Lewis’s Medical-Surgical Nursing 5e
Assessment and Management of Clinical Problems

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Preface

The fifth Australian and New Zealand (ANZ) edition of Lewis’s Medical–Surgical Nursing: Assessment and Management of Clinical Problems builds on the combined strengths of the fourth ANZ edition and the tenth US edition. It has been written to address the needs of ANZ students and educators. Professors Di Brown and Helen Edwards and Associate Professors Tom Buckley and Robyn L Aitken have once again worked closely with a team of specialist nurse clinicians and academic contributors from across ANZ to develop this cutting-edge text.

The fifth edition has been thoroughly revised and incorporates the most recent nursing knowledge in an engaging and reader-friendly format. More than a textbook, this is a comprehensive resource containing essential information that students need in order to prepare for lectures, classroom activities, examinations, clinical assignments and the professional care of people and their families with healthcare needs. In addition to its accessible writing style and high-quality illustrations, the text provides special features to facilitate student learning such as evidence-based practice boxes, review questions and clinical reasoning exercises. Recurring topics include patient teaching guides, advice about care and considerations for older people, management of chronic and ongoing conditions, interprofessional care, considerations of cultural and ethnic diversity, nutrition, community and home-based care, and nursing research. In addition to the new chapter dedicated to ‘Working with Indigenous peoples of Australia and New Zealand’, each chapter throughout the book also considers the specific vulnerabilities and cultural considerations that nurses should be cognisant of when caring for Māori, Aboriginal and Torres Strait Islander people and their families/whānau. Another new chapter, ‘Stress and coping’, acknowledges the impact that stress plays in people’s lives, both as health consumers and as health providers, as well as the central role of coping in mitigating the potential impact of stress on emotional and physical health. The ‘Stress-Busting Kit for Nursing Students’ on the website for the book provides students with resources to assist them as they make their transition to the role of Registered Nurse.

The use of the nursing process as an organising framework for nursing practice has been retained and new content has been added to reflect rapid changes in practice. The early chapters in the book have been extensively revised to reflect the contemporary and dynamic practice context that is not only influenced by global change, but is also unique to nursing in the Australasian healthcare setting. These chapters also support development of capability in relation to the Australian Registered Nurse Standards for Practice and the New Zealand Registered Nurse Competencies. The new chapters ‘Recognising and responding to the deteriorating patient’ and ‘Cardio-pulmonary resuscitation: Basic and advanced life support’ particularly reflect the latest evidence-based practice where Australia and New Zealand are at the forefront of the translation of research into clinical practice. Similarly, the thoroughly revised ‘Substance use and dependency’ chapter highlights how Australian and New Zealand are leading the way with a harm minimisation approach. The chapter on cognitive impairment and dementia responds directly to government-designated National Health Priorities in New Zealand and Australia and provides best practice, evidence-based resources and information that have been developed by local nursing researchers and others to assist users of this book to effectively recognise and support people who are suffering with cognitive impairment in both hospitals and the community.

Contributors have been selected for their expertise in specific areas, and clinical specialists have thoroughly reviewed each chapter to ensure accuracy, currency and regional relevance. We were privileged to have Professor Roianne West and Professor Denise Wilson as contributors for the chapter on ‘Working with Indigenous peoples of Australia and New Zealand’, providing an opportunity to role-model non-Indigenous nurses working alongside Aboriginal and Torres Strait Islander people to reset the power balance in nursing education and healthcare. This edition also endeavours to extend medical and surgical nursing beyond the acute hospital setting, considering, where applicable, health promotion, disease prevention and primary healthcare nursing and interprofessional activities. The chapter on ‘Rural and remote area nursing’ includes a primary healthcare model of consultation that has been developed by and for Australian remote area nurses. Additionally, the chapter on ‘Chronic illness and complex care’, written specifically for the ANZ edition, highlights the principles of chronic disease self-management based on social cognitive theory, to assist people to integrate their own disease management as well as highlight the nurse’s multiple roles within the chronic disease pyramid model.

In line with the contemporary approach to healthcare, this edition of the text aims to assist students to understand and apply the guidelines developed in Australia and New Zealand to improve medication safety by harmonising drug names so that they are consistent with World Health Organization guidelines, and thus similar across countries and across the world. This is a long-term process to ensure patient safety, and in this edition we have used both the old and new names for the medications, written as ‘old name (new name)’, e.g. frusemide (furosemide). In future editions, in line with the Therapeutic Goods Administration guidelines, we will move to ‘new name (old name)’ format and thereafter will use the new names as appropriate for the Australian and New Zealand context.

Organisation

The content is organised into 12 sections. Section 1 (Chs 1–7) introduces key healthcare concepts within Australia and New Zealand. Sections 2–12 (Chs 8–70) present nursing assessment and nursing management of medical and surgical patient problems both within acute-care settings and within the community. The focus of each section is across the whole trajectory of healthcare, including health promotion, risk assessment, management of acute and chronic conditions,
and the various nursing roles and responsibilities, as well as the contribution of the interprofessional healthcare team. The various body systems are grouped to reflect their interrelated functions. Each section is organised around two central themes: assessment and management.

Chapters dealing with assessment of a body system include a discussion of the following:

1. A brief review of anatomy and physiology, focusing on information that will promote an understanding of nursing care.
2. Health history and non-invasive physical assessment skills to expand the knowledge base on which decisions are made.
3. Common diagnostic studies, expected results and related nursing responsibilities to provide easily accessible information.

**Management** chapters focus on the pathophysiology, signs and symptoms, diagnostic study results, interprofessional care and nursing management of various diseases and disorders. The sections on nursing management are organised into assessment, identification of priority care problems, planning, implementation and evaluation. To emphasise the importance of patient care in various clinical settings, nursing implementation of all major health problems is organised by the following levels of care:

1. Health promotion.
2. Acute intervention.
3. Ambulatory and community/home care.

**Classic features**

- **Critical thinking, clinical judgement and clinical reasoning skills** (introduced in Ch 2) are developed throughout the text. In Chapter 2 a new and easily applied framework for clinical decision-making provides students with a structured way to think about patient situations effectively. The use of multiple case studies at the end of each section enables students to practice prioritising care across a number of different patients. The multiple case studies and the individual ones in the assessment and management chapters are structured so that students are encouraged to use their clinical reasoning and judgement skills to plan and outline care priorities.

- **National patient safety and quality goals and standards** for both New Zealand and Australia are introduced in Chapter 2, and are then addressed in more detail in relevant chapters throughout the book. Important patient safety information such as medication interactions are highlighted within specific chapters.

- **Key epidemiological information** is provided to enable students to understand the incidence and prevalence of the various conditions in the Australian and New Zealand context. Vulnerable populations are identified, as are epidemiological changes that have occurred over time, including the emergence of new patterns of disease and improvements in population health that arise from health promotion activities and advancements in clinical care.

- **Priority care problems** outlined in each of the management chapters illustrate the interprofessional nature of contemporary healthcare practice.

- **Interprofessional care** is further highlighted in focused care sections in all management chapters and in more than 80 interprofessional care boxes and tables throughout the text.

