



A report looking into Pacific patient and family experiences of care in General Medicine wards at Auckland DHB

Adult Medical Services, Cultural Experience Project



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Acknowledgements:

Malo e lelei,

We acknowledge our late colleague Hilary Boyd who initiated this work, and her tireless contribution supporting the health system to truly hear and value the voices of those who experience it.

Secondly, Auckland DHB acknowledges and appreciates the large range of people who have contributed their time and energy to support this work.

We would not have been able to create this report without the generous and courageous patients and their families who opened their stories to us. Hospital stays can be distressing and heavily weighted with emotion, so we are grateful for those who revisited their experiences in order to improve our services for those who come in the future.

We thank you for your willingness to support us to learn, as we strive to improve our health system.

We also thank the Tautai Fakataha Pacific Health Team, Pacific Equity team and Pacific Health leadership team at Auckland DHB for their support and thought leadership. Particularly for the integral role they played in creating a safe space for patients and their families to participate.

Following on from this, is our nursing team in General Medicine services who made the first contact with patients and opened the space for this work to occur, thank you.

Finally, thank you to the Adult Medical services leadership team for initiating this work and supporting it to create tangible change for Pacific patients and families in the future.

**Meitaki Maata. Vinaka. Malo ‘Aupito.
Fa’afetai lava. Fakafetai lahi lele.
Fakaaue. Fakafetai lasi.**

Introduction

Inequity arises where the health system delivers unfair, unjust and unnecessary differences in health outcomes between distinct groups¹. In Aotearoa (indigenous name for New Zealand) New Zealand, inequitable health outcomes are experienced predominantly by Māori (indigenous people of Aotearoa New Zealand), Pacific ethnicities, and those of lower socioeconomic status². Operating within the context of Te Tiriti o Waitangi (the Treaty of Waitangi), Aotearoa New Zealand is a bi-cultural nation with an obligation to address inequities experienced by Māori³ and this is addressed in a parallel tranche of this project. However, evidence shows that people of Pacific ethnicities in Aotearoa suffer substantial disparities in health outcomes; life expectancy for Pacific people is five years lower for males and 4.5 years lower for females than that of the general Aotearoa population⁴. Pacific people experience greater access barriers to the determinants of health, they are more likely than any other ethnic group to live in neighbourhoods of 'high deprivation' resulting in disproportionate exposure to risk factors⁴. Compounding this are high rates of long term conditions, on-setting at a younger age than for non-Pacific³. There is clear evidence that higher rates of risk factors and unhealthy lifestyles are not due to a lack of knowledge, but a lack of economic resources⁵.

These poorer health outcomes are inequitable; and a commitment to address inequity is strongly embedded in the strategic aims of Auckland DHB:

HEALTHY COMMUNITIES:

Achieving the best, most equitable health outcomes for the populations we serve

WORLD-CLASS HEALTH CARE:

People have rapid access to healthcare that is reliable, equitable, high quality and safe

ACHIEVED TOGETHER:

Working as active partners across the whole system: staff, patients, whānau, iwi, communities and others

To deliver on these strategic aims, we must address the institutional racism that leads to health inequities through exploring and prioritising the experience of Pacific patients and families in our care. This project has arisen out of the dedication of the Adult Medical Team to understand how their Pacific patients are experiencing care in the General Medicine wards, to then learn how they can do better to serve this population and ameliorate the inequitable health outcomes Pacific peoples experience.

This report focuses on the lived experience of Pacific patients and their families within the Adult Medical services, bringing forward their voices on what mattered during their time in Auckland City Hospital. By centering the words of interviewees through quotes the report conveys the vivid fidelity of patients' perspective as shared with the researchers. These stories belong to the individuals interviewed, however they are consistent with research pointing to issues repeatedly encountered by Pacific peoples in the healthcare system⁶.

¹ The Ministry of Health. "Annual Data Explorer 2017/18, New Zealand Health Survey".

² Sheridan et al., "Health equity in the New Zealand health care system: A national survey."

³ Jansen, Bacal and Crengle. "He Ritenga Whakaaro: Māori experiences of health services."

⁴ The Ministry of Health. *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025*.

⁵ Pacific Perspectives. *Health system review - Pacific report*.

⁶ Pacific Perspectives. *Ibid*,

This report confirms that these issues have still not been addressed effectively and reiterates key focus areas. Our findings align with the newly formed Pacific Equity team’s framework to address Pacific health equity, which is discussed in more detail below.

Background

In the context of Auckland DHB seeking to eliminate health inequities for Pacific peoples, Adult Medical services recognise that hearing from and understanding the experience of Pacific patients and families in our care provides an opportunity to explore access, quality and improvement initiatives that are culturally appropriate. As such, a qualitative research project was set up to explore the experience of Pacific patients and their families who have spent time in Auckland City Hospital’s General Medicine wards.

Currently, 11% of Auckland DHB’s population is made up of Pacific ethnicities, a higher proportion of the population than the national average⁷. Over the next 20 years this is expected to increase by 22%; we need to develop services that meet the needs of this changing population demographic⁸. It is important to note here that the term ‘Pacific’ or ‘Pacific peoples’ is being used as a collective term to describe a diverse population, made up of more than 16 ethnicities, each owning distinct languages and cultures⁹. This diversity must be acknowledged and celebrated, and the overarching term not used as an excuse for reductionist practices.

Within this diversity however, there are a set of enduring cultural values that are shared among Pacific groups. These include the importance of family, collectivism and communitarianism, spirituality, reciprocity and respect¹⁰. These values form a strong foundation for thriving and resilient Pacific communities, a vision articulated by the Ministry of Pacific Peoples following an extensive Pacific community engagement process⁸. It is from this position of strength that we orient this project, reflecting the strength and diversity of Pacific peoples in the methodology chosen.

Methodology

An interpretative approach to gathering qualitative data was chosen, to enable patients and family to lead the direction of the interview and tell their stories in the way best suited to them. Following the initial opportunity to tell their story, a semi-structured prompt format was used to draw out further insights.

Cultural safety was of utmost priority during the formation of this project. Through conversations with Tautai Fakataha - Pacific Health Team (PHT) and the Pacific health leadership; Talanoa was chosen as the methodology, guidelines for engaging with Pacific peoples were created and the project team underwent Auckland DHB’s ‘Best Practice in Engaging with Pasifika’ training.

⁷ The Ministry of Health. “Population of Auckland DHB”.

⁸ The Auckland DHB. *Health Needs Assessment*.

⁹ The Ministry of Health. *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025*.

¹⁰ Pacific Perspectives. *Health System Review – Pacific Report*.

'Talanoa' is a concept consistent across Pacific nations, explained by Halapua (2002) as being made up of two words - "'tala' meaning talking or telling stories, and 'noa', meaning zero or without concealment"¹¹. Associated most often with storytelling, it is transferable to qualitative research as a narrative gathering methodology¹². The familiarity of the concept throughout Pacific cultures supports a sense of ease for patients and families participating.

Thought was given as to how the project team might mitigate or inadvertently reinforce the colonial power structures of the medical institution.

