

# Closing the Miscommunication Gap

A User Guide to Developing Picture-based Communication Tools for Aboriginal and Torres Strait Islander Peoples in Emergency Department Settings





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Emergency Department Settings

Aishah Jameel, Lauren Penny and Kerry Arabena

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# Acknowledgments

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# Abbreviations

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<b>ACCO</b>	Aboriginal Community Controlled Organisation
<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>ACEM</b>	Australasian College for Emergency Medicine
<b>ALERT</b>	Assessment, Liaison & Early Referral Team
<b>ATS</b>	Australasian Triage Scale
<b>ED</b>	Emergency Department
<b>IHEWG</b>	Indigenous Health Equity Working Group
<b>LGBTQIA+</b>	lesbian, gay, bisexual, transgender, queer, intersex, asexual +
<b>NSW</b>	New South Wales
<b>PPE</b>	personal protective equipment
<b>SVHM</b>	St Vincent's Hospital Melbourne
<b>VACCHO</b>	Victorian Aboriginal Community Controlled Health Organisation
<b>VAHS</b>	Victorian Aboriginal Health Service

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# Introduction

**The Australasian College for Emergency Medicine (ACEM) is the non-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.**

As the peak body for emergency medicine, ACEM has a significant interest in ensuring and maintaining the highest standards of medical care for patients who present to the emergency department (ED) across Australia and Aotearoa New Zealand.

In August 2021, Karabena Consulting was engaged by ACEM to develop and trial pictorial guides to assist with culturally safe communication between Aboriginal and Torres Strait Islander patients and clinicians in the ED. The project stemmed from *Recommendation 6: Trialling picture/illustration-based communication techniques in pre-ED and ED settings to enhance culturally safe communication with people who speak English as a second or third language* (Arabena et. al 2020:120) in the *Traumatology Talks – Black Wounds, White Stitches* (Traumatology Talks) report by Arabena et al. (2020). Karabena Consulting partnered with ACEM to develop this national, multi-sited research project to study cultural safety in ED settings.

The report found that communication plays a vital role in ensuring patient safety and providing quality health care, particularly in high-stress environments such as EDs. Furthermore, the project also noted several incidents of miscommunication experienced by Aboriginal and Torres Strait Islander patients when engaging with ED staff, including issues of language use (including Aboriginal English) and diversity of dialects that make it difficult for staff and patients to communicate with each other. Research has shown that pictorial guides, such as cartoon illustrations, are an effective strategy in conveying information and significantly improve patient comprehension and compliance with ED discharge instructions.

The initial plan was to trial the illustrations at St Vincent's Hospital Melbourne by training ED staff and conducting an evaluation to assess the effectiveness of the illustrations from both patient and staff perspectives. This site was selected as Karabena Consulting has a pre-existing relationship with SVHM and it is also an accredited ACEM hospital. However, due to the ongoing impacts of COVID-19, and the enormous disruption it continues to have on ED services, the hospital had to suspend all non-essential staff training and education. This made it difficult to trial the illustrations at SVHM's ED within the planned timeframe. As a result, the scope of the project was altered to document the methodology undertaken in developing the illustrations for use in the SVHM ED, with the hope that the same process can be adapted and translated to other EDs around Australia.

**...PICTORIAL GUIDES, SUCH AS CARTOON ILLUSTRATIONS, ARE AN EFFECTIVE STRATEGY IN CONVEYING INFORMATION AND SIGNIFICANTLY IMPROVE PATIENT COMPREHENSION AND COMPLIANCE WITH ED DISCHARGE INSTRUCTIONS.**

## Introduction (cont.)

### Purpose of this report and project overview

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The purpose of this report is to document the methodology undertaken, and the lessons learned, in developing cartoon illustrations for use in an urban ED in Victoria. We hope it will serve as a guide for others wanting to develop pictorial techniques to increase culturally safe communication with First Nations people in hospitals, thus enhancing their patient journey.

The project ran from August 2021 to February 2022 and was developed across four stages:

- ▶ **Stage 1:** Project commencement and planning
- ▶ **Stage 2:** Development of the consultation plan
- ▶ **Stage 3:** Development of cartoon illustrations and submission of an ethics application
- ▶ **Stage 4:** Development and delivery of a final report – *Closing the Miscommunication Gap: A User Guide to Developing Picture-based Communication Tools for Aboriginal and Torres Strait Islander Peoples in Emergency Department Settings*

#### **Stage 1** **Project commencement and planning**

Developing the project plan and holding initial meetings with ACEM.

#### **Stage 2** **Development of the consultation plan**

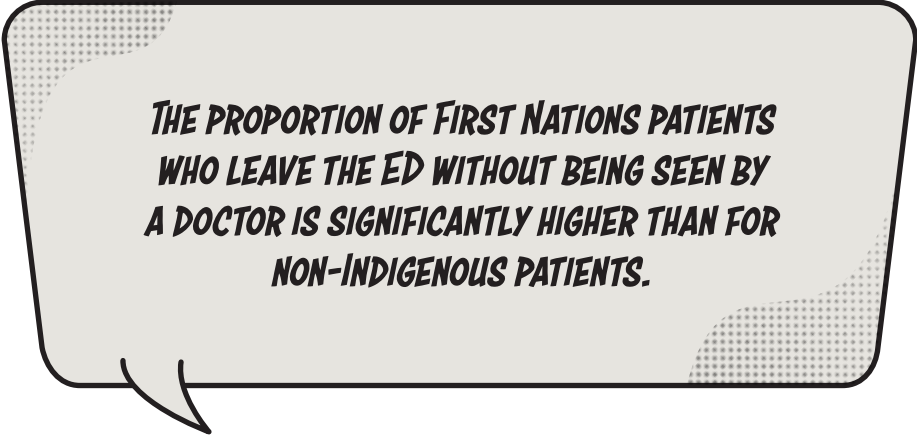
Identifying key stakeholders and strategies to engage them.

#### **Stage 3** **Development of cartoon illustrations and submission of an ethics application**

Obtaining approval to trial the illustrations in an ED, co-developing the content of the illustrations with ED staff, professionally designing the illustrations, and obtaining feedback from service providers and Aboriginal and Torres Strait Islander community members. Two online roundtables were held with ED staff in November 2021 to co-develop the content of the illustrations, and three roundtables were held in January 2022 to present the draft illustrations and obtain feedback.

#### **Stage 4** **Development and delivery of a final report**

Conducting a literature review on communication tools used in hospitals, particularly in the ED, and documenting the methodology undertaken in developing the cartoon illustrations as outlined herein.



***THE PROPORTION OF FIRST NATIONS PATIENTS WHO LEAVE THE ED WITHOUT BEING SEEN BY A DOCTOR IS SIGNIFICANTLY HIGHER THAN FOR NON-INDIGENOUS PATIENTS.***

## **About St Vincent's Hospital Melbourne**

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SVHM is a tertiary public hospital located in inner-suburban Fitzroy. It is one of five A1 (principal referral) hospitals in Melbourne and provides a range of services to residents in metropolitan Melbourne and regional Victoria including medical and surgical care, emergency and critical care, aged care, diagnostics, rehabilitation, allied health, mental health, palliative care and residential care. SVHM also provides care to prisoners at Port Phillip Prison under St Vincent's Correctional Health Service.

For many Aboriginal and Torres Strait Islander people, the ED is often the first point of contact when accessing hospital services. According to SVHM's 2020–2021 Reconciliation Action Plan, 1688 Aboriginal and Torres Strait Islander patients presented to SVHM's ED in 2020, a 25.3 per cent increase since 2018 (SVHM n.d.).

SVHM has a commitment to improve its emergency care services and cultural safety for First Nations people. To support these aspirations, it has been actively implementing several measures including the establishment of a multidisciplinary Indigenous Health Equity Working Group (IHEWG). This group comprises a team of doctors, nurses, allied health practitioners and SVHM's Aboriginal Health Unit (established in 2015), all of whom have an interest and dedication to make the ED a more welcoming and culturally safe environment for First Nations patients.

The proportion of First Nations patients who leave the ED without being seen by a doctor is significantly higher than for non-Indigenous patients (ACEM 2018; Australian Government n.d.). To improve this situation, St Vincent's ED now uses its Rapid Assessment Team for early assessment of, and to explain procedures to, First Nations patients. Aboriginal and Torres Strait Islander patients are also now immediately triaged as Category 3 once identified, which means they will be seen by a doctor within 30 minutes. In addition, St Vincent's Hospital Australia Inclusive Health Program has funded a project to investigate the reasons why Aboriginal and Torres Strait Islander patients presenting to the ED at SVHM leave without being seen.

SVHM's commitment to improving care for Aboriginal and Torres Strait Islander patients extends beyond the ED. In 2021, it engaged Karabena Consulting and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to undertake a collaborative Aboriginal Cultural Safety Audit of SVHM. This project was developed to explore the experiences of Aboriginal and Torres Strait Islander patients and staff in regard to cultural safety issues at SVHM. We have since completed both a review of SVHM's policies and procedures and the ethics application process, and will soon commence a review of historical complaints made by Aboriginal and Torres Strait Islander patients and staff, and conduct a retrospective analysis of hospital admission databases.

## Introduction (cont.)

### Key recommendations

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#### Key Recommendation 1

That a **network of emergency departments** across Australasia undertake a project to trial different communication techniques for underserved or over-represented groups within their jurisdictions, emphasising the use of the methodology developed through this project.

#### Key Recommendation 2

That a **practice guide be developed** from this project which distils and documents the efforts of this extended network in its efforts to reduce miscommunication.

#### Key Recommendation 3

That ACEM commits to supporting emergency departments across Australasia in **implementing knowledge exchange** opportunities aligned to the undertakings from these EDs. Support might include advocating for localised methodological development, multijurisdictional ethics approval processes, and evaluating the impact of these communication strategies with staff, patients and referring agencies. Where possible, the findings of this work should be shared in peer-reviewed publications to develop an evidence base through emergency departments internationally.

#### Key Recommendation 4

That other strategies be developed to support the effective carriage of these communication techniques through **locally determined distribution channels**. Access and utility are at the forefront of this work, and may involve referring agencies, first responders, community information providers (local radio and television), and a social media campaign as part of the launch activities.

#### Key Recommendation 5

That a training package be developed and delivered to train all emergency department staff, including triage nurses, clerks, the care coordinator team, and security guards, on the comics and expectations patients can have from their triage, waiting and service experience.

#### Key Recommendation 6

That the annual ACEM conference includes a workshop or conference stream dedicated to emergency staff efforts to reduce miscommunication with patients by developing and implementing localised communication tools.

# Literature Review

**As we found in our Traumatology Talks – Black Wounds, White Stitches report, communication plays a vital role in ensuring patient safety and providing quality health care, particularly in demanding, high-stress environments such as emergency departments.**

In situations where miscommunication occurs between patients and clinicians, there can be serious adverse health consequences for patients including patients leaving the ED without receiving the appropriate care. A comprehensive literature review on miscommunication and comprehension issues can be found in Section 2: Optimising Emergency Services for Patients of the *Traumatology Talks* report.

This literature review outlines a number of successful and innovative strategies that have been trialled in EDs to improve communication with patients, namely the use of video programs, language boards, mobile and web-based education, and comic illustrations. Most of the literature focuses on international findings around discharge care and instructions, with a recent systematic review and meta-analysis finding that pictorial discharge advice improves comprehension, compliance and patient satisfaction (Dermody, Hughes & Smith 2021).

However, in Australia there is a dearth of videos, animations, comics, artworks and illustrations for use in caring for Aboriginal patients in health care settings. Artworks are often on covers of health reports and Reconciliation Action Plans; illustrations have been used to describe disease impacts on the physical health of a patient; animations used to illustrate microbiome and communicable disease transmission; and, more recently, there have been a wide range of posters, videos and health promotion activities focusing on mental health, ‘talking about suicide’, and how to use face masks during COVID-19 outbreaks. In hospital settings, artwork has been used as wall murals in birthing suites, and illustration-based pamphlets outlining what patients need to do to attend to their health care upon release from hospitals and EDs are common. By comparison, there is very little information to support patients preparing for the ED experience.

We identified many gaps in the health promotion literature in Australia, particularly around communication, process and the experience of waiting. Consequently, there are limitations in the peer-reviewed literature evaluating the efficacy of these materials in supporting Aboriginal and Torres Strait Islander people’s access to ED settings. There is also no peer-reviewed information that describes the methodology employed in the development of these resources, and whether these styles of materials enhance the patient experience of ED services.

***IN SITUATIONS WHERE MISCOMMUNICATION OCCURS BETWEEN PATIENTS AND CLINICIANS, THERE CAN BE SERIOUS ADVERSE HEALTH CONSEQUENCES FOR PATIENTS INCLUDING PATIENTS LEAVING THE ED WITHOUT RECEIVING THE APPROPRIATE CARE.***

## Literature Review (cont.)

### Video programs

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Video programs or animated cartoons have been used to address the issues of miscommunication with populations who are not medically literate. Medical literacy is not only concerned with medical content, but with the transmission of this content in a way that is relatable. Several studies show that well-designed videos or animated cartoons are more effective in transmitting knowledge than when the same information is provided in written material form (Leiner, Handal & Williams 2004; Smith et al. 2021; Kayler et al. 2021; Wray et al. 2021). They have also been positively received by staff and professional groups, who claim they would use animations in communicating health issues (Leiner, Handal & Williams 2004).