- **The whole trajectory of care**, from prevention and health promotion, through the acute care phase into rehabilitation and chronic disease management, is included where appropriate. Chapters have been thoroughly updated to reflect current nursing practice and include defining characteristics, expected patient outcomes, specific nursing interventions with rationales, and interprofessional care. The book is structured to enable nursing students to gain a comprehensive understanding of the nursing role and the differences (and similarities) in nursing and other healthcare roles and functions. The information and structure of the chapters increases students’ understanding of the Interprofessional nature of current healthcare practice and the roles that nurses play.

- **Patient and carer education** is an ongoing theme throughout the text. Coverage includes more than 80 patient teaching guides throughout the text.

- **The needs of older people** are included in each chapter where the differences in assessment and the effects of ageing are detailed. Chapter 38 provides a thorough explanation of delirium, dementia and depression in older adults who are admitted to an acute-care setting, using the latest research from Australian nurses who are world leaders in dementia care.

- **Nutrition** is highlighted throughout the book and in a separate chapter (Ch 38). Nutritional therapy boxes and tables summarise nutritional interventions for patients with various health problems. Chapter 39 specifically focuses on obesity and the role and responsibilities of nurses in educating and caring for patients who are obese when they come into contact with healthcare providers.

- **Complementary and alternative therapies** boxes in various chapters summarise what nurses need to know about non-traditional therapies, such as herbal remedies and acupuncture.

- **Evidence for practice** boxes included throughout the text demonstrate how clinical research and evidence can be used to enhance clinical knowledge and nursing practice.

- **Culturally competent care** is covered in Chapter 4 in a way that encompasses the comprehensive set of congruent behaviours, attitudes and policies that enable nurses as professionals to work effectively in cross-cultural situations. It describes the continuum of cultural awareness, cultural respect, cultural safety, cultural security and cultural responsiveness. Each concept is then integrated into chapters throughout the book and, consistent with the new content of Chapter 4, highlights health inequities across and within populations. The increased focus on Indigenous health in Chapter 5 ensures that the concepts developed in Chapter 4 are applied to the specific needs of Māori, Aboriginal and Torres Strait Islander people to ensure that new nursing graduates are better equipped to provide care in line with the specific needs of our Indigenous populations.

- **Rural and remote area nursing** is covered in Chapter 9, and not only continues the theme of population health but also presents the unique influence that geography and climate have on people’s health in rural and remote
Australia and New Zealand. Burden of disease is described, acknowledging the multiple contributing factors including access to healthcare services, cultural diversity, chronic disease, mental health, injury and trauma. The specialist skills required by nurses working in rural and remote settings are identified along with the challenges and rewards of working and living in tightly knit and often isolated communities.

- **Current issues in healthcare** such as advances in genetic research, use of technology, the ageing population, emerging therapies, end-of-life decision-making, and the role of the social determinants of health in the incidence of various conditions provide students with a broad overview of many of the key challenges currently facing nursing and healthcare consumers. Contemporary approaches such as patient-centred care, consumer and family engagement and partnerships, and self-management models are presented as key strategies to address these challenges, with examples of how to implement these models of care included throughout the book.

- Several **Genetics in clinical practice** boxes highlight the genetic basis, genetic testing and clinical implications for genetic disorders that affect adults. These are listed in Chapter 11 along with page numbers for easy reference.

- **Professional practice** boxes promote critical thinking about key elements of the nursing role, including ethical dilemmas relating to timely and sensitive issues that nursing students may deal with in clinical practice.

- **Emergency management** tables and boxes outline the emergency treatment of health problems that are most likely to require emergency intervention, including: responding to the patient with arrhythmias (in Ch 54), the deteriorating patient (in Ch 69), and the patient in cardiac arrest (in Ch 70). A list, with page numbers, can be found in Chapter 67.

- **Assessment abnormalities** tables in assessment chapters alert the nurse to frequently encountered abnormalities and their possible aetiologies.

- **Nursing assessment** tables summarise the key subjective and objective data related to common diseases. Subjective data are organised by functional health pattern.

- **Health history** boxes and tables in assessment chapters present key questions to ask patients related to a specific disease or disorder.

- Additional student-friendly pedagogy includes the following:
  - **Learning outcomes** and **key terms** at the beginning of each chapter help students to identify the goals of the chapter and key content for each topic, body system or disorder.
  - **Structure and function** sections within assessment chapters review the anatomy and physiology of each body system to provide a sound basis for nursing assessment.
  - **Nursing management** sections of individual chapters identify key priority care problems to illustrate the specific needs of individual patients and their carers. Specific nursing and interprofessional care is outlined in each chapter and detailed nursing care plans are available on the website for the book.
  - **Case studies** throughout the book enable students to apply their learning to real-life situations and guide them through the steps involved in planning and implementing nursing care. At the end of each section, students are able to apply their critical thinking and clinical knowledge to the assessment and management of multiple patients. This enables both students and teachers to explore issues in planning and prioritising care for multiple patients and thus further assists the student’s transition to the role of Registered Nurse.
  - **Review questions** at the end of each chapter help students learn the important points in the chapter. Answers are provided in the web resources of the book so that the review questions may serve as a self-study tool. Further questions can also be found in the web resources.
  - **Resources** at the end of each chapter contain information about nursing and healthcare organisations that provide patient teaching, health promotion and disease prevention, and disease and disorder information. Resources also include internet sites to help students find current information online, legislation, policies and standards, as well sites that provide access to the best practice, evidence-based guidelines developed by many of the specialty clinical colleges and organisations within Australia and New Zealand.

### Ancillary website

**LEARNING SUPPLEMENTS FOR THE STUDENT AND INSTRUCTOR**

The fifth edition Evolve website (available at http://evolve.elsevier.com/AU/Brown/medsurg/) hosts an eBook and features the following valuable learning aids:

- **Instructor resources**
  - Test bank
  - Power Point slides
  - Image bank

- **Student resources**
  - Review questions
  - Conceptual Care Map creator
  - Student Case studies
  - Fluids and Electrolytes tutorial
  - Nursing Care Plans
  - Clinical Cases case studies
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This chapter recognises that Māori are the Indigenous people of New Zealand, and that Aboriginal and Torres Strait Islander people are the traditional owners of Australia. It recognises that, like other Indigenous people who have survived the processes of colonisation, Māori and Aboriginal and Torres Strait Islander people experience poorer health outcomes and socioeconomic disadvantage compared with non-Indigenous people in the New Zealand and Australian populations. With respect to elders past, present and emerging, this chapter acknowledges the importance of dedicating a stand-alone chapter to the role of nurses in improving the health outcomes of Indigenous people in both countries by paying overt attention to improving the healthcare experiences of Māori and Aboriginal and Torres Strait Islander people and their families/whānau. This is not an easy task, as highlighted in the sections on culturally appropriate care in Chapter 4, and requires a concerted effort at healthcare system, health service organisation, professional and individual levels.

