Cultural Responsiveness Framework Implementation Plan 2010-2013

For collection from:

Sloane Street, Stawell

To request a copy by post:

Phone (03) 5358 8500
Fax (03) 5358 3553
Email info@srh.org.au

Website www.srh.org.au

Enquiries

contact Sarah Warren, Quality Manager on

☎ (03) 5358 8500

Reference:
Department of Health 2009, *Cultural Responsiveness Framework - Guidelines for Victorian health services*, Melbourne.

CONTENTS

Message from the Chief Executive Officer 3

Introduction - Stawell Regional Health 4

A summary of the Local Healthcare Environment 4

Cultural Diversity In our Catchment 5

What is Cultural Responsiveness? 9

What is the Cultural Responsiveness Framework? 9

Reporting and Responsibilities 11

Governance Structure 12

Policy frameworks and Legislation 13

Government Policy and Programs 14

A summary of Relevant Organisation Policies and Strategies 14

Development of the Plan : 15

Implementation of the Plan 15

Standard 1: A whole-of-organisation approach to cultural responsiveness is demonstrated. 17

Standard 2: Leadership for cultural responsiveness is demonstrated by the health service 23

Standard 3: Accredited interpreters are provided to patients who require one 27

Standard 4: Inclusive practice in care planning is demonstrated, including but not limited to: dietary, spiritual, family, attitudinal, and other cultural practices. 36

Standard 5: CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis. 40

Standard 6: Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness. 43

Appendices: 47

Appendix 1: Glossary of Terms 47

Appendix 2: SRH Services 49

Appendix 3: Additional Resources Available 51

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

Stawell Regional Health aims to provide excellent health services and facilities that are accessible to all people who live, work in or visit the area.

Stawell Regional Health provides an extensive range of acute, residential, home and community based services in Stawell. Our Rural Primary Health Services Program operates throughout Northern Grampians Shire. Under this Commonwealth funded program, staff provide regular services to small regional towns and their surrounding areas including Halls Gap, Landsborough, Navarre and Marnoo.

The preparation of this 'Cultural Responsiveness Framework Implementation Plan' has identified opportunities to eliminate barriers preventing access and participation.

Development of this Plan reflects the organisation's commitment to continuing to provide equitable and inclusive health services. The Plan will seek to improve the organisation's planning, services, facilities, programs, communications and employment processes.

This plan includes a range of strategies and actions to remove barriers that face people from a cultural and linguistically diverse (CALD) background. Implementation of the plan will be staged over the next three years, starting with areas of immediate need.

The strategies in this Plan include:

- Improved provision of information internally and externally
- Removal of barriers to community participation
- Improved resources and education for staff

This strategy will be an integral link to many other Plans that already exist across Stawell Regional Health, especially the organisation's Strategic Plan and Disability Action Plan.

This plan is an important step along the road to reducing barriers and increasing access for all. Through the implementation of this Plan, we look forward to making further progress over the next three years and beyond.

Claire Letts
Acting Chief Executive

INTRODUCTION - STAWELL REGIONAL HEALTH

Stawell Regional Health (SRH) aims to improve the quality of service delivery and ensure that the health service caters appropriately to cultural and linguistic diversity in all of its services and activities.

SRH commits to working to implement the strategies contained in the Implementation Plan over the next three years and to regularly monitor progress. We will seek to identify barriers that people face and investigate how these barriers can be removed.

We will continue to improve our services and adhere to the organisation's Mission Statement:

Our Mission Statement

Stawell Regional Health provides a complete continuum of integrated health and related services, by providing the highest quality facilities and skills delivered in a personalised and caring environment.

A SUMMARY OF THE LOCAL HEALTHCARE ENVIRONMENT

The Health Status of Stawell Community

Stawell is centred within the Northern Grampians and surrounded by Ararat and Pyrenees local government areas, all of which are reported as having significantly lower life expectancy, for both males and females, than the Victorian average, especially in the following areas: Cardiovascular disease, cancer, diabetes and asthma.

Demographic Profile

The Northern Grampians Shire is rated as the fourth most disadvantaged local government area in regional Victoria, with a 2006 SEIFA index of disadvantage of 946.4.

The Northern Grampians Shire is one of 11 Local Government Areas in regional Victoria that has a declining population, This is likely to continue over the next 10 years as in the previous 10 years, which experienced a decline from 13,055 to 12,316 residents.

It is expected that the average age of the residents in the area will increase over time. The largest changes in age groups is persons aged 50 years and over, and is generally 2% higher than the regional Victorian average.

The implications of these changes in population are:

- an increasing demand on residential aged care services
- preferences for outpatient and community services, and residential care
- increasing numbers of consumers with a chronic disease
- demands by consumers for a range of treatment options
- increasing demands for home based services and
- changes for midwifery services.

Key statistics (summary statistics)	Northern Grampians Shire						
	2006			2001			
Enumerated data	number	%	Regional Victoria %	number	%	Regional Victoria %	Change 2001 to 2006
Enumerated population, including overseas visitors							
Total population (a)	11,875	100.0	100.0	12,700	100.0	100.0	-829
Males (a)	5,886	49.6	49.2	6,361	50.1	49.3	-475
Females (a)	5,985	50.4	50.8	6,339	49.9	50.7	-354
Overseas visitors	86	.07	.04	84	.07	.04	2
Enumerated population, excluding overseas visitors							
Total population (b)	11,787	100.0	100.0	12,616	100.0	100.0	-829
Males (b)	5,849	49.6	49.2	6,324	50.1	49.4	-475
Females (b)	5,938	50.4	50.8	6,292	49.9	50.6	-354
Population characteristics							
Indigenous population	92	0.8	1.2	107	0.8	1.0	-15
Australian born	10,425	88.5	84.4	11,330	89.8	85.0	-905
Overseas born	712	6.0	10.0	653	5.2	9.9	59
Australian citizens	10,991	93.3	91.5	11,889	94.2	92.5	-898
Australian citizens aged 18+	8,329	70.7	68.0	8,707	69.0	67.3	-378
Institutional population	371	3.1	3.5	381	3.0	3.3	-10
Age structure							
Infants 0 to 4 years	662	5.6	6.2	853	6.8	6.7	-191
Children 5 to 17 years	2,186	18.5	19.2	2,525	20.0	20.3	-339
Adults 18 to 64 years	6,823	57.9	59.3	7,223	57.3	58.8	-400
Mature adults 65 to 84 years	1,824	15.5	13.4	1,730	13.7	12.6	94
Senior citizens 85 years and over	288	2.4	1.9	286	2.7	1.7	2

Source: Australian Bureau of Statistics, Census of Population and Housing, 2006, 2001, 1996, and 1991.

CULTURAL DIVERSITY IN OUR CATCHMENT

Australian Bureau of Statistics (ABS) data obtained in the 2006 Census indicates the following cultural roots for our consumers.

Northern Grampians LGA – Country of Birth

88.7 percent of residents of Northern Grampians Shire were born in Australia. 3.1% of residents were born in English–speaking countries and 0.5% of residents were born in non-English speaking countries. Only 5% spoke a language other than English at home.

Of those born overseas, the majority of residents were born in England, New Zealand, Scotland, Netherlands and Germany.

Pyrenees LGA – Country of Birth

84.6 percent of residents of Pyrenees Shire were born in Australia. English was stated as the only language spoken at home by 92.7% of people. The most common languages other than English spoken at home were German, Italian, Dutch, Croatian and Filipino.

4.9% of residents were born in English–speaking countries and 3.2% of residents were born in non-English speaking countries.

Of those born overseas, the majority of residents were born in England, New Zealand, Netherlands, Scotland and Germany.

It is important to note that the township of Landsborough, in the Pyrenees Shire, is almost equal in distance from both Ararat and Stawell. As a result, residents access health services in both towns. The predominant non-English-speaking country of birth in Landsborough is Malta. All residents speak fluent English.

Indigenous Population:

0.7% of residents (86 people) of Northern Grampians Shire (NGS) are of Aboriginal or Torres Strait Islander origin. 0.5% of residents (35 people) of Pyrenees Shire are of Aboriginal or Torres Strait Islander origin. This is compared with 2.3% Indigenous persons in Australia.

The majority of indigenous people in our catchment live in Halls Gap (NGS), Pomonal (Ararat Rural City), and Stawell (NGS).

Chinese Population:

Not included in the ABS data is the developing Chinese population in Stawell. For the last 6-7 years Stawell Secondary College have had a program in years 10, 11 and 12 that caters for students from China. There are approximately 30 Chinese students at Stawell Secondary College per year. The students are billeted out with host families in the district. When these students arrive, many of them do not speak English. There are health issues associated with dietary changes, and many are reluctant to access Western medicine.

Understanding clients and their needs

Access to mainstream health services has improved significantly with the involvement in the past four years of the male Indigenous Health and Community Development Worker who is now employed full-time.

