.

ADMISSION TO THE WARD

After your delivery you may have spent some time in the birthing suite prior to moving up to the Maternity ward on the 5th floor.

54. How did you find the transition from the BSU to the Maternity Ward?

55. How long did you stay in hospital after you gave birth? Did you feel this was long enough?

56. Did you find your experience during your stay on the ward culturally safe?

    If yes: In what way?

    If no: Why not? How could this be improved?

57. Do you have any suggestions as how to make the ward more culturally safe?

58. What information were you provided while on the ward? What form was it in? *(eg pamphlet, fact sheet)*

59. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

60. Were you referred to any service while on the ward?

61. Were you asked the question if your baby was A&TSI?

    If yes: When were you asked? Did you feel comfortable when asked?

    If no: Did you identify and at what point? Did you feel comfortable when identifying?

MATERNAL DISCHARGE

After your stay on the maternity ward it is now time for you to leave the hospital, however we understand how difficult this would have been to not be going home with your baby. We are interested to hear about what planning was in place for you at the time of discharge.

62. What information were you provided with on discharge? What form was it in? *(eg pamphlet, fact sheet)*

63. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

64. Did you have contact with the AHLO during the time your baby was in NICU?

    If yes: Did you find this supportive and what did they assist you with?

    If no: Would you have like to be supported by the AHLO and what with?

65. While your baby was in NICU/SCN, did you find the NICU/SCN culturally safe?

    If yes: In what way?

    If no: Why not?

66. Do you have any suggestions as to how the NICU/SCN could be made more culturally safe?

67. Were you provided with enough information and support by Mercy Hospital for Women staff throughout the time your baby was in NICU?

68. What information were you provided with during the time your baby was in NICU/SCN? What form was it in? *(eg pamphlet, fact sheet)*

69. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

70. Were you referred to any other service on discharge?

BABY DISCHARGE

Now we would like to finish up by hearing from you what it was like when your baby was discharged from Mercy Hospital for Women, whether this be to another hospital or to home.

71. Was your baby transferred to another hospital from Mercy Hospital for Women? Were you informed of appropriate A&TSI services available at the referred hospital?

72. Were you visited by DOM mid-wives?

    If yes: Did you benefit from this service?

    If no: Why not?

73. Have you continued to see your Maternal Child Health Nurse since having your baby?

    If yes: Which service? Do you find this useful? What practical advice/support do they assist you with?

    If no: Why not?

74. What information were you provided with by the Maternal Child Health Nurse? What form was it in? *(eg pamphlet, fact sheet)*

75. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

76. Did Mercy Hospital for Women require any further follow up with you or your baby?

    If yes: What follow-up?

    If no: Why not

77. Did you find it difficult to attend your follow up appointments?

    If yes: Why?

    If no: What made it easy for you to attend follow up appointments?

78. Can you suggest what might make it easier for you to attend follow up appointments at Mercy Hospital for Women?

79. If you missed an appointment, were you followed up by Mercy Hospital for Women?

    If yes: Who followed up?

80. Did you continue to breast feed your baby after discharge? If yes, for how long? *Between 1-2 weeks. 2-4 weeks. 1-2 months. 2-3 months. 3-6 months. More.*

    If under 3 months can you tell us why you stopped breast feeding?

81. Would you choose to go to Mercy Hospital for Women to have another baby?

    If yes: Why?

    If no: Why Not?

82. Has your child seen a paediatrician for follow-up?

    If yes: Where?

    If no: Why not?

83. Is your child immunised?

    If yes: Where was this done?

    If no: Why not?

    (If applicable)

    Are your other children immunised?

    If yes: Where was this done?

    If no: Why not?

84. What services do you use with your baby now? How do you find these services? What practical advice/support do they assist you with? Is the information easy to understand?

85. Hypothetically, if you imagine the ideal service for you and your baby can you tell us what that might look like?

86. Were there any other services you might want to be connected with or introduced to?

Would you like to raise any other issues for us to consider that haven't been discussed today?