The focus of this chapter is to describe the broader social and cultural factors that contextualise the health and health experiences of Māori and Aboriginal and Torres Strait Islander people and their families, and to provide a framework to guide nurses to work in a culturally responsive way. The aim is to make a positive contribution to reducing the gap between the health status of Indigenous and non-Indigenous people in Australia and New Zealand. The chapter introduces national guidelines and individual nursing actions, which will be presented using an adapted model of the Australian curriculum framework for providing culturally safe healthcare to Aboriginal and Torres Strait Islander people (Fig. 5.1). The content of the chapter endeavours to role-model cultural respect, including the language used when referring to Māori and Aboriginal and Torres Strait Islander people (see Box 5.1). The term Indigenous is used when content refers to the shared experiences of first-nations people globally, or Māori, Aboriginal and Torres Strait Islander people across Australia and New Zealand, and/or when this is the term used in the source material.

Aboriginal and Torres Strait Islander people and health

Australia has been continually inhabited for over 50,000–60,000 years by Indigenous peoples, known as Aboriginal and Torres Strait Islander people, living and moving about different regions of Australia, speaking different languages, holding various local beliefs and engaging in varying cultural practices. In 1788 there was an estimated Indigenous population of 750,000 people, with approximately 700 languages spoken throughout Australia, and over 400 Aboriginal nations. In 2016 the estimated Indigenous population was 744,956 Aboriginal and Torres Strait Islander people, representing around 3% of the total Australian population. Of this population, 90% identify as Aboriginal people, 6% identify as Torres Strait Islander people, and 4% identify as both Aboriginal and Torres Strait Islander people. Most Indigenous people live in New South Wales (31% of all Aboriginal and Torres Strait Islander Australians), with Aboriginal people representing the highest percentage of the overall population in the Northern Territory (Table 5.1).
Despite improvements in health status over the years (see Closing the Gap, below), Aboriginal and Torres Strait Islander health is characterised by Aboriginal and Torres Strait Islander people continuing to have lower life expectancy and being much more likely to die before they are old, compared with non-Indigenous Australians. They have higher rates of chronic and preventable illnesses, a higher likelihood of being hospitalised, and higher rates of traumatic injury, suicide and family violence than non-Indigenous Australians. They also have poorer self-reported health, including mental health and social and emotional wellbeing, compared with the overall Australian population. Aboriginal and Torres Strait Islander men live to around 69 years compared with 80 years for non-Indigenous men; Aboriginal and Torres Strait Islander women are likely to live to 74 years compared with their non-Indigenous counterparts who live to around 83 years.

The diseases contributing most to morbidity and mortality among Aboriginal and Torres Strait Islander people include coronary heart disease, diabetes, chronic lower respiratory disease, lung disease and related cancers. Cardiovascular disease is responsible for around 25% of all Aboriginal and Torres Strait Islander deaths, with a likelihood of dying from ischaemic heart disease being twice as likely as for non-Indigenous Australians. Rheumatic heart disease, which is rare among non-Aboriginal Australians, is prevalent among Aboriginal people aged 45–54 years. Diabetes is experienced earlier and Indigenous people die younger, with a death rate five times higher than for non-Indigenous Australians. Respiratory disease

### TABLE 5.1 Estimated Aboriginal and Torres Strait Islander (Indigenous) population, by jurisdiction, Australia, 2018

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Indigenous population (number)</th>
<th>Proportion of Australia Indigenous population (%)</th>
<th>Proportion of jurisdiction population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>7,525</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>New South Wales</td>
<td>239,587</td>
<td>31</td>
<td>3.0</td>
</tr>
<tr>
<td>New Territory</td>
<td>76,845</td>
<td>9.9</td>
<td>31</td>
</tr>
<tr>
<td>Queensland</td>
<td>223,883</td>
<td>29</td>
<td>4.5</td>
</tr>
<tr>
<td>South Australia</td>
<td>43,317</td>
<td>5.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Tasmania</td>
<td>28,328</td>
<td>3.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Victoria</td>
<td>56,528</td>
<td>7.3</td>
<td>0.9</td>
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<tr>
<td>Western Australia</td>
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<td>13</td>
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</tr>
<tr>
<td>Australia</td>
<td>778,064</td>
<td>100</td>
<td>3.1</td>
</tr>
</tbody>
</table>


### BOX 5.1 Language used in this chapter

- **Indigenous person:** The United Nations identifies Indigenous peoples as those groups of people who populated areas before other people arrived, and have become minority groups through processes of domination. Indigenous peoples retain connections to their lands and territories, and possess distinct political, linguistic and cultural practices. The United Nations includes self-identification as a fundamental human right. Accordingly, rather than define the term Indigenous person, this chapter takes the approach that a person is Māori or Aboriginal or a Torres Strait Islander when they identify as Māori, Aboriginal or Torres Strait Islander and are accepted as such by the community in which they live.
- **Māori** is used as a collective term in this chapter to describe New Zealand’s Indigenous people who belong to one or more different whānau, hapū and iwi (tribal groups) located across the country.
- **Aboriginal people and Torres Strait Islander people** are recognised in this chapter as two distinct cultural groups, within which there is also great diversity exemplified by the over 250 different language groups spread across the nation. People may identify with:
  - the region they are connected to, for example Koori, Murri or Nunga
  - a language group and traditional country (a specific geographical location); for example, Gunditjmara people are the traditional custodians of western Victoria, the Gadigal people of the Eora nation are from Sydney, the Walpiri are the traditional owners of the central western desert of the Northern Territory; and the Yawuru people are the traditional custodians of Broome in Western Australia
  - the nature of their traditional lands, for example, ‘saltwater people’, ‘freshwater people’, ‘rainforest people’, ‘desert people’ or ‘spinifex people’
  - a traditional totem, or kinship name
  - Torres Strait Islander people may prefer to use the name of their home Island, even if they were born and/or lived only on the mainland; for example, a Saibai man or woman is from Saibai, or a Meriam person is from Mer.
  - Aboriginal and Torres Strait Islander people prefer not to be referred to as an abbreviation, i.e. ATSIC.

The collective term **Indigenous Australian** is often used in policy documents and government publications and is used in this chapter when used as such in another source. Nurses are encouraged to ask Māori, Aboriginal and Torres Strait Islander people themselves how they would like to be referred to.
accounts for around 8% of the total burden of disease among Aboriginal and Torres Strait Islander people, accounting for five times the likelihood of being admitted to hospital three times or more with chronic obstructive pulmonary disease (COPD) over a lifetime and/or with respiratory infections, and being twice as likely to be admitted to hospital for asthma, compared with non-Indigenous Australians. Although cancer incidence rates can be lower for Aboriginal and Torres Strait Islander people, they often present later and have higher mortality than for non-Indigenous people. Cancers associated with smoking have a high prevalence.

Poor kidney health also contributes to the burden of disease in the Aboriginal and Torres Strait Islander population. Similar to diabetes, Aboriginal and Torres Strait Islander people experience end-stage renal disease (ESRD) when they are much younger than non-Indigenous people, with the overall rate being seven times greater than for non-Indigenous people. Aboriginal and Torres Strait Islander people are less likely to receive organ transplantation, and are therefore much more likely to require regular renal dialysis. Not surprisingly, dialysis is one of the most common reasons for hospitalisation of Aboriginal and Torres Strait Islander people.