In the next twelve months, further work with members of Budja Budja Aboriginal Co-Operative, including changes to the physical environment at Stawell Regional Health to increase cultural safety and sensitivity, is designed to impact positively both on individuals' willingness to identify as an indigenous person, and to access mainstream health services.

Partnerships with multicultural and ethno-specific agencies

Our organization has undertaken to work in partnership with the appropriate ethno-specific and multi-cultural agencies to assist in obtaining a better understanding of our local CALD communities, liaising directly with Budja Budja Aboriginal Co-Operative on a regular basis.

A workforce with skills in cultural diversity

Stawell Regional Health actively seeks to engage new employees who are from different backgrounds, or who have different experiences or perspectives. The employment application process identifies people from culturally and linguistically diverse backgrounds, and a general register is kept.

Using languages to best effect

Timely and effective interpreting and translation services improve both access to services, and the quality of the service provided. There has been significant education of staff to ensure they are trained and proficient in accessing the Department of Health interpreting and translation services.

Encouraging participation in decision-making

Despite extensive advertising and targeted recruitment in 2009, we have been unable to establish our own Community Consultation and Cultural Diversity Committee.

We have subsequently formed a partnership with the WestVic Division of General Practice that enables us to access their Consumer Health Network. The network works on an information sharing basis. Members of the community are sent quarterly newsletters to keep them informed on Division and local health service activities. Their views on certain issues are sought as needed. This may be in the form of small group discussions, questionnaires or written comments.

Promoting the benefits of a culturally diverse community

Whilst there is limited cultural diversity in the Stawell Regional Health catchment area, assisting in promoting and sustaining cultural diversity should result in positive benefits to health and well-being. Acknowledgment of cultural diversity does not necessarily require special events, but can be through enduring initiatives such as displaying artwork that is culturally important to a particular CALD group. SRH now displays the Aboriginal and Torres Strait Islander flags, and is considering artwork that is relevant to our local community.

Country of Birth top 6 overseas birthplaces ranked for 2006 (persons)	Northern Grampians Shire						
	2006			2001			
Enumerated data	number	%	Regional Victoria %	number	%	Regional Victoria %	Change 2001 to 2006
United Kingdom	335	2.8	3.6	330	2.6	3.7	5
New Zealand	71	0.6	0.9	77	0.6	0.8	-6
Netherlands	38	0.3	0.6	42	0.3	0.6	-4
Germany	31	0.3	0.5	30	0.2	0.5	1
China	22	0.2	0.1	3	0.0	0.1	19
South Africa	22	0.2	0.2	5	0.0	0.1	17
Non-English speaking backgrounds	261	2.2	5.0	213	1.7	5.0	48
Main English speaking countries	451	3.8	5.0	440	3.5	5.0	11
TOTAL OVERSEAS BORN	712	6.0	10.1	653	5.2	9.9	59
AUSTRALIA	10,425	88.5	84.4	11,330	89.8	85.0	-904
NOT STATED	647	5.5	5.5	627	5.0	5.1	20
Total	11,784	100.0	100.0	12,610	100.0	100.0	-826

Source: Australian Bureau of Statistics, Census of Population and Housing, 2006 and 2001.

Proficiency in English (overseas born persons aged 5 years and over)	Northern Grampians Shire						
	2006			2001			
Enumerated data	number	%	Regional Victoria %	number	%	Regional Victoria %	Change 2001 to 2006
Speaks English only	584	81.1	67.8	557	85.0	67.8	27
Speaks another language and English not well or not at all	20	2.8	5.5	12	1.8	5.6	8
Speaks another language and English well or very well	108	15.0	25.5	83	12.7	25.1	25
Speaks another language and English - proficiency not stated	0	0	0.4	0	0	0.4	0
	8	1.1	0.9	3	0.5	1.0	5
Total	720	100.0	100.0	655	100.0	100.0	65

Source: Australian Bureau of Statistics, Census of Population and Housing, 2006 and 2001.

WHAT IS CULTURAL RESPONSIVENESS?

The term cultural responsiveness refers to health care services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. That is, those communities whose members identify as having a particular cultural or linguistic affiliation by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home.

Cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities. This requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.

WHAT IS THE CULTURAL RESPONSIVENESS FRAMEWORK?

The framework encompasses a strategic and whole-of-organisation approach and is designed to be aligned with health services' strategic planning processes.

The framework is underpinned by the following four principles:

- Every person has the right to receive high-quality health care regardless of their cultural, ethnic, linguistic and religious background or beliefs.
- Understanding and addressing the links between ethnicity, culture and language will improve health care for culturally and linguistically diverse communities.
- Embedding cultural responsiveness in health care systems is a viable strategy to reduce disparities in health outcomes which may be exacerbated by cultural, language and religious differences.
- CALD consumer, carer and community participation will enhance culturally responsive heath care delivery.

The framework is based on the four key domains of quality and safety which are congruent with the *Victorian clinical governance policy framework 2009*:

- organisational effectiveness;
- risk management;
- consumer participation
- and effective workforce,

The cultural responsiveness framework articulates *six standards* for culturally responsive practice and specifies key performance improvement measures to achieve the standards over time.

Standard 1

A whole-of-organisation approach to cultural responsiveness is demonstrated

Stawell Regional Health has :

- a Cultural Awareness Policy which reflects the Equal Opportunity Act 1995 and Racial and Religious Tolerance Act 2001
- an Advocacy Policy which reflects the Aged Care Act 1997, Health Services Act 1998 and the Charter of Human Rights and Responsibilities Act 2006

Standard 2

Leadership for cultural responsiveness is demonstrated by the health service

Standard 3

Accredited interpreters are provided to patients who require one

Standard 4

Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices

Standard 5

CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis

Standard 6

Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness. It aims to consolidate the multiple cultural diversity reporting requirements for health

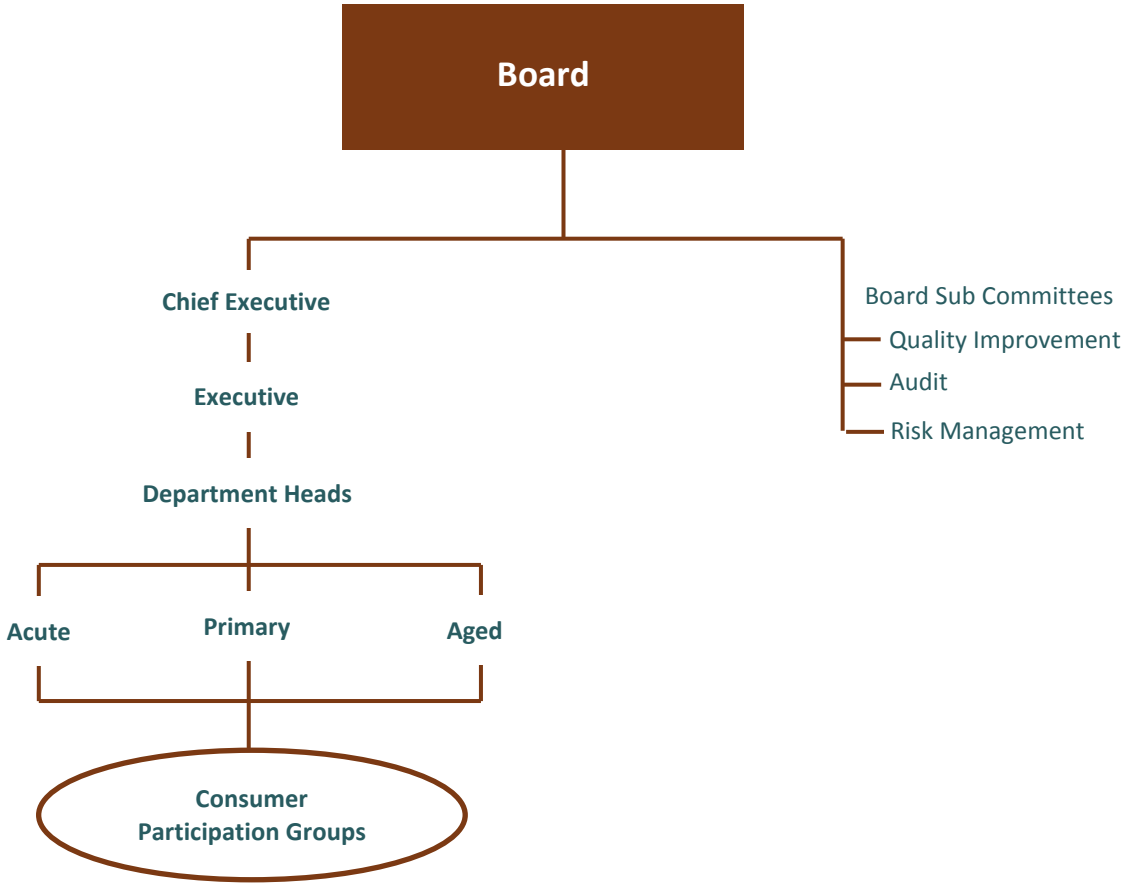
The Plan sets out strategies and actions to improve CALD access over the next three years to 2013. Many strategies involve simple changes to regular practice and attitudes, whilst other changes may be implemented over a lengthier period of time.

