To deliver services and programs in the ways described in the previous section, health professionals require organisational support. Key organisational strategies for improved care for Aboriginal people include:

a. Reconciliation Action Plan to outline the organisation’s vision for reconciliation through meaningful yet practical plans to develop relationships, show respect and increase opportunities for Aboriginal people (http://www.reconciliation.org.au/raphub/about/)

b. High quality, respectful, culturally appropriate care, including guidelines, staff training, and involvement of Aboriginal community representatives

c. Better communication and linkages between health services to improve the discharge or referral follow-up processes that take into account the challenges facing the Aboriginal patient journey

d. Aboriginal professional involvement in healthcare and resources to support their professional development

e. Audit, evaluation and research of health programs and services

Points b-e are discussed in more detail below.

b. Culturally appropriate programs and services

High quality, respectful, culturally appropriate care, includes guidelines for the system of care (e.g., in the hospital), staff training, and involvement of Aboriginal community representatives in the way the programs and services are delivered. Fundamental to the success of services and programs is engagement with Aboriginal people through intercultural partnerships, working together from the outset on planning and development. In order for staff to have the necessary skills and confidence to engage in community partnerships, and to deliver culturally appropriate care (culturally safe care) cultural awareness/safety training is essential (see Glossary for definitions of these terms).
Many non-Aboriginal people are apprehensive about working with or initiating programs for Aboriginal people because they lack knowledge and skills in this area and do not want to offend. This can interfere with engagement between health professionals and Aboriginal people. Organisational support in terms of opportunities for education and training is important to ensure health professionals increase their confidence to deliver high quality care that is non-discriminatory and respectful of cultural differences. These programs need to focus on health providers expanding their understanding of the broader social and historic factors that undermine Aboriginal health.

Evidence suggests that by reflecting on and questioning their own biases and assumptions about Aboriginal people, health providers will be less likely to impose them in practice. Training in this area needs to be flexible, and offered frequently. This is required to allow for workforce turnover and individual staff development that takes into account different levels of awareness and receptivity (i.e., people aren’t always ready to ‘hear’ this training, and it may need to be repeated). This will also help ensure that workplaces are more likely to be non-discriminatory and culturally safe, which is important in retaining Aboriginal staff. Box 19 lists questions for reflective practice to improve communication, avoid misunderstanding and achieve culturally safe healthcare.31

c. Communication between services, including referrals to specialists, and between services and clients

Improving communication between different health services was a significant theme from the workshop. Good communication is essential between services (including referrals to specialists), as well as between services and clients, particularly when people are dealing with many complex health issues. Health professionals need institutional support to make this happen.

For example, there are many situations where patients need to be or can be referred to private sector GPs and specialist practices that are prepared to bulk bill Aboriginal patients. When there are transport difficulties or waiting lists for public hospital/out-patient investigations it may be more convenient or clinically appropriate to refer to private practitioners. However, there is a need to formalise partnerships which will enable this to occur. Without a formalised agreement on protocols for Aboriginal clients, policies (e.g., circumstances in which a public patient will be allowed into a private clinic/service) may not be applied consistently. The patient may also need to be reassured beforehand and at the time that there will be no costs to them, particularly as they may witness other patients being told about charges or paying gap fees. It is important to recognise a person’s anxiety and reluctance to use a service that they can’t afford to pay for. GPs at some AMSs may be able to provide advice on this issue.
Questions for reflective practice to improve communication avoid misunderstanding and achieve culturally safe healthcare

- Have you attended training about local Aboriginal culture and belief systems? Do you check what training other staff in your team have attended?

- Do you model cultural respect towards Aboriginal people and those of other cultures?

- Does your organisation have a Reconciliation Action Plan? Do you know what is in it? How have you contributed to its development and implementation?

- Do you see patients who are Aboriginal Australians?

- What are the income, education and power differentials between you and an Aboriginal patient? How might this affect your interactions?