Each of these chronic diseases is preventable. The poorer health status and health outcomes of Aboriginal and Torres Strait Islander people reflects the socioeconomic disadvantages experienced by this population. In broad terms, the ‘social determinants of health’ reflect the disadvantages that Aboriginal and Torres Strait Islander people experience in terms of employment, physical infrastructure (including running water and housing), education, connection to land, racism and incarceration. Aboriginal and Torres Strait Islander people also experience lower access to health services. This may be related to distance (rural and remote people), affordability, user-friendliness, or lack of cultural safety. Together, these factors result in Australian Indigenous people presenting for medical surgical nursing care further along the trajectory of their disease process than non-Indigenous Australians.

**Māori people and health**
Māori are New Zealand’s Indigenous people, making up around 16% of the population. Māori are a youthful population, with the median age (23.9 years) just over 14 years less than for non-Māori (38 years). One in three Māori is aged 15 years or younger (33.8%, compared with 20.4% for non-Māori), while only 5.4% of Māori live beyond 65 years compared with 14.3% of the non-Māori population. Māori life expectancy is just over 7 years less than for non-Māori, with Māori men living to 72.8 years and Māori women living to 75.6 years.

Fundamentally, Māori health is characterised by Māori being sicker and dying younger than non-Māori population groups. New Zealand’s Ministry of Health (2015) utilises ambulatory sensitive hospitalisation, amenable mortality and adverse events as indicators of how well the health system is responding to the needs of its various population groups, like Māori. Māori have a greater likelihood (1.64 times) of having an ambulatory sensitive hospitalisation than non-Māori. These are hospitalisations that could have been prevented through timely access to primary healthcare services or by effective engagement in health prevention activities (e.g. smoking cessation or mammography for breast cancer screening). Māori are also more than twice as likely (2.39 times) to die prematurely of a preventable health condition than non-Māori, related to not receiving the primary healthcare they needed. Ambulatory sensitive hospitalisations and amenable mortality are indicative of inadequate coverage of healthcare services as well as quality-of-care issues. Furthermore, Māori are also more likely to encounter adverse events and often have a longer average length of stay in hospital than non-Māori. Poor-quality and unsafe health experiences have led to inequitable health outcomes for Māori that have persisted over time and influence their ability to live longer and disability-free lives.

Māori continue to experience cultural, social and economic disenfranchisement compared with others living in Aotearoa New Zealand. One in four (24%) Māori live in the most deprived neighbourhoods (decile 10) compared with 7% of non-Māori, with three-quarters (76% vs 44%) of all those identifying ethnically as Māori experiencing some form of deprivation (decile 6–10). Poverty in Aotearoa is associated with income, housing and food insecurity. It is a significant health risk factor. While Bécares, Cormack and Harris (2015) found that ethnic density in neighbourhoods—i.e. Māori living in the same neighbourhood—was a health-protective factor, poverty hid this benefit. Increasing evidence shows the protective features for people’s health and wellbeing of having robust cultural engagement and feelings of cultural efficacy and hence that ethnic density is potentially a positive feature.

Institutional structures (such as healthcare) and endemic structural and interpersonal racism have been found to contribute to the socioeconomic deprivation of Māori and its detrimental effects on their health. Many Māori experience daily concerns about income, housing and food security, and for some this involves homelessness and being forced to live in overcrowded homes. Furthermore, food affordability (the proportion of the weekly income required for food costs) compromises access to both the quality and the quantity of food that whānau have access to.

**Respect for Indigenous people**
Too often, the health outcome statistics above are all that are cited when describing the health status of Māori, Aboriginal and Torres Strait Islander people. These figures paint a deficit picture that overlooks the colonial and postcolonial history that has contributed to the Indigenous people of Australia and New Zealand experiencing the negative effects of the social determinants of health. Understanding the impact of the history of colonisation and the ongoing racism, marginalisation and discrimination that affects Māori, Aboriginal and Torres Strait Islander people is also important in terms of understanding the determinants of health. Under the framework used for this chapter, the theme of respect acknowledges how important it is for culturally safe healthcare practice to recognise and learn about Indigenous people’s ‘ways of knowing, being and doing in the context of history, culture and diversity, and affirm and protect these factors’.

**COLONISATION AND ITS EFFECTS**
Indigenous peoples worldwide have been subjected to colonisation – the deliberate invasion and occupation of other territories. For Australia and New Zealand, colonisation was a British endeavour. While Indigenous peoples have similar but different experiences of colonisation, they all have histories that have resulted in their mass depopulation through disease and ‘warfare’; dislocation from their land; disconnection from their cultural identity, cultural practices and language; and their social and economic disenfranchisement. Accompanying colonisation is historical trauma and its intergenerational
transmission, stemming from activities such as the forceful removal of many from their land and the removal of children from families.\textsuperscript{19,23} In Australia the removal of children took place under ‘protection’, ‘assimilation’, and ‘welfare’ policies and resulted in the ‘Stolen Generations’. From 1910 until 1970, between one and three in every ten Aboriginal and Torres Strait Islander children were forcibly removed from their family.\textsuperscript{24} Nurses were involved in many cases (see Box 5.2). In New Zealand, children were forcibly removed through the State taking Māori children into care and in many cases adopting them into Pakehā (white) families.\textsuperscript{25} Policies of assimilation resulted in deliberate strategies to further remove traditional cultural practices through, for example, education (banning traditional languages) and urbanisation (restructuring family roles and support systems). The result was the removal of protective factors associated with cultural values and practices.\textsuperscript{19,23}

For contemporary Indigenous people the effects of colonisation and historical trauma are ongoing, promulgated by generalised structural racism and social marginalisation, including in health.\textsuperscript{17} Culturally, this background has added to the diversity among Māori. In addition to whānau, hapū and iwi diversity that existed before colonisation, there is now another layer of diversity, created by the degree to which individuals and groups identify with their past. This occurs along a continuum spanning from those who are totally disconnected from their Māori identity to those who are fully immersed in Māori cultural activities and have command of te reo Māori (Māori language). Aboriginal and Torres Strait Islander people have experienced, and continue to experience, disruption of family structures. Such disruption is a legacy of the Stolen Generations and, more recently, has arisen from the gravitation of youth to regional centres and capital cities, incarceration, domestic violence, and drug and alcohol use.\textsuperscript{28}

Across both countries, such historical trauma constitutes another social determinant of health. It is the collective psychological and emotional harm arising from a massive, devastating event affecting a large number of people, and is cumulative and persists across generations. It is a ‘soul wound’ that negatively affects a group of people’s spiritual wellbeing.\textsuperscript{23} Historical trauma also manifests itself in neurobiological, hypothalamus–pituitary–adrenal axis and epigenetic changes, and in these ways contributes to the intergenerational transmission of poor health.\textsuperscript{20,29}

**BOX 5.2 Submission to the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families**

’My mother told us that the eldest daughter was a twin—it was a boy. And in those days, if Aboriginals had twins or triplets, they’d take the babies away. Mum swore black and blue that boy was alive. But they told her that he had died. I only found out a couple of years ago—that boy, the nursing sister took him. A lot of babies were not recorded.’