Pacific nurses and the Tautai Fakataha (PHT) made initial contact with potential interviewees in order to foster a safe space for the patients and their families to think through their participation. While the project team are trained in social research, both interviewers were non-Pacific, meaning Pacific representation in the interviewing team was pivotal to creating a culturally safe space for participants¹³.

Once interest in participation was confirmed, written consent was gained prior to the interview starting, to ensure the patient or family member was confident in the confidentiality of the research and understood that what was shared in taking part in the interview would not compromise their care in any way. Participants were offered a prayer to open and close, and could choose the place and time for the interview.

A highly valuable contribution to this project was the support of Tautai Fakataha (PHT). Members of Tautai Fakataha (PHT) came on board to interview patients and family members of their same ethnicity, so where possible and appropriate the interview could be conducted in the first language of the patient or family member.

Interviews took place between April and June of 2019, with the majority undertaken at Auckland City Hospital and some at the patients' homes. They were transcribed by the project team, and then analysed using NVivo software, allowing emergent themes to shape the direction of the findings. An emergent approach places value on the experience as told by the patient or family member, enabling them to highlight what was most important to them, rather than imposing pre-determined themes. Positioning patients and their families as the expert of their own experience is integral to providing patient-centred care; the researchers are there to firstly listen, enquire deeper and record. These stories were then thematically analysed, in a collaborative practice with Tautai Fakataha (PHT) to ensure what arose held true to the stories uncovered in the interviews, and corroborated from a range of Pacific perspectives. The emergent themes were then considered alongside existing research to provide a critical discussion and explore how the findings compare to Pacific patient experience findings across New Zealand literature.

This report was then taken to the nursing leadership team to explore and inform potential improvements – the 'Suggested actions' sections have become an iterative collaboration between patients, their families, Tautai Fakataha (PHT), Ara Manawa and the General Medicine nursing team. This process and resulting principles and actions for implementing change are detailed in the 'Recommendations' section below and throughout the report.

¹¹ Halapua. "Talanoa process: The case of Fiji."

¹² Southwick, Kenealy and Ryan. *Primary care for pacific people: A Pacific and health systems approach*.

¹³ Solis and Rodriguez. *Listening to Client Voices: Using Focus Groups and Individual Surveyors to Gather Information*.

Important note on language(s) used:

Throughout this report a number of Pacific languages are referenced; to support familiarisation with Pacific worldviews some commonly used words will be integrated into the writing. There is a glossary at the back of this document, and the digital version will link each word through the glossary to support understanding.

Who we spoke to:

Age range	30 – 85 years old
Gender	5 females, 10 males
Ethnicity	15 participants – A range of Samoan, Tongan, Niuean, Cook Island Māori, Kiribati

Weaknesses of the study

Recruitment of participants for this study was challenging, particularly through the pressures of the lead-up to winter in an acute hospital. Throughout the study period the hospital experienced some of its highest recorded capacity levels, meaning the nurses in the project team were understandably not always able to prioritise recruitment alongside a full care load. Face-to-face recruitment was essential to the ethos of the study, but this did limit the number of available participants further. The project team acknowledges the limited number of interviewees means the data is indicative rather than representative of Pacific patients in General Medicine wards, however the in-depth nature of the interviews provides a richness of data that is not feasible to gain at a wider scale. Additionally, there is a selection bias in that only the views of those patients who wished to speak with us were heard, risking the omission of the voices of those who are particularly disenfranchised by the system – although the work of the Tautai Fakataha (PHT) ameliorated this as much as possible.

Recommendations

Connecting the findings of the research with tangible actions that produce meaningful change is a key goal of this report. Following the interviews and thematic analysis, the findings were examined to develop suggested actions to address the issues highlighted. This was a collaborative and iterative process, involving input from the nursing leadership team, Tautai Fakataha (PHT), Pacific interviewees, the General Medicine nursing team and Ara Manawa research team. In a series of workshops the themed patient and family stories were considered and participants contributed ideas for how they could make change within their practices. These discussions developed and tested ideas for implementing change that could be put into action on the wards; these suggested actions are integrated within the themes presented.

Drawing on the findings within each theme, the report asks “what does good look like?” and describes a vision state, integrating the details and principles derived from the interviews and subsequent improvement discussions. Following this, specific suggested actions indicate a way of putting this vision into practice. The suggested actions offer a starting point for the Adult Medical services to develop a programme of improvement measures. It is recommended that this report provides the basis for an ongoing programme of work focused on making sustained changes. This may include smaller scale ward based initiatives, but will also benefit from a more systematic, organisational level approach. It is vital that the issues described here and consistently across the research on Pacific health outcomes and experiences of care are addressed¹⁴. It is recommended that measures to affect change are targeted, and their ongoing effectiveness evaluated. Meaningful change is most effective if Pacific led, with teams such as Tautai Fakataha (PHT) and the Pacific Equity team resourced to lead the design and implementation.

While the qualitative research aspect of this report focuses on deepening an understanding of the lived experiences of Pacific patients and their families, the aim is to use these insights as an impetus for much needed change. Patients’ stories convey what it is like to be a recipient of care within the Adult Medical wards, however they do not speak to the experience of ward staff and clinicians, nor to the systems and institutional culture and demands that make up the organisational context.

Auckland DHB’s Pacific Equity team works on equity issues for Pacific patients and families within the hospital, community, and broader health system. In reviewing this work, they found consistency with the areas they have identified as requiring systemic change. The Pacific Equity team advocate for the importance of organisation wide system and service level change; they have developed a framework to address Pacific health equity, detailed below, which offers principles for effecting meaningful change across the whole healthcare journey.

¹⁴ Pacific Perspectives. *Health System Review – Pacific Report*

Framework to Address Pacific Health Equity: Recommendations for Auckland DHB

We know our data

Services must collect, report, monitor and act on data on Pacific peoples' health outcomes, access to care, quality of care received and experience of care. Using meaningful data, services must assess and evaluate the appropriateness and effectiveness of their models of care and make changes/improvements accordingly. Services must actively build an evidence base for Pacific health improvement and equity.

We facilitate access and ensure continuity of care all along the care pathway

Services must ensure that care is accessible and that barriers to care (e.g. cost, transport, parking, opening hours, cultural appropriateness) are minimised. Services must also liaise closely with other services and parts of the health system to ensure that care is seamless (e.g. through careful discharge planning and medication reconciliation).

We optimise patient experience through high quality interactions

Services must act on patient feedback and data on patient experience, be culturally safe, and ensure that policies and processes respect Pacific values (including the importance of family, respect, reciprocity and collectivism).

We communicate clearly and effectively using health literacy principles

All patients have the right to effective communication, including the right to a competent interpreter, under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Using health literacy principles, services must work to reduce demands on people, and build the health literacy skills of their workforce and the individuals and families who use their services. This includes not using medical jargon, regularly checking patients' understanding, and providing relevant resources in written and other forms (in languages other than English where necessary).