- Do you have an Aboriginal person in your healthcare team? How well is your Aboriginal team member treated? Are they included in team meetings, and not exclusively expected to work with Aboriginal staff? What support mechanisms are in place to assist them in their work?

- Is your hospital welcoming and safe to Aboriginal people who attend for care? Can they find their way around easily? Have you asked Aboriginal patients what they think?

- How well do you engage the Aboriginal patient and their wider family in decision-making in relation to their care and subsequent management?

- How do you talk with Aboriginal patients and family members? Do you know what community they are from? Are you sure they understand you and what you are saying? What are you doing to check that they do? How often have you used an Aboriginal interpreter to assist communication?

- Do you treat the whole person or just the body part? Do you ask about the major concerns of your Aboriginal clients and their life circumstances as part of caring for them? What mechanisms for psychosocial support are in place for Aboriginal patients and their family members?

- Do you ensure that when patients are discharged they will receive good follow up care—how? What healthcare resources are available in their home community?

- After discharge, how do Aboriginal patients get home and how long does it take? What about their family members who supported them?

- Does your system for communicating with primary care providers work for Aboriginal clients, not just those seeing urban GPs? How often do you ring the primary healthcare service to provide information and reinforce messages about the need for follow-up care of Aboriginal clients?

- If the system is not working adequately for Aboriginal patients, are you constructively engaged in systems reform?

- Are you part of the problem or part of the solution to poor Aboriginal health outcomes?

Western Australian Centre for Rural Health: online Aboriginal Cultural Orientation self-directed learning package: http://lms.cucrh.uwa.edu.au/login/index.php
And having this knowledge and understanding is not enough on its own—using that knowledge to inform their practice is integral to health providers improving the care of Aboriginal people and their health outcomes (Box 20 gives some examples).

**Ways Organisations Can Support Culturally Appropriate Care**

- Add Aboriginal art/arterfacts/symbols to make a friendlier environment, for example, a map of Aboriginal language groups at a cardiac gym got a lot of positive comments from Aboriginal participants and staff.

- Make services more flexible (e.g., offer some ‘drop-in’ rather than at fixed appointments, and services available out of working hours). The hospital policy of discharging patients because of a single missed outpatients appointment disadvantages those people who have transport problems, personal barriers to attending appointments, or are difficult to contact because they frequently move house.

- Increase collaboration between hospital management, health providers and Aboriginal people on issues/practices/rules in the hospital, for example as is happening with the South Metro District Aboriginal Health Action Groups (DAHAGs) (see Box 12)

- Reduce the factors that make it difficult or unpleasant for Aboriginal people to benefit fully from their hospital stay, e.g., cultural misunderstanding and poor communication between hospital staff and Aboriginal patients. (See Part I, Section 9 ‘Discharge against Medical Advice’ for more detail.) This includes being aware of language barriers, and difficulties in understanding terminology.

- Have a genuine interest in patient care, including anticipating physical and/or emotional discomfort in Aboriginal patients, and actively and sensitively enquire about this. Delay in responding to symptoms or failure to recognise them is likely to occur precisely because of communication problems and cultural misunderstandings. Address Aboriginal patients’ cultural, social and emotional needs in practical ways to minimise discomfort.

- Ensure that reminder calls/texts to patients’ mobile phones show caller identity (e.g., ‘FHOP’ appears on Fremantle Hospital SMS messages). When the display shows as ‘Blocked number’, some patients may be reluctant to answer due to suspicion or fear. (It is important to note that many Aboriginal people have had unpleasant past experiences dealing with institutions).

- Ensure staff are aware of issues involved in discharge to remote communities. For example, some patients are unlikely to have a conventional street or postal address (and therefore it is better to ask, ‘What is the best way to contact you?’, rather than, ‘What is your address?’) Similarly, where health services are limited, asking: ‘Who is your GP?’ may result in ‘nil-GP’ being recorded on discharge notes with serious implications for post-discharge care (see Case study Incorrect Entry of ‘Nil-GP’ in Hospital Records Box 27).
**Ways to Improve Communication Between Health Services**

- Determine and record the Aboriginal status of all clients. This ensures that they have access to Aboriginal-specific health subsidies such as *Closing the Gap* medicines and that organisations can do appropriate monitoring and planning.

- Accurately record the name of every patient’s GP on the clinical records or hospital discharge summary. This ensures that the GP and/or community nurse gets a summary promptly, and that primary care follow-up is immediate and more likely to be effective. (‘Nil GP’ on a hospital record is not acceptable). Clerical staff and clinicians may need to be trained how to ask this simple question as some patients don’t relate to the term ‘GP’ or only know first names. If the patient can’t remember at the time of admission, this should be flagged and checked at a time when they are less anxious or unwell, or the family should be asked (See Box 27).

- Ensure continuity of care where possible. When doctors in training rotate through hospitals this can be difficult. Aboriginal professionals can assist by being a constant in the hospital environment.

- Develop better referral mechanisms, particularly focusing on communication between primary and hospital/specialist care, i.e., both to arrange hospitalisation and also following discharge. Changing the language and mindset for staff to take responsibility for ‘transfer of care’ rather than ‘discharge’ will encourage hospital providers to consider beyond the walls of the hospital.

- Aboriginal health professionals can assist in liaising between health services and ensuring follow-up procedures are put in place, including with families and Aboriginal health workers in other services.

- Patient Journey Mapping tools: The tools developed by the Managing Two Worlds Together project in South Australia help document and map entire patient journeys from home to hospital to home, involving multiple services. This can help in planning and evaluate services, auditing, justifying costs, identification of areas for improvement, and staff training. The tools and examples are available from: [http://www.flinders.edu.au/medicine/sites/health-care-management/mtwt](http://www.flinders.edu.au/medicine/sites/health-care-management/mtwt)


- Some hospitals have no ‘Closing the Gap’ (CtG) medications available or patients have to wait 3-4 hours for the hospital to dispense medicines. The situation is worse on weekends when the local AMS is shut and patients cannot get their CtG medicines and blister packs through the AMS. Although patients can leave with a script, they may then have to pay for medicines. GP Liaison doctors at the tertiary hospitals may be able to suggest the best way to deal with this difficult situation (see Appendix 3 for more detail).
Ways to Improve Communication Between Health Providers and Patients

• Take time to hear patients’ concerns and allow them to ask questions. Become comfortable with pauses and silence.

• Be genuinely interested in the person as patients are sensitive to this. Understand the person, where they come from and their family context and concerns.

• Address issues related to discharge planning and understanding of medications by hospital patients and families, prior to discharge. This means health providers need to know how to give clear instructions to patients and check patients have understood. Involve family members if the patient desires. Using telephone or Skype to involve family members from a geographically distant place has been helpful. Encourage questions from the client/relative, and ask for feedback on whether the message has been communicated adequately.

• Provide medical records to patients in a user-friendly format and advise them to carry these records when they visit a health service.

• Encourage patients to register for the Personally Controlled Electronic Health Record (PCEHR) scheme. This is an online summary of the patient’s health information that allows doctors, hospitals and other health care providers to view and share important details that can help patients get more integrated care.

• Use direct one-on-one communication when contacting a patient, e.g., phone/text/visit.

• Follow up clients actively over time, for example, with periodic follow-up calls.
Box 23

Initiatives of an Aboriginal Health Liaison Officer—Systems Change for Heart Health

Aboriginal Health Liaison Officers (AHLOs) make a critical contribution to ensuring that Aboriginal people have equitable access to health care by helping Aboriginal patients negotiate the complexities of the hospital system, facilitating communication between health service providers and Aboriginal patients, and promoting cultural awareness. However, in many cases, their input may not be integrated as well as it could be within a hospital's organisational system.

An AHLO working in the Cardiology department of a Perth teaching hospital took a proactive approach to improving the effectiveness of the AHLO role at a system level. AHLOs in her hospital had previously been poorly resourced and supported (e.g., a predecessor was not even provided with desk space) perhaps because of the importance of their role being underestimated. Also, the scope of AHLOs’ contribution was restricted by their lack of access to the hospital’s electronic databases.

The AHLO understood the necessity of embedding her practice more formally within the hospital’s existing organisational practices, thereby being able to contribute more fully to improving the care of Aboriginal patients. Notably, she recognised possibilities for AHLOs using existing hospital information computer systems for improving the care of Aboriginal patients. Hospital databases contain detailed patient (address, GP, next of kin) and clinical (diagnoses, medicines, out-patient appointments, past admissions) information. From this information, issues such as a history of missing appointments, mistakes due to communication lapses, and patients discharging against medical advice (see DAMA – Part 1, Section 9) can be identified, and ‘high-risk’ patients who need extra support can receive the care they need. She realised that, given access to the databases, AHLOs’ understanding of the needs of individual clients could be improved, their patient follow-up tasks simplified, and communications with health professionals in and outside the hospital enhanced. This would ensure better integration of the care of hospitalised Aboriginal patients. She also recognised that better recording of Aboriginal patient-specific data would make evaluating the AHLO role easier.

Consequently, the AHLO lobbied for access to the databases and offered suggestions on how additional information items (e.g., on cardiac rehabilitation referrals and attendances) could be added to enhance patient care.

She also instigated other initiatives to enhance the AHLO role, e.g.:

- adding AHLOs’ own progress notes to patients’ admission records (the result of access to hospital databases)
- training of hospital pharmacists to deal with the special dispensing issues of remote AMSs, e.g geographical locations of remote areas and logistical challenges
- creation of an information resource for Aboriginal patients on the role of hospital social workers
- accessing and/or developing resource folders for health professionals, e.g., AMS contacts, maps to assist with discharge, discharge medications, geographical locations and logistics involved in returning patients home
- starting the discharge process on admission, from the first meeting discussing the health service they will return to, and occasionally including three way link ups with those services
• distribution of out-patient appointment follow-up reminders and discharge summaries to multiple health services, nursing posts and PATS (as patients are often transient for cultural, family and other reasons)

After much persistence, and with assistance from allies among the hospital staff, she was able to realise most of what she had set out to achieve, and to establish this expanded AHLO role formally for her successors in the job. The benefit of creating culturally appropriate systems is the potential for them to continue to be implemented despite staff changes. However, they are also dependent on staff being adequately trained, resourced and supported.

‘If we’re going to make a difference for our mob, we have to be part of the system.’

Source: unpublished interviews with an Aboriginal Health Liaison Officer working in Cardiology.

d. Aboriginal Workforce

The limited number of Aboriginal staff working within hospital and mainstream primary health care services and programs is often a barrier to Aboriginal participation. The importance of having Aboriginal health staff in services with Aboriginal clients is well recognised. Challenges with achieving this include securing funds for positions as well as in recruiting, supporting and retaining Aboriginal health staff.

There are strong arguments for having dedicated positions for Aboriginal staff. Examples of specific Aboriginal positions in health care include coordinators to tackle smoking, health workers and liaison officers. There are many benefits to having Aboriginal people working in a range of clinical disciplines such as doctors, nurses, pharmacists, dieticians and physiotherapists. In addition, involving more Aboriginal people in non-clinical roles in the health system, such as interpreters, administrators and receptionists, not only increases the Aboriginal workforce, but can help to increases the cultural security of an organisation. These roles need to be integrated, ensuring that Aboriginal and non-Aboriginal employees work together as valued members of the health service team. This is also important as some Aboriginal clients may prefer a non-Aboriginal service provider. Finally, health services need to work in partnership with the community to educate and train community members to deliver programs to ensure continuity when staff members are unavailable, as well as building community capacity. Figure 19 outlines steps that organisations need to take to support Aboriginal Health Professionals.

It is important that supporting Aboriginal patients is not seen solely as the responsibility of Aboriginal health professionals. A strong inclusive culture, in which knowledge is exchanged and two-way learning occurs, will help optimise Aboriginal patient outcomes.
A key recommendation, following an extensive Community consultation process by the Public Health Unit at the South Metropolitan Health Service (SMHS), was the urgent need to increase access to culturally suitable hospital care for Aboriginal people in the region. As part of the Council of Australian Governments (COAG) National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, SMHS implemented the Aboriginal Health Liaison Officer (AHLO) program in seven hospitals in 2010 across the South Metropolitan region (now funded under the WA Footprints to Better Health Strategy).

The AHLO program employed Aboriginal health professionals in the hospital system to improve the cultural capacity of hospitals by providing a liaison role to support the Aboriginal patient journey from admission through to discharge planning and community referral. Key findings from evaluation of the program were (i) that AHLOs were able to demonstrate their skills and experience, where providing support and education to patients was a rewarding experience, and they felt valued and satisfied in their role; (ii) AHLOs were allocated sufficient time to engage with community and to participate in meetings with each other; (iii) they supported non-Aboriginal staff to increase their understanding of Aboriginal experiences and implement care practices respectful of cultural differences; (iv) AHLOs also learnt about hospital settings and the health system, and this two-way learning experience led to strong relationships between the AHLOs and the rest of the health care team.

These findings contributed to AHLOs feeling safe in their workplace and able to be proud advocates for Aboriginal culture. Findings also showed that health care teams’ knowledge about the program resulted in improved patient linkages to the program and an increased awareness of culturally appropriate care and accountability to provide that care. Good organisational support and ongoing community engagement have been major elements in the program’s success. Similar programs are delivered throughout Western Australia by Area Health Services and the Aboriginal community controlled sector.

Source: Taylor K, Brankovich J, Katzenellenbogen JM, Crowe S, Durey A, Bessarab D. Evaluation of the South Metropolitan Aboriginal Health Liaison Officer Program. Aboriginal Health Education and Research Unit, Curtin University; Perth 2014.58
e. Audit, research and evaluation

Many interventions and service models to improve Aboriginal health care have been proposed. Once they have been introduced, it is important to review to what extent they have been implemented by health services and how effective they have been. Reviews can focus exclusively on Aboriginal-specific programs and services, or in other instances may include a comparison with non-Aboriginal patients in mainstream settings. Short- and long-term evaluations of programs are recommended to determine their effectiveness. Clinical audits are often considered as a first step in quality improvement and may be a part of accreditation processes. They can involve reviews of patient records and documentation of adverse events. Feeding back the results from these audits can help organisations to improve their processes and programs by setting goals as a team on how to improve. Repeated Plan-Do-Study-Act (PDSA) cycles underpin quality improvement in clinical care. Data from audits and other evaluation exercises can be published as research, for the benefit of other organisations. Additionally, organisations can initiate or participate in research into other aspects of Aboriginal health, such as epidemiological studies or clinical trials.

Some Aboriginal people are frustrated when they participate in health program/service evaluation or research but do not see the findings translated into benefit, in terms of improved health care. This highlights again the importance of ensuring that all such exercises are undertaken with a strong commitment to knowledge translation, capacity building and sustained effort to ensure that findings influence policy and practice. It is also important to recognise that change takes time (indeed often far too much time), but that the information from research is an important step in increasing knowledge about the need for improvements. In all research on Aboriginal health, Aboriginal people need to be engaged in the design and implementation. Developing intercultural partnerships to ensure Aboriginal people are part of the research team helps to create a greater understanding of the issues and potential solutions.
Useful outcome measures when planning research/evaluation

Measures to evaluate organisational effectiveness include:

• recruitment and retention of Aboriginal staff
• implementation of recommended changes to clinical practice, administrative processes and health programs (with formal documentation such as 'milestones' reports)
• cost-effectiveness data
• trends in numbers of people attending (and returning regularly to) programs and services
• participant feedback and follow up of non-participants to identify barriers of care
• sustainability of programs (e.g., at 3 years)
• long-term impact of programs on health outcomes and community engagement

Measures to evaluate effective care for individuals/community include:

• improvements in patients’ ability to recognise symptoms
• improvements in medication adherence
• increased referrals from relatives
• reductions in hospital readmissions
• increases in booked rather than emergency admissions
• increased use of primary care for ongoing management
• improvements in health outcomes
• improvements in other related outcomes, e.g., employment, training, housing

Systematic and strategic reporting and documentation of program/service implementation:

• baseline and interim evaluation, including formal Key Performance Indicator (KPI) measures where appropriate
• qualitative appraisal of participant experiences (e.g., videos of program activities, participant interviews)
• quantitative evaluation of health outcomes, with reference to evidence-based guidelines where available
• regular audits as part of Plan-Do-Study-Act cycle
Acute Coronary Syndrome Audit at regional hospital

In 2011-2012, BAHHWA collaborated with a team of researchers at a busy regional hospital to investigate potential treatment differences between Aboriginal and non-Aboriginal patients. An audit was designed to measure disparities among those who presented with Acute Coronary Syndrome (ACS) at the Emergency Department, and was conducted by a public health registrar in the context of a supervised physician-training placement. In developing the study, members of the regional health service were consulted, including the Medical and Emergency Department Directors. The audit results suggested a number of deficiencies in the way ACS was managed for both Aboriginal and non-Aboriginal patients, and suggested that Aboriginal patients tended to receive fewer interventions. The results were provided to the WA Country Health Service and presented to hospital management. From the outset, the audit team concentrated on how best to maximise uptake of recommendations, rather than merely on exposing institutional failures. Dissemination of the audit findings and resulting advocacy had to be timed and directed appropriately. It was important to tailor ‘actionable’ messages to different audiences. The public health registrar leading the audit was sensitive to context when presenting findings to various stakeholders: he sought permission before presenting the findings to external agencies, and took care not to disclose the identity of the health service and to adopt a no fault quality assurance approach.

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The audit has prompted a number of changes within the hospital, including increased access to exercise stress tests and the employment of a highly experienced general physician to visit the hospital four times a year in order to train staff in the treatment and management of Aboriginal clients. The audit has also influenced modification of state-wide ACS pathway for the WA Country Health Service (WACHS). (The higher incidence of ACS and comorbidities at younger ages in Aboriginal people may mean that Aboriginal status needs to be a consideration in the guidelines for ACS presentations.)

Besides prompting a number of practical changes, the audit has been a positive demonstration of the way small-scale knowledge translation (KT) interventions can be implemented and how they can act as a precedent for further change within institutions. There is a concern that recommended evidence-based actions to address Aboriginal heart health disparities have not been effectively translated into practice. As a result, in-depth interviews with the audit team were examined using an equity-oriented framework by BAHHWA researchers to explore barriers and enablers and identify effective ways to improve knowledge translation.

The audit resulted in a collaborative process being established, with improved communication channels and new working relationships between stakeholders, making the possibility of further internal audits of quality of care indicators more likely.
A follow-up audit will investigate whether there have been any changes between 2011-2012 and 2013-14 in the quality of care provided for patients with ACS, and whether differences still exist between Aboriginal and non-Aboriginal populations. Undertaking audits such as this can provide valuable insight into mechanisms that contribute to the effective uptake of evidence by clinicians, policy-makers, and health service managers.

Sources:

Haynes E, Hohnen H, Katzenellenbogen JM, Scalley, BD, Thompson SC. (under review) Knowledge Translation lessons from a regional hospital’s audit of Aboriginal patients presenting with Acute Coronary Syndrome.

Conclusion
The actions suggested for organisations in this section may improve Aboriginal healthcare. However, they require staffing, logistical and resource support. Resourcing is therefore a crucial issue, requiring government and policy level action, either to provide additional funding or to promote and support the redistribution of existing funds. In particular, inter-agency, intra-government and agency-government collaboration needs to be supported at a policy level. Some of the actions required of governments and policy makers are described in the next section.
Incorrect Entry of ‘Nil GP’ in Hospital Records

Following a patient’s discharge from hospital, continuity of care through communication with their general practitioner (GP) is critically important: a hospital discharge summary should contain correct and complete information on a patient’s condition (particularly, lists of all the major diagnoses and of all current medications and their doses) and be sent promptly to the correct GP/practice. High quality handover following an admission has become even more important in light of the trend towards early discharge after an acute event (e.g., a heart attack), with the responsibility for ‘post-acute’ care being shifted increasingly to the primary care sector.

Unfortunately, discharge summaries often are not received by the patient’s usual GP or practice, resulting in patients not receiving the medications and referrals they need. Frequently, this is because the GP/practice is never correctly identified and recorded during the admission. A doctor with extensive experience as a GP caring for Aboriginal people—and who also works at a major teaching hospital—was very familiar with instances of poor communication between hospitals and GPs about discharged patients. She discovered through tracking audits at the hospital that, in many cases, the GP Details box in the hospital medical notes recorded ‘Nil GP’ even when the patient did in fact have a GP, and that this error was more common for Aboriginal patients. There were several reasons for this: (i) the importance of the GP details wasn’t fully appreciated by hospital staff; (ii) collection of this information was generally left to clerical staff in the Emergency Department (ED), who often had difficulties obtaining the correct GP details from patients because of their acute illness; (iii) patients did not identify with an individual named GP and this was misinterpreted by the clerical staff as having no identified general practice; (iv) hospital staff were unfamiliar with the names of the Aboriginal Medical Services and (v) hospital policy made it more convenient to enter ‘Nil GP’ as a default rather than ‘GP Unknown’ when the GP details were uncertain, because the latter entry would be recognised as inadequate and create a problem for hospital KPIs—and more work for someone to follow up.

The doctor had approached hospital clinicians about the problem repeatedly over a period of several years, but her concerns had generally been met with indifference. However, she was eventually able to raise the issue with staff from the hospital Quality and Customer Service Unit, who immediately appreciated its importance, and who quickly instituted a hospital-wide audit of ‘Nil GP’ admissions. This one-day audit of every patient in the hospital found that nearly 10% of patients had ‘Nil GP’ recorded and that in more than half of these cases, this entry was wrong; these patients actually did have a current GP.

Informally, the audit process itself opened the eyes of hospital staff to the magnitude of the problem; many ward staff were quite shocked to discover how often the ‘Nil GP’ had been incorrectly recorded for their own patients. The hospital administration responded to the audit by making substantial systems changes: meetings of the hospital’s senior staff were held to discuss the problem; workshops were held regularly for the ED staff on the clinical importance of correctly identifying the GP/practice and other important patient details (e.g., current address and next of kin); and there is now no penalty for entering a ‘GP unknown’ record and thereby less incentive to enter the ‘Nil GP’ default. Also, the doctor who instigated the audit process has been able to teach hospital staff how to elicit the correct details of a patient’s GP more carefully and in a culturally-appropriate manner.

The doctor attributed the success of instigating the changes to recognition that it was a ‘systems’ problem so that no individual needed to feel personal blame. Also, the process was facilitated by the engaging a diverse range of senior hospital management personnel (including administration, quality and safety, clinical, clerical, medical records) who—as a group—were empowered to introduce systems changes.

Source: unpublished interview with a Perth GP