Confidential evidence 450, New South Wales: woman removed at 2 years in the 1940s, first to Bomaderry Children’s Home, then to Cootamundra Girls’ Home; now working to assist former Cootamundra inmates.

Source: Australian Human Rights and Equal Opportunity Commission, 1997 p. 6

**CULTURE AS A HEALTH-PROTECTIVE FACTOR**

As mentioned above, there is significant evidence that cultural identity and connection are protective factors for health and wellbeing.\textsuperscript{18} In other words, culture counts! As described in Chapter 4, culture is evident in the values and beliefs that each individual nurse holds about the world he/she lives in, and how each nurse comes to understand it—culture underpins who nurses are as individuals, what is important to each nurse, and how nurses interact with others. Māori hold a spiritual and holistic worldview that is intrinsically connected to relationships with other people and the natural world they live within, and is evident in their whakapapa (genealogy) that links them to their atua (gods), tūpuna (ancestors), maunga (mountains), awa (rivers) and other people. Thus, individuals form part of a greater collective whereby their role, first and foremost, is based on their responsibilities and obligations to other members of the whānau, hapū or iwi and these entities as a whole—this means that most Māori concern will be about other whānau members rather than themselves. Therefore, practices like whakawhanaungatanga (making connections with others), values like manaakitanga (the obligation to care for others) and the importance of whānau are central to most activities, including healthcare. Fundamental for Māori is the notion that wellbeing, spirituality and whānau are highly important along with forming relationships with nurses and other healthcare providers. Importantly, nurses need to understand that for the majority of Māori, regardless of how weak or strong their cultural identity and connections are, their worldview, particularly as it relates to health, is vastly different from that informing the way the New Zealand health system operates; it is a system mainly focused on individuals and their illness or disease.

Similarly, Aboriginal and Torres Strait Islander people have a view of health that incorporates notions of body, spirit, family and community. Traditional treatment includes the use of bush medicines, involvement of a traditional healer, singing/chanting, or employing counter-spells and charms to remove evil influences. Traditional healers provide strong spiritual support and can identify the underlying causes of a serious injury or illness. In contrast to the Western biomedical model, the Aboriginal worldview does not see the primary function of the Western healthcare provider as being able to remove the cause of the illness, except for illnesses relating to colonisation. Instead, the role of Western medicine is often to relieve symptoms and to hasten the cure (provided that it does not conflict with traditional beliefs).\textsuperscript{30} For the nurse, this means making an effort to understand and assist patients and families to link into Aboriginal health beliefs (such as facilitating the presence of an Aboriginal healer) while at the same time explaining how Western interventions can assist.

Aboriginal and Torres Strait Islander culture is based on a deep sense of spirituality and oral history. Traditionally, knowledge has been passed down from generation to generation through storytelling and yarning.\textsuperscript{31} Taking time over establishing a relationship for verbal communication (see below) is therefore particularly important. Also remember that in some communities traditional languages are still being used, and English may be a second or third language for many Aboriginal people.

‘Family’ is also considered to be one of the most enabling and enduring pillars of Aboriginal and Torres Strait Islander culture, and the fundamental unit of contemporary Aboriginal and Torres Strait Islander society. Concepts of family are, however, a potential point of cultural tension between Aboriginal and Torres Strait Islander people and health professionals educated in dominant models of health that emphasise a strong ethical and legal commitment to individual rights, confidentiality and autonomy. In contrast, health may not be an individual...
issue within Aboriginal family constructs. The construct of an extended family with a complex set of kinship rules and different levels of sharing and support is often cited as distinguishing Aboriginal from Western culture.  

Within the Aboriginal extended family, relationships are defined through the traditions of culture: the biological mother’s sisters are also called mother, while her brothers are uncles. The sisters’ children become brothers and sisters rather than cousins. The children of the father’s brothers are also considered brothers and sisters rather than cousins, and the father’s brothers are called uncle. This system carries over to grandparents and grandchildren. In the healthcare environment, this kinship system has significance in terms of the Western concept of ‘next of kin’. Spokespeople such as ‘Aunties’ or ‘Uncles’ are often nominated to speak on behalf of the Aboriginal family, but would not usually fulfil this role for non-Aboriginal people. Another feature of traditional Aboriginal and Torres Strait Islander kinship systems is avoidance relationships. Kinship laws determine who can and cannot speak to each other, associate with each other or have physical contact with each other. This might mean that certain visitors are not able to be present in the same room at the same time—an important consideration for the nurse when convening a family conference. Some communities also have lore that dictates that only women talk ‘women’s business’ or only men talk ‘men’s business’. It is therefore important to identify from the outset who is the spokesperson for a person and who is the right person to talk to about all aspects of the care. Identifying the right spokesperson is of additional importance when the person receiving care is a long way from home. Early notification of family when an important decision is to be made is essential if they are required to travel long distances to join their family member.

Kinship systems also mean that Aboriginal and Torres Strait Islander people may have a number of names. A person may have a European first name and surname, a bush name, a skin name and maybe a nickname. A person’s name may also change over the period of his/her life. If a person shares a name with a person who dies, he/she may be given a new name at that time. Retrieving past results/records may therefore be essential to inform current care, so knowing whether the patient has multiple names or medical histories is important, particularly if these need to be retrieved from regional hospitals or remote health clinics.

Respecting kinship structures may assist in relieving some of the culture shock experienced by Aboriginal and Torres Strait Islander people and their families when accessing healthcare. However, it is also important to acknowledge that there are variations to the traditional ‘extended’ family. Compound families are the urban and contemporary equivalent of the traditional extended family. Compound families are a group of people who share a dwelling and where the household head agrees to accept cohabitation with a diversity of relatives and other people who are not related biologically but are considered ‘kin’. Another new form of family structure is the grandparent family, where grandmothers in particular take responsibility for child-rearing. This occurs due to parents being unable to look after their children because of the need to relocate for work, being unwell, family violence, or being parents who are very young. Regardless, individual decision-making continues to be influenced by communal relationships, family groupings that may go beyond a specific locality, and shared health beliefs. These elements become particularly important in intercultural communication.

### Communication

Improving communication in healthcare is critical to improving health outcomes for Māori, Aboriginal and Torres Strait Islander people. In some Aboriginal and Torres Strait Islander communities traditional languages are still being used, and English may be a second or third language for many Aboriginal people. Effective communication between nurses and patients is fundamental to ensuring safe, ethical and high-quality healthcare and is a key characteristic of a culturally secure, and health-literate organisation.  

Communication is particularly challenging when staff and patients do not share the same cultural and language backgrounds. The consequences of ineffective communication include discharge against medical advice; absence of informed consent; confusion and frustration; unnecessarily prolonged admission and distrust of healthcare providers.