In Australia, Aboriginal health leaders have utilised videos to develop campaigns in support of increasing people's understanding of the impacts of COVID-19 (Australian Government 2021), and to describe the role of microbiome (University of Melbourne 2020) and DNA (QIMR Berghofer n.d.). Videos have also been developed in local languages and dialects to raise awareness of how and when to access health resources. Hospitals have started to follow suit. For example, in 2020 St Vincent's Hospital Sydney created a short video with its Aboriginal Health Unit to help inform Aboriginal and Torres Strait Islander patients who visit the ED (St Vincent's Hospital Sydney n.d.). Featured on the hospital's website, this short video showcases Aboriginal and Torres Strait Islander doctors, nurses and Aboriginal Health Liaison Officers in a bid to help First Nations patients navigate their way through the ED.

### Photo voice

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Health information videos are more popular than ever, especially since the rise in access to mobile devices, secure Internet access and social media platforms. Participatory videography has been developed as a method of combining participatory action research and videography to explore concepts of health and wellbeing from the perspective of people involved in making the videos (Sinclair et al. 2015). Forerunners to this approach include Photo Voice, a method developed to promote social transformation through empowerment.

Studies exploring the impact of this medium and methodology found that positive changes were apparent in three dimensions of empowerment: 1) participants acquired new knowledge and developed critical awareness of their community; 2) participants received social recognition, which transformed their self-perception; and 3) participants expanded their social networks so were able to build new links with different actors (research partners, local decision makers, media and the wider public) (Budig et al. 2018). In some instances, advocates of participatory videography found that the methodology could destabilise traditional power relationships between service provider and patient, or researcher and research subject. Putting cameras into the hands of people in the community elicited different perspectives: for example, on determining what was 'good' or 'bad' for children's health and wellbeing (Smith 2004); on what triggered young people to start smoking (Johnston et al. 2013); and on understanding Aboriginal male's health literacy (Smith et al. 2019).

## Language boards

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As outlined in *Traumatology Talks*, language boards ‘are described as being some of the most helpful tools for communicating in the field’ by enabling communication through words and pictures where there are barriers (Arabena et al. 2020:43). A range of products have been designed specifically for emergency situations, such as the Kwikpoint Medical Translator (Pressman, Pietrzyk & Schneider 2011). This resource assists medical professionals to help patients better understand their symptoms and conditions, including with falls, bites, wounds, allergic reactions, toxic ingestions, critical pain, illness identification, and medication dosage and treatment options (Kwikpoint n.d.). There is also a language identification panel to assist medical professionals in finding an appropriate interpreter if necessary. These language boards allow patients to point to illustrations that will help them to describe their condition. For instance, Kwikpoint provides a body chart that outlines a pain scale from 1–10 and uses facial expressions to illustrate which number is the most appropriate. It also includes different types of pain and pain duration to enable patients to indicate more easily their experience of pain. Kwikpoint has also developed language boards showing English and Spanish alongside each other, which have been used successfully in the United States. These include phrases such as ‘What did you swallow?’, ‘Describe the pain’ and ‘Where does it hurt?’ (EMS Magazine 2008). Language boards are simple and easy to understand, and provide emergency staff with the necessary communication skills to assess patients when communication barriers present (Pressman, Pietrzyk & Schneider 2011).

In Australia, a resource that arises frequently in the literature is a communication board designed specifically for use in the pre-hospital setting by the Queensland Ambulance Service and by Disability and Community Care Services (see resource [here](#)). Although this board is not used in the ED, it is a good example of a tool that enhances communication between first responders and patients in emergency medical situations. The communication board includes ‘expressive messages that could be used by both the patient and paramedic’, as well as ‘messages to support patients’ understanding and interaction tips for the paramedic’ (Eadie et al. 2013:3). The communication board has proven successful, particularly when used by culturally and linguistically diverse patients, with paramedics finding that it is ‘relatively simple to use and reduces frustration for the patient’ (Eadie et al. 2013:13). It is one of a variety of communication boards currently being used in emergency and other health care settings with many types of patients, including people living with a wide range of disabilities (Pressman, Pietrzyk & Schneider 2011).

## Mobile and web-based education

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Mobile web-based education in emergency settings is a relatively new concept that has been piloted in a handful of EDs around the world. The ubiquitous use of Internet-enabled mobile devices or ‘smartphones’ has provided a unique opportunity to improve engagement with patients, particularly younger patients, such as adolescents, and those with lower health literacy and varying language proficiency (Saidinejad & Zorc 2014; Ray et al. 2016). Most of the mobile applications for use in EDs have been developed and tested to support discharge instructions and follow-up (Tolins et al. 2019; Schellenbach n.d.; Steel et al. 2021).

For example, Markham Stouffville Hospital in Canada developed Dash MD, the first smartphone app of its kind to support patients with treatment-specific after-care instructions, to access relevant community care resources, and to manage medications, appointments and contacts (Schellenbach n.d.). In the United States, a similar application, Mobile Post-operative Wound Evaluator (mPOWER), has been piloted to support patients with follow-up after-wound care in the ED (Tolins et al. 2019). Although the study reported a limited sample size, it found overall patient satisfaction with the platform was high. Another example was the trial and evaluation of MyEDCare, a text message and smartphone-based electronic ED discharge process (Steel et al. 2021). Piloted at two urban EDs in the United States, the study found that patients who were discharged via MyEDCare reported higher satisfaction related to nursing care, and had fewer unscheduled return visits to the ED.

In Australia, the New South Wales Government developed the GoShare web platform as part of its Emergency Department Patient Experience initiative to improve the ED experience for patients, carers and their families (NSW Government 2021). Two ‘Welcome to ED’ animations were developed and hosted on the GoShare platform, which can be viewed on mobile devices. The animations were created to describe the ED process for both children and adults, and have been translated into nine languages to support the needs of NSW’s diverse population.

## Graphic medicine: Comics

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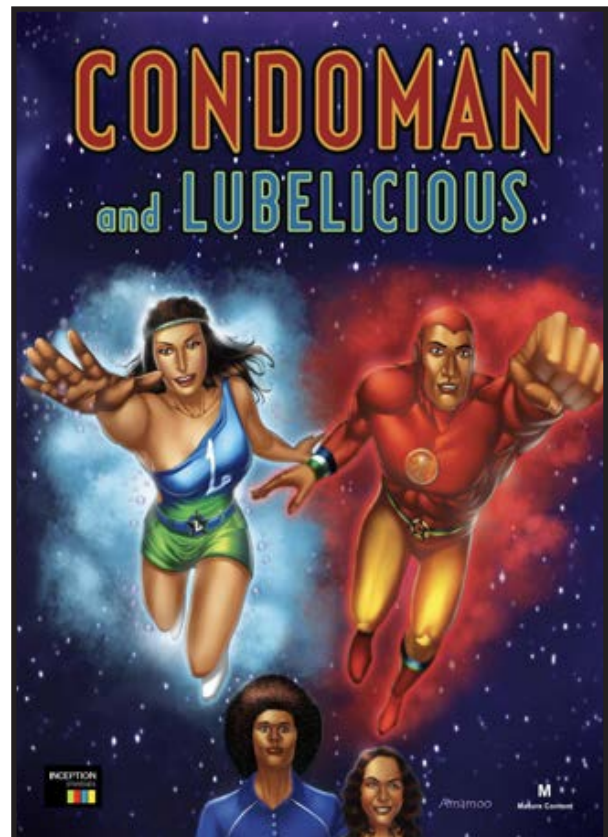
Graphic Medicine – that is the use of graphics in medical education and patient care – is an emerging field of practice. The use of comics or illustration-based techniques in emergency settings is not widespread, possibly because the merits of such an approach have not been sufficiently considered by medical teams (Green & Myers 2010). In Australia, comics and cartoon characters have populated the health promotion landscape disseminating information about key social issues for decades. Non-profit organisations such as Streetwise Pty Ltd (1984–2007), for example, developed comics, posters and other resources on health, education, employment, the law and Indigenous-specific issues (Museum of Applied Arts & Sciences 2021). Comics have often been used to research and communicate social issues to young people and hard-to-reach groups, particularly those who are disadvantaged or excluded from access to mainstream sources of information. Comic characters such as *Condoman* and *Lubelicious* (see illustration of covers opposite) were essential in raising health awareness through non-judgmental formats that engaged young Aboriginal and Torres Strait Islander people at risk of sexually transmitted infections and blood-borne viruses (Condoman n.d.).

Although comic books have been described as an ‘untapped medium’ for health promotion, there is little literature available to describe the process of developing comics as a health promotion or communication tool (Branscum & Sharma 2009). Multimodal literacy, a product of modern technology, has been found to aid in the recall of simple-to-complex information both for children and adults (Rosas-Blum et al. 2018). As health education information presented using educational comics takes advantage of this approach, we adopted multimodal learning for this project.




**COMICS HAVE OFTEN BEEN USED TO RESEARCH  
AND COMMUNICATE SOCIAL ISSUES TO YOUNG  
PEOPLE AND HARD-TO-REACH GROUPS...**

In multimodal formats, comics depict a story in a sequence of pictures that can be helpful for patients with language, education and/or literacy levels that differ to those providing emergency care services. As communication styles and processes in EDs can be unfamiliar to presenting patients and their family members, comics that are made specifically to explain these processes have the potential to be relatable and memorable communication tools. Additionally, if these comics are specific to the sites delivering emergency services, they can make a unique contribution to emergency patient care. Site specificity is an important consideration in the development of these resources, and comics are deemed appropriate for a Melbourne-based ED setting.



**Comic book cover of Condoman and Lubelicious (Condoman n.d.)**



***...PICTOGRAMS CAN BE USED SUCCESSFULLY IN SUCH POPULATIONS TO CONVEY MEDICAL INFORMATION, 'PARTICULARLY IF THEY ARE DEVELOPED IN COLLABORATION WITH THE TARGET COMMUNITY AND CULTURAL INFLUENCES ARE ACKNOWLEDGED'***

### Practical implications

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The incorporation of illustrations into health communication aims to increase the likelihood that people will engage with a health message (Houts et al. 2006). According to Delp & Jones (1996), instruction sheets distributed in the ED are often not read by patients, particularly if they are functionally illiterate and/or are unable to comprehend instructions. Pictograms, however, have been found to be an effective method of conveying health information as they assist in engaging the patient's interest and improve comprehension, particularly for at-risk patient groups including the elderly, children and those with low literacy (Dermody, Hughes & Smith 2021). There is also evidence that simple drawings are the 'most effective in facilitating comprehension' as they have fewer distracting details (Houts et al. 2006). These should be accompanied by simple, clear language.

When using pictures in health materials, Houts et al. (2006:189) recommend 'systematic evaluation of their effects' in a clinical setting, including follow-up interviews to assess attention, understanding, remembering and adherence. Further research has confirmed the need to test, evaluate and refine illustrations used in an ED setting to ensure their success (Dermody, Hughes & Smith 2021).

### Cultural considerations

As outlined by Houts et al. (2006:177), evidence shows that people 'prefer pictures in health messages that are culturally sensitive and include representations of people like themselves'. It is difficult to predict how patients from a variety of backgrounds will respond to different types of illustrations, with responses influenced by cultural factors and personal characteristics. Therefore, it is important that illustration-based communication tools are trialled with the intended audience (Houts et al. 2006).

One study compared responses to standardised pharmaceutical pictograms from United States Pharmacopeia with locally developed, culturally sensitive pictograms in a low-literate South African population. They found significantly higher comprehension of the locally developed pictures, with respondents indicating an overwhelming preference for them. The study concluded that pictograms can be used successfully in such populations to convey medical information, 'particularly if they are developed in collaboration with the target community and cultural influences are acknowledged' (Dowse & Ehlers 2001:93). Houts et al. (2006) noted that although the variances in the pictograms appear to be minor, those 'subtle, but important culturally relevant differences' proved to have a significant impact on comprehension. Studies have found that culturally relevant pictures will facilitate comprehension and will likely be 'especially important for people in cultures that have had little contact with western medicine' (Houts et al. 2006:182).

# Methodology

**This section details the methodology used to develop a pre-ED communication tool to support the interests and concerns of Aboriginal and Torres Strait Islander patients in EDs.**

The resultant communication tool detailed in this report is specific to the experiences of those presenting at St Vincent's Hospital Melbourne ED. The comic strips developed for this project are, therefore, particular to a metro-urban context in Victoria, a State in which there has been considerable effort and attention given to progressing Treaty and achieving self-determination. The methodology is premised on both Indigenous and non-Indigenous methods of engagement and research.