Appendix 4

Questionnaire 3

Questions for mothers of babies that were transferred to Mercy Hospital for Women NICU from another hospital.

ADMISSION TO MERCY HOSPITAL FOR WOMEN

We would like to hear from you a little bit about your experience from when you and/or your baby were transferred to Mercy Hospital for Women. Is it ok if we ask you some questions?

1. When your baby was transferred to Mercy Hospital for Women NICU were you also transferred as a patient?

   If yes: How long after your baby was transferred? *(Go to question 2)*

   If no: Why not? *(Go to question 10)*

2. How long did you stay in Mercy Hospital for Women as an inpatient after you gave birth? Do you feel this was long enough?

3. Were you asked the question if you were A&TSI?

   If yes: When were you asked? Did you feel comfortable when asked?

   If no: Did you identify and at what point? Did you feel comfortable when identifying?

4. What is your definition of cultural safety for Aboriginal patients?

5. Did you find your experience during your stay on the ward culturally safe?

   If yes: In what way?

   If no: Why not?

6. Do you have any suggestions as to how the ward could be made more culturally safe?

7. What information were you provided with while on the ward? What form was it in? *(eg pamphlet, fact sheet, form)*

8. Was the information you received useful/easy to understand?

   If no: What would have made it more useful/easy to understand?

9. Were you referred to any service while on the ward?

10. Were you asked the question if your baby was A&TSI?

    If yes: When were you asked? Did you feel comfortable when asked?

    If no: Did you identify and at what point? Did you feel comfortable when identifying?

11. Do you know what an AHLO is?

12. Were you made aware of the AHLO? Were you introduced?

    If yes: Did you find this supportive and what did she assist you with?

    If no: Would you have like to be supported by the AHLO and how?

13. Was your partner or family assisted with transport from home to Mercy Hospital for Women when your baby was transferred to NICU? By whom?

14. Were you or your family supported to access accommodation close to Mercy Hospital for Women while your baby remained in NICU? By whom? How did you find this accommodation?

MATERNAL DISCHARGE

After your stay on the maternity ward it is now time for you to leave the hospital, however we understand how difficult this would have been to not be going home with your baby. We are interested to hear about what planning was in place for you at the time of discharge.

15. What information were you provided with on discharge? What form was it in? *(eg pamphlet, fact sheet)*

16. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

17. Did you have contact with the AHLO during the time your baby was in NICU?

    If yes: Did you find this supportive and what did they assist you with?

    If no: Would you have like to be supported by the AHLO and what with?

18. While your baby was in NICU/SCN, did you find the NICU/SCN culturally safe?

    If yes: In what way?

    If no: Why not?

19. Do you have any suggestions as to how the NICU/SCN could be made more culturally safe?

20. Were you provided with enough information and support by Mercy Hospital for Women staff throughout the time your baby was in NICU?

21. What information were you provided with during the time your baby was in NICU/SCN? What form was it in? *(eg pamphlet, fact sheet)*

22. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

23. Were you referred to any other service on discharge?

BABY DISCHARGE

Now we would like to finish up by hearing from you what it was like when your baby was discharged from Mercy Hospital for Women, whether this be to another hospital or to home.

24. Was your baby transferred to another hospital from Mercy Hospital for Women? Were you informed of appropriate A&TSI services available at the referred hospital?

25. Were you visited by DOM mid-wives?

    If yes: Did you benefit from this service?

    If no: Why not?

26. Have you continued to see your Maternal Child Health Nurse since having your baby?

    If yes: Which service? Do you find this useful? What practical advice/support do they assist you with?

    If no: Why not?

27. What information were you provided with by the Maternal Child Health Nurse? What form was it in? *(eg pamphlet, fact sheet)*

28. Was the information you received useful/easy to understand?

    If no: What would have made it more useful/easy to understand?

29. Did Mercy Hospital for Women require any further follow up with you or your baby?

    If yes: What follow-up?