In their seminal work, Cass, Lowell and colleagues identify six main areas that impede effective communication between the patient and treating clinician. These researchers also suggest some strategies to improve communication with Indigenous patients, as do other researchers who include communication as a component of organisational cultural safety. Table 5.2 presents both the barriers and the enablers to communication as identified by the respective researchers.

With regard to interpreters, family members are frequently the first choice and there are advantages and disadvantages of this practice. On the positive side, family may be the most expedient choice for interpreting because they are immediately available and can translate culture and context as well as language. If the family member has the appropriate cultural authority there may also be significant trust which an interpreter would not be able to foster. On the negative side, there is the potential for bias, inaccurate information, selective transfer of information, transgressing laws relating to gender and kinship, and relatives receiving information that the person would prefer they did not know. Utilising the important cultural brokerage abilities of Māori health staff or Aboriginal and Torres Strait Islander Health Practitioners, Health Workers or Aboriginal Liaison Officers is an important strategy to enhance communication between Indigenous patients, families and health professionals. However, health professionals have been known to use health workers to excuse their own deficits in communication rather than observing some basic verbal and non-verbal communication cues and principles when working with Aboriginal and Torres Strait Islander people. Box 5.3 (overleaf) provides some guidance in this respect.

Some important points for shared understandings in communicating with Aboriginal and Torres Strait Islander people relate to health belief systems and how they influence a person’s understanding of their health, wellbeing, illness and disease. In the context of these beliefs, understanding how people conceptualise disease and illness is particularly important in the healthcare environment. The interconnected aspects of connection to country and kinship obligations place an emphasis on social and spiritual dysfunction causing illness (e.g. transgressing kinship and family relationships, entering prohibited sacred sites), and more-serious ‘direct supernatural’ causes that result from transgressing Aboriginal law. Ill-health may also be caused by ‘Western influences’, deemed responsible for alcohol-related illnesses, substance abuse, infectious diseases, heart disease, cancer and sexually transmitted diseases.
TABLE 5.2 Enhancing cross-cultural communication

<table>
<thead>
<tr>
<th>Factors impeding effective communication</th>
<th>Strategies to improve communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of control</td>
<td>Informed choice and right of refusal</td>
</tr>
<tr>
<td>Staff commonly have control over the decision as to whether an interpreter is required; the clinician controls the topic of discussion and style of verbal discourse.</td>
<td>Respect the right that people have to make decisions about their care and their right to informed refusal.</td>
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<td></td>
<td>Provide people with the option for, and access to, interpreter services for clinical discussions.</td>
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<tr>
<td></td>
<td>Do not make assumptions about the need for interpreters based on apparent English language competency.</td>
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<tr>
<td></td>
<td>Offer an interpreter because you don’t speak the person’s language.</td>
</tr>
<tr>
<td>Modes of discourse</td>
<td>Staff attitudes and respect</td>
</tr>
<tr>
<td>In some cultures the ‘question–answer’ interview style of Western health interactions is not utilised during discussion of personal topics. This may result in a person feeling that it is impolite to give what they view as a negative answer, and instead saying whatever they believe the interviewer wants to hear.</td>
<td>Remember that some of the behaviours that generate or manifest respect are culturally specific. Consider sharing information about yourself and using ‘yarning’ and conversations. Be guided by family and Indigenous health professionals.</td>
</tr>
<tr>
<td></td>
<td>Display humility and compassion, and maintain a friendly demeanour during your interactions. Being officious or overly assertive may not be well received.</td>
</tr>
<tr>
<td>Cultural and linguistic distance</td>
<td>Specific indigenous programs</td>
</tr>
<tr>
<td>English is a second or third language for many Aboriginal and Torres Strait Islander people living in rural/remote communities, and conversely most treating health professionals have no ability to communicate in the person’s first language. Culturally specific terminology can also present problems during health discussions, e.g. discussion of quantitative measures while explaining medications or diagnostics might have little or no meaning to certain linguistic/cultural groups.</td>
<td>Consider whether there are specific programs that you can offer people that acknowledge traditional/cultural beliefs about health, and whether you can work with health professionals with the same cultural identification to provide this care.</td>
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<tr>
<td></td>
<td>Communication resources</td>
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<tr>
<td></td>
<td>Engage with educational resources that promote a shared understanding of the relevant health complaint, related treatment options, and the cultural, social and economic realities confronting Indigenous people.</td>
</tr>
<tr>
<td></td>
<td>Tools to measure cultural competence</td>
</tr>
<tr>
<td></td>
<td>Engage in reflection to monitor the effectiveness of your nurse–patient communication, to ensure that episodes of miscommunication are minimised.</td>
</tr>
<tr>
<td>Lack of shared knowledge</td>
<td>Cultural education programs</td>
</tr>
<tr>
<td>An understanding of the pathophysiology of the disease being treated is needed to enable meaningful discussion around treatment with a patient. If a shared understanding of the topic is not present, effective communication is compromised.</td>
<td>Ensure that you have had appropriate education in cross-cultural communication issues.</td>
</tr>
<tr>
<td></td>
<td>Culture-specific guidelines</td>
</tr>
<tr>
<td></td>
<td>Ensure that you are familiar with how to access interpreter services and follow guidelines that are in place to facilitate this access.</td>
</tr>
<tr>
<td>Lack of staff training in cross-cultural communication</td>
<td>The factors above incorporate 8 of the 14 characteristics identified by Kruske (2012), and organisational initiatives identified by Aitken, Skinner &amp; Clark (in press).</td>
</tr>
<tr>
<td>In many cases, clinicians delivering care to Indigenous patients have had minimal formal training in relevant communication issues.</td>
<td></td>
</tr>
<tr>
<td>Limited use of interpreters</td>
<td></td>
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<tr>
<td>Research identifies that even when interpreters are available, they are underutilised.</td>
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</tbody>
</table>

The factors above are derived from the work of Cass, Lowell, et al (2002). On the other hand, also important for communication interactions, preventative measures for Aboriginal and Torres Strait Islander people to ensure wellbeing include actions that avoid repercussions, such as observing kinship obligations to others, containing anger, violence or jealousy, respecting and honouring elders and the dead, and leading a moral life. Safety and quality

This element of the framework used for this chapter incorporates population health knowledge described previously, applying best practice regarding clinical presentation and disease prevention that appears throughout the book, and applying knowledge of effective policies and strategies relating to Māori, Aboriginal and Torres Strait Islander people. These are discussed in more detail below.

CLOSING THE GAP BETWEEN INDIGENOUS AND NON-INDIGENOUS HEALTH IN AUSTRALIA

Between 2008 and 2013, a number of landmark events occurred for social justice in Australia, and for advancing the health status of Aboriginal and Torres Strait Islander people. The first event was the formal apology to Aboriginal and Torres Strait Islander people from Prime Minister Kevin Rudd. The apology acknowledged the suffering and loss experienced by Aboriginal and Torres Strait Islander people as a direct impact of policies and practices of past governments, including the long-lasting trauma experienced by members of the Stolen Generations. The Closing the Gap partnership (see Box 5.4) was announced within the formal apology, endorsed later at the Indigenous Health Equality Summit, and is funded by the Health Ministers in each Australian state and territory with an initial AS$4.6 billion.
Consider kinship relationships
- Certain people will have rights to access particular knowledge and make specific decisions within family and community.
- The passing of information often depends on a person’s position in the family/community or relationship with the holder of information.
- Find out the relationships between the Aboriginal or Torres Strait Islander person, positioning yourself within your family context and your ‘place’ is important. For example, sharing where you are from, relationships you are comfortable talking about (children, brothers, sisters, grandparents), the football team you support, and food you like is culturally appropriate.