REPORTING AND RESPONSIBILITIES

The Plan aims to consolidate the multiple cultural diversity reporting requirements for health services. Reporting on the achievements of the plan will take place annually, through the health services' *Quality of Care Report.*

The responsibilities for implementation and review of this strategy are identified in the implementation plan. Status reports will be provided to the SRH Board via the Quality Improvement Committee. Internal progress reports will be tabled as an agenda item at the SRH Quality Improvement Committee. Stakeholders will be encouraged to participate in the review process.

GOVERNANCE STRUCTURE



POLICY FRAMEWORKS AND LEGISLATION

Stawell Regional Health utilises the BACeS policy and legislative compliance system, which enables policies to reflect relevant and current legislation.

Australian Charter of Healthcare Rights Victoria

Australian Council of Healthcare Standards 2010, *Evaluation and Quality Improvement program* (EQuIP) 5, Sydney.

Department of Human Services 2005, *Language services policy,* Victorian Government Department of Human Services, Melbourne, viewed July 2009,

http://www.dhs.vic.gov.au/multicultural/html/langservpolicy.htm

Department of Human Services 2004, *Cultural diversity guide* Victorian Government Department of Human Services, Melbourne, viewed August 2009,

http://www.dhs.vic.gov.au/multicultural/html/cultdivguide.htm

Department of Human Services 2006, *Health service cultural diversity plans,* Victorian Government Department of Human Services, Melbourne, viewed August 2009, http://www.health.vic.gov.au/cald/hlth_service.htm

Department of Human Services 2007/ DoH, *Quality of care reports – guidelines and minimum reporting requirements for 2006-2007,* Victorian Government Department of Human Services, viewed and produced annually.

http://www.health.vic.gov.au/consumer/pubs/guidelines0607.htm

Department of Human Services 2009, *Victorian clinical governance policy framework* Victorian Government Department of Human Services, Melbourne, last viewed Jan 2011.

http://www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm

Multicultural Victoria Act 2004

Parliament of Victoria, Charter of *Human Rights and Responsibilities Act 2006,*State Government of Victoria, viewed 31 August 2009,

http://www.legislation.vic.gov.au/

Parliament of Victoria, *Multicultural Victoria Amendment Act 2008,* State Government of Victoria, viewed 24 August 2009,

http://www.legislation.vic.gov.au/

State Government of Victoria, 2009 *All of Us,* viewed 2 September 2010,

www.multicultural.vic.gov.au/Web24/vmc.nsf/HeadingPagesDisplay/PublicationsAll+of+Us+Victorias+Multicultural+Policy?Open...

Victorian Charter of Human Rights and Responsibilities Act 2006

GOVERNMENT POLICY AND PROGRAMS

Community participation is an important mechanism recognised at both Federal and State policy and program levels.

- "Doing it with us not for us" Strategic Framework 2010-2013.
- Cultural Responsiveness Framework 2009
- Growing Victoria Together to 2010 and beyond
- Victorian Patient Satisfaction Monitor
- Home and Community Care
- Public Sector Residential Aged Care Services
- Disability Services
- All of Us, 2009
- Victorian clinical governance policy framework, 2009
- Australian Charter of Healthcare Rights in Victoria, 2009
- A Fairer Victoria 2008: Strong People, Strong Communities, 2009
- Multicultural Victoria Amendment Act 2008
- The Charter of Human Rights and Responsibilities Act 2006
- Language services policy, 2005
- Cultural diversity guide, 2004

A SUMMARY OF RELEVANT ORGANISATION POLICIES AND STRATEGIES

The SRH 'Cultural Responsiveness Framework' Plan relates to the following plans or Strategies within the organisation's structure:

Internal Polices or Procedures:

- SRH Strategic Plan
- Clinical Governance
- Management of Feedback: Suggestions, Complaints and Compliments
- Admission and Discharge
- Equal Employment and Opportunity
- Recruitment and Selection
- Access

DEVELOPMENT OF THE PLAN :

Sessions were held with selected members of staff and community members, who make up the Reference Group, including:

- Chief Executive Officer
- Director of Clinical Services
- Director of Finance
- Risk Manager/Complaints Manager
- Quality Manager
- Primary Care Manager
- Human Resources Manager
- Community Services Manager
- Education Manager
- Food Services Manager
- Nutrition and Dietetics Department

The Plan was tabled and approved at the Stawell Regional Health Quality Improvement Committee (QIC) . The QIC is a subcommittee of the SRH Board.

IMPLEMENTATION PLAN

Four Framework Domains:

1. Organisational Effectiveness
2. Risk Management
3. Consumer Participation
4. Effective workforce

Six Standards:

1. A whole-of-organisation approach to cultural responsiveness is demonstrated
2. Leadership for cultural responsiveness is demonstrated by the health service
3. Accredited interpreters are provided to patients who require one
4. Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices
5. CALD consumer, care and community members are involved in the planning, improvement and review of programs and series on an on-going basis
6. Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness

Timeframes:

- Implementation Plan Submission Date: 31st May 2011
- Report key achievements in Quality of Care Report 2010-2011:
    - Standard 1: Measure 1.1
    - Standard 3: Measures 3.1 and 3.2
    - Standard 5: Measure 5.1
- Report key achievements in Quality of Care Report 2011-2012:
    - Standard 2: Measure 2.1
    - Standard 3: Measures 3.1 and 3.2
    - Standard 4: Measure 4.1, 4.2
    - Standard 6: Measure 6.1
- Report key achievements in Quality of Care Report 2012-2013:

  All six standards and key measures

Domain 1: Organisational effectiveness

There is considerable agreement in the research literature that culturally responsive health care cannot be effectively delivered without a systemic and whole-of-organisation approach (Betancourt, et.al.2002; Chrisman, 2007). It reveals that a key weakness in developing culturally responsive practices is the tendency to deal with cultural diversity in an ad-hoc way rather than developing high-level strategic governance structures and policies that can deeply embed culturally responsive practices across the whole of the health service. A key challenge, therefore, is that of repositioning cultural responsiveness from being 'bolted on' to organisational systems and management practices to being 'built in' as a core activity.

Leadership in cultural responsiveness recognises that the governance structure, the public health service board, the Chief Executive Officer, health professionals, clinical and organisational leaders and managers *all* share responsibility for and play a key role in planning, developing, implementing, monitoring and evaluating cultural responsiveness performance and achievements (National Quality Forum, 2009). As well, it is important to recognise health services' organisational culture and the role of the executive in "promoting and sustaining active attention to cultural factors in care" (Chrisman, 2007: 69).

STANDARD 1: A WHOLE-OF-ORGANISATION APPROACH TO CULTURAL RESPONSIVENESS IS DEMONSTRATED.

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.0 Measures The following four policies, guidelines and processes are implemented:					**EQuIP 5** Standard 1.6, 1.6.3 **Aged Care Standards** Standard 3, 3.8
1.1 The health service has developed and is implementing a Cultural responsiveness plan (CRP) that addresses the six standards of the Framework	Cultural Responsiveness Plan 2010 to be completed. Monitoring of progress of planned strategies	Primary Care Manager Quality Manager	CRP completed and submitted to DH and available on SRH Website	(31/05/11) August 2011 (on-going)	Draft ACSQH **National Safety and Quality Health Service** Standard 2: Partnering for Consumer Engagement

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.2 Reporting on the cultural responsiveness standards in the health services' Quality of care report	Compliance with CRP planned strategies and reporting timeframes.	Quality Manager Quality Manager Quality Manager	**2010-11 Q of C** will include key improvements against Standards 1,3,5 **2011-2012 Q of C** will include key improvements against Standards 2,3,4,6 **2012-13 Q of C** will include key improvements against all Standards	September 2011 September 2012 September 2013	**EQuIP 5 Standard 1.2.1:** The community has information on health services appropriate to its needs.
1.3 A functioning Community Advisory Committee (CAC), Cultural Diversity Committee (CDC), or other structure demonstrating CALD participation and input	Review of SRH participation and access to the WestVic Division of GPs Consumer Network. The consumer network composition to be reviewed to ensure presence of broader CALD community representation.	SRH CEO Director of Clinical Services Quality Manager Primary Care Manager	The consumer network membership reviewed to ensure broader CALD representation. Reporting to Board of Management (BOM) via the SRH Quality Improvement Committee.	October 2011 August 2011 December 2011	1. **EQuIP 5 Standard 1: 1.6.1** 2. Aged Care Outcomes Standard 1, 1.8 3. CCCS. Standard 1 E.O 1.3 Draft ACSQH **National Safety and Quality Health Service** Standard 2:

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.4 Implementation of the Department of Human Services Language services policy.	**Requirement 1:** Clients have access to information in their preferred language at critical points: • Informed of their rights • Informed consent • Critical information relating to their decision making-medical and other human service matters Relevant links eg DoH website to be included on Intranet and trialled with staff to ensure confidence in using and ease of access. Cultural Diversity Resource folder to be reviewed and included on Intranet.	Project Officer Quality Manager	Intranet developed and relevant policies and protocols reviewed. Staff are aware and have ease of access to information available on SRH Intranet for: • DH website - Health translations • ONCALL Interpreter Services • SRH Policies: Consent Policy and Cultural Awareness Policy SRH Cultural Diversity Resource folder updated and easily accessible for staff. Rights & Responsibilities Policy 30/03/2011	December 2011 July 2011	**EQuIP 5 Standard 1.6, 1.6.2** **EQuIP 5 Standard 1.1, 1.1.2 & 1.1.3** **Community Care Common Standards (CCCS) Standard 3:** User Rights and Responsibilities **CCCS Standard 3.1:** Information provision. **Aged Care Standards Standard 3, 3.9**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.4 Implementation of the Department of Human Services Language services policy.	**Requirement 2:** Language services are provided by appropriately qualified professionals. Relevant links eg DH website to be included on Intranet and trialled with staff to ensure confidence in using and ease of access Relevant SRH Policies including Consent and Cultural Awareness reviewed and updated if required **Requirement 3:** Persons, including family members, under 18 years of age are not used as interpreters Relevant SRH Policies including Consent and Cultural Awareness reviewed and updated if required, and staff are aware.	Primary Care Manager Quality Manager Risk Manager Quality Manager Primary Care Manager Director of Clinical Services Quality Manager	Intranet developed and relevant policies reviewed. Staff are aware and have ease of access to information available on SRH Intranet for: • DH website - Health translations • ONCALL Interpreter Services • SRH Policies: Consent Policy and Cultural Awareness Policy SRH Cultural Diversity Resource folder updated and easily accessible for staff. SRH Policies: Consent and Cultural Awareness are reviewed regularly and accessible on Intranet and staff are aware	December 2011 July 2011 May 2011 May 2011	**EQuIP 5 Standard 1.6, 1.6.2** **EQuIP 5 Standard 1.1, 1.1.2 & 1.1.3** **Community Care Common Standards (CCCS) Standard 3: User Rights and Responsibilities** **CCCS Standard 3.1: Information provision.** **Aged Care Standards Standard 3, 3.9**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.0 Sub-Measures Organisational guidelines and protocols that guide staff in working with CALD communities, consumers and carers.	Review of SRH Cultural Diversity Policy and Consent Policy Reference available: Centre for Cultural Diversity in Ageing - http://www.culturaldiversity.com.au/resources/management/policy-development/ policy-checklist	SRH CEO Director of Clinical Services Quality Manager Human Resources Manager Education Department	Policies reviewed, accessible on Intranet and staff are aware.	December 2011 May 2011	EQuIP 5 Standard 3.1, 3.1.5 Aged Care Outcome: Standard 1, 1.8 CCCS. Standard 1, E.O 1.3
Allocation and specification of financial resources for cultural responsiveness.	No specific allocation presently as incorporated into existing budgets eg Education. To be reviewed and allocated as appropriate.	Finance Department Director of Clinical Services Education Department Quality Manager	Funding requirements reviewed and allocated as appropriate.	June 2011	**EQuIP 5 Standard 3.1, 3.1.1** **Aged Care Outcome: Standard 1, 1.5** **CCCS. Standard 1, E.O 1.7**
Development of appropriate information technologies and strategies for data collection, reporting and sharing information on cultural responsiveness.	Capabilities of existing Client Management Systems (CMS) eg iPM for Acute, Aged Care and Primary Care to be reviewed and refined as required.	Health Information Manager Primary Care Manager SRH IT	Review of future requirements- acute, aged and primary care completed and updated as required. Report included in QOC as appropriate, whilst also considering consumer confidentiality i.e. small figures may be identifiable.	August 2011 June 2011	**EQuIP 5 Standard 2.3, 2.3.4** **Aged Care Outcome: Standard 1, 1.8** **CCCS. Standard 1, E.O 1.3**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
1.0 Sub-Measures Monitoring of community profile and changing demographics supported by employment of relevant in-house interpreters, appropriate translations and signage.	Continue partnership with Northern Grampians Shire (NGS) including Regional Skilled Migration Coordinator. ON CALL Interpreter service and translations available on Intranet and promoted to staff.	SRH CEO Primary Care Manager Quality Manager Indigenous Community Liaison Officer	On-going communication with NGS. Appropriate signage throughout organisation	July 2011 March 2011	**EQuIP 5: Standard 1.6 16.3; Standard 3.1, 3.1.1** **Aged Care Outcomes: Standard 1, 1.5; & Standard 3, 3.8** **CCCS: Standard 1, E.O 1.1** **NSQHS Standards: Standard 1**
Partnerships with multicultural and ethno-specific community organisations in the area/region are developed and maintained.	Continue partnerships with: Northern Grampians Shire (NGS) including Regional Skilled Migration Coordinator Budja Budja Aboriginal Co-Operative Grampians Pyrenees Primary Care Partnership	SRH CEO Director of Clinical Services Primary Care Manager Quality Manager Indigenous Community Liaison Officer	On-going communication and partnership with NGS and community links. Further development as identified in the SRH Community Participation Plan and Community Responsiveness Plan.	June 2011 Ongoing	**EQuIP 5: Standard 1, 1.1.5** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 2, E.O 2.5**
1.0 Sub-Measures Partnerships with multicultural and ethno-specific community organisations in the area/region are developed and maintained.	Continue partnerships with: Ballarat Regional Multicultural Council (HACC Cultural Diversity Officer) Centre of Cultural Ethnicity and Health Attendance at local CALD community events.	SRH CEO Director of Clinical Services Primary Care Manager Quality Manager Indigenous Community Liaison Officer	Attendance at local CALD community events. SRH services brochures available in relevant languages e.g. Arabic	June 2011 Ongoing	**EQuIP 5: Standard 1, 1.1.5** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 2, E.O 2.5**

STANDARD 2: LEADERSHIP FOR CULTURAL RESPONSIVENESS IS DEMONSTRATED BY THE HEALTH SERVICE

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Measures 2.1 Numerator: The number of senior managers who have undertaken leadership training for cultural responsiveness	17 senior staff are on the Leadership Team. Of these, 5 have undertaken leadership training for cultural responsiveness.	SRH Senior Staff Education Manager Director of Clinical Services	Relevant opportunities identified by Managers and Education Department., included in annual Education Plan and accessed. Audit of education records confirms increased number of senior managers undertaking cultural responsiveness training.	August 2011 June 2011	**EQuIP 5: Standard 2.2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, E.O 1.7**
Denominator: The total number of senior managers	SRH has 17 senior Managers		A/A		
Sub-measures 2.0 An executive staff member has portfolio responsibility for cultural responsiveness and (KPIs) against the Cultural responsiveness plan.	In place: Primary Care Manager Supported by the Quality Manager	SRH CEO Director of Clinical Services Primary Care Manager Quality Manager	Identified responsibility and reporting structure in place, supported by: • Cultural Responsiveness Plan • SRH Policies and Procedures	June 2011 Ongoing	**EQuIP 5: Standard 1.6, 1.6.3:** . **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 1, E.O 1.7**

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-Measures 2.0 Employment of a cultural diversity staff member where 20% or more of health service patients are of CALD background.	N/A		N/A		
Research opportunities are identified and undertaken to develop new and improved initiatives and resources for cultural responsiveness.	SRH is open to opportunities for research and development of new and improved initiatives and resources for cultural responsiveness, but are aware of the very small CALD community demographic.	Director of Clinical Services	Opportunities are monitored and accessed as appropriate.	June 2012 Ongoing	**EQuIP 5: Standard 1.6, 1.6.3; Standard 2.5, 2.5.1** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 1, E.O 1.5**
Training opportunities for senior managers on: • culturally responsive service delivery strategies	Training opportunities to be identified promoted and accessed. Training will include on line e learning, video conferencing and invited speakers.	Senior Managers Education Manager Human Resources Manager	Relevant opportunities identified by Managers and Education Department, included in annual Education Plan and accessed. Best Practice approaches incorporated into SRH culture, policies and procedures.	June 2012 Ongoing	**EQuIP 5: Standard 1.6; & Standard 2.2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3 Education and staff development** **CCCS: Standard 1, E.O 1.7**