    If no: Why not

30. Did you find it difficult to attend your follow up appointments?

    If yes: Why?

    If no: What made it easy for you to attend follow up appointments?

31. Can you suggest what might make it easier for you to attend follow up appointments at Mercy Hospital for Women?

32. If you missed an appointment, were you followed up by Mercy Hospital for Women?

    If yes: Who followed up?

33. Did you continue to breast feed your baby after discharge? If yes, for how long? *Between 1-2 weeks. 2-4 weeks. 1-2 months. 2-3 months. 3-6 months. More.*

    If under 3 months can you tell us why you stopped breast feeding?

34. Would you choose to go to Mercy Hospital for Women to have another baby?

    If yes: Why?

    If no: Why Not?

35. Has your child seen a paediatrician for follow-up?

    If yes: Where?

    If no: Why not?

36. Is your child immunised?

    If yes: Where was this done?

    If no: Why not?

    (If applicable)

    Are your other children immunised?

    If yes: Where was this done?

    If no: Why not?

37. What services do you use with your baby now? How do you find these services? What practical advice/support do they assist you with? Is the information easy to understand?

38. Hypothetically, if you imagine the ideal service for you and your baby can you tell us what that might look like?

39. Were there any other services you might want to be connected with or introduced to?

Would you like to raise any other issues for us to consider that haven't been discussed today?

Appendix 5

Discussion questions

Focus Group, Mercy Hospital for Women Staff

Identification

1) Do you ask every patient if they identify as Aboriginal and Torres Strait Islander? If no, why not?

2) Do you have any suggestions as to how the identification process could be improved? Eg what would make it easier to ask the question or what would make it easier to know if a patient is Aboriginal or Torres Strait Islander?

3) Provide explanation about why it's a hospital requirement to ask the identification question.

4) Discuss the importance of asking the partner's identification at a relevant time.

Cultural safety

5) Explain about cultural safety – that it's different for everyone or that the term might be unknown. Provide explanation of Cultural Safety.

6) Is Mercy Hospital for Women a culturally safe place for Aboriginal patients?

Referrals

7) In regards to referrals that you make internally and externally, do you hear back from the service you've referred to as to the outcome of that referral? Where is this information inputted?

8) If a patient doesn't show up at a referral you've made – do you find out?

Barriers and gaps

9) One of our aims is to assess the barriers and gaps for Aboriginal women accessing Mercy Hospital for Women. Can you identify any barriers and/or gaps from your experience?

Cultural awareness training

10) If an action plan was developed in the hospital to improve Aboriginal cultural safety and awareness training within Mercy Hospital for Women, do you think you would benefit from this training?

11) What kind of topics or subjects would you be interested in learning about in a cultural awareness training session?

12) Can you suggest ways in which we can deliver a program which will best ensure staff participation?

Anything else that you would like to discuss today?

Appendix 6

Participant information and consent form

TEMPLATE FOR NON-CLINICAL DRUG TRIAL PROJECTS

Dated: February 2010

Full Project Title: New Directions: an Equal Start in Life for Indigenous Children- Mothers and Babies Services

Principal Researcher: Joanne Borg (Mercy Health)

Associate Researcher(s): Jessica Brooks, Olivia Kerr and Kellie Hunter Loughron (Mercy Health)

---

1. Your Consent

You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative, friend or health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

Mercy Hospital for Women, in partnership with the Children's Protection Society (CPS) and Banyule Community Health Service, has received 4-year New Directions funding from OATSIH (Dept. of Health & Ageing). New Directions is the government's policy framework for Aboriginal maternal and child health, and an important part of the 'Closing the Gap' strategy.

The purpose of this project is to collect information from past and current clients of Mercy Hospital for Women expecting an Aboriginal/Torres Strait Islander baby, about any difficulties they had in accessing or attending recommended care and appointments. Aboriginal Health workers, Mercy Hospital for Women staff and relevant stakeholders will also be consulted about their perception of clients' needs, but will not be asked for any identifying information.