We ensure our care is integrated and comprehensive, acknowledging that health is a holistic concept

Services must be 'joined up' to ensure that the often complex needs of individuals and families are tailored to their specific circumstances. This includes connecting up health services in a holistic (rather than siloed) way, and facilitating rapid access to social, financial and housing supports within the health system.

We support our Pacific workforce

To ensure their workforce is able to respond effectively to Pacific patients and families, services must develop, act on, and measure the impact of plans to actively recruit and retain Pacific staff, to build Pacific capacity and capability within their workforce, and to develop Pacific health leadership.

We engage authentically with Pacific communities

Services must engage authentically with Pacific communities, working to understand their aspirations, needs, challenges and priorities.

This framework offers a valuable systems level view as a broader context for the ward based, patient experience perspective detailed in the following report. These seven principles and the themes in the findings draw a clear picture of the healthcare issues for Pacific and moreover, are the direction of action needed to provide equitable, world-class care and improved health outcomes.

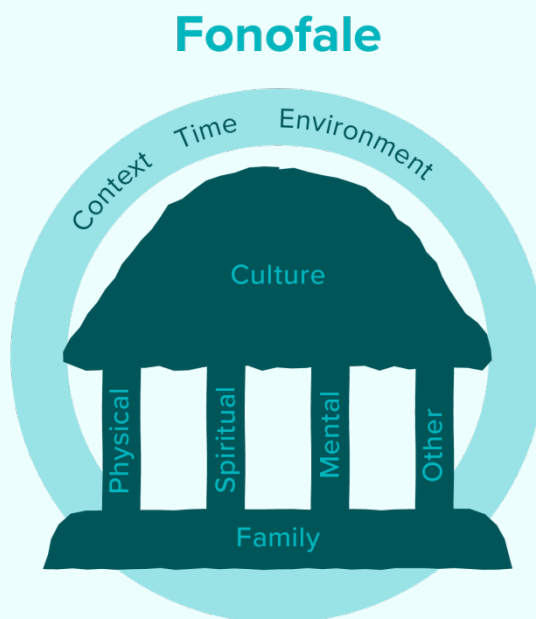
If you would like more detail on this framework, please contact the Pacific Equity team at Auckland DHB.

Summary

Key themes

There were two themes to arise particularly strongly throughout the interviews; family as the foundation for everything, and the importance of culture – a clear alignment with the Fonofale model of health.

Fonofale was developed by Fuimaono Karl Puloto-Endemann as a Pacific Island model of health to be used in the New Zealand context, arising from a need to understand what Pacific people consider the major determinants of health. Within the Fonofale model, the foundation or floor of the fale (Samoan, home structure) represents family as being the foundation of health for all Pacific cultures. This is covered by the roof of cultural values and beliefs that shelter the family for life. The roof is held up and connected to the foundation by four pou (Samoan, posts), representing the spiritual, physical, mental and ‘other’ dimensions that influence health.



The fale is then encapsulated in a contextual cocoon, reflecting the influence of environment, time, and context on health outcomes. As this project is exploring inpatient experience in an acute hospital, the thematic areas reflecting the links between Pacific cultures and family came through as talanoa (reflecting communication), and tautai fakataha (‘navigating in unison’, akin to the Auckland DHB Pacific support service of the same name – a blend of Samoan/Tongan).

Findings

The primary focus of the interviews was to understand people’s experiences in General Medicine wards at Auckland City Hospital – from the perspective of both patient and their families. While the experience of each participant was unique, certain themes emerged.

The following themes arose from the data: (each theme links to a section in the report)

TALANOA		RECIPROCAL COMMUNICATION
CULTURE		CULTURAL SAFETY AND PACIFIC CULTURE
FAMILY		FAMILY AS THE FOUNDATION FOR EVERYTHING
TAUTAI FAKATAHA		CULTURAL SUPPORT SERVICE

Transforming these finding into tangible actions for change is an important part of this research. Each thematic analysis is concluded with a section titled ‘What does good look like?’ and a table summarising the key findings and principles into suggested actions.

Talanoa, as reciprocal communication

Clear, open and responsive communication is an essential enabler of a good patient experience; this requires consideration of what, how, where and with whom communication is happening. Talanoa is a concept consistent across Pacific nations, that describes a way of story sharing and story gathering¹⁵. The reciprocity of talanoa creates space between clinicians and participants to build rapport, enabling a relationship to develop. This way of communicating builds trust, facilitates a two way conversation, and reduces the negative impact of power hierarchies inherent to the Western biomedical model of health. Within the theme of talanoa, subthemes around time, family involvement and language barriers arose and will be discussed below.

Taking time to talk

Participants consistently expressed a desire for more time and space to ask questions when they described their interactions with health professionals.

**“It took me a while.... [to understand], and I only understood because I kept asking questions – I had to keep asking questions to the nurses.”
– Kiribati participant**

A participant’s need for more time was often coupled with a request for patience, and an emphasis that English is not a first language for them and many other Pacific patients. Medical jargon and the heightened stress associated with a hospital experience contributed to communication difficulties.

“Communication is the first thing they should know, because us Pacific patients only a few have English. So they have to be very patient in communication with us.” – Samoan participant

**“It’s always rush rush rush... authenticity, I generally want to ask questions.”
– Kiribati participant**

A feeling of being rushed was raised by a number of participants. This occurred in a number of ways, such as not having enough time to converse and ask questions in their interactions with clinicians, or upon discharge feeling rushed out of the hospital without their concerns being truly heard, or before they felt ready to go home safely.

"Met the social worker the day Dad was discharged. Feel we were rushed out until the Pacific health team came around" – Kiribati participant

When communication with clinicians was rushed, when information was not communicated in a way that could be understood, and the participant did not feel their needs had been understood, their overall experience was negative. An approach to communication that incorporates the spirit of talanoa supports more effective communication with Pacific patients, facilitating trust, respect and mutual understanding. Without this, patients are at risk of navigating their health journey without the information or guidance that should be available to them to improve their health outcomes.

¹⁵ Halapua. “Talanoa Process: The case of Fiji.”

Communicating with respect

Occasionally participants raised concerns around clinicians' style of communication, particularly regarding the way older family members were spoken to. Hierarchies form an important part of social structure for a number of Pacific cultures; it is expected that the elderly will be respected – and this includes people from 50 years onwards who may not be considered 'elderly' by other cultures. There are complex rules for how to address people at each phase of life with the appropriate level of respect – for example those at a parental age will be called "Matua" by those who are younger. The creation of a dictionary or navigation guide was suggested to support staff in knowing how to respectfully address Pacific patients in their care.

"There is no respect from the medical team for me as an elderly. They talk very fast. They don't give me an opportunity to say anything - or my children." – Samoan participant

"They do communicate, however I don't like the language they use. They talk over me sometimes. My children always point that out to me." – Samoan participant

Cultural norms also influence the success of communication. Participants noted they will at times refrain from responding or voicing their concerns if they feel sensitivity discussing body parts, and they are not comfortable with doing so in front a clinician or staff member of a different gender. New Zealand literature further reiterates this, with Pacific patients and families reporting a clash in cultural worldviews reducing the efficacy of communication^{16,17}.