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-Measures 2.0 conducting organisational cultural assessments/ audits.	Health Information Manager to assist with audits of health records and outcomes for CALD consumers.	Director of Clinical Services Health Information Manager	Audits conducted and findings and outcomes included in QoC reports	Annually for QoC report 2011 2012 2013 (Annually July)	**EQuIP 5: Standard 1, 1.1.1 & 1.1.4** **Aged Care Outcomes: Standard 3, 3.1** **Education and staff development** **CCCS: Standard 1, E.O 1.5**

Domain 2: Risk management

Providing healthcare that is culturally responsive and safe is a risk management strategy. Many culturally and linguistically diverse communities and Indigenous people do not feel safe accessing mainstream health services (Garret, 2008; Divi. et.al. 2007). Research within Australia clearly demonstrates the link between culture, language and patient safety outcomes (Johnstone & Kanitsaki, 2006). The implementation of the department's *Language services policy* and the provision of NAATI accredited interpreters in health settings have been well supported by Victorian health services. The delivery of safe high quality care is premised on effective communication between the consumer/ patient and the health care provider. Limited English language proficiency is defined as the 'limited ability or inability to speak, read, write or understand the English language at a level that permits the person to interact effectively with healthcare providers or social service agencies'. Limited English language proficiency can adversely affect the communication process and the health outcome as well as infringe the rights of the consumer/patient. In their pilot study of *Language Proficiency and Adverse Events in US Hospitals,* Divi et al (2007) firmly contend that an increasing evidence base is emerging to suggest that patient–provider communication is a serious patient safety concern and a common root cause of adverse events in healthcare delivery (Divi, et al. 2007).

They describe the effects of language barriers as follows:

For consumers:

- limiting patient access
- undermining trust in the quality of the medical care received and the patient-health professional relationship
- compromising appropriate follow-up and care which may result in a 'trajectory of accident opportunity' for the patient
- misunderstandings and inadequate comprehension of diagnoses and treatment
- problems with informed consent
- dissatisfaction with care
- preventable morbidity and mortality
- disparities in prescriptions, test ordering and diagnostic evaluations.

For health professionals:

• inhibiting a clinician's ability to elicit patient symptoms which can result in an increased use of diagnostic resources or invasive procedures, inappropriate treatment and diagnostic errors.

For health systems:

- increased cost through unnecessary procedures or increased interventions to rectify errors.

Underutilisation of accredited interpreters, even when they are made available, commonly referred to as "getting by" has also been identified as another serious risk management issue (Diamond, et.al. 2008). As such, it is critical that health services accurately document and track the provision of language services (an accredited interpreter) during the clinical encounter and that patients who identify as requiring an interpreter in their preferred language are provided with one.

STANDARD 3: ACCREDITED INTERPRETERS ARE PROVIDED TO PATIENTS WHO REQUIRE ONE

Reporting period/ Year 2010-2011	**Gaps to be resolved**	**Actions/Strategies (By whom and by when)**	**Target outcome (what would it look like)**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
Measure 3.1 Numerator: Number of CALD consumers/ patients identified as requiring an interpreter and who receive accredited interpreter services	To review the identification of need, access and appropriate usage of the accredited interpreter service. CALD data (Language and ATSI status) is collected for admission to all SRH services through use of Service Coordination Tool Templates (SCTT), Patient Registration Form MR1, Risk Screening Tool MR199, and Residential Aged Care	Director of Clinical Services Health Information Manager Inpatient Unit Manager Primary Care Manager Aged Care Manager	Staff are aware of and complete admission assessment procedures, including identification of consumers/ patients requiring an interpreter and access to accredited interpreter service. Need identification, access and appropriate usage of the accredited interpreter service is assisted by: SRH Intranet Staff Education.	July 2011 (Reviewed Nov 2010, Next review July 2011)	**EQuIP 5: Standard 1, 1.1.1** **Aged Care Outcomes: Standard 2, 2.4 & Standard 3, 3.8** **CCCS: Standard 2 , E.O 2.2**
Measure 3.1 Numerator: Number of CALD consumers/ patients identified as requiring an interpreter and who receive accredited interpreter services	**VPSM, Provision of Interpreters:** 100% interpreter not needed	Quality Manager		Every 6 months via VPSM	**EQuIP 5: Standard 1, 1.1.1** **Aged Care Outcomes: Standard 2, 2.4 & Standard 3, 3.8** **CCCS: Standard 2, E.O 2.2**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Denominator: Number of CALD consumers/ patients presenting at the health service identified as requiring interpreter services	Acute admissions: 100% interpreter not needed	Director of Clinical Services Health Information Manager Quality Manager		June 2011 Every 6 months via VPSM	
Measure 3.2 Numerator: Number of community languages used in translated materials and resources.	DoH translation service is utilised when necessary. SRH information currently available in Arabic. Liaise with NGS Regional Skilled Migration Coordinator. Emerging languages in community to be identified and available on website links.	Director of Clinical Services Health Information Manager Peri-Operative Unit Manager Aged Care Manager Acute Unit Manager Primary Care Manager	Relevant community languages available by website link. SRH information resources developed in conjunction with CALD community and NGS as required.	December 2011 As needed	**EQuIP 5: Standard 1.6, 1.6.3** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 3, E.O 3.1**
Denominator: Total number of community language groups accessing the service	Additional needs to be identified. Admissions with Language other than English: 2009-10 12 Arabic 2008-09 12 Arabic	Director of Clinical Services Health Information Manager Quality Manager	Information available and accessible in relevant languages by website link.	June 2011 May 2011	

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 3.0 Implementation of the Department of Health Language services policy.	**Requirement 1:** Clients have access to information in their preferred language at critical points: • Informed of their rights • Informed consent • Critical information relating to their decision making-medical and other human service matters Consumers have access to 10 tips for Safer healthcare and Australian Charter of Healthcare rights in their preferred language Relevant links e.g. DoH website to be included on Intranet and trialled with staff to ensure confidence in using and ease of access.	In place. Director of Clinical Services Health Information Manager Quality Manager	Intranet developed and relevant policies reviewed. Staff are aware and have ease of access to information available on SRH Intranet for: • DoH website - Health translations • ONCALL Interpreter Services • SRH Policies on Consent and Cultural Awareness SRH Cultural Diversity Resource folder updated, easily accessible and staff are aware.	June 2011	**EQuIP 5: Standard: 1, 1.1.2 & 1.1.3; Standard 1.6, 1.6.2** **Aged Care Outcomes: Standard 3, 3.5 & 3.9** **CCCS: Standard 3, E.O 3.1**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
	Cultural Diversity Resource folder to be reviewed and incorporated into Intranet. **Requirement 2:** Language services are provided by appropriately qualified professionals Relevant links eg DoH website to be included on Intranet and trialled with staff to ensure confidence in using and ease of access Relevant SRH Policies including Consent and Cultural Awareness reviewed and updated if required. **Requirement 3:** Persons, including family members, under 18 years of age are not used as interpreters Relevant SRH Policies including Consent and Cultural Awareness reviewed and updated if required.	Risk Manager Primary Care Manager Quality Manager Director of Clinical Services Quality Manager	SRH Policies on Consent and Cultural Awareness are reviewed regularly and accessible on Intranet and staff are aware. SRH Policies on Consent and Cultural Awareness are reviewed regularly and accessible on Intranet and staff are aware.	(March 2011) (March 2011)	