Body language
- Become familiar with non-verbal forms of communication among Aboriginal and Torres Strait Islander people, e.g. hand signs and facial gestures.
- Do not assume that all Aboriginal and Torres Strait Islander people do not make direct eye contact. However, if the person is avoiding eye contact this does not mean that they are not listening or are being rude.

Use of silence
- Use of silence is a key feature of communication with and between Aboriginal and Torres Strait Islander people. Pauses or silence during an interaction may mean that a person is thinking carefully before speaking or divulging information. It may also be time for translation between languages. Pauses may be quite pronounced, and time should be allowed for responses before seeking to fill in the silence by repeating the question.
- Cultural protocols may also mean there are times when it is culturally inappropriate to respond. Try reframing the question in a different way, or ask if the person may like someone else to respond.

billions overall and an ongoing commitment to achieve the targets expressed in the National Aboriginal and Torres Strait Islander Health Plan and Implementation Plan (Box 5.4). The state and federal governments are held accountable for achievement of the goals, which are measured by the annual Closing the Gap Report and tabled in Parliament, and through the Health Performance framework reports.

Although there have been significant improvements, many Aboriginal and Torres Strait Islander people do not or cannot access the medical care they need; and when they do access hospital care, take their own leave (discharge against medical advice) at much higher rates than non-Indigenous people (Fig. 5.2). Lack of cultural security, safety and capability together with racism, poor health literacy, the need for interpreters and other language services, and navigating the health system as barriers to good healthcare access for Aboriginal and Torres Strait Islander people have been identified as contributing to this situation, particularly in patient and specialist services. It stands to reason, then, that health services and health professionals who pay attention to minimising these barriers can promote, rather than undermine, the health and wellbeing of Aboriginal and Torres Strait Islander people.

REALISING MĀORI ASPIRATIONS FOR THEIR HEALTH AND WELLBEING

Māori, like Aboriginal and Torres Strait Islander people, also tend to present to healthcare services later rather than earlier for a variety of reasons. These reasons include cost, access to transport, and the complexity in navigating health services, or may relate to the quality of care that the person or their whānau members have received in the past. For instance, it is not uncommon for Māori to report disrespectful and racist interactions with health professionals or to report not having their health needs met. These are all factors that nurses can influence. First and foremost, nurses should carefully consider how they form relationships with Māori and their whānau: they need to be welcoming and genuine in their approach, introducing themselves and where they come from. This initial interaction is important in establishing trust and a relationship. Recognising that Māori may be uncomfortable in a health setting based on previous experiences is important, and there are system-wide policies and strategies that guide health service delivery in New Zealand from this perspective.

In Aotearoa, the New Zealand Health Strategy affirms the Treaty of Waitangi/Te Tiriti o Waitangi (a treaty signed in 1840) that sets out the relationship between Māori and the Crown, and the government’s obligation to protect Māori health. Nurses working in publicly funded health services also have an obligation to engage in relationships that aim to realise Māori aspirations regarding their health and wellbeing. The Health Strategy outlines the need for equity and for timely health and disability services and outcomes. Supporting the overall health strategy is He Korowai Oranga—the Māori health strategy. He Korowai Oranga is metaphorically a protective cloak of wellbeing, and this health policy sets out the key threads and pathways for achieving pae ora (healthy futures) for Māori, achieved through whānau ora (healthy families), mauri ora (healthy individuals), and wai ora (healthy environments).

Combined, these documents provide the policy and legislative intents to improve health experiences for Māori users of health services and for their whānau.
## Closing the gap

In 10 years, halve the gap in:

- literacy, numeracy and employment outcomes and opportunities for Indigenous children
- infant mortality rates between Indigenous and non-Indigenous children.

Within a generation (by 2030), close the 17-year life gap between Indigenous and non-Indigenous people.

### Goals

- Effective strategies that address environmental, economic and social inequalities that are pivotal to achieve health equality.
- All healthcare, whether government, community or private, is free of racism.
- The health system delivers clinically appropriate care that is culturally safe, high-quality, responsive and accessible for all Aboriginal and Torres Strait Islander people.
- Health policies and programs are clearly evidence-based and informed by robust health research and data systems.
- Aboriginal and Torres Strait Islander people have the best possible mental health and wellbeing.
- Social and emotional wellbeing strategies are integrated in all healthcare service delivery and health promotion strategies.
- The capabilities, potential and aspirations of Aboriginal and Torres Strait Islander people are realised and optimise their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing.
- Aboriginal and Torres Strait Islander people are as healthy as non-Indigenous people and enjoy the same life expectancy by 2031.
- Aboriginal and Torres Strait Islander mothers and babies get the best possible care and support for a good start to life.
- Aboriginal and Torres Strait Islander children have long, healthy lives, meeting key childhood developmental milestones.
- Aboriginal and Torres Strait Islander youth get the services and support they need to thrive and grow into healthy young adults.
- Aboriginal and Torres Strait Islander adults have the healthcare, support and resources to manage their health and have long, productive lives.
- Older Aboriginal and Torres Strait Islander people are able to live out their lives as active, healthy, culturally secure and comfortably as possible.

### Indigenous Australians were discharged from hospital during July 2013–June 2015 at 7 times the rate of non-Indigenous Australians, despite medical advice to the contrary. They were also more likely to leave the Emergency Department before being seen by a healthcare provider.

![Figure 5.2 Patterns of healthcare access by Aboriginal and Torres Strait Islander people, 2012–2013](image)


Creating a culturally secure healthcare environment

The next section of this chapter provides some practical advice about creating a culturally safe, responsive and respectful environment and is designed to assist nurses in their everyday practice.

ORGANISATIONAL-LEVEL CULTURAL COMPETENCE

Improving the healthcare experiences of Aboriginal and Torres Strait Islander people occurs not just at the policy and legislative levels, but also needs to be specifically operationalised for nurses within the organisations where they work. Nurses contribute both on an individual level, as a member of the profession of nursing, and as role models and in leadership positions within healthcare organisations and the community.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is an Australian Government agency that sets guidelines for health services to work towards and to be measured against in terms of providing services that meet minimum standards for patients and carers. The ACSQHC has created a set of six actions specifically aimed at improving the quality of healthcare provided to Aboriginal and Torres Strait Islander people (Fig. 5.3).