"My culture – I am very sensitive when it comes to my body parts. Who can voice that for me? I don't speak English... unless my children are there and they can ask for me. Medical staff should be aware of this." – Samoan participant

Within Pacific cultures there is often a high level of respect for the medical profession; this leads to a reluctance to "burden" doctors time, with patients and family members reporting they feel that they shouldn't be asking questions^{18, 19}. Despite arising from an attitude of respect, this reluctance can become a barrier to patients asking the questions they need to. When clinicians are aware of this potential tension, they can help patients overcome it by actively encouraging questions, showing patience and equalising the power dynamic through gestures of respect for the patient.

¹⁶ Arlidge et al., "Experiences of whānau/families when injured children are admitted to hospital: a multi-ethnic qualitative study from Aotearoa/New Zealand."

¹⁷ Brown. "Surviving the system: Māori and Pacific whānau coping strategies to overcome health system barriers."

¹⁸ Arlidge et al., *ibid*

¹⁹ Brown. *ibid*

Le va

Participants expressed a desire that clinicians demonstrate an understanding of their needs within the context of their lives²⁰, which includes an appreciation of concepts such as le va.

Throughout many Pacific cultures, 'le va' or 'va' is a concept that refers to the relational and spiritual connection that exists between people.²¹ This 'space' also has a temporal and physical dimension and exists in the literal space between one person and another. By communicating with the respectful and relational approach of talanoa, the va between people is nurtured. Holding in mind and taking care of the physical dimension of le va also shows respect for this space.

Talking across or above a patient can disrupt this space. Intruding on a patient's personal space by leaning over a bed or crossing between the patient and someone else when they are in conversation appears disrespectful. Turning your back to people, especially family, can also be damaging to le va.

Ways to nurture le va include taking care to not intrude on a patient's personal space by leaning over them, to avoid physically putting yourself in the space between people and to avoid abruptly interrupting a conversation where possible.

Role of family in communication

Family played an integral role in communication for our patients; understanding and making sense of clinical conversations was often described as occurring "with the support of" or "with the help of" a family member.

"Always important [to have family] making sure there is good understanding, Dad will talk about the pros and cons of treatment." – Kiribati participant

"[On understanding clinical communication] yes, with the help of my daughter." – Samoan participant

"My daughter always makes sure we understand what was being discussed." – Samoan participant

"My son will ask for help on my behalf." – Tongan participant

Some participants felt they were only able to communicate with staff when their family was present, creating a dependence on visiting hours and policies that enable family to be at the bedside when important conversations were taking place. It is important to note here that family are not to be relied upon as interpreters, they are there to support their family member, thus their presence does not negate the need for the DHB to provide interpreters. Furthermore, relying on family members as interpreters can be viewed as a breach of Pacific patients' rights to privacy and confidentiality.

"In English only when my son was there, I'd like for Pacific services to be involved." – Tongan participant

²⁰ Sheridan et al., "Health equity in the New Zealand health care system: A national survey."

²¹ Alrini et al., "Teu le va: Relationships across research and policy in Pasifika education."

Having family included in clinical conversations was considered crucial for support with decision making by many participants. “Your family will be the ones caring for you when you go home” was a common rationale for this emphasis; for clinical communication to be successful, family need to have a strong understanding of the patient’s medical situation, including any medication or on-going care required.

Within this, there are cultural sensitivities around body parts and gender – concerns were raised around personal care or clinical conversations occurring in front of certain visitors, including extended family, or family of a different gender. Care must be taken early on to establish with each patient what kinds of conversation or cares are acceptable in the presence of which family members.

Language barriers

Concerns around language barriers were raised by a number of participants; they reiterated their need for patience from clinicians, a slow pace and language support – in the form of both interpreters and support from Tautai Fakataha (PHT). Language is a conduit for culture, and some language barriers reflected cultural disconnects rather than a lack of comprehension – such as asking sensitive questions in front of family members or visitors of a different gender. Communicating with language needs in mind, and taking time and care with the communication of medical information is a key enabler for better understanding.

“My concern is the language; there should be Pacific volunteers who help direct people where they want to go.” – Samoan participant

When staff were felt to be responsive and approachable, a relationship of trust was more easily established – enabling the patient and their family to engage confidently with the medical team. The availability of interpreters enhanced this, when interpreters were available patients and family felt valued and supported by the system – which in turn resulted in more positive experiences. Tautai Fakataha (PHT) contributed to participant’s understanding of their hospital experience both with language comprehension and understanding differences between the patient’s culture and the hospital or ward culture or way of doing things. They also contribute to patients and family feeling like they could be understood.

“Very good communication with staff, there was always an interpreter to translate during ward rounds.” – Tongan participant

“Very approachable, I love to engage with staff” – Tongan participant

“Worked with the doctors, nurses and dieticians – didn’t have any complaints. Last time we were here two and a half weeks, so they know us now and it’s easy to communicate.” – Cook Island participant

Talanoa - what does good look like?

Good communication experiences occurred when participants felt they had been given the time, space and respect to contribute to a reciprocal conversation. Communication between staff and patients was more successful when family were present for emotional support, when interpreters were available for language support, when Tautai Fakataha (PHT) were readily available for cultural support, and when information was received in a way that made sense to their worldview. Effective communication helped patients feel comfortable, make important decisions and clarify next steps – particularly around discharge and home care options.

Suggested actions

Talanoa

Communicate with respect and reciprocity

Why? Aim to build patient and family trust and reduce power hierarchies through communication cues.

- Identify and annotate on notes the patient's preferences for clinical conversations and family meeting protocols.
- Take care to pronounce names correctly. Ask correct pronunciation on admission; ensure all staff know how to pronounce the patient's name as accurately as they can.
- Consider cultural context when engaging with patients, especially how to show respect. Before discussing clinical matters or performing cares, sit down, smile and acknowledge any visitors or family present, identify and acknowledge their spokesperson.
- Tailor communication to the needs of the patient to support and enhance patient understanding of clinical conversations. Be aware patients may need interpreters to help address language barriers or the support of Tautai Fakataha (PHT) to enable full understanding across cultural barriers. Annotate the chosen options onto clinical records.
- Make any written resources available in multiple Pacific languages and offer video options where possible.
- Ensure patients and their family are aware of cultural support services through Tautai Fakataha (PHT) on arrival in the wards. Emphasise the confidentiality of this service and gain patients' consent for referral (include service information in patient orientation resources).
- Invite patients and their family members to participate in clinical conversations. Allow plenty of time for clinical conversations, show patience and encourage patients to ask questions.
- Match your pace of communication with the patient's, bearing in mind they may struggle with English and medical jargon. Offer consistent support from interpreting services, ensure family members are not relied upon for interpretation as this may be viewed as a breach to a Pacific patient's rights to privacy and confidentiality. Annotate the chosen language options onto clinical records.
- Respect 'le va', the space between people in conversation. Do not physically interrupt this space between others, and show respect for this space between yourself and others, for example not leaning over people or turning your back to them (where possible).