The information gathered will be used to help develop a program to better assist women to access the hospital and other health services to receive recommended antenatal and postnatal care.

You are invited to participate in this project because OATSIH and the research team, led by Aboriginal health professionals employed by Mercy Hospital for Women, believes you can provide important information about the needs of women who were- or are now- expecting an Aboriginal baby at Mercy Hospital for Women.

3. Procedures

Participation in this project will involve giving information about any difficulties in attending or accessing care- either by telephone, one on one consultation or by participation in a Focus group. Consultations may be taped with a Dictaphone. No identifying information will be recorded about past clients. For current clients, information about any difficulties in attending for care, and possible ways to assist, will be noted in the woman's confidential medical file. No identifying information about past or current clients will be made available to non Mercy Hospital for Women staff members. No identifying information will be recorded about Mercy Hospital for Women staff.

4. Possible Benefits

Possible benefits include participation in the development of a program to improve accessibility and appropriateness of care for women expecting an Aboriginal/Torres Strait Islander baby at Mercy Hospital for Women. The program may eventually be recommended by state and federal governments as a model for other hospitals caring for A/TSI mothers and babies.

5. Possible Risks

Possible risks and discomforts include emotional distress when discussing past difficulties in attending for care, and assistance you believe is needed but not currently available. If needed, trained counselling, independent of the research team, is available. In this case, please ask Joanne Borg, Manager of New Directions (Mercy Hospital for Women) to arrange this.

6. Privacy, Confidentiality and Disclosure of Information

There will be no identifying information recorded for this project, except in confidential medical files of women currently expecting an Aboriginal/Torres Strait Islander baby at Mercy Hospital for Women.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. If you give us your permission by signing the Consent Form we plan to share, discuss or publish non-identifying results with staff from:

- Mercy Hospital for Women and partner organisations
- Aboriginal Community health and research organisations
- OATSIH and DHS ICAP (Improving Care for Aboriginal Patients)

in order to develop the New Directions program and improve access to antenatal and postnatal healthcare for women expecting an A/TSI baby.

No identifying information will be disclosed or published.

7. Results of Project

A copy of the project report will be sent to all participants on request.

8. Further Information or Other Issues

If you require further information or if you have any problems concerning this project, you can contact Joanne Borg on 84584392.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact

- Carole Branch, Secretary Research Ethics Committee, Mercy Health & Aged Care, PH: 8458 4808

9. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with Mercy Hospital for Women.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw.

10. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Mercy Health.

11. Reimbursement for Your Costs

You will receive a $30 gift voucher for your participation.

CONSENT FORM
(ATTACH TO PARTICIPANT INFORMATION)

Consent Form
Version Dated 1. February 2010
Site: New Directions

Full Project Title: New Directions: an Equal Start in Life for Indigenous Children- Mothers and Babies Services

---

I have read, and I understand the Participant Information version ***1*** dated ***x***.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) ……

Signature Date

Name of Witness to Participant's Signature (printed) ……

Signature Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature.

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Glossary of terms

AHLO	Aboriginal Hospital Liaison Officer
AWFSU	Aboriginal Women & Family Support Unit
BCHS	Banyule Community Health Service
CPS	Children's Protection Society
CRCAH	Cooperative Research Centre for Aboriginal Health
IAAD	"I'm An Aboriginal Dad" program
M&CH	Maternal & Child Health Nurse
HREC	Mercy Health Human Research Ethics Committee
NICU	Neonatal Intensive Care Unit
OATSIH	Office of Aboriginal and Torres Strait Islander Health
SCN	Special Care Nursery
VAHS	Victorian Aboriginal Health Service

Nangnak Wan Myeek – "Nurture, care and look after me and mine"

Mercy Health
Care first

Mercy Hospital for Women
163 Studley Road
Heidelberg Victoria 3084
Phone (03) 8458 4444
mercyhealth.com.au