In New Zealand, the Ministry of Health also sets out standards explicitly guiding health service providers on what is needed to improve Māori health and reduce their health disparities. Achieving the Ministry of Health standards regarding Māori requires healthcare services and providers, such as nurses, to:

- Provide discrimination-free healthcare experiences;
- Provide accessible and appropriate services for Māori;
- Ensure involvement of whānau;
- Enable Māori and their whānau to be involved in their health experiences and decision-making;
- Provide safe, timely, and effective care that is responsive to the needs of each Māori person;
- Be respectful and inclusive of each person’s individual and cultural beliefs and needs;
- Apply a quality improvement system which ensures that Māori are receiving services according to their health needs.

Research commissioned by the Australian Health Ministers’ Advisory Council, although specific to maternity services, identified and tested 14 characteristics of organisational cultural competency that strongly align with the actions outlined by the ACSQHC and the New Zealand Ministry of Health. These indicators can be useful for reflecting on individual nursing actions towards improving people’s experience within an organisational context. Some of these indicators are included in Table 5.2.

PERSONAL CULTURAL COMPETENCE

Chapter 4 describes some of the learning required, and mechanisms for, developing cultural competence. Acknowledging that cultural competence is developed along a continuum, the improvements to Māori, Aboriginal and Torres Strait Islander people’s experiences of organisational care also depend on the individual nurse’s own journey towards creating a culturally secure environment (see Ch 4 for a definition of cultural security). The reflective process is described below. Some suggestions for reflective questions to prompt thinking about contributions that individual nurses can make are provided in Box 5.5 (overleaf).

Building on the Framework for Practice Thinking (described in detail in Ch 2), this part of the chapter provides some strategies to enable nurses to increase their understanding and conscious decision-making in relation to culture and clinical care, to potentially improve and transform their nursing practice. The stages of critical reflective practice include (1) defining and discussing the issue and its key themes; (2) reflecting on how the nurse’s own culture (life experiences and worldview) and professional nursing culture influence his/her understanding of the issue (nurses need to then reflect on how this influences their perceptions of, and interactions with, Māori, Aboriginal and Torres Strait Islander people in healthcare); (3) analysing the viewpoints and assumptions of others and the dominant cultural paradigm relating to the issue, and how this influences their perceptions of and interactions with Australian and New Zealand Indigenous people in healthcare; (5) discussing what has been learned from this reflective process and how this might contribute to lifelong learning within nursing; and, finally, (5) reflecting on what has been learned from undertaking this critical reflection process, including the potential that this process has to transform individual nursing practice.

Examples of where critical reflective practice is valuable include the following:

- Critical reflection is supported by partnerships and relationships with Indigenous health professionals and organisations by challenging current beliefs and practices in relation to Māori, Aboriginal and Torres Strait Islander health within the healthcare environment.
- Critically reflecting on the enablers and barriers within the healthcare system regarding the delivery of high-quality, comprehensive, equitable and culturally safe healthcare to Māori, Aboriginal and Torres Strait Islander people.
- Critical reflection is a vehicle to developing resilience to manage resistance to change from others within the healthcare environment.
- Critical reflection provides a framework to examine personal responses to applying a strengths-based approach in Aboriginal and Torres Strait Islander health and Māori health.
- Critical reflection provides a framework and a vehicle for shifting from reflection to action, through agency and awareness that challenges dominant racist/colonial discourses.
- Critical reflection is foundational to transforming experiences into knowledge and deeper wisdom and application in personal and professional lives.

Reflection

Under the framework used for this chapter, reflection consists of examining and considering how one’s own culture and the dominant culture of Australian and New Zealand society influence perceptions and interactions with Aboriginal, Torres Strait Islander and Māori people. In this context it demands that nurses understand the history of Australia’s and New Zealand’s Indigenous people along with the postcolonial experience and the impact that racism and associated stereotypes and assumptions has had and continues to have on the contemporary health status of Indigenous Australian and New Zealand people. Understanding these matters proposes a way
Guides

Efforts to improve cultural competence within a health service organisation are more likely to be effective when they include a range of strategies involving all levels of the organisation. A range of strategies are outlined in the six guides developed by the Commission to support health service organisations implementing change. By considering these strategies health service organisations can, in partnership with Aboriginal and Torres Strait Islander people, improve the safety, quality and cultural appropriateness of care delivered.

1. Setting safety and quality goals for Aboriginal and Torres Strait Islander people in health service organisations

Setting organisational goals which specifically address the needs of Aboriginal and Torres Strait Islander people can provide a common vision of what is important in providing care and focus the whole organisation on what needs to be improved. Plans should include the identification of resources and timeframes to achieve goals and evaluation to demonstrate changes over time.

2. Cultural competence in caring for Aboriginal and Torres Strait Islander consumers

A culturally competent health service organisation will improve access to and outcomes of its services for Aboriginal and Torres Strait Islander consumers. Better access can help to reduce the health disparities between Aboriginal and Torres Strait Islander people and other Australians.

3. Improving identification rates of Aboriginal and Torres Strait Islander consumers

Effective and accurate processes to routinely ask patients if they identify as being of Aboriginal and Torres Strait Islander origin can contribute to better care by enabling specific cultural needs of a patient and their family to be understood and met. It also enables accurate monitoring of disparities in health care which can inform improvement strategies.

4. Creating safe and welcoming environments for Aboriginal and Torres Strait Islander consumers

One strategy for building effective and trusting partnerships with Aboriginal and Torres Strait Islander communities is to create a welcoming and culturally sensitive environment by displaying signs and symbols to acknowledge local cultures.

5. Effective and safe communication with Aboriginal and Torres Strait Islander consumers

In Australia, 60% of adults do not have the level of health literacy needed to understand and follow health messages, or make choices based on an understanding of health issues. This problem is exacerbated for Aboriginal and Torres Strait Islander people when English is not their first language, there is cultural bias, the engagement and involvement of family and carers is limited and clinicians are time-poor. Understanding and addressing these barriers is key to effective communication with Aboriginal and Torres Strait Islander consumers.

6. Comprehensive care for Aboriginal and Torres Strait Islander consumers

Providing comprehensive care to consumers means conducting screening and assessments to identify risks an individual may face and planning care that is tailored to the needs and goals of an individual. Comprehensive care takes into consideration the impact of care on the consumer’s life and wellbeing.

Figure 5.3 Australian Commission on Safety and Quality in Health Care’s actions to improve care for Aboriginal and Torres Strait Islander communities.

Source: Reproduced with permission from ACSQHC Overview: Guide to better care for Aboriginal and Torres Strait Islander communities. Developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). ACSQHC, Sydney 2016.

in which nurses can deliberately engage with issues of power and privilege, including the power that non-Indigenous nurses are afforded or that Māori, Aboriginal and Torres Strait Islander people experience as both nurses and recipients of care. Being critically reflexive in this space requires being prepared to challenge racism and critically examine associated assumptions and stereotypes. This process can be emotionally confronting and expose vulnerabilities, powerlessness and feelings of being out of place. Having the ability to work outside one’s own comfort zone is crucial to the development of the growth of cultural capabilities.

RACISM

With strong evidence that racism harms both physical and mental health, racism is clearly a social determinant of health. Chapter 4 describes both the different forms of