Culture

Understanding cultural practices different from one's own is a part of cultural competence. This can enhance a clinician's skill in working cross culturally, and improve patients' experience of care. Awareness and appreciation of Pacific cultures in relation to concepts and practices around health and wellbeing can begin with having an open mind and an attitude of acceptance toward cultural difference. In addition to learning about different cultures it is crucial for clinicians to learn about their own cultural identity and worldview and to reflect on how that might influence the way they engage and treat others. This approach is known as 'cultural safety'²². 'Culture' here broadly means the various forces that shape us, including place of origin, ethnicity, spirituality, language, also things such as family culture, professional frameworks and status or class. These beliefs and understandings may seem so normal they can become invisible, especially if they are reinforced by the dominant culture; it takes repeated effort to reflexively look at what we might be assuming or not seeing and how this affects our actions and decisions. Practicing in a culturally safe way affects patient outcomes and is an important step towards achieving equity in healthcare.

As discussed in the 'Background' section, there are more than 16 ethnicities that come under the umbrella of 'Pacific nations' and as such, care must be taken to not essentialise 'all Pacific people' as having the same cultural values and needs. The depth and richness of diversity between ethnicities in the Pacific region is to be celebrated and learnt from. Alongside this depth of diversity, is a set of enduring cultural values that are shared by many Pacific groups - these include the central place of family, collectivism and communitarianism, the importance of spirituality, reciprocity and respect²³. These cultural values form a strong foundation for thriving communities; this section will consider themes from the interviews that arise at the intersection of Pacific cultures and health care services.

Cultural safety

Building a health system mind-set that is equitable includes cultural competency and cultural safety practices, and ultimately requires a fundamental re-positioning of the Western medical model that is currently dominant. Cultural safety requires staff to think about the power relationships between the patient and the health system. It asks the professional to think about their own culture, their own biases and the way they think about their interactions with those from different cultures and how their biases affect outcomes for the patient²⁴. Cultural safety is reached when patients and their families feel comfortable expressing cultural needs, that these are well understood and inform the way they are cared for. Moreover, culturally safe practice means that patients are not disadvantaged because of cultural differences and receive the highest standard of care.

Participants in our interviews did not always experience care informed by cultural competence or cultural safety. They indicated a desire for clinicians and staff to recognise when assumptions or oversights were being made and to address this by seeking to engage in dialogue to ensure a fuller understanding of their cultural needs.

“They should understand Tapu (culture) [sic] for body parts; ask questions and it's best to meet with the family.” – Samoan participant

²² Papps and Ramsden, “Cultural Safety in Nursing: The New Zealand Experience”, 491.

²³ Pacific Perspectives. *Health system review – Pacific report*.

²⁴ The Health Quality Safety Commission. “Cultural Safety”.

Participants noted concerns that elderly people were sometimes overlooked, with staff not recognising their capability, intellect and language abilities. They reported this occurred more often when the patient had been speaking in a Pacific language with their family in the presence of staff. This suggests that staff may have been making assumptions that influenced the way they treated patients and affected the quality of care they received.

**“For Cook Island Māori it is always difficult to understand – language but also culture. Understanding that it is more than just language.”
– Cook Island participant**

It may be important to emphasise that ‘understanding’ is a multi-directional process: patients need to understand clinicians, also clinicians and the hospital and the wider health system must strive to understand their patients and the communities they serve. In addition, when staff and clinicians understand their own culture and the culture of the health system they work within they are more able to mitigate inbuilt bias and inequity.

Openness to learning about Pacific culture

One third of the patients explicitly expressed a desire for staff to have asked them questions in order to understand their needs. This was consistent across Pacific ethnicities interviewed and indicates an openness to share and engage, reflective of the humility with which Pacific patients often engage with hospital systems.

“They should talk to me with respect and should understand my needs as Pacific by asking questions.” – Samoan participant

“Ask questions first.” – Niuean participant

Participants did not expect medical professionals to know everything about their culture, but they did desire open dialogue. Previous research on Pacific patient and family experiences in New Zealand highlighted a number of areas of cultural disconnect when in the health system; health professionals showed a lack of understanding on the cultural significance of prayer, sleeping in the same bed, and the role of extended family – whose presence was treated as a nuisance²⁵.

Understanding and acknowledging the diversity across the more than 16 Pacific ethnicities was commonly discussed by participants. Staff who conveyed an appreciation of this diversity supported a good patient and family experience, conversely a lack of knowledge left participants feeling less valued in their interactions with staff and thus less confident in their care.

**“People not knowing about the Cook Islands... thinking it’s just one island.”
– Cook Island participant**

Generational hierarchies play a large role in organising social structures for a number of Pacific ethnicities. As described in the ‘Talanoa’ section, elders in the family and community generate a large amount of respect, and cues that acknowledge this are important. Both patients and family members expressed frustration with medical teams for not acknowledging elderly family members with enough respect.

One participant raised an interesting insight into the way respect is shown in some Pacific cultures. They explained that patients looking down or responding through support people, as detailed in the quote below is a sign of respect to the medical professional. However, if

²⁵ Pacific Perspectives. *Health system review – Pacific report.*

unaware of this social cue, the medical professional may interpret it as a lack of engagement and respond by re-directing their attention to the support person, missing an opportunity to demonstrate mutual respect. Tautai Fakataha (PHT) are often called to support when a patient is declining treatment, however, earlier integration of these services would support cross-cultural understanding.

“The older generation will be looking down instead of directly at, as a respect gesture. They will talk to their support person to speak to the doctor, and then respond through their person too.” – Cook Island participant

These examples show some of the ways in which openness and awareness of Pacific cultural practices can significantly improve patients’ experience of care. They also show how lack of understanding can inhibit effective communication and opportunities for providing the best care.

Spirituality

Spirituality is integral to Pacific culture; it is one of the four Pou holding up the roof in Fuimaono Karl’s Fonofale model²⁶. Spirituality is closely related to health and wellbeing for Pacific peoples, playing a significant role in the navigation of health journeys and comprehension of diagnosis and forecasted outcomes. Fatalism (subjugation of events and actions to destiny) and denial have been commonly reported responses to diagnosis, identifying a need to reconsider what the best path of treatment may look like for different conceptions of health and wellbeing²⁷.

“To me I needed someone like a Minister or a Matua who can encourage me emotionally, culturally, spiritually.” – Samoan participant

**“Since I’m slowly recovering from my mental disability, my spiritual needs had helped me with any healing – singing, praying, reading etc.”
– Tongan participant**

When discussing with participants the aspects of their inpatient experience that could have been improved upon, spirituality featured strongly. Biomedical Western models of health care do not often feature spirituality or faith, and when it is accommodated, it is not integrated to the degree of Pacific Health models.

“Probably more spiritual needs... [These were not met].” – Samoan participant

“I didn’t know there were chaplains available, it would be great to understand the services that are in the hospital.” – Samoan participant

When spiritual needs were met during a patient’s hospital stay, this was often achieved through actions taken by the family rather than the hospital.

