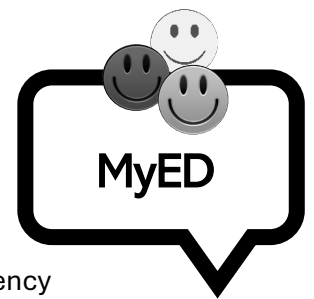


MyED Touchpoints - CALD Populations



Summary:

For this cohort, the differing perspectives of the meaning and purpose of Emergency Departments between users and providers was most apparent. Providers considered Emergency Department purpose was to provide urgent care and disposition for people who present with *life-threatening illness or injury*. In contrast, adults from a CALD background believed Emergency Departments are to provide immediate care for people who present with *perceived urgent need*. It is not surprising that these definitions are considered to be equivalent by the general public; for those who have English as a second language, it is even more confusing. Presenting to an Emergency Department for care then posed two communication-related issues for CALD users in this study: 1. Comprehension due to language barriers, and 2. health system literacy.

Step 1.1 – Non-participant observations (NPOs)

NPOs were conducted at Mount Druitt, Blacktown and Westmead Emergency Departments. Working to overcapacity and long patient wait times were evident at all EDs. The multicultural health workforce at Mount Druitt and Blacktown were broadly representative of the community they served; staff confirmed that a doctor or nurse was often available to help interpret for non-English speaking patients of larger population groups. The CALD groups most under-represented in the ED staff were the smaller population groups such as Turkish or Kurdish. Language barriers potentially added to patient anxiety about care; patients didn't understand the ED care process and there was need to manage expectations by letting people know what their journey would look like. Staff were observed using gestures to communicate with some CALD patients – if interpreters were used at all, they were predominantly called to assist during full patient assessment with a doctor (where the need for procedural informed consent might also arise) rather than the 'smaller' moments in between. As engaging an interpreter may take up to 30 minutes, triage (which must be completed within 5 minutes of patient arrival), observations, investigations and waiting were typically performed without an interpreter. However, there was little to aid communication and wayfinding.

Step 1.2 – Interviews with providers

A total of 43 interviews were conducted with 44 staff members. Interviews were coded to the Work Domain Analysis framework (WDA). The main processes identified for improvement were Communication (e.g., between staff and patients, for teamwork, patient education), Unit Management and administration (e.g., adequate resources for bed capacity, skill mix), Patient administration (e.g., data collection for records, admission and discharge processes, collaboration with stakeholders); all related to a shared value and priority to minimise wait times and ED length of stay.

Staff confirmed interpreters were used sporadically at Mount Druitt and Blacktown EDs. A staff member of the same language group was often called upon – this took the staff member from their own workload, but they were readily available and reliable. The CALD populations identified by staff to be least represented by staff members were Spanish/Greek at Mount Druitt, Turkish at Blacktown. At Westmead, there were issues with telephones that did not reach to the bedside and were sometimes broken so staff used their own mobile phones to communicate with interpreters.

Medico-legal reasons guided hospital policy that required the use of an accredited interpreter for procedural informed consent, and precluded the use of apps such as Google Translate - staff did not always follow this direction as they considered it was better to get some understanding than none.

Step 1.3 – Interviews with users

Focus groups and interviews were conducted with a total of 45 participants, with predominantly Mandarin, Cantonese, Hindi, Arabic and Korean as first language. The data was independently coded by two participants, with final codes agreed via consensus. The themes arising from the data were:

- Provision of care - Clear information from ED staff about all aspects of care is sought by CALD users including use of non-technical language, explanation of patient prioritisation, provision of likely wait times and explanation of next steps in ED care.
- Navigating through the care pathway in ED - CALD patients and carers expressed frustration with their lack of understanding of the journey into, through and out of the ED.
- ED physical environment - Lack of food and water, coupled with overly cold temperatures in the ED and waiting areas were flagged by numerous CALD participants. Accessing the ED was also problematic with poor signage and no easy vehicle drop-off points that would enable family members to accompany CALD patients into registration and triage to interpret for them.
- Communications – Users often preferred to speak in English, but they sometimes overestimated their capacity to communicate in English, particularly if stressed or confronted with medical terms. An interpreter was not always offered by staff or favoured by users. Barriers to CALD users requesting an interpreter included perception it would increase wait time and mistrust:

“I did not ask for an interpreter because I could understand and communicate a bit back with the doctors. The reason why I did not ask for an interpreter because I assumed that it’s going to take a while to get me an interpreter and I couldn’t wait.”

Mistrust of translation arose through experience of an interpreter from a different dialect or cultural group, or perception that their voice was not interpreted accurately. Some users preferred to have a family member interpret or to have a doctor write down communications because users could then translate themselves using phone apps such as Google Translate.

“Basic conversation I can manage. Some words, like the medical terms, I don’t really understand. So, I would ask the doctor to write the words down, so I can use some translation apps.”

- Carer and patient emotions – Users often arrived in a heightened emotional state and subsequent frustration with language, and confusion over ED procedures, exacerbated the initial concerns/anxieties experienced by users.

While interviewer/facilitators prompted for racial or cultural issues, these were largely dismissed by users who felt that staff were respectful. A few cultural issues were identified including Ramadan observances colliding with time users spent in ED, provision of cold water rather than room temperature water in rooms that were already too cold; and provision of only Western style ‘junk’ food in vending machines in waiting areas.

The priorities identified by the CALD user groups for ED change:

1. Minimise wait times (Priority for all three hospitals)

“My overall impression of the emergency services is actually very good. Maybe one thing – you know, everybody – most people that go emergency because they have a [quick] emergency issue, they need to be seen quickly by a doctor. If they can – if I, or they can be seen a bit faster by the doctor it would be better.”

2. Provide more information about how the ED works

“... at the beginning when we're sent back to the emergency department waiting room we found they only have two nurses and I tried to talk with one nurse because I just want - this is the first time to that department. I just wanted to ask what would be the next step?”

“So you have to be waiting in the waiting room and they did not explain, so we get very confused. Especially in the first two hours when we wait we don't know what happened and we see that many people. We don't know how long we need to wait. Maybe we guess we may need to wait a whole night and, as you know, it's very, very cold and we did not wear very thick clothes. So we were very, very confused and a little bit exhausted at the beginning. Once they started to do blood tests for my mum and do other tests we started to understand a little bit more about the procedure and then not that nervous anymore”

Touchpoints:

The themes from the user and provider data were both coded to the WDA. The single area of common concern, as indicated in the WDA was *Communication*. Triangulating all data, there were two main communication issues identified:

1. Language barriers – interpreters are not present for the entire patient journey. For those who were not fluent in English, their capacity to comprehend and express themselves was often reduced due severity of presenting injury or illness, and further diminished with stress and use of medical terms that added to patient anxiety. There is a need to ensure communication is maintained for the whole of the patient journey.
2. Health system literacy – participants did not always understand the way ED worked - long wait times did not meet their expectation for urgent attention and was confusing, causing additional stress. There is a need to provide better understanding of how the ED works and how it fits into the overall health system, and to manage expectations for the ED care pathway.



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