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 3.0 Documentation of lack of provision of interpreters and reasons why (including face-to-face, telephone interpreting).	Identification of any gaps in provision of Interpreters. To continue to review via VPSM, SRH Suggestions, Compliments and Complaints, Incident and Risk Identification systems. Interpreter not needed in 100% of complaints.	Complaints Manager Quality Manager	Interpreters are provided when needed.	June 2011 May 2011	**EQuIP 5: Standard 2.1, 2.1.1, 2.1.3, & 2.1.4** **Aged Care Outcomes: Standard 1, 1.4** **CCCS: Standard 3, E.O 3.3**
Audit of documentation of provision/use of interpreter in medical files.	Audits are currently not conducted owing to the statistically small number of patients requiring an interpreter.	Director of Clinical Services Health Information Manager	Regular audits will be conducted if there is an increase in the number of people requiring an interpreter. Issues with provision of interpreters, they will be identified and difficulties resolved.	June 2011 March 2011	**EQuIP 5: Standard 2.1, 2.1.1** **Aged Care Outcomes: Standard 3, 3.1** **CCCS: Standard 1, E.O 1.5**
Policies on consent include directions about the role of interpreters and family.	SRH policy on Consent & Cultural Awareness policy to included direction about the role of interpreters and family when reviewed	Director of Clinical Services Quality Manager	Policies reviewed and compliant.	June 2011 March 2010	**EQuIP 5: Standard 1, 1.1.3** **Aged Care Outcomes: Standard 3, 3.5 & 3.9** **CCCS: Standard 3, E.O 3.5**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 3.0 Feedback from patients on the use of interpreters in decisions about treatment and care planning.	Continued awareness and monitoring of systems. VPSM, Provision of Interpreters Jan-Dec 2010: (n=332/864) 100% interpreter not needed	Quality Manager	Monitoring of VPSM, Risk Management, Incident and Suggestions, Compliments and Complaints reporting systems identifies interpreter service as appropriate.	June 2011 (Ongoing VPSM data collection)	**EQuIP 5: Standard 1.1, 1.1.1 & 1.1.2** **Standard 2.1, 2.1.4** **Aged Care Outcomes: Standard 3, 3.9**
Evidence of appropriate translations, signage, commonly used consumer/patient forms, education and audio visual materials, in languages other than English for predominant language groups utilising the service.	Continue to identify and develop required information in appropriate formats, including utilising translation services and appropriate information on DoH website. To work in conjunction with NGS to continue to identify appropriate translations. HACC Planned Activity Group (Day Centre) information available in varied format, including pictorial information, when required. Use of Aged Care Cue Cards when required.	Director of Clinical Services Primary Care Manager Community Services Manager	Appropriate translations, signage, commonly used consumer/patient forms, education and audio visual materials, in languages other than English for predominant language groups utilising the service.	June 2011 (Ongoing)	**EQuIP 5: Standard 1.2, 1.2.1** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 2, E.O 2.2**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 3.0 Quality and risk management committee develop initiatives to track miscommunication errors for CALD consumers/patients.	Continue to monitor VHIMS risk and incident reporting system monthly to identify and track issues related to CALD. 29/4/10-29/4/11: 28 complaints, nil interpret req'd, all born in Australia.	Quality Manager	All quality/risk issues relating to miscommunication errors for CALD consumers identified, reported and dealt with appropriately.	June 2011 (Ongoing)	**EQuIP 5: Standard 2.1, 2.1.4** **Aged Care Outcomes: Standard 1, 1.4** **CCCS: Standard 3 E.O 3.3** **NSQHS Standards: Standard 1**
Number of cases reported through 'adverse event' reports related to communication issues for CALD consumers/ patients.	No issues identified in Risk Management and Incident Reporting systems. Continue to monitor monthly.	Quality Manager	All quality/risk issues relating to miscommunication errors for CALD consumers identified reported and dealt with appropriately.	June 2011 (Ongoing)	**EQuIP 5: Standard 2.1, 2.1.2** **Aged Care Outcomes: Standard 1, 1.1** **CCCS: Standard 1, E.O 1.6** **NSQHS Standards: Standard 1**
Number of complaints lodged by CALD consumers/ patients.	Nil complaints reported Continue to monitor monthly. To identify problems and implement strategies to ensure CALD clients understand and are able to use the SRH Suggestion, Compliment and Complaint process	DDCS Complaints Manager Quality Manager	SRH Suggestions, Compliments and Complaints process identifies issues relating to CALD consumers and any issues identified are dealt with appropriately. Strategies implemented to ensure CALD clients understand and are able to use the SRH complaint system.	June 2011 (Ongoing)	**EQuIP 5: Standard 2.1, 2.1.4** **Aged Care Outcomes: Standard 1, 1.4** **CCCS: Standard 3, E.O 3.3** **NSQHS Standards: Standard 1**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 3.0 Strategies in place to communicate with CALD consumers/ patients even when the CALD demographics are low.	Intranet to be developed and relevant policies reviewed. Information to be available on SRH Intranet for : • DoH website - Health translations • ONCALL Interpreter Services • SRH Cultural Diversity Policy Education to ensure staff awareness of and ease of access.	Primary Care Manager Community Services Manager Quality Manager	Strategies in place include: • ONCALL interpreter service utilised • Intranet information source accessible and utilised • Information available in relevant languages • Community Advisory Committee representation effective Education provided for staff improved staff awareness of and accessibility.	June 2011 (March 2011)	**EQuIP 5: Standard 1.2, 1.2.1; Standard 2.3, 2.3.4** **Aged Care Outcomes: Standard 1, 1.8** **CCCS: Standard 3, E.O 3.1** **NSQHS Standards: Standard 2**
Research is conducted into outcomes of CALD patient care needs (for example comparative studies between English Speaking and Non-English Speaking patients regarding length of stay, emergency presentations, diagnostic tests, failure to attend appointments, evaluation of post consultation outcomes, etc.).	SRH is open to opportunities for research into outcomes of CALD patient care needs and opportunities for improved initiatives and resources for cultural responsiveness, but are aware of the very small CALD community demographic.	Director of Clinical Services	Opportunities are monitored and accessed as appropriate.	June 2011 (Ongoing)	**EQuIP 5: Standard 2.5, 2.5.1** **Aged Care Outcomes: Standard 3, 3.1** **CCCS: Standard 1, E.O 1.5**

Domain 3: Consumer participation

Consumer participation and quality are reciprocal. Engaging consumers and patients as 'safety partners' with health service providers is gaining support as an effective strategy to identify and help prevent adverse events and improve patient safety outcomes (Johnstone & Kanitsaki, 2009). It is important that health services work with diverse consumers to increase individual and organisational awareness and understanding of the experiences of consumers and communities from culturally and linguistically diverse backgrounds to improve health service delivery and health outcomes.
Consumers, carers and community members from culturally and linguistically backgrounds face a number of specific barriers in accessing health care and optimising health outcomes. These include:

- a lack of understanding of consumer/patient rights and responsibilities
- a lack of familiarity with the Australian health system. This is particularly relevant for recently arrived communities and refugees (who may continue to suffer health consequences as a result of refugee experiences including torture, trauma and deprivation in refugee camps)
- a lack of knowledge and confidence to: engage in participation, planning, monitoring and decision making activities, and to challenge the quality of care received, participate in client satisfaction surveys and or make complaints known to relevant health authorities.

These can be further exacerbated by: limited English language proficiency; inadequate language services provision; the impact of culture and belief systems; culturally constructed understandings of health, wellbeing, treatment and compliance; a lack of cultural congruence between health professionals and consumers/patients; insufficient data; unequal partnerships with key culturally and linguistically diverse stakeholder groups; as well as systemic and organisational constraints within health service systems.

STANDARD 4: INCLUSIVE PRACTICE IN CARE PLANNING IS DEMONSTRATED, INCLUDING BUT NOT LIMITED TO: DIETARY, SPIRITUAL, FAMILY, ATTITUDINAL, AND OTHER CULTURAL PRACTICES.

Reporting period/ Year 2011-2012	**Actions/Strategies**	**Person Responsible**	**Desired Outcome**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
Measures 4.1 Numerator: Number of CALD consumers/ patients who indicate that their cultural or religious needs were respected by the health service (as good and above)	VPSM July-Dec 2010, N=195 40.6 % response rate Responses indicated: 4.17 mean = very good HACC Planned Activity Group (Day Centre) survey indicates high level of client satisfaction. Monitoring is to be continued for all mechanisms and opportunities for consumer feedback.	Director of Clinical Services Quality Manager Risk Manager	All mechanisms and opportunities for consumer feedback are monitored to ensure high level of satisfaction that cultural and religious needs were respected by the health service. Mechanisms include: • VPSM • Organisational Client Satisfaction surveys • Suggestion, Compliment and Complaints process	June 2012 (June 2011)	**EQuIP 5: Standard 1.6, 1.6.3** **Aged Care Outcomes: Standard 3, 3.8; Standard 4, 4.8** **CCCS: Standard E.O 2.3**
Denominator: Total number of CALD consumers/ patients surveyed on the Victorian Patient Satisfaction Monitor (VPSM) or other patient satisfaction surveys.	VPSM July-Dec 2010, N=195 0% completed in non-English language version SRH Client Satisfaction surveys and contributors to the Suggestions, Compliments and Complaints process who are CALD patients/consumers.	Quality Manager		June 2012 (Ongoing)	

Reporting period/ Year 2011-2012	**Actions/Strategies**	**Person Responsible**	**Desired Outcome**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
Measure 4.2 Policies and procedures for the provision of appropriate meals (vegetarian, Halal, Kosher, etc.) are implemented and reviewed on an ongoing basis.	Policies and procedures are in place to ensure provision of appropriate meals. Additional sources for information and meal provision to be identified To be reviewed including information, access and availability to cultural appropriate options. Presently, families may provide appropriate food if desired and complete the "Brought in Food" register. Menu to be reviewed by Dietician. Potential Reference: **http://www.culturaldiversity.com.au/resources/direct-care-services/food-services**	Food Services Manager SRH Dietitian	Provision of appropriate meal options for CALD consumers/ patients, supported by policies and procedures. Menus continue to be reviewed on a regular basis.	June 2011 (March 2011)	**EQuIP 5: Standard 1.5, 1.5.7 & 1.6, 1.6.3 Standard 3.1, 3.1.5** **Aged Care Outcomes: Standard 1, 1.8; Standard 2, 2.10; Standard 3, 3.8 & 3.9; Standard 4, 4.8** **CCCS: Standard 2, E.O 2.1 & 2.3**

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 4.0 Feedback from patients on the provision of information about their care and treatment is used to inform planning, develop-ment and review of services and support.	Suggestions, compliments and complaints process collects feedback from patients, which informs future planning, development and review of services and support. To include CALD elements in the annual Catering client satisfaction survey for all areas. To continue to monitor the Suggestions, compliments and complaints process to collect feedback from patients and utilise for future planning, development and review of services and support.	Quality Manager Complaints Manager Food Services Manager SRH Dietitian Departmental Managers	Effective feedback mechanisms exist and are utilised to inform planning, development and review including: • VPSM • SRH Suggestions, compliments and complaints process monthly reports identifies feedback on availability, quantity and temperature. • SRH Client Satisfaction surveys – Planned Activity Groups, Aged Care, and Primary Care and Midwifery.	June 2011 (March 2011)	**EQuIP 5: Standard 2.1, 2.1.4** **Aged Care Outcomes: Standard 1, 1.4** **CCCS: Standard 3, E.O 3.3**
CALD patient satisfaction data collected and analysed (VPSM and other).	To continue to collect and analyse patient satisfaction data including VPSM: 0% completed in non-English language version VPSM July-Dec 2010, N=195	Quality Manager	VPSM and patient satisfaction data monitored for CALD patient satisfaction.	June 2011 (Ongoing)	**EQuIP 5: Standard 2.1, 2.1.4** **Aged Care Outcomes: Standard 1, 1.4** **CCCS: Standard 3, E.O 3.3**

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 4.0 Consumer evaluation of cultural appropriateness of particular programs or services.	Regular meetings with Budja Budja Aboriginal Co-Operative, communication with WestVic Consumer Advisory Network and specific focus groups are currently utilised as a means of consumer evaluation. The consumer network composition to be reviewed to ensure presence of broader CALD community representation. To continue to utilise VPSM data.	SRH CEO Director of Clinical Services Primary Care Manager Quality Manager	VPSM feedback utilised.	June 2011 June 2011	**EQuIP 5: Standard 1.6, 1.6.3** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 2**
Development of and/or use of suitable instruments for assessment (clinical diagnosis and treatment) incorporating cultural considerations used by medical, clinical and allied health staff.	To review existing and investigate availability of suitable instruments for assessment (clinical diagnosis and treatment) incorporating cultural considerations used by medical, clinical and allied health staff. Eg Mini mental state examination. **Potential resource:** COAG LSOP toolkit	Director Of Clinical Services Nurse Unit Manager, Simpson Wing Primary Care Manager Community Services Manager Aged Care Manager Quality Manager	Suitable instruments utilised for assessment (clinical diagnosis and treatment) incorporating cultural considerations used by medical, clinical and allied health staff as identified in the COAG LSOP toolkit.	June 2012 June 2011	**EQuIP 5: Standard 1.1, 1.1.1 & 1.1.2** **Standard 1.6, 1.6.3** **Aged Care Outcomes: Standard 2, 2.4** **CCCS: Standard 2, E.O 2.2**

STANDARD 5: CALD CONSUMER, CARER AND COMMUNITY MEMBERS ARE INVOLVED IN THE PLANNING, IMPROVEMENT AND REVIEW OF PROGRAMS AND SERVICES ON AN ONGOING BASIS.

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Measures 5.1 CALD consumer membership and participation is demonstrated in the Community Advisory Committee (CAC) the Cultural Diversity Committee (CDC), or other specified structure.	SRH has been unsuccessful in setting up a dedicated CAC or CDC. SRH formed a partnership with WestVic Division of GPs in 2010, and utilise their Consumer Network. The consumer network composition to be reviewed to ensure presence of broader CALD community representation. The consumer network composition to be reviewed to ensure presence of broader CALD community representation.	SRH CEO Director of Clinical Services Quality Manager	Continued communication with Budja Budja Aboriginal Co-Operative. Reporting to Board of Management (BOM) via the SRH Quality Improvement Committee.	June 2011 (March 2011)	**EQuIP 5: Standard 1.6, 1.6.1** **Aged Care Outcomes: Standard 1, 1.4 & 1.8** **CCCS: Standard 1, E.O 1.4** **Draft ACSQH National Safety and Quality Health Service Standards (NSQHS): Partnering for Consumer Engagement**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Sub-measures 5.0 Minutes of meetings show that the CAC/CDC or other specified structure has provided advice on planning and evaluation to the board (CAC) or executive (CDC) of the health service.	Agendas, minutes and key topics of focus groups to be used as indicators for active participation in providing advice on planning and evaluation to the Board and SRH Executive.	Chief Executive Director of Clinical Services Quality Manager	Regional Health Services Program report informs the Board via Quality Improvement.	June 2011 (March 2011)	**EQuIP 5: Standard 2, 2.1** **Aged Care Outcomes: Standard 1, 1.8** **CCCS: Standard 1 E.O 1.4** **NSQHS Standards: Standard 2**
CALD consumer and stakeholder involvement in performance review and quality improvement processes.	Present processes to be reviewed and reformed to include broader CALD community representation. Present Agendas, minutes and TOR to be used as indicators for active participation in SRH performance review and quality improvement processes. SRH Consumer Participation Policy to be developed.	Chief Executive Director of Clinical Services Quality Manager	Develop a community participation pathway for SRH staff and committees to use when planning, monitoring and evaluating health care.	June 2011 (March 2011)	**EQuIP 5: Standard 1.6, 1.61** **Aged Care Outcomes: Standard 3, 3.1** **CCCS: Standard 3, E.O 3.3** **NSQHS Standards: Standard 2**

Reporting period/ Year 2010-2011	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Policies in place for facilitation of different degrees of participation from CALD consumers, carers and community members.	SRH Consumer Participation Policy to be developed.	Chief Executive Director of Clinical Services Quality Manager	SRH policies are in place for facilitation of different degrees of participation from CALD consumers, carers and community members.	June 2011 (March 2011)	**EQuIP 5: Standard 1.6, 1.6.3 & Standard 3.1, 3.1.5** **Aged Care Outcomes: Standard 1, 1.8 & Standard 3, 3.8** **CCCS: Standard 1 E.O 1.3** **NSQHS Standards: Standard 2**

Domain 4: Effective workforce

Professional development activities aimed at improving the cultural responsiveness capabilities of health professionals and health care organisations is recognised as a key strategy to improve outcomes for consumers, carers, communities as well as health care providers. Evidence provided through systematic reviews suggest that multifaceted interventions could lead to improved knowledge, attitudes and skills for health professionals, which, in turn, lead to improved patient satisfaction and improved patient health outcomes.

Providing culturally responsive care is not simply the memorisation of cultural facts, or a recipe book approach to understand key characteristics of specific culturally and linguistically diverse communities. It is not the sole domain of health professionals. Cultural responsiveness is everybody's business as health services need a culturally capable workforce to develop, implement and evaluate culturally responsive health care policy, programs and interventions.

Health services are urged to establish more effective systems of workforce development to develop the cultural responsiveness capabilities of staff across all areas of the organisation including executive, management, health professionals and frontline staff.

STANDARD 6: STAFF AT ALL LEVELS ARE PROVIDED WITH PROFESSIONAL DEVELOPMENT OPPORTUNITIES TO ENHANCE THEIR CULTURAL RESPONSIVENESS.

Reporting period/ Year 2011-2012	**Actions/Strategies**	**Person Responsible**	**Desired Outcome**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
Measure 6.1 Numerator: Number of staff who have participated in cultural awareness professional development (PD)	Specific CALD Professional Development (PD) session conducted. Staff have accessed professional development sessions, which have included cultural awareness related topics ie individualised care, person centred care, Health Coaching.	Director of Clinical Services Education Department	SRH will continue to identify and access relevant educational opportunities, such as: • Budja Budja Aboriginal Co-Operative • NGS Skilled Migration Coordinator • Centre for Culture, Ethnicity and Health	June 2012 Ongoing	**EQuIP 5: Standard 2.2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, 1.7**

Reporting period/ Year 2011-2012	Actions/Strategies	Person Responsible	Desired Outcome	Review date	Links to other CALD reporting frameworks, accreditation, etc
Denominator: Total number of employed staff within the current two year period	Total Number of Staff employed at SRH = 105 new staff to 24/11/2010 34 of these have participated in cultural awareness professional development. Training will be increased across SRH.	Human Resources Manager Education Manager		June 2012	
Sub-measures Budget allocation for culturally responsive workforce development.	No specific allocation presently incorporated into existing budgets eg Education. To be reviewed and allocated as appropriate.	Finance Department Education Department	Funding requirements reviewed and allocated as appropriate.	June 2012 June 2011	**EQuIP 5: Standard 3, 3.1.1** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, E.O 1.7**
Suggested training opportunities for staff (i.e. Admission, reception, clinical staff, management, executive) on: • provision of language services and use of interpreters (at commencement of employment, as part of orientation program)	SRH Intranet to be developed and relevant policies reviewed. Education to be conducted for staff re usage and information available on SRH Intranet for : • DoH website - Health translations • ONCALL Interpreter Services • Relevant SRH Policies & protocols • Utilisation of on line e learning opportunities • COAG LSOP Toolkit • Utilisation of generic but relevant training sessions e.g. Health Coaching Australia - Dealing with	Director of Clinical Services Education Department Finance Manager HR Manager	Intranet developed and relevant policies reviewed. Education conducted for staff re usage and information available on SRH Intranet for: DoH website - Health translations ONCALL Interpreter Service Relevant SRH Policies Cultural awareness is incorporated into existing orientation programs and mandatory education.	June 2012 June 2011	**EQuIP 5: Standard 2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, E.O 1.3**

	Interpreters				
Reporting period/ Year 2011-2012	**Actions/Strategies**	**Person Responsible**	**Desired Outcome**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
			Staff have completed training that enhances knowledge of culturally inclusive practices and their responsibility in implementing culturally appropriate services.		
• culturally responsive service delivery strategies	In place. Utilisation of on line e learning opportunities	June 2011	Relevant training completed and staff confident.	June 2012	**EQuIP 5: Standard 2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, E.O 1.7** **NSQHS Standards: Standard 2**
• conducting organisational cultural assessments/ Audits	To conduct audit of organisational cultural assessments	Director of Clinical Services Quality Manager Departmental Managers	Audits conducted and utilisation of existing systems e.g. Performance Appraisals indicate increased staff awareness of CALD following education and improved Intranet access.	June 2012 June 2011	**EQuIP 5: Standard 2.1, 2.1.1** **Aged Care Outcomes: Standard 3, 3.8** **CCCS: Standard 1, E,O 1.5** **NSQHS Standards: Standard 1**
• conducting cultural assessments to understand consumer/patient's explanatory model for health and illness	Further development of person centred care initiatives, including Health Coaching which identifies individual needs.	Director of Clinical Services Quality Manager Education Manager Nurse Unit Manager Simpson Wing & Residential Aged Care	Demonstrated understanding of consumer/patient's explanatory model for health and illness	June 2012 June 2011	**EQuIP 5: Standard 1, 1.1.1** **Aged Care Outcomes: Standard 2, 2.4** **CCCS: Standard 2, E.O 2.2 & 2.3** **NSQHS Standards: Standard 1**
Demonstrated post training staff evaluation on effectiveness and application of professional	Conduct post training evaluation of attendees with regards to effectiveness and implementation of training information.	Education Manager HR Manager	Post training evaluation of attendees demonstrates effectiveness, understanding and implementation of information provided in training.	June 2012 December 2011	**EQuIP 5 : Standard 2, 2.2.4** **Aged Care Outcomes: Standard 3, 3.3** **CCCS: Standard 1, E.O 1.7**

development.					
Reporting period/ Year 2011-2012	**Actions/Strategies**	**Person Responsible**	**Desired Outcome**	**Review date**	**Links to other CALD reporting frameworks, accreditation, etc**
Human resources management policies and practices include cultural responsiveness references in position descriptions, performance review and promotion.	To review present HR policies and Position Descriptions to ensure inclusion of cultural responsive references. Identification of bi lingual staff who volunteer to assist as interim measure. **Potential Reference:** Centre for Cultural Diversity in Ageing - http://www.culturaldiversity.com.au	HR Manager Director of Clinical Services	HR policies and Position Descriptions include cultural responsive references. Identification of bi lingual staff having volunteered to assist as interim measure, but does not include interpreting health information.	June 2012 December 2011	**EQuIP 5: Standard 2.2, 2.2.1 & Standard 3.1, 3.1.5** **Aged Care Outcomes: Standard 1, 1.6 & 1.8** **CCCS: Standard 1, E.O 1.7**
Internal communication systems for sharing cultural diversity information and data are developed, maintained and periodically reviewed.	Intranet to be developed and relevant policies reviewed. Internal monthly SRH newsletter to be used to share CALD information and policy reviews.	SRH CEO Department Managers Newsletter Editor	Intranet developed and regularly updated Regular CALD related information articles are included in Echo. CALD related information is included as Agenda items in Departmental staff meetings and Staff Briefings.	June 2012 December 2011 and Ongoing	**EQuIP 5: Standard 2.3, 2.3.4** **Aged Care Outcomes: Standard 1, 1.8** **CCCS: Standard 1, E.O 1.3**

APPENDICES:

APPENDIX 1: GLOSSARY OF TERMS

Adverse event

An incident in which harm resulted to a person receiving healthcare (Department of Human Services, 2009)

Consumer

A current or potential user of a health service. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations and health and illness conditions (Department of Human Services, 2006).

Communities

Groups of people who have interests in the development of an accessible, effective and efficient health and aged care service that best meets their needs (Department of Human Services, 2006).

Cultural and linguistic diversity (CALD)

Refers to the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home (Department of Human Services, 2006).

Cultural competence

A set of congruent behaviours, attitudes and policies that come together in a system or agency or among professionals that enable that system, agency or those professionals to work effectively in cross-cultural situations (Cross, et.al. 1989).

Cultural responsiveness

Cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities.

Framework

A set of principles and long term goals that form the basis of guidelines and overall direction to planning and development (Department of Human Services, 2009).

Measures

Indicators which enable organisations to track and assess progress. Some are quantitative and include a numerator and denominator.

Quality

Doing the right things, for the right people, at the right time and doing them right the first time (Department of Human Services, 2009).

Safety

A state in which risk has been reduced to an acceptable level (Department of Human Services, 2009).

Standards

General statements against which organisations can audit their performance. The Australian Council of Healthcare Standards (ACHS) defines standards as “a statement of the level of performance to be achieved” (ACHS 2006).

Sub-measures

Additional guides towards achieving the measure

APPENDIX 2: SRH SERVICES

Stawell Regional Health provides an extensive range of acute, residential, home and community based services

Stawell

Acute Hospital

- **Cardiac Stress Testing**
- **Chemotherapy**
- **Emergency Care (Urgent Care Service)**
- **General Medicine**
- **Obstetrics**
- **Pharmacy**
- **Surgery (includes Day Surgery)**

Specialities:

- Ear Nose & Throat
- Gynaecology
- Ophthalmology
- Orthopaedics
- Urology

Allied & Community Health

- **Ante Natal**
- **Cardiac Rehabilitation**
- **Continence**
- **Diabetes Education**
- **Nutrition & Dietetics**
- **HARP**
- **Health Promotion**
- **Occupational Therapy**
- **Physiotherapy**
- **Pulmonary Rehabilitation**
- **Podiatry**
- **Social Work / Counselling**
- **Speech Pathology**
- **Women's Health**
- **Transitional Care Progam**

Home Based Care

- District Nursing
- Domiciliary Midwifery
- Hospital In The Home
- Post Acute Care
- Transitional Care Program

Diagnostic

- St. John of God Pathology
- Medical Imaging (x-Rays)
- Ultrasound

Residential & Aged Care

- Macpherson Smith Residential Aged Care.
- Bennett Centre for Community Activities
- Aged Care Assessment Service

Rural Primary Health Services Program:

The Rural Primary Health Services Program operates throughout Northern Grampians Shire, and in Landsborough, which is in the Pyrenees Shire.

- **Community Health Nurse**
- **Counselling**
- **Diabetes Education**
- **Dietetics**
- **Health Promotion**
- **Occupational Therapy**
- **Physiotherapy**
- **Podiatry**
- **Speech Pathology**

APPENDIX 3: ADDITIONAL RESOURCES AVAILABLE

Skilled Migration Coordinator

Bi monthly migrant community newsletter,
"Out and About in the Grampians Pyrenees
www.grampianspyrenees.com

Centre for Culture, Ethnicity and Health
http://www.ceh.org.au/

Centre for Cultural Diversity in Ageing
http://www.culturaldiversity.com.au

Ballarat Regional Multicultural Council (HACC Cultural Diversity Officer)
www.brmc.org.au/

Government Services:

- Diversity Health Institute Clearinghouse
  www.dhi.gov.au/clearinghouse
- VicHealth
  www.vichealth.vic.gov.au
- Victorian Government Health Information
  www.health.vic.gov.au/patientcharter/resources/links.htm
- Victorian Government Health Information / Health Translations Directory
  www.healthtranslations.vic.gov.au
- Victorian Multicultural Commission
  www.multicultural.vic.gov.au

Health services:

- Australian Drug Foundation - Multicultural Drug Info
  www.druginfo.adf.org.au/multicultural
- Women's Health Information Centre
  www.thewomens.org.au
- Victorian Refugee Health Network
  www.refugeehealthnetwork.org.au

Acknowledgements to East Grampians Health Service