**“My minister always visits, but my family asked if that was allowed.”
– Samoan participant**

Spirituality is intertwined into the rhythms and rituals that make up daily life for many Pacific ethnicities, and this does not change upon arrival at the hospital. If anything, the elevated stress levels associated with a hospital stay would increase the need for connection to

²⁶ Pulotu-Endemann. "Fonofale model of health Pacific models for health promotion."

²⁷ Ryan et al., *Primary care for Pacific people: A Pacific and health systems review*.

this support. Illness can bring people closer to death, when spiritual beliefs are especially important.

Culture - what does good look like?

In the Fonofale Pacific model of health, culture is the roof of the fale – it covers and protects everything within.

‘Good’ is when the ward staff culture is to show respect and understanding for the patients cultural beliefs and values in the way staff engage with patients; through strong cultural safety practices of reflexivity, awareness of bias; and close attention to the ways in which power dynamics and power imbalances affect patients’ care.

A workforce that is knowledgeable and capable of supporting Pacific people’s cultural values in the ward will serve this community well. Staff taking an open and interested approach to patients’ cultural needs will improve such understanding– asking questions and having conversations is key.

Ensuring patients and family have easy access to cultural and spiritual support services enhances the care provided on the ward.

Suggested actions

Culture

Ward culture and individual staff cultural identities form a safe environment around Pacific patients and families' cultural practices and values. Pacific cultural needs will be best supported by a strong Pacific workforce.

Why? Aim to have Pacific patients cultural needs well understood and met to a high standard.

Pacific Workforce

Prioritise recruitment of Pacific peoples to multiple patient facing roles across the ward.

Cultural safety

Establish yearly mandatory training to support staff development of culturally safe practices. Provide ongoing support for staff to understand their own cultural context, identity and how this plays out in their work.

Encourage staff personal and collective reflexivity around cultural matters; this could include regular discussion groups or creating time for staff to reflect on cultural dimensions of care.

Pacific culture

Provide educational opportunities for staff to deepen their understanding of Pacific cultures. Preferably Pacific Best Practice training should be undertaken face to face. Topics to learn about might include:

- Diversity of language and culture across Pacific ethnicities
- Language support – for staff to know basic greetings, and how to connect interpreters
- Culturally respectful ways to address people of different ages, especially elderly.
- How to respectfully ask Pacific patients and family questions about themselves, their culture and their needs
- Generational hierarchies and the role of a spokesperson
- Understanding culturally informed body language and non-verbal cues
- Concepts of Tapu and sensitivities around body parts
- The importance of cultural practices such as prayer and bed sharing
- The role of spirituality in Pacific concepts of health and wellbeing

Integrate the Fonofale model into care plans. Consider how each element of health may be supported. Utilise ward systems to note specific needs or preferences i.e. on records and whiteboards.

Create staff resources, such as a written guide, to support their understanding of how to address patients of different cultures, ages or genders in a culturally respectful way.

Ensure patients and their families are aware of cultural support services through Tautai Fakataha (PHT) on arrival in the wards. Emphasise the confidentiality of this service and gain patients' consent for referral (include service information in patient orientation resources). Resource Tautai Fakataha appropriately to meet this level of demand.

Spirituality

Improve access to pastoral care and ministers, ensure patients and family are aware of these services on arrival at the hospital; include information in patient orientation resources.

Family, the foundation of everything

The most significant theme to come through these interviews was a focus on family as the foundation of everything. In each and every interview undertaken, the conversation returned to family and the importance of family to a Pacific view of health. It is a holistic view and health is inextricably linked to the wellbeing of family and communities; these relationships are facilitated by strong connections to language and culture. As such, family forms the foundation of the Fonofale model of health by Fuimaono Karl Pulotu-Endemann²⁸.

Support

The presence of family during a hospital stay was a consistent indicator of positive experience. Participants reported feeling more relaxed, encouraged, cared for and supported when their family were able to spend time and be involved during their hospital stay.

“What worked well for me was to have my family with me all the time to help me understand what’s going on, especially with my treatment.” – Samoan participant

“Very important, they cared for me; they talked to the doctor for me and do everything for me.” – Samoan participant

“Being in hospital at December time I was mostly alone and really needed support. Being in there and not knowing [what’s going to happen], having support in hospital is crucial.” – Cook Island participant

As well as fulfilling emotional support needs, family members enacted a number of other support roles for patients; supporting clinical conversations, and supporting personal cares for patients.

**“He helps me with moving around, and gives me what I need.”
– Tongan participant**

“My daughter is my main carer, she does a good job looking after me... she will stay all night and staff organise sleeping gears.” – Kiribati participant

“They bring me food, clothing, but also communicate with the medical team regarding my needs.” – Nieuwan participant

The opportunity for family to do this created a softening of the cultural boundaries between home and hospital. Through the presence of family, a sense of familiarity and comfort was supported. Furthermore, the support of family members in personal cares was a way for patients to retain dignity and privacy around cultural gender dynamics, reducing their distress.

Advocacy and the role of a spokesperson

The presence of a family spokesperson is a key part of many Pacific cultures. For many families this is defined long before a patient’s experience in the healthcare system, and is determined through complex hierarchies – and will normally not be the next of kin. The lack of cultural sensitivity within the Western health model to Pacific patients further reinforces their need for an advocate, with adult children, nieces and nephews often fulfilling this role and mediating between the two worldviews.

²⁸ Pulotu-Endemann. "Fonofale model of health Pacific models for health promotion".

“I have to stand up for my dad.” – Kiribati participant

The role of this spokesperson is to advocate for the patient, championing their needs and rights. They hold the weight of clinical conversations and communicate between medical teams, next of kin and extended family. Their presence is particularly important around diagnosis, as Pacific cultures have their own ways to express illness and health, with specific ideas on what should be shared if the patient is nearing end of life. Participants spoke of a transformation that needs to happen, to translate medical information in a way that is culturally safe.

The value of having family support in clinical conversations is highlighted below in a simple yet powerful example.

“I wanted someone to be there with me, when the doctors talk to me... rather than just 2 ears, 4 or 6 ears is better.” – Cook Island participant

Having more than one ‘set of ears’ to take in medical information and treatment options ensures there is space after the meeting for the patient to talk through and digest what has been discussed. Creating an opportunity for deeper engagement in medical conversations increases knowledge and supports better health outcomes.

Family staying overnight

A desire for overnight support from family was expressed a number of times. Elderly participants in particular desired family members to be able to stay alongside them and care for them through the night. This seemed to be underpinned by fear of sleeping in an unfamiliar space. Furthermore, if an elderly patient passes away without family present, a level of cultural shame will follow that family in their community.

“I’d prefer accommodation for visitors. Especially for older people, their family members should stay to support and help. I’m talking about my safety and my health!” – Samoan participant

“I think there should be more room for big families! In any case, I need my wife/someone to help me during the day/ night... there should be a room for them to stay temporarily.” – Samoan participant

Some participants requested more facilities for larger numbers of family members, recognising that when someone is very unwell it is important for the extended family to come and support them to heal.