## Indigenous methodological considerations

### 'Nothing about us without us'

Co-design is a key consideration in the development of locally specific resources. In this instance, an Indigenous business was engaged to lead the development of this resource. After working with Aboriginal doctors from ACEM and local triage nursing staff to understand the process and gather content, Karabena Consulting undertook consultations with Aboriginal and Torres Strait Islander people in community controlled organisations (with staff who refer people to the ED including Aboriginal Health Workers and nurses) and in hospital settings (Aboriginal and Torres Strait Islander hospital staff and those working with the ED, e.g. social workers, Aboriginal Health Unit Managers), and with the Indigenous Health Equity Working Group at SVHM.

In a COVID-19 environment, co-design was done through online workshops and in committee meetings. Karabena Consulting made two staff members available for these consultations: one to facilitate the sessions and another to take notes and to transcribe the recordings of these meetings for accuracy.

### A focus on process, content and experience

Given our previous experience with *Traumatology Talks* and time considerations, we decided to develop three evidence-based communication tools in consultation with ED staff. As a consequence of this evidence-gathering activity, we focused on three tools covering *process, content and experience*. The first comic would describe the *process* of being triaged and admitted, the second comic the *content* of communicating levels of pain, and a third comic the *experience* of a parent (as a patient) bringing their children to the ED. We wanted to develop this third comic after hearing of a woman and her children being in the ED for 36 hours while fleeing domestic violence and awaiting emergency accommodation. We verified these foci with ACEM and SVHM (our funders and sponsors) before progressing with the development of the three scripts. Once developed, the scripts were tested with emergency staff for accuracy and given to the illustrator to support the development of preliminary comic strips for wider consultation. However, for the purposes of this project, we only developed Comics 1 and 2 due to time constraints and the overall change in scope of the project.

### Embedding culture and symbols in the communication tools

Recognising the importance of embedding cultural considerations into the communication tools, we referred to the cultural determinants of health and wellbeing, and to local totemic connections and language in their development. We did this in the following ways.

### Use of Aboriginal urban slang as a key way of communicating messages

Aboriginal people in South-East Australia have particular ways of communicating in a system that reflects meaning, values and culture. We used the VACCHO guidelines on the use of 'Koorified Language' to include a complex mix of grammar, sounds, tones, timing, politeness, humour, visual communication and body language (Eades 1988; VACCHO & La Trobe University 2014). We also used lists of common words and sentences from Aboriginal English specific to the region (Roberts 2007).

## Methodology (cont.)

### Use of totems symbolising authority and trust

Totems can be used in illustration-based communication tools to define people's roles, responsibilities and relationships with each other. They are often portrayed as having a role in guiding, supporting and healing people and Country. Totems can also be descendants of the Dreamtime and are seen as heroes or champions. The major narrator in this comic series, Bunjil the Wedge-tailed Eagle, is a totem specific to the place where SVHM is located. Using this totem makes the locality and use (of the resource) clear, i.e., the boundaries of the Kulin Nation and those who respect Bunjil as the Creator being for the region.

### Including stories founded on lived experience

In developing this resource, we included people's lived experiences of mental health, sporting injuries, accidents and the full impacts of chronic disease, along with information relating to poor spiritual health. We tried to be as inclusive as possible to encourage users to think critically about identity, representations and power. In previous consultations, for example, women described feeling unsafe in the ED because of the threat of child removals from ED waiting rooms. When this experience was shared with community and referring agencies during the consultations, this perception was validated as a legitimate concern.

### Visualisation and critical reflection

The comic strips and ensuing discussions proved to be educative for those practitioners who wanted to use them as a way of encouraging patients to approach EDs, and those who thought that they also needed to reflect Aboriginal and Torres Strait Islander peoples' lived experience of being discounted, ignored or their identities suppressed. The aim of the comics was to visualise these stories as resilient and instructive counter-narratives of a population often described as 'sick, desperate, passive actors in our own health experience'. In this way, comics might be reframed as a way of playing with our stories to understand the historical and socio-economic forces that shape our lives and identities (Newbigging 2018).

### Promoting empowerment and self-determination

The evidence from long-term empowerment and participatory action research found that empowerment strategies enhance Aboriginal and Torres Strait Islander people's 'sense of self-worth, resilience, problem-solving ability, and the ability to address immediate family difficulties as well as belief in the mutability of the social environment' (Tsey et al. 2007:S34). The empowerment approach we took in the comics allows for people, their families and communities to provide information appropriate to their concerns, needs and experiences. For example, in Comic 2 (How to communicate pain) we provided 'body maps' on which people could circle ALL parts of their body that might be affected by pain, rather than experience shame from communicating these problems verbally. And in Comic 1 (What to expect at SVHM ED) we referred to 'asking the Indigenous question' as an empowering experience. Similarly, in the pain chart, we attempted to categorise the experience of pain so it can be described and explained in the shortest possible time.

Additional empowerment messages are embedded throughout the comic strips, promoting self-agency and self-advocacy where needed, to encourage people:

- ▶ to bring in their current medications
- ▶ to answer confronting questions as honestly and openly as possible
- ▶ to provide communication strips to staff or AHLOs where and when needed.

Empowerment interventions can bring about powerful changes in individuals and communities by enabling them to take control of their lives and forming a basis for other learning. The aim of these comics has been to enhance self-determination and to facilitate Aboriginal and Torres Strait Islander people taking control in an environment where they are often identified as patients only. The empowerment approach was used to shift social norms towards respect for self and others, taking responsibility for our part in the ED experience, and improving wellbeing outcomes for Aboriginal and Torres Strait Islander people by encouraging them to stay rather than leave without being seen. In this way, EDs can actually provide opportunities for social inclusion, community cohesion and preparedness on the patient journey.

## Non-Indigenous methodological considerations

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### Interpreting real-world data

In the absence of data from randomised trials, non-experimental studies are needed to estimate treatment effects on clinically meaningful outcomes (Stürmer et al. 2020). In this instance, we developed the comics (treatment effects) on clinically meaningful outcomes (the ability to represent health interests and concerns in triage, and for Aboriginal and Torres Strait Islander people to wait in the ED until being seen). Some of the input into the design of these comics – including hospital data, photographs from the ED (see Appendix A) and audio recordings of the ED environment – provided the background needed to conceptualise the context of the illustrations. For example, we asked the nursing staff to take photos of people in full personal protective equipment (PPE), the outside of the ED, waiting rooms and triage desk, as well as the inside treatment rooms and cubicles. These critical design elements allowed the illustrator to reflect the reality of the emergency department (see Appendix B for details of this process).

### Studying social processes

As one of our comics was centred on process issues, we used methodologies that focused on social processes (Patterson et al. 2012) that include time, change and human interactions. These are well illustrated in Comic 1, where we reflected on the experiences of triage, of waiting and of being seen by ED staff. Given that the full process of engaging with an ED is difficult to document in full, we used two methodological approaches to illuminate the dynamics of its social processes: participant observation (patients and those who work closely with clients) and process improvement (including simulation techniques to represent more accurately the patient journey through the ED (Ortiz-Barrios & Alfaro-Saiz. 2020). In this way, the comic was able to formulate improvement scenarios with data derived from a real-life ED environment.

### Process improvement: Queuing theory

Process improvement techniques are a key methodological consideration in the development of these pre-ED and in-ED resources. In addition to queuing theory – which can address staffing, scheduling, and patient service shortfalls – simulation and lean techniques could also be used to underpin the development of the comics. Queuing theories indicate that there are times in the ED when congestion is going to increase, thus decision makers can facilitate a rapid intervention on patient flow to reduce waiting times (Ortiz-Barrios & Alfaro-Saiz 2020). To embed queuing theories in the comics, we showed where and when people would be able to wait, and provided advice on how to wait successfully. Queuing has often been described as a barrier to receiving health care in the ED, which has recently been a major issue in Victoria because of the pandemic. Hospitals that respond to queuing theories have been shown to significantly reduce ED waiting times, in some cases by up to 15 per cent (Xu & Chan 2016).

### Continuous quality improvement

St Vincent's Hospital Melbourne places a strong emphasis on continuous quality improvement. By implementing low-cost, low-risk improvements, such as giving patients comics to prepare them for their ED experience, SVHM has shown a commitment to meeting the challenge of providing culturally sensitive care and to driving changes in its ED to optimise the delivery of that care and the responsiveness of its staff. Some models use suggestion-based strategies that do not require a large time commitment, are easy to implement and have the potential to empower both service providers and service users. Although the comics in themselves would not take the place of other improvement processes, they can alert patients on how to enable, navigate and sustain engagement along their ED journey (Jacobson et al. 2009). In addition to discussing the content of the comics, we also devoted a great deal of time in our consultations to their implementation into the ED practice landscape, and the implications of this work.

### Illustrator methodological considerations

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There are several steps to the development of comic books from conception to completion. The first requires someone to develop or write a script that can be used to ground the storyline of the comic strip. Translating the script (which for this project was written by an Indigenous consultant) is the work of the comic developer/illustrator, who then develops the elements of the story line after giving due consideration to character development, pace and messaging. This is referred to as the art development phase, which is normally done in pencil then inking and eventually colouring. After this stage comes the lettering phase, in which all lettering is inserted into the dialogue balloons. The final stage is the editorial phase in which all lettering and composition is reviewed prior to being printed. In some instances, the comic can be completed in colour, while in others, black and white content will suffice, sometimes with a coloured cover.

The role of comics in health care can range from sharing factual information, to dealing with feelings and attitudes towards health conditions, to providing reassurance to patients experiencing vulnerability (McNicol 2017). Key to the effectiveness of comics in health care are including features that patients can connect with – narratives, characterisation and images (Caldwell 2012). How these are illustrated is dependent on the comic drawing traditions embedded in the practices of the illustrator. There are different comic drawing traditions and ‘schools’ of practice; Walt Disney animators, for example, consistently use three fingers and a thumb, rather than being anatomically correct.

### Emotion, anatomical correctness and ethics

Conveying emotion, value, ethics and facilitating memory skills such as recall, memorisation and interpretation is the work of the illustrator. In these processes, health care staff can provide factual information, but it is then the role of the illustrator to communicate these facts to the reader in ways that balance the outline of the details on a page, and what is left unsaid. There are several elements to character development that communicate emotion, values and ethics that are not dependent on anatomical correctness. Hands and faces are the main components of the characters that communicate the emotional intensity of the stories, and can be used to illustrate direction, reflect facial expressions and enhance overall comprehension. Although some health care workers may focus on the anatomical representation of the character’s body parts, there are three main dimensions that need to be considered in analysing or interpreting medical content in comic form:

- ▶ The cognitive dimension. What do we understand and how do we understand it?
- ▶ The emotive dimension. What do we feel and how do those feelings come about?
- ▶ The ethical dimension. What are we asked to value in these stories, how do these judgments come about, and how do we respond to being asked to take on these values and make these judgments? (Phelan 2005).

Graphic medicine comics often feature characters who experience illness or injury. As some of these experiences will be familiar, the reader is engaged not only in interpreting the comic’s information, but also in judging its ethical importance for them and their situation (Raphael & Rowell 2018).


## Creative design and development

Comics have been used by researchers in Indigenous health to articulate both the ethical tensions in research and the need to develop respectful and reciprocal relationships with research participants – the essence of ethical practice (Strangeways & Papatraianou 2018). In the creative design and development of comic strips, a collage of images and their associated metaphors direct the reader in generating meaning by interacting with the work and ensuring that these meanings ‘are not closed off, but rather open, multiple, suggested and implied’ (Leavy 2015:241). Comic strips combine visual and narrative modes of representation, both of which ‘foreground the embodiment of a lived experience and the affective-emotional component of that experience’ (Strangeways & Papatraianou 2018:80). In the development of the comics for our project, the illustrator was focused on resilience and empowerment, rather than on deficit and vulnerability. The resulting scripts identified unique ways of translating vulnerability into empowerment.

## Working ‘in-culture’ or ‘cross-culturally’

The **Indigenous Artists Manifesto** (Livingston n.d.) states how artists want to be viewed by those who engage with them in the development of artworks. There are many benefits to working with local Aboriginal and Torres Strait Islander artists and illustrators in the development of health care resources, including:

- ▶ their capacity to communicate in the languages (including Aboriginal English) and dialects understood by the patients of services.
- ▶ that they or their family members have been patients themselves, so can empower other patients from their own personal experience.
- ▶ their shared knowledge and understanding of the circumstance of patients, and similar cultural and linguistic patterns, phrases and representations of the Country, dreaming stories and symbols.



**COMICS HAVE BEEN USED BY RESEARCHERS IN INDIGENOUS HEALTH TO ARTICULATE BOTH THE ETHICAL TENSIONS IN RESEARCH AND THE NEED TO DEVELOP RESPECTFUL AND RECIPROCAL RELATIONSHIPS WITH RESEARCH PARTICIPANTS...**

## Methodology (cont.)

For **non-Indigenous illustrators**, all advice in the literature states that it would be best to work with an Aboriginal and/or Torres Strait Islander reference or advisory group in the development of characters, narratives and context. When developing images for publications, illustrators will need:

- ▶ to work with material which has had permission granted, e.g., for names of creator beings and images of children (as background for character development)
- ▶ to develop content that is culturally relevant and representative of the communities with whom they are communicating
- ▶ to ensure that the terms used in the artwork have been agreed to by the reference or advisory group, or tested with local focus groups to ensure the appropriateness of the language and of the images used to relay the requisite messages.

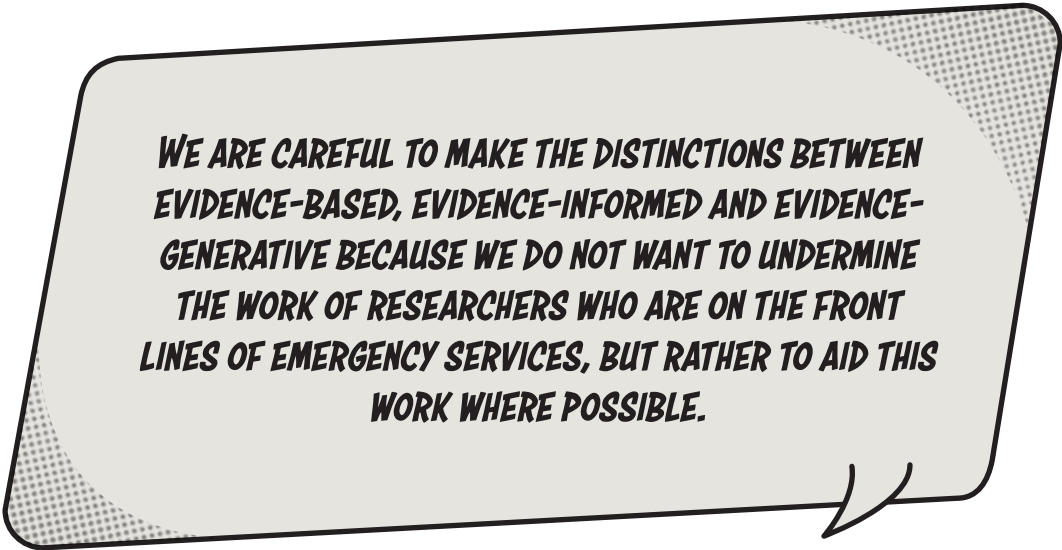
In some instances, it may be **health care practitioners** who lead the illustration process, or who invest in compiling visual images to represent different components of hospital-based graphics. Medical graphics have also been shown to improve physician-patient communication in a variety of cultures, particularly in identifying symptoms (Medhi et al. 2007; Lim 2010) and in comprehending discharge instructions (Austin et al. 1995; Delp & Jones 1996) and education materials (Michielutte et al. 1992; Leiner et al. 2004). In a research project looking at key design elements that impact upon patient comprehension,

Xiaojuan Ma (2016) developed design guidelines for a visual vocabulary that can be used when creating and delivering visual resources in health care settings. Based on Mijksenaar and Westerdorp (1999), the design elements that need to be considered must refer to and reflect the institutional culture within which the work is being developed. Thus, health information graphics need to emphasise features that:

- ▶ highlight important facts to attract people's attention to critical objects and locations, thereby improving comprehension and recall of information related to identification and location/direction
- ▶ reveal detail to make it easy for people to map mental states to real-life situations, and thus enhance understanding and disambiguation
- ▶ demonstrate cause and effect to help explain the conditions and relations often embedded in diagnostic information so as to improve people's comprehension and recall
- ▶ elicit identification and measurement allowing people to make visual comparisons, thereby promoting memorisation of information related to dimension, degree and scale.

Importantly, health care practitioners have a crucial role in constructing diagnostic pathways and how diagnoses are conducted, detailing the symptoms and treatments, and explaining the whole process to get a resolution. This may include information about the questions that are asked, and the assessment and treatment options available for patients in and out of hospital. Staged photos and other strategies to provide context for the visual artwork is also important, and health practitioners' involvement in this staging exercise is key.





**WE ARE CAREFUL TO MAKE THE DISTINCTIONS BETWEEN EVIDENCE-BASED, EVIDENCE-INFORMED AND EVIDENCE-GENERATIVE BECAUSE WE DO NOT WANT TO UNDERMINE THE WORK OF RESEARCHERS WHO ARE ON THE FRONT LINES OF EMERGENCY SERVICES, BUT RATHER TO AID THIS WORK WHERE POSSIBLE.**

## **Evidence-based, evidence-informed and evidence-generative approaches**

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The National Health and Medical Research Council has developed guidelines that support research and exploratory works undertaken with Aboriginal and Torres Strait Islander peoples (NHMRC 2018). These guidelines recognise that how people see the world is generally informed by their own cultural experiences, values, norms and learning. Along with others developed by the Lowitja Institute and the Australian Institute of Aboriginal and Torres Strait Islander Studies, the guidelines recognise the power of ill-informed perceptions and assumptions that underpin miscommunication, and seek to foster environments that support shared learning opportunities.

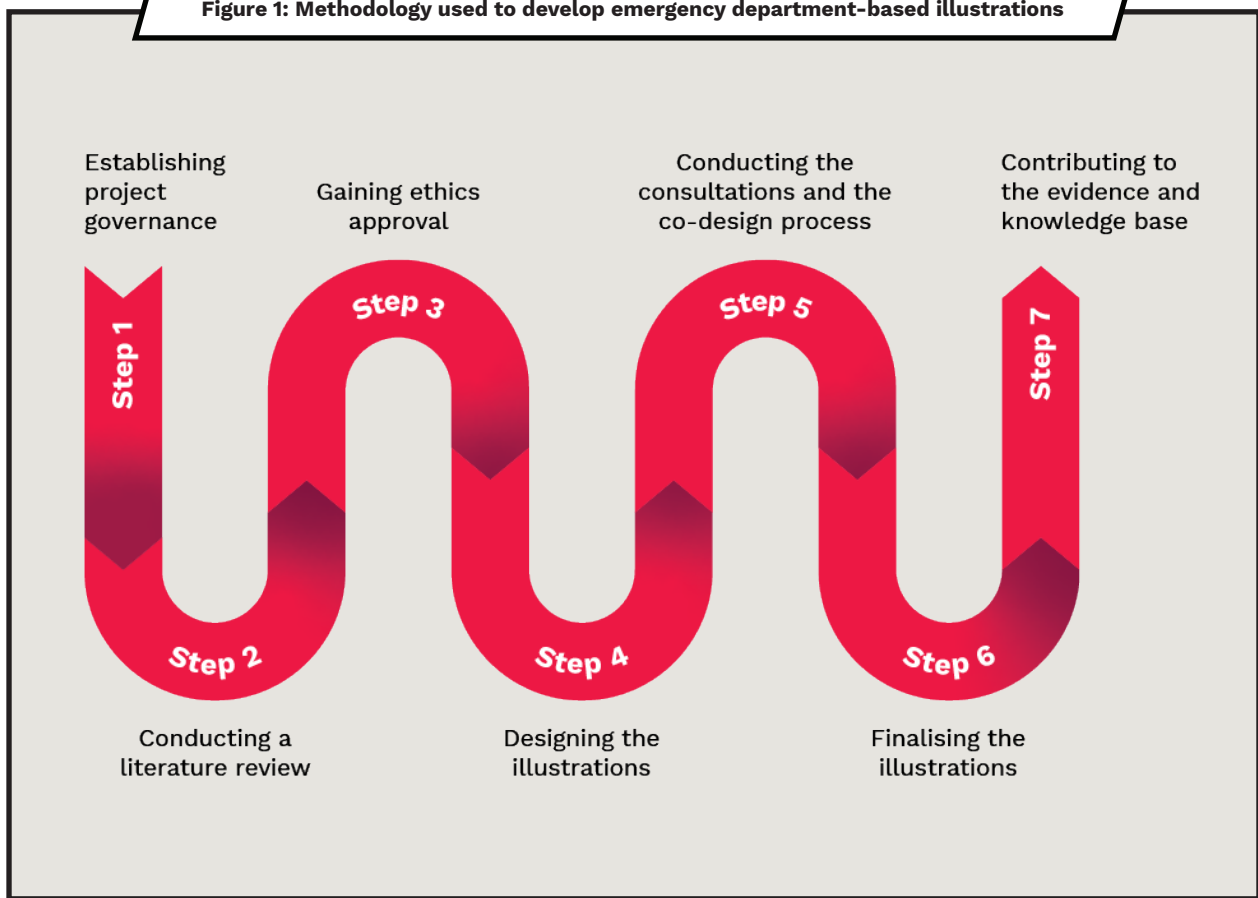
Where possible and practical, all the content of communication tools in emergency settings should be evidence based, that is, the content-focused communication tools (describing pain, medical procedures, diagnosis and treatment information) should be based on peer-reviewed literature that has been through a validated scientific process. The evidence needs to be relevant and appropriate for the situation in which this communication tool will be used. Most evidence-based research is seen in clinical settings because studies can be controlled and evaluated more effectively.

Evidence-informed research is already available and has been tested thoroughly. This evidence is then combined with the experiences and expertise of the organisation developing the best communication tools for the target population. Using evidence-informed research allows EDs to access the best practice possible, without having to invest in research of their own.

We do not claim to be evidence-based or to have all the answers when it comes to developing resources for ED services. However, we are heavily invested in being evidence generative, that is, generating evidence that can be used by others to trial in different regions. To do this work (i.e. generate evidence) we use the best evidence available, which may be peer-reviewed, unpublished, survey results or information gathered during advisory meetings, community workshops and focus groups. We then adopt an evidence-informed approach to developing resources that will allow for information to emerge from the experiences of the people involved. We are careful to make the distinctions between evidence-based, evidence-informed and evidence-generative because we do not want to undermine the work of researchers who are on the front lines of emergency services, but rather to aid this work where possible.

# Implementing the Methodology

Figure 1: Methodology used to develop emergency department-based illustrations



## Step 1: Establishing project governance

Project governance involves describing and implementing functions and processes that guide the project throughout its entire life cycle, and defining the structured roles, responsibilities and accountabilities within the project. The benefits of project management oversight include improved control, integration and decision making. While there is no one project governance framework that is effective in all circumstances, essential elements of successful project governance with Aboriginal and Torres Strait Islander people include:

- ▶ knowing the different cultural groups of your project management team and the wider community, as well as their interconnections and their different rights and interests
- ▶ understanding their concerns and priorities and the need to be clear about which cultural values, rules, relationships and processes will be part of strengthening your project's governance, and which ones are not appropriate or might undermine it
- ▶ being clear about how cultural rules and values will be implemented within your project; for example, you may want to focus on the way members are chosen, how decisions are made and how you feed information back to members.

Project steering committees are one form of project governance. Other governance structures that may already be established in hospitals include Indigenous Health Equity Working Groups, such as the one at SVHM. Ultimately, the development of these types of resources will need input from staff and community members, as well as from staff working in referring agencies, such as Aboriginal Community Controlled Health Organisations (ACCHOs), ambulatory services or mainstream community health organisations. Project governance structures include the need for project sponsors, steering committee members, project managers and the consultants brought in to develop the resources. Additional consideration should be given to paying members for their time and contribution, particularly if they are not in full-time employment. More information on good governance principles for working cross culturally is available on Reconciliation Australia's [Indigenous Governance webpage](#). For the communication tool project, the key activities of the governance group were to decide on:

- 1 Appropriate remuneration for members – especially any who are underemployed.
- 2 The story foci – on the process, content and experience.
- 3 The narratives or 'story outlines' – which can be based on hospital data, a review of historical complaints or through identification of communication barriers or difficulties that staff have explaining, for example, informed consent.
- 4 The symbols, contexts, words and language used – to communicate the essence of the story.
- 5 The communication strategy – whether it be print, illustrations, paintings, animations, cartoons, music, posters, which is the best strategy to convey what is in the stories.
- 6 When and where the cartoon can be implemented or disseminated – to maximise the patient experience in referral pathways into the ED.
- 7 The training strategies required for triage and ED staff to complete so they respond appropriately to the communication tool and integrate it into their practice.



## Implementing the Methodology (cont.)

### Step 2: Conducting a literature review

As part of our *Traumatology Talks* report, we undertook an extensive literature review to get a better understanding of the cultural safety needs of Aboriginal and Torres Strait Islander patients in ED environments. The literature review is of peer-reviewed national and international journal articles – with a particular focus on First Nations populations across Australia and Aotearoa New Zealand, Canada and the United States of America – as well as books and grey literature including government reports and guidelines in Australia.

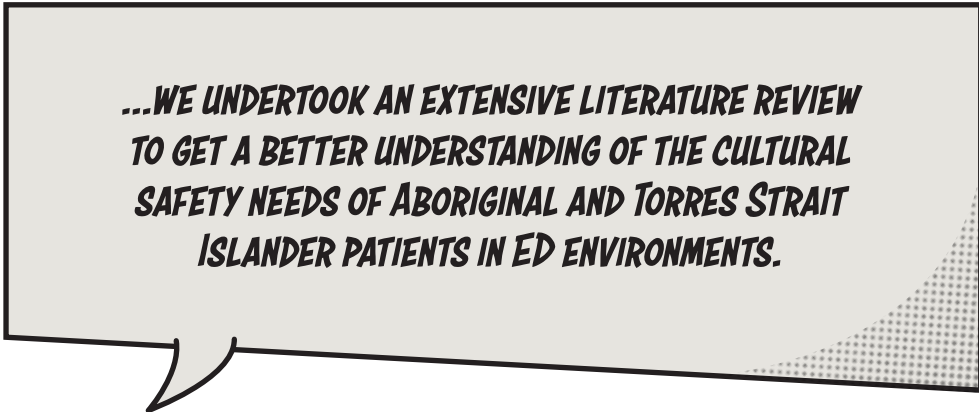
When developing a communication tool, it is important to ensure that it is informed by evidence. We recommend that each ED undertakes a literature review of the content area that is relevant to their communication tool. For example, our pain-related comic was informed by literature on how to communicate and assess the level and intensity of pain.

We recommend including at least 10 sources of literature per content area. After consulting with ED staff, we chose two of the major themes that arose from the patient interviews in *Traumatology Talks* as the focus of our communication tools – comprehension issues and pain management in the ED – and reviewed more than 40 sources of literature about them.

The relevant literature can be found in ‘Section 2: Optimising Emergency Services for Patients’ of the *Traumatology Talks* report. In the development of our communication tools, we conducted a further literature review of 34 sources to explore the types of illustration-based tools that have been used in Australia and internationally.

Key activities in conducting a literature review include:

- 1 Identifying processes, content or experiences that enhance patient experience (e.g., what happens in the ED, pain management in the ED, bringing children to the ED) that you want to develop into a communication tool.
- 2 Identifying local unpublished reports or resources that speak to the experiences of people in the region.
- 3 Identifying peer-reviewed publications that focus on First Nations experiences in EDs.
- 4 Writing a report detailing your literature review to share with the governance group and the illustrator.
- 5 Referring to the literature in *Traumatology Talks* as a place to start. Other reports outlining cultural determinants of health and Indigenous science and wellbeing can be found using Google Scholar, or accessing Lowitja Institute publications and the Australian Indigenous HealthInfoNet.



***...WE UNDERTOOK AN EXTENSIVE LITERATURE REVIEW TO GET A BETTER UNDERSTANDING OF THE CULTURAL SAFETY NEEDS OF ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS IN ED ENVIRONMENTS.***

### Step 3: Gaining ethics approval

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An ethics application was submitted to the SVHM Human Research Ethics Committee as there were initial plans to trial the illustrations at SVHM's ED, and to conduct interviews and surveys with Aboriginal and Torres Strait Islander ED patients and staff. The process was led by Associate Professor Aziz Rahman, an experienced researcher who was supported by the Karabena Consulting team and staff at SVHM. Despite ethics approval being granted in January 2022 (Project ID Number: 79182), we were unable to trial the illustrations in the ED as initially planned. The ongoing impacts of COVID-19, and the enormous disruption it continues to have on ED services, meant the suspension of all non-essential activities such as staff training and education. Thus, it became too difficult to train ED staff and to trial the illustrations at SVHM's ED in the planned timeframe. Furthermore, the ethics application underwent an extensive review and amendment process, which also contributed to the delay of the trial. However, if ACEM decides to extend the project, we will be able to trial the illustrations at SVHM's ED and conduct an evaluation of its impact.

An important reason to gain ethics approval for this type of work is that there is only limited peer-reviewed literature available on strategies to overcome miscommunication in ED settings. With such miscommunication adversely impacting patient outcomes, it is vital to create an evidence base to guide the development of future resources. However, the ethics approval process can be a harrowing experience for Indigenous businesses and consultants, because of the length of time needed for it to be built into project timelines. As the 'research project' is hospital-based, approvals have to be site-specific, which is time consuming and may involve further costs. In addition, it is rare that a hospital ethics committee will have an Aboriginal or Torres Strait Islander member, which can lead to misunderstandings and further delays.

You may need to allow up to five months for the approval process to be completed, even though developing the resource and trialling its acceptability with patients may be low risk. Additional costs in the project may relate to trialling the communication tool with patients' families. All hospitals will have an ethics committee, but you will need to check to see if the committee you are working with has the capacity to assess an Aboriginal and Torres Strait Islander-focused ethics application to be considered.

All hospitals provide details about the process of ethics approvals along with some basic steps we have outlined here. When applying for ethics approval, be aware that you will not be able to start the project until you are in receipt of written approval to commence. Key activities needed to gain an ethics approval are as follows:

- 1 Assemble your application documents package.
- 2 Undertake a risk assessment.
- 3 Obtain sign off by the Director of ED or equivalent.
- 4 Ethics Review Committee will review the application.
- 5 Notification of approval so project can begin.

### Step 4: Designing the illustrations

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To develop the cartoon illustrations, Karabena Consulting engaged with a professional illustrator Nick Love, who was recommended by Mullum Mullum Indigenous Gathering Place, a Victorian Aboriginal Community Controlled Organisation (ACCO) partner of Karabena Consulting that had used his services previously. As the illustrations were to be trialled at SVHM's ED they were localised to the ED's physical location, but due to the ongoing restrictions of the pandemic we were unable to conduct site visits. However, SVHM ED staff were able to capture the environment of a busy ED for us through staged photographs (see Appendix A) and audio recordings, which were then given to the illustrator to assist with the illustrations.

## Implementing the Methodology (cont.)

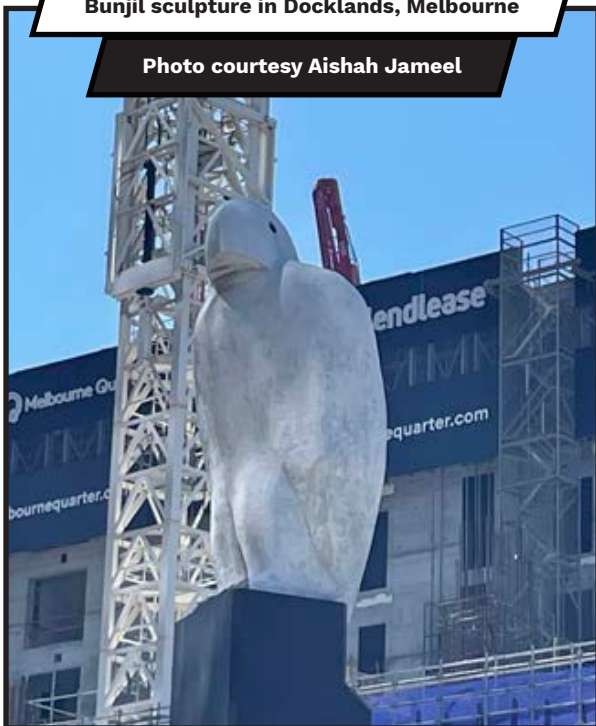
In addition to these photos and soundscapes, we also worked closely with ED and triage staff to develop scripts for the illustrator, as it was critical to have a clear understanding of how the ED operates. An example of this process can be found in Appendix B, in which we outline in detail how we went about designing the scripts and illustrations to develop Comic 1: What to expect at SVHM ED.

With regard to character development for our illustrations, we felt it would be useful to have a character that could narrate the story and be the focal point of the comics. The main character needed to be friendly, relatable and have significance to Aboriginal people in Victoria.

In determining the character that would have the greatest local relevance, we decided on the 'Wedge-tailed Eagle' and, after receiving feedback in the consultations, decided to name him 'Bunjil' to ensure cultural relevance and understanding among the Koori community. There are multiple references to Bunjil across the Melbourne landscape, including the 25-metre-high sculpture in Docklands (ENESS n.d.). Bunjil the Eagle is a creator deity, cultural hero and ancestral being in the Kulin Nation, and is considered a moiety ancestor with relevance for many across Victoria.

**Bunjil sculpture in Docklands, Melbourne**

Photo courtesy Aishah Jameel



Bunjil is a cultural hero and ancestral being depicted as a Wedge-tailed Eagle in Aboriginal communities across Victoria. As such, we thought that having a Wedge-tailed Eagle would resonate with Aboriginal and Torres Strait Islander patients. The following illustrations show some examples of the way that Bunjil was conceptualised as the main narrator for the illustrations.

Other characters developed for the comics can be found in Appendix B.

**Character draft 1: Wedge-tailed Eagle**



**Character draft 1A**



**Character draft 1B**

## Step 5: Conducting the consultations and the co-design process

Karabena Consulting is committed to the principle of co-design to ensure that the voices and experiences both of service providers and of Aboriginal and Torres Strait Islander people are reflected in our work to improve health outcomes. To support the process of co-design, we held a number of online consultations with ED health professionals – including the SVHM Indigenous Health Equity Working Group members and ACEM’s Co-Chair of Indigenous Health Committee – to co-develop the content and messaging of the illustrations and also present the character drafts. We asked ED staff what topics would be useful to illustrate to ED patients and what they needed to communicate effectively with them.

Through these discussions, it was identified that the illustrations would focus on the following key messages:

- ▶ What to expect in an ED
  - This includes the process of how a patient is seen, the ED staff that patients will meet and the services available to enhance their patient journey.
- ▶ How to communicate pain
  - This includes understanding what pain is, how it is diagnosed, the questions that patients will be asked, how to communicate the different types of pain, and explaining how pain is treated.
- ▶ Bringing children into the ED
  - This includes information that would support a parent or carer who had no alternative except to bring their children to the ED, even though they are not the patient.

We were then able to develop three scripts (each to correspond to the identified key messages), which we shared with some of the ED staff at SVHM to verify the accuracy of the information. Samples of the scripts are available in [Appendix C](#). Once the scripts were endorsed, they were given to the illustrator to guide the narratives of the illustrations.

After drafts of the illustrations were developed, we organised and facilitated three online workshops to present the drafts and obtain feedback from Aboriginal and Torres Strait Islander community members, SVHM’s Indigenous Health Equity Working Group and other hospital service providers. A list of invitees can be found in [Appendix D](#). Participants included First Nations and non-Indigenous hospital staff (both ED and non-ED staff), Aboriginal Hospital Liaison Officers (AHLOs), social workers, and First Nations representatives from ACCHOs and ACCOs. A full list of participants from the workshops can be found in [Appendix E](#).

Prior to the workshops, we circulated the draft illustrations (Comics 1 and 2) and script (Script 3) so that participants had a chance to review the resources beforehand. Although we had initially planned to develop three comic strips, only the first two were developed due to time constraints and the overall change in scope of the project. We also sought written consent from the participants to participate in the workshops and to be recorded. The workshops were held online, recorded over Zoom and notes were taken by the Karabena Consulting team. Some people were unable to attend the workshops due to work commitments but provided us feedback through email and scheduled phone calls. During the workshops, we presented the illustrations page by page and the discussions were mainly guided by the following targeted questions, which helped us obtain valuable feedback on the drafts (see [Appendix F](#)). This included:

- ▶ Is the language used in the comics appropriate?
- ▶ When and where should Aboriginal and Torres Strait Islander people be able to access this information?
- ▶ How culturally appropriate are the comics?
- ▶ Is the anatomy drawing to indicate pain useful to you?
- ▶ What is the quality/accuracy of the information in the comics?

## Implementing the Methodology (cont.)

### Step 6: Finalising the illustrations

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After the workshops were completed, we compiled the feedback received and sent it to the illustrator to revise the drafts and produce final versions of the illustrations. The comics underwent several rounds of revision before final versions were produced. **The final illustrations can be found on pp. 28–51.**

### Step 7: Contributing to the evidence and knowledge base

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Knowledge exchange (or knowledge translation or knowledge mobilisation) is putting research knowledge or evidence into policy, practice and individual behaviour. It involves translating complex pieces of information (usually in the form of research findings) to make it applicable to other groups that may find the information useful. While a vast amount of knowledge is created and published in peer-reviewed academic journals annually, only 14 per cent is effectively translated and used in real-life (Morris, Wooding & Grant 2011). Furthermore, it takes a considerable amount of time and effort to mobilise new knowledge and social innovations into practice. For example, in health research, it can take up to 17 years for research evidence to be implemented into clinical practice (Green et al. 2009; Morris, Wooding & Grant 2011).

As such, there is a wide discrepancy between what is known (from evidence) and what is used (in practice), resulting in significant knowledge-to-action gaps in the world. Knowledge exchange is a two-way process and requires active planning, strategizing and dissemination of knowledge from knowledge producers (e.g., researchers) and active engagement and collaboration from knowledge users (e.g., policymakers, practitioners). For research knowledge to be successfully utilised in practice and have real-world impact, the following things should be considered and factored in:

- ▶ the research knowledge should be simplified and written in plain language
- ▶ knowledge users need to be engaged with and involved early on to ensure maximum collaboration and knowledge uptake
- ▶ that the right methods and mediums for dissemination of knowledge are tailored for each target audience.

For the purposes of these communication tools, we have identified a myriad of ways in which these tools can contribute to the evidence base. These include:

- ▶ published and unpublished resources such as:
  - peer-reviewed journal articles
  - conference proceedings and presentations
- ▶ colouring books for children waiting in EDs
- ▶ posters
- ▶ animations to be played on closed circuit TVs in waiting rooms
- ▶ staff training packages, including orientation programs.

With regard to the comics produced in this project, there is an opportunity to distribute them at ACCHOs with referral pathways to hospitals and at local housing corporations or ACCOs. Once these tools have been disseminated in the community and piloted for several months, it would be beneficial to then evaluate them to assess their effectiveness with ED patients and their families. If the comics are shown to be successful at reducing the number of Aboriginal and Torres Strait Islander patients who leave the ED without being seen, this would trigger an opportunity to scale-up the comics and develop a series of them (with the same characters) to focus on other equally important issues such as mental health, disability and social emergency care.



# Challenges

**Throughout this project we encountered the following challenges, which we address here.**

## **Addressing cultural sensitivities**

In developing the characters for the comics, we were unsure whether to seek Traditional Owner approval for naming the Wedge-tailed Eagle character Bunjil. If the comics were being introduced to the community, we would be going to local Traditional Owners to ascertain whether the character could be named Bunjil.

Aboriginal English is significantly different to English. Accommodating Aboriginal English and illustration-based anatomy into the development of the resources needs guidelines and support, particularly because hospital-based staff are focused on clinical correctness rather than engagement. We used the Koori Language Guide, and would urge others to use similar language guidelines when developing resources. As a result of the consultations, we were able to identify that having Aboriginal and Torres Strait Islander people developing or guiding all aspects of our script, character development and language use is critical to the success of the resource.

## **COVID-19**

Due to the ongoing impacts of COVID-19, and the enormous disruption it continues to have on ED services, all non-essential staff training and education is still suspended. This made it difficult to trial the illustrations at SVHM's ED in the planned timeframe (December 2021– January 2022), and ultimately delayed the trial altogether.

## **Limited first-hand perspectives**

We were unable to do a physical walk through of the ED space due to COVID-19 restrictions in hospitals. As a result, we had to rely on audio recordings and photos taken by ED staff that, while useful, were unable to provide real-life context. We were also unable to engage with non-clinical staff members, such as the concierge, ALERT team, clerks and security guards, which meant that there were limited staff perspectives on the characters developed for the comics.

## **Low participation rates in consultations**

We had extended the invitation to co-develop and provide feedback on the illustrations to many ED health professionals and Aboriginal and Torres Strait Islander community members. Unfortunately, due to increased work commitments as a result of the pandemic, many clinicians were unable to participate in the workshops, which resulted in lower participation rates than anticipated. Nonetheless, we were able to obtain valuable input from those who attended and also received feedback via email.

## **Distribution networks**

Throughout the consultation process, considerable thought went into where and when the comics could be distributed along the pre-ED patient journey, and the implications of paper-based communication tools in an ED setting. As the focus of these resources was on pre-ED preparation and admission processes, it became clear that the communication tools would need to be embedded into the information for patients that is shared through ACCHOs and ACCOs. Furthermore, staff would need to understand the purpose of providing this type of information to patients if they are to help them overcome issues of miscommunication. Thus, the concerns around distribution networks were not able to be resolved in this phase of the project. However, evaluating the patient experience of accessing and using the resources certainly would provide a better understanding as to when these resources would make a difference.

# Lessons Learned

**Ultimately, the development of these types of resources will need input from staff, community members and staff working in referring agencies (ACCHOs, ambulatory services or community health organisations). Project governance structures provide a much-needed coordination point and will necessarily involve project sponsors, steering committee members, project managers and the consultants brought in to develop the resources.**

In developing resources, there may be a preference for engaging with an Aboriginal or Torres Strait Islander illustrator, artist and/or consultant to ensure illustrations are culturally safe. Also helpful was the opportunity to include staged photos, soundscapes and photos of staff in COVID-19 PPE clothing, and the glossary of terms that was agreed to by people in the region. It is important to gain the views of Aboriginal and Torres Strait Islander staff involved in the project to ensure the drawings, language, imagery and context can be communicated in a way that maximises the benefit of this work.

We found that choosing a main character/narrator of significance to First Nations people within the region (e.g., a totem or a local champion) was a key element in the design of the comic. If a totem is used, permission may need to be sought from local land councils or Traditional Custodians. If a local champion is more appropriate, they need to be approached early on in the consultation process to ensure there is an alignment between the characters and symbols used and the message to be communicated.

While one resource is unlikely to meet everyone's needs, diverse communities, such as people living with a disability or the LGBTQIA+ community, need to be considered. Karabena Consulting, for example, consulted with an Aboriginal representative from the deaf community who gave us a lot of feedback, and things to consider and include in the comics' production process.

We learned that illustrators have a particular way of developing their animations and characters, and that there are various artistic traditions or schools of thought which provide the philosophic and ethical intent of their production and content. These also provide a means to navigate the space between the ways in which characters are developed, and how the pictures communicate meaning with the reader. There is a lot being communicated in the artwork through pictures and story lines, and there is a lot that is surmised by the reader – depending on who the reader is.

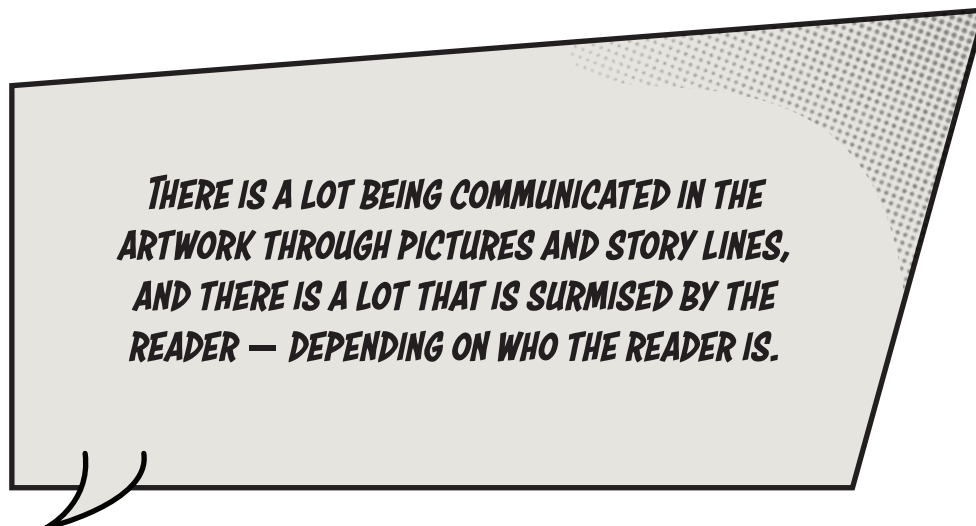
Medical graphics is a communication strategy that attempts to bridge the gap between medical knowledge and the knowledge of readers, many of whom will have varying life experiences and comprehension capabilities. To enhance this communication process, we found that providing the artist with a script containing dialogue supported the development of the storyline. To generate the comics we produced for this project, we drafted three scripts, each approximately 1500 words long. During the consultation process there are 'drafting phases' and then the 'polished phase', which takes approximately two or three weeks to complete. It is important for communication tool developers to compile all the feedback from the consultations to allow the artist to develop what they do well. There is additional expense in the number of times they have to update a draft.

We found there were tensions between the artist's dialogue, the dialogue used by hospital staff and referral agencies, and the dialogue promoted as 'urban Koori language' in other resources used by government departments and community-controlled agencies in the region. Dialogue is important to get right. We consulted with triage nurses and emergency staff to identify the questions that they ask patients at triage. We also asked for their personal opinions on how they assess people who present with pain, or who need to bring children into the ED with them. These conversations translated into strategies that could be used by patients to communicate their needs with triage nurses, in the shortest amount of time possible.

Issues such as shame need to be addressed in comics. This might be done in ways that are non-verbal, or in language or are symbolic – and that are familiar to those people living in different regions. We sought to overcome the issue of shame by providing patients with a ‘body map’ so they can point to where the pain is. We also included some words that could be used to describe the pain. Pain management and assumptions made by staff about people’s presentations with pain will need to be addressed in further training packages.

It is important that ACCHOs and other agencies with a direct referral pathway to the ED are identified and involved early in the co-development and co-implementation process. While we were unable to address this in this project, discussions with ED staff and community members revealed where these resources could be introduced along the pre-ED journey.

Finally, consideration needs to be given on how and where to introduce the comics as part of the pre-ED journey, i.e., distribute at ACCHOs to promote community awareness/education instead of presenting it at EDs. Comics and other communication resources do not need to be ‘word heavy’. If there is too much information for patients to process, particularly those who are in pain, the value of the resource could be diminished over time. If this resource was to be distributed at EDs, there may be alternative ways of making the messages in the comics more accessible, i.e., to condense the images into more comics and into video format if needed.



# Finalised Illustrations

## Comic 1: What to expect at St Vincent's Hospital Melbourne emergency department





**BEEP  
BEEP**

PAGING DOCTOR JONES

**DING!**

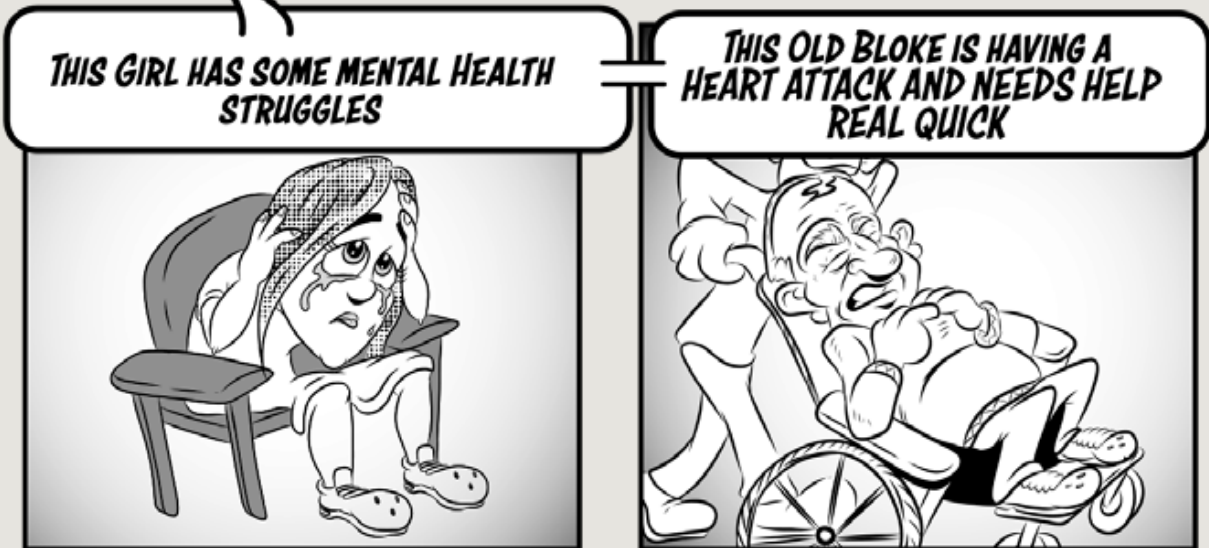
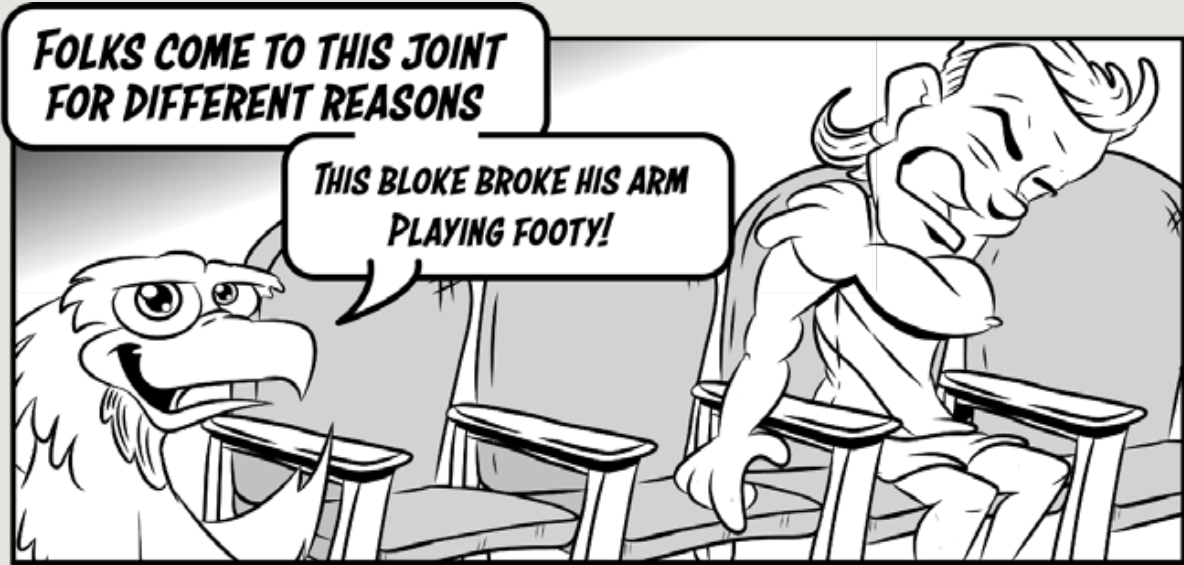
HOW LONG IS IT GOING TO TAKE?

WHERE'S THE PAIN?

← EMERGENCY

PLEASE CHECK IN

**EMERGENCY DEPARTMENTS (ED) ARE BUSY, NOISY PLACES TO VISIT ESPECIALLY WHEN YOU ARE STRESSED OR ACCOMPANYING A PATIENT. THEY ARE OPEN 24 HOURS A DAY, AND ARE AVAILABLE TO ANYONE WHO NEEDS THEM.**





**DID YA NOTICE THIS FELLA ON THE WAY IN?  
DOES A RIPPER JOB, HE'S A SECURITY GUARD.**

**SECURITY GUARDS ARE EMPLOYED BY THE HOSPITAL AND  
HAVE AN OBLIGATION TO SUPPORT A TRUSTING ENVIRONMENT  
WHILE ALWAYS MAINTAINING CONFIDENTIALITY**

**THIS MOB HAVE A DUTY TO  
LOOK AFTER YOU  
AND TO HELP THEM HELP YOU,  
USE A NICE, LOUD VOICE  
AND ANSWER QUESTIONS  
HONESTLY.**

**TO MAKE IT A LITTLE EASIER  
I MADE YA A CHECKLIST**



**1. THE HOSPITAL AND STAFF HAVE A DUTY OF CARE,  
YOU HAVE A RIGHT TO HAVE YOUR HEALTH NEEDS MET.**

**2. PATIENTS ALSO HAVE A RESPONSIBILITY  
TO TREAT STAFF RESPECTFULLY.**

**3. EVERYONE SHOULD BE ASKED IF THEY IDENTIFY  
AS ABORIGINAL AND/OR TORRES STRAIT ISLANDER.  
THIS IS A POSITIVE QUESTION TO BE ASKED, TO MAKE SURE  
YOU CAN ACCESS THE BEST CARE AND RESOURCES.**

**4. YOU ARE GOING TO GET ASKED THE SAME QUESTIONS  
TIME AND AGAIN, BY DIFFERENT PEOPLE ON YOUR WAY  
THROUGH YOUR ED JOURNEY.**

**PEOPLE ASK YOU THESE BECAUSE IT IS PART OF THE ED'S  
DUTY OF CARE.  
YOU SHOULD FEEL VERY EMPOWERED TO ANSWER  
THESE QUESTIONS.**

# STEPS THROUGH THE ED

## STEP 1 CONCIERGE

THEY WILL ASK YOU TO CHECK IN WITH A QR CODE, GIVE YOU A MASK AND DO A TEMPERATURE CHECK

## STEP 2 TRIAGE

TRIAGE STAFF WILL ASK YOU QUESTIONS ABOUT YOUR PAIN. SOME OF THE QUESTIONS MAY BE DIFFICULT TO ANSWER AND MAKE YOU FEEL SHAME BUT THAT'S OK

## STEP 3 CLERK

A CLERK WILL ASK YOU FOR YOUR DETAILS, ADDRESS, DATE OF BIRTH, ETC.

## STEP 4 WAITING

THERE ARE MULTIPLE WAITING AREAS, YOU MAY BE ASKED TO WAIT IN DIFFERENT AREAS BUT THIS HAS NOTHING TO DO WITH WHO YOU ARE

SIT TIGHT IN THE WAITING AREA



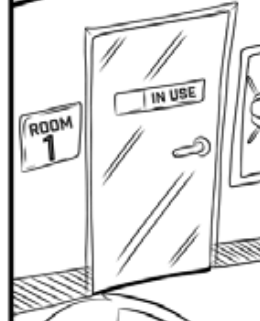
OR GET SOME AIR BY THE OUTSIDE POND  
(JUST LET TRIAGE KNOW)



YOU MIGHT NEED TO WAIT IN A CUBICAL WITH A CURTAIN



OR A CLOSED ROOM



## STEP 5 HELP HAS ARRIVED

BE IT A DOCTOR OR ANOTHER TRAINED LEGEND, THEIR ONLY AIM IS TO HELP





IT ALL SEEMS PRETTY FULL ON AND YOU MIGHT BE

**OVERWHELMED**



BUT YOU MOB, THIS PLACE SHOULD  
**ONLY** BE CONCERNED ABOUT YOU & YOUR HEALTH  
TO ASSIST YOU,  
WE HAVE FORMED THE

**SUPERHEROES  
OF HELP**

**HERO 1**

**CONCIERGE**

THIS HERO CHECKS YOUR TEMPERATURE,  
CHECKS YOU IN AND GIVES YOU A MASK



**HERO 2**

**TRIAGE NURSE**

THIS HERO SITS AT THE FRONT DESK AND WILL  
ASK YOU QUESTIONS ABOUT YOUR PAIN.  
THIS LETS THEM KNOW HOW URGENTLY YOU NEED  
TO BE SEEN BY A DOCTOR.



# HERO 3

## CLERKS

THESE ARE THE HEROES THAT WILL GET YOUR DETAILS. WE NEED TO KNOW WHO WE ARE HELPING.



# HERO 4

## RAPID ASSESSMENT TEAM

THEY MAY ASK YOU TO COME TO A CUBICLE OR A ROOM AND DO ANOTHER ASSESSMENT. THIS IS USUALLY A **QUICK ASSESSMENT** WHERE YOU MIGHT BE ASKED TO GO BACK TO THE WAITING ROOM.



# HERO 5

## ALERT TEAM

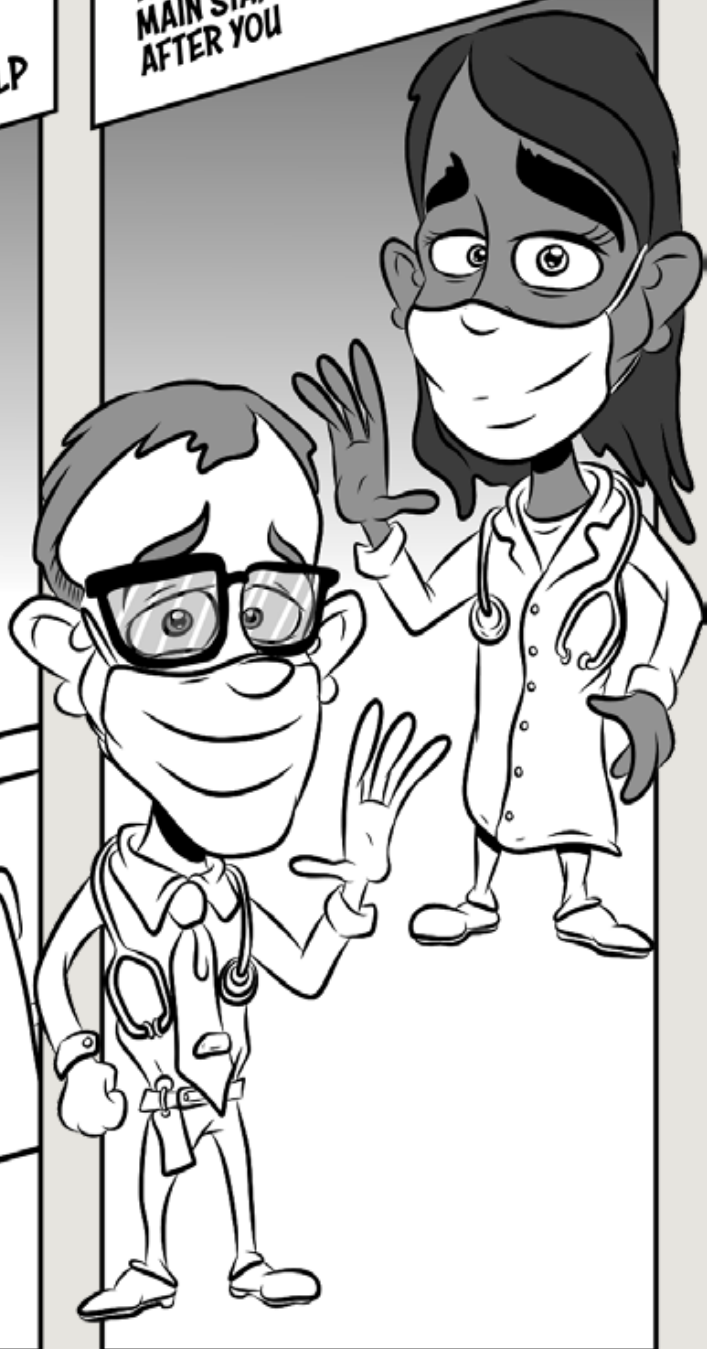
YOU CAN ASK THE CONCIERGE TO  
SEE THE ALERT TEAM TO HELP YOU  
MAKE THE BEST DECISIONS FOR  
YOUR SITUATION.  
THEY CAN ALSO MAKE CALLS  
ON YOUR BEHALF FOR FURTHER HELP



# HERO 6

## DOCTORS & NURSES

THE DOCTORS AND NURSES ARE THE  
MAIN STAFF WHO WILL BE LOOKING  
AFTER YOU



# HERO 7


## AHLO'S (ABORIGINAL HOSPITAL LIAISON OFFICERS)

YOU CAN ASK THE CONCIERGE, TRIAGE STAFF OR CLERK TO CALL THE AHLO AT ANY TIME.  
AHLO'S WORK MONDAYS-FRIDAY 8.30AM - 5PM

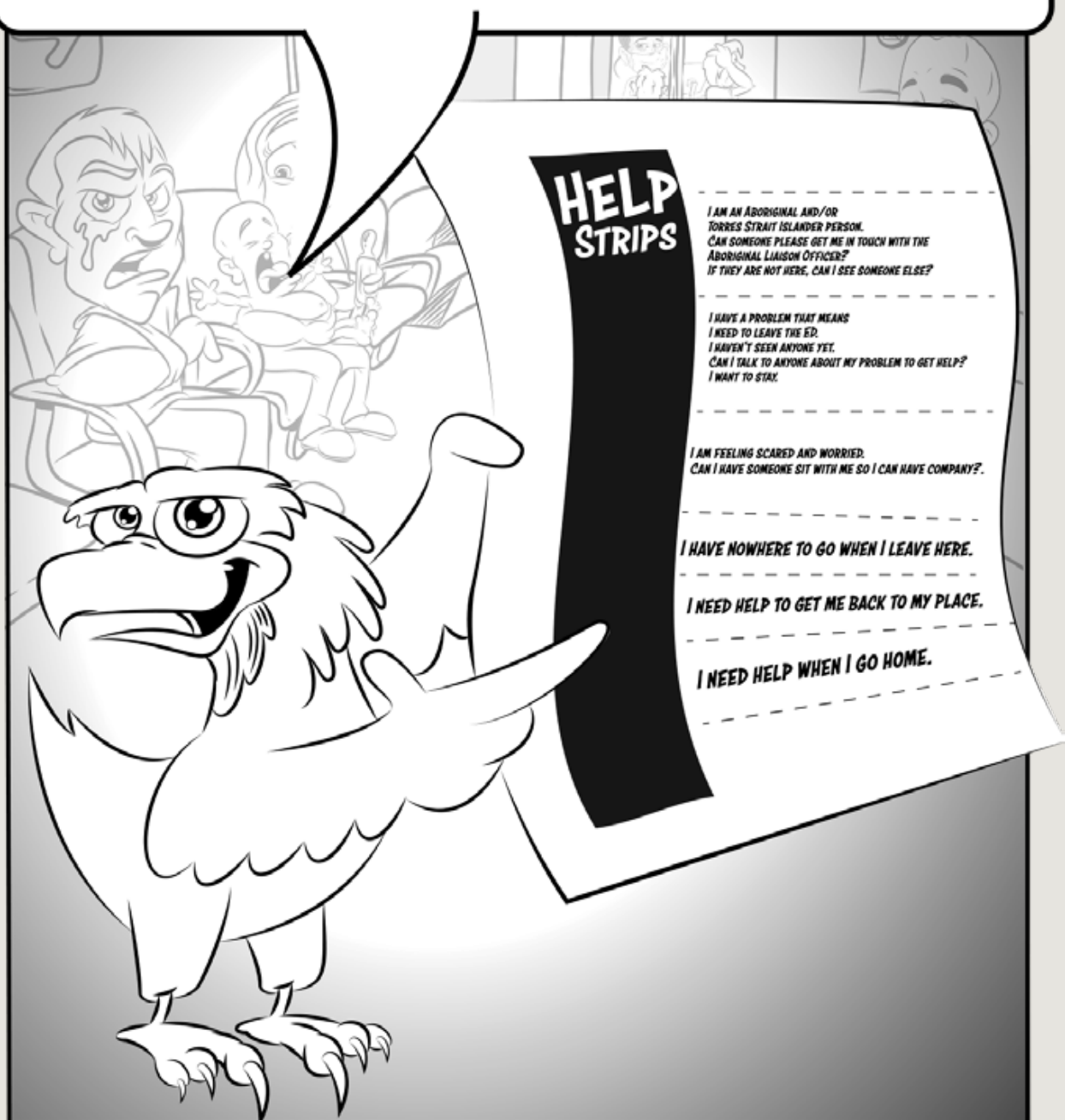
WHEN THE STAFF ASK: DO YOU IDENTIFY AS AN ABORIGINAL OR TORRES STRAIT ISLANDER PERSON?

YOU CAN REPLY: YES... AND CAN I PLEASE SPEAK TO THE AHLO?

THE AHLO WILL DO THEIR BEST TO ASSIST YOU & HAVE YOUR BACK!



**IT CAN BE HARD TO FIND THE RIGHT WORDS  
OR HOW TO EXPRESS HOW YOU'RE FEELING.  
THAT'S WHY WE HAVE MADE YOU SOME  
HELP STRIPS THAT MIGHT HELP**



# HELP STRIPS

**SIMPLY TEAR ONE OUT  
AND HAND IT TO ONE OF  
THE SUPERHEROES OF HELP**



**I AM AN ABORIGINAL AND/OR  
TORRES STRAIT ISLANDER PERSON.  
CAN SOMEONE PLEASE GET ME IN TOUCH WITH THE  
ABORIGINAL HOSPITAL LIAISON OFFICER?  
IF THEY ARE NOT HERE, CAN I SEE SOMEONE ELSE?**

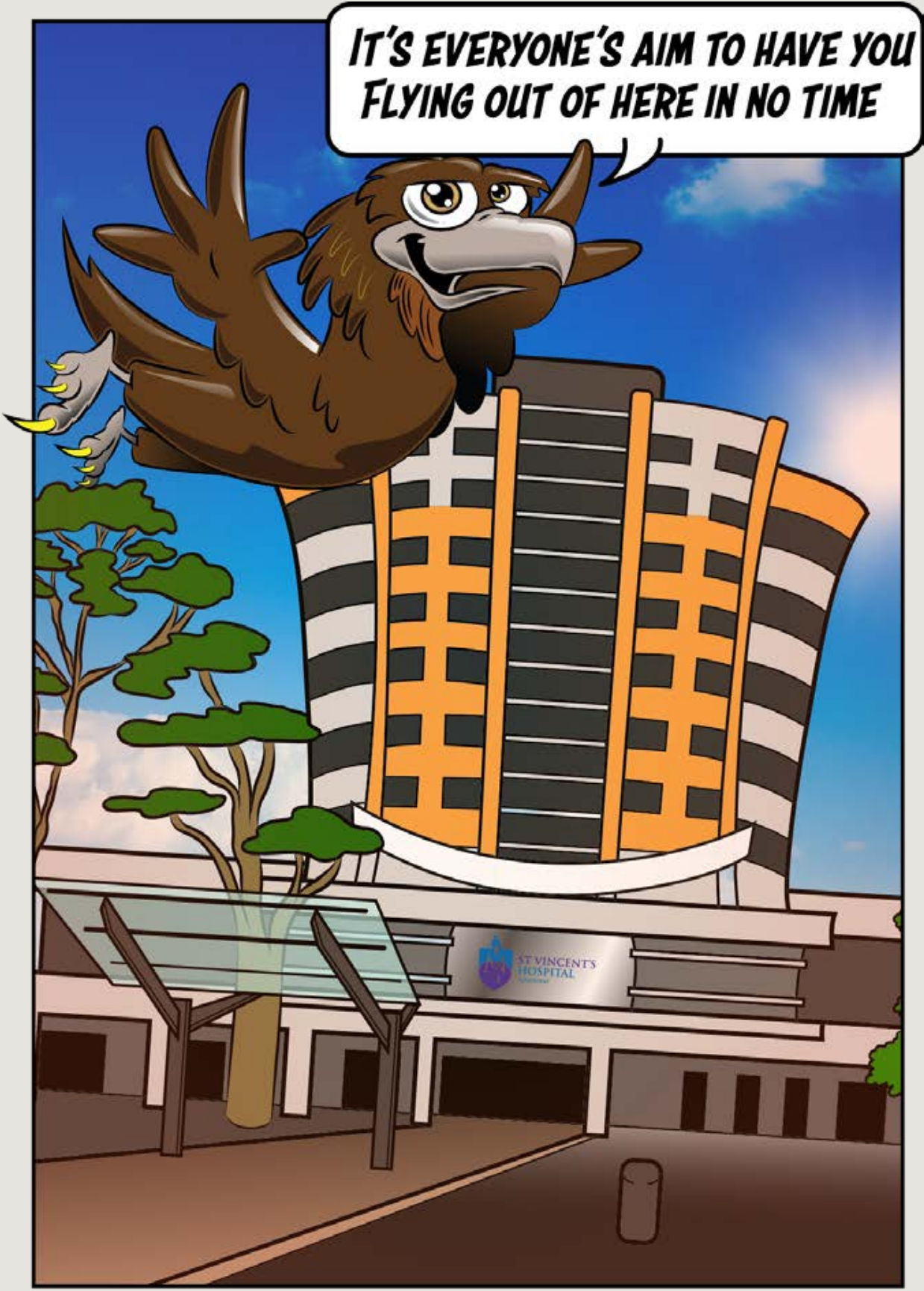
**I HAVE A PROBLEM THAT MEANS  
I NEED TO LEAVE THE ED.  
I HAVEN'T SEEN ANYONE YET.  
CAN I TALK TO ANYONE ABOUT MY PROBLEM TO GET HELP?  
I WANT TO STAY.**

**I AM FEELING SCARED AND WORRIED.  
CAN I HAVE SOMEONE SIT WITH ME SO I CAN HAVE COMPANY?.**

**I HAVE NOWHERE TO GO WHEN I LEAVE HERE.**

**I NEED HELP TO GET ME BACK TO MY PLACE.**

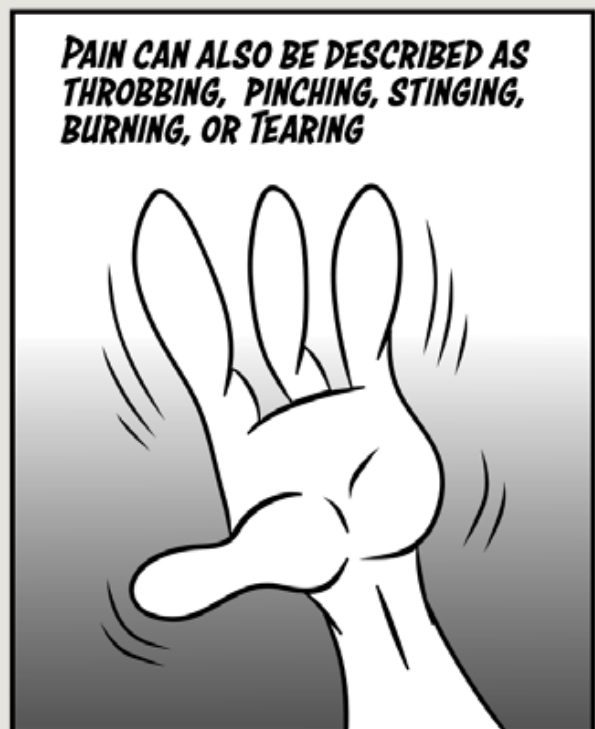
**I NEED HELP WHEN I GO HOME.**



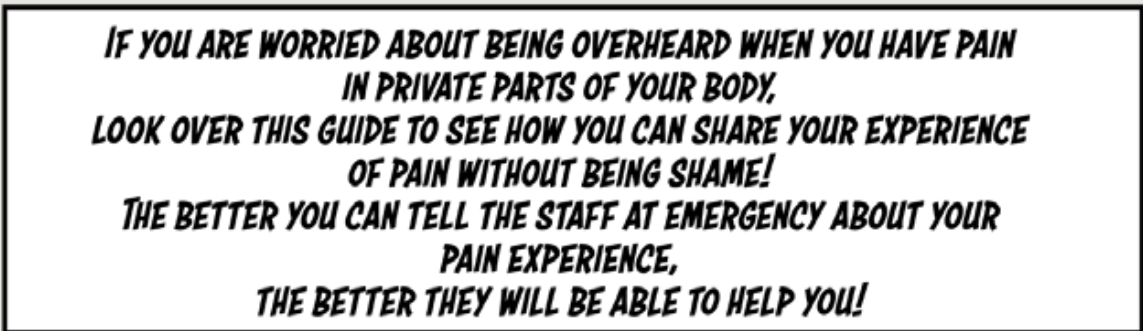
**Comic 2: How to communicate pain**

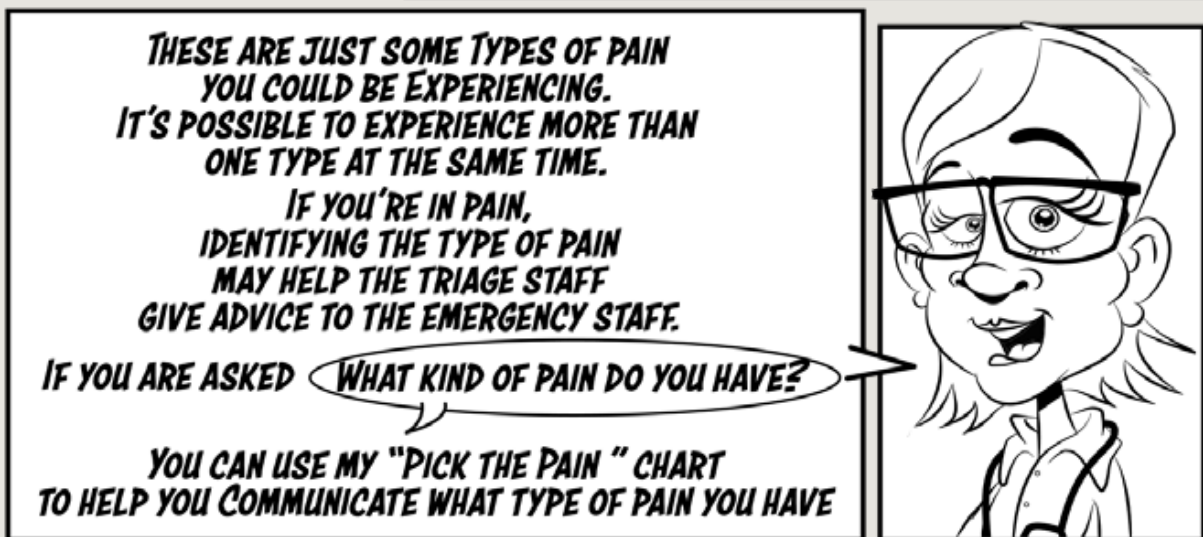
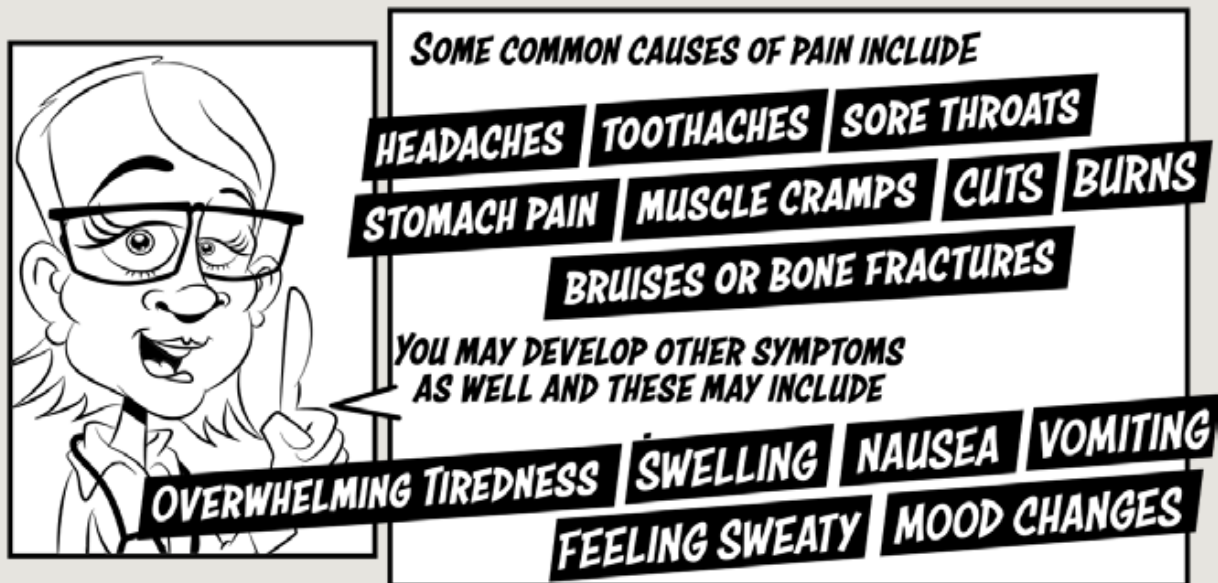