“For a number of people, when someone is very sick just being there is enough to support... So they come in droves.” – Cook Islands participant

Alongside the significant role family plays in an individual’s health and wellbeing, they often carry a large burden of responsibility. It is important that staff are aware of the complex family obligations, particularly financial, that are prevalent within Pacific communities and often increase pressure during periods of ill-health²⁹.

²⁹ Southwick, Kenealy and Ryan. "Primary care for pacific people: a Pacific and health systems approach."

Family - what does good look like?

What 'good' looks like for family is a ward that makes it comfortable for family to be there and be able to participate in the care of their loved one. This includes whānau rooms with enough space for large family groups, support for 'partners in care' or designated family members to stay overnight, also bathrooms and showers that they are welcome to use. It is good when staff are aware of the financial burdens for family to be present in hospital, and mitigate this when possible by offering parking subsidies and communicating clearly around timing to reduce waiting and uncertainty. Designing processes that integrate family into patients' care plan support them to be involved in care and clinical conversations. It is great when staff are knowledgeable about Pacific models of care and understand the essential role family play in health. While family play an important role in supporting patients to make meaning around their healthcare journey they must not be relied on as interpreters, which is current common practice. It is essential that professional interpreters fulfil this need, as discussed in the Talanoa section.

Suggested actions

Integrate Fonofale model of health into the Auckland DHB model of care.

Why? Aim to support and enable family as the foundation of health for Pacific peoples.

Patient orientation

Develop ward orientation processes, resources and staff routines that reflect and enable the role family can play in the patient's care.

- Provide information (written and video, in multiple Pacific languages) about support for families.
- Collect, record and report the preferred level of involvement of family, including a spokesperson who may be required to lead or support important conversations.
- Be aware that family meetings may be expected for all clinical conversations.

Family orientation

If family are to be present in the hospital, welcome and support their involvement in cares and in clinical conversations by providing, in multiple Pacific languages, information about:

- the ward space, routines and key contacts.
- staying overnight when this is appropriate and possible.
- facilities that can host large families.
- facilities such as bathrooms, showers and accessible (affordable and timely) food outlets and options.

Be aware of the financial burden on family caring for a loved one; offer available financial support with parking and connections to social services.

Integrate the 'partners in care' approach.

Assist provision of accommodation facilities, particularly for families who are supporting elderly or young patients.

Consistently make interpretation services available; to ensure families are able to be supportive in ways only they can, whilst protecting a patient's right to privacy and confidentiality.

Tautai Fakataha: Together we guide, in unison we navigate.

'Together we guide, in unison we navigate' is the guiding principle and translation of Tautai Fakataha (PHT), describing their role of supporting patients and family through their hospital experience. This name was formed by the Pacific Health team; the range of languages integrated acknowledging the diversity of both the service and population they serve.

The hospital experience for many is unknown and distressing; Tautai Fakataha (PHT) provide cultural and social support for Pacific patients during this difficult time.

This section looks at some of the more logistical concerns raised by participants, and considers how we might support patients and their families as they navigate their hospital experience.

Accessibility and transport

Concerns about getting to the hospital were not often raised as an issue; two of the patients had arrived via ambulance for this admission, one in their own vehicle and the remaining 12 through family members driving them in. Strong family support networks ensured participants felt able to access the hospital care when it was required.

“My daughter always helps with transport; it’s a good place to come into when I’m sick.” – Tongan participant

“Travel is all good, I have my own vehicle. But the parking for visitors needs to be subsidised.” – Samoan participant

“No problem with travelling, but I would prefer accommodation for visitors.” – Samoan participant

“No problems [with transport], my family bring me.” – Niuean participant

Those participants who held transport concerns were reliant on an individual family member as the sole driver for their extended family.

“Yes, it’s ok when my transport is available... I mean my sister-in-law is the only one who can drive me to the hospital. If she isn’t free, then I won’t be able to come in.” – Samoan participant

“Challenge for me is when I have no-body to take me to the hospital, especially when there is only one person in the family who drives the car.” – Tongan participant

Holding this responsibility for their extended family may place a large amount of pressure on an individual. As discussed in the previous section 'Family as the foundation', familial responsibilities, financial and otherwise, play a large role in maintaining the structure of Pacific communities. It is important for staff to keep this in mind when communicating potential admittance and discharge timeframes and to remain open to exploring ways to support the family as they care for their loved one. The below example came from a patient during the early part of their journey arriving at the hospital:

“I have a concern about waiting too long to see a doctor, no information about the plan of treatment... If I’m going to admit or not, so my sister-in-law can attend to her work.” – Samoan participant

In this example, the sister-in-law was the sole driver for the extended family but also had to try to meet her work commitments; consideration of these pressures and clear communication around timeframes may have eased the patient's anxiety and supported the family member to fulfil the important role of transport.

Language support

As discussed earlier in the Talanoa section, participants expressed a desire for more language support. Negative experiences of communication arose when a patient felt they did not receive enough information to navigate their hospital experience, or they felt rushed. Not having enough information is commonly reported across the health system as patients and families struggle to navigate hospitals, often not knowing what resources are available to them or what to expect at various stages of care³⁰. This is exacerbated by written resources not being available in Pacific languages, and often including substantial medical jargon.

“I wish they tell us the support services available in the hospital. Language support is very important to us Pacific, especially since I have very limited English.” – Samoan participant

Language support was required not only in clinical conversations but also for logistical concerns such as navigating around the hospital. Support is required to orient patients and their families to the physical spaces of the hospital, and also to the services that are available to them, such as Tautai Fakataha (PHT). Orientation resources should be available in a range of Pacific language options.

Tautai Fakataha Pacific Health Team

Tautai Fakataha (PHT) engage at a number of levels; supporting patients and families, advising staff, mediating and taking on Matua (parental or mediating) roles when required. The limited resource available to the team means they are often referred only to complex cases. Discussions about Tautai Fakataha (PHT) brought out several interesting insights. Participants who had experiences with Tautai Fakataha (PHT) really appreciated the support, but wanted more of it, and also more communication from the ward staff about what was available. Those who had not heard of it, were firstly excited to hear it existed, but felt more could have been done to communicate the availability of that option while they were in the ward. These experiences were reiterated by Tautai Fakataha (PHT), who noted they are often called in at the point of discharge to explain what is happening to the patient. Being called in at the end of stay is a barrier to the Tautai Fakataha (PHT) forming supportive relationships, yet the literature suggests this is a common occurrence for Pacific Health support workers in the New Zealand health system³¹.

“I needed a Pacific person that works in the hospital” – Samoan participant

“I would love to talk to a Pacific staff if I'm lonely and I don't have my family with me.” – Samoan participant

“I would love to talk to someone of my own culture.” – Samoan participant

³⁰ Pacific Perspectives. *Health system review - Pacific report*.

³¹ Pacific Perspectives. *Ibid*.

“I am more confident now I know I can ask for Pacific support. The chaplains have been in contact but this is the first time meeting Tautai Fakataha, they need more people and the wards need to know to refer.” – Cook Island participant

**“It’s very important to talk to my own Samoan people. When I’m in a strange place, having a bad day, it would be nice if someone could be there for me.”
– Samoan participant**

The comfort provided by interacting with someone of their own culture was greatly appreciated, particularly when family were not able to be present. As with the Auckland DHB experience, wider research on Pacific patient experiences in New Zealand found that Pacific support services were often overloaded and under-resourced – as such, patients and their families were not aware such services existed. A dependency on nursing staff to call the team meant they were often called either just prior to discharge (as indicated in an earlier section), at a point of crisis, or for security³². Greater awareness, in both staff and patients, of cultural support services and the scope and benefits of their involvement may facilitate their engagement at an earlier stage and improve the overall experience of patients hospital stays. This must be facilitated by increased resourcing to enable Tautai Fakataha to respond to the level of need in the system.

Tautai Fakataha - what does good look like?

It is ‘good’ when patients and families have access to the information and facilities that allow them to make choices about their own care and participate actively in their own health journey. This can mean making it easy for Pacific patients and their families to find their way around the hospital, to know what services are available and how to reach them, and to be supported to fully understand clinical conversations and decision making processes. For many this involves language support, or cultural and social support through Tautai Fakataha (PHT). Navigating a health journey can involve difficult decisions and unknown futures; it is good when ward staff support fundamental needs such as access to the hospital and access to essential services. It is even better when there are more Pacific staff on the wards; a DHB workforce that reflects the people it serves can be more responsive to their needs.

³² Pacific Perspectives. *Health system review – Pacific report.*

Suggested actions:

Tautai Fakataha

The organisation must prioritise funding for Tautai Fakataha so they are resourced sufficiently to provide culturally embedded support for Pacific patients, with capacity to support systematic change initiatives.

Ensure patients know about and have easy access to support services available, including Tautai Fakataha (PHT), interpreters, social services, accommodation and parking subsidies provided by the hospital

Why? Aim to make it easy for Pacific patients and their families to navigate the hospital environment and journey.

Establish and maintain the relationship between wards and Tautai Fakataha (PHT).

- Integrate Tautai Fakataha (PHT), with patient consent, into care early in the stay. Make it clear this service is available for Pacific patients and is confidential.
- Integrate standard operating procedure of Tautai Fakataha (PHT) into training for staff, so there is clarity on their role.
- Make space on the whiteboard to note patients' preferences for Tautai Fakataha (PHT) involvement.
- Include information about Tautai Fakataha (PHT) in written orientation resources; offer these in multiple Pacific languages, and in video where possible.

On admission, clarify involvement of a spokesperson or family member(s), shared decisions, prayer and spiritual needs, having a minister present, Tautai Fakataha (PHT) involvement, or interpreter services. Note these details on records at admission and keep these preferences in mind when planning conversations or administering cares.

- Ask the patient who they would like to be involved in their care and what kind of information or care they are comfortable, or not comfortable sharing with whom.
- Ask if there is a family spokesperson, who may or may not be next of kin.
- Be aware some patients may feel uncomfortable discussing intimate body parts or having personal cares performed by or in the presence of someone of a different gender.

Find out about the patient's transport needs, how do they get to and from the hospital? Many families have only one driver for the extended family – if this is the case support this person with clear communication around timing and offering parking vouchers.

Support recruitment of Pacific staff.

Organisational action: Prioritise resource for Tautai Fakataha to increase capacity to be able to meet the level of need so they are not called in only at crisis point. Once supported, promote Tautai Fakataha to the wider public, setting patients up to know about the service before coming into hospital.

Conclusion

Hearing directly from our patients and their families about their experiences of care is essential to understanding opportunities to work on access, quality and improvements that will resonate with Pacific patients and families. Once we understand how our patients are experiencing our services, it is important to look deeper into the academic literature on Pacific patient and family experience to understand where we are situated in the New Zealand context.

The emergent themes of Talanoa, Culture, Family as the foundation and Tautai Fakataha (PHT) create a framework against which we can learn from and understand Pacific patient experience at Auckland DHB. ‘What does good look like?’ and the ‘Suggested actions’ sections were created collaboratively from the insights of patients, families, Tautai Fakataha (PHT) staff, adult medical ward staff and the research team provide a road map which can be implemented to improve services. As referenced throughout this work, these themes identified are consistent with the insights gathered through other research and engagement with Pacific peoples about their experiences of healthcare – i.e. that language support, effective communication, cultural support, and cultural safety, involving family in care are all important in terms of improving equity of healthcare and health outcomes for Pacific³³. The recurrence of these themes confirms that these issues have not yet been addressed in an effective way.

We suggest that Adult Medical Services approach these insights with a systems level and quality improvement approach; focus on specific things, change them and measure what kind of a difference that change has made. This will create a shift, rather than interviewing Pacific patients/families to identify the issues that keep arising, the focus will become identifying the effectiveness of targeted interventions to address those very concerns.

This work arose from the daily experiences of patients and families on the wards, providing insights that can help the Adult Medical leadership and workforce reflect on their practice and implement changes that benefit the individual clinician-patient-family relationship. However, in line with the approach of the Pacific Equity team we suggest that the organisation use these insights to think about and implement organisation wide system and service level changes targeting the specific issues Pacific peoples have identified time and time again.

These findings can be a lever to drive change at a system level, promoting reconsideration of the whole model of care – including what and how advice is communicated at the time of discharge to support on-going management so patients and their family know what they need to do to stay well once home. Seamless and integrated care at the hospital - primary care interface is a crucial component to our communities staying well.

To conclude, we must acknowledge those at the heart of this work. We would not have been able to create this report without the generous and courageous patients and family members who opened their stories to us. Hospital stays can be distressing and heavily weighted with emotion, so we are grateful for those who selflessly revisited their experiences in order to improve our services for those who come in the future.

**Meitaki Maata. Vinaka. Malo ‘Aupito.
Fa’afetai lava. Fakafetai lahi lele.
Fakaaue. Fakafetai lasi.**

³³ Pacific Perspectives. *Health System Review – Pacific Report*

Glossary

The words below come from a range of Pacific languages and have been used to support the meaning of the work and familiarise readers with Pacific knowledge.

Fale

House/home (Tongan, Samoan)

Le Va

'the space that relates' to nurture/maintain/respect the sacred space that exists between two people (and also between people and the environment, ancestors and the heavens) (Samoan, Cook Island Māori – dialects Penrhyn (Tongareva) and Rarotongan)

Matua

Parent (Samoan, Cook Island Māori - Penrhyn (Tongareva))

Pou

the pillars that hold up the roof of the fale (Samoan, Cook Island Māori – dialects Rarotongan, Mangaia)

Talanoa

'tala' meaning talking or telling stories, and 'noa', meaning zero or without concealment, associated most often with storytelling, it is a concept consistent across Pacific ethnicities. Also a Pacific research methodology. (Fijian, Samoan, Tongan)

Tautai Fakataha

'together we guide, in unison we navigate' – the name of the Pacific Support service at Auckland DHB, formed by the team (Samoan & Tongan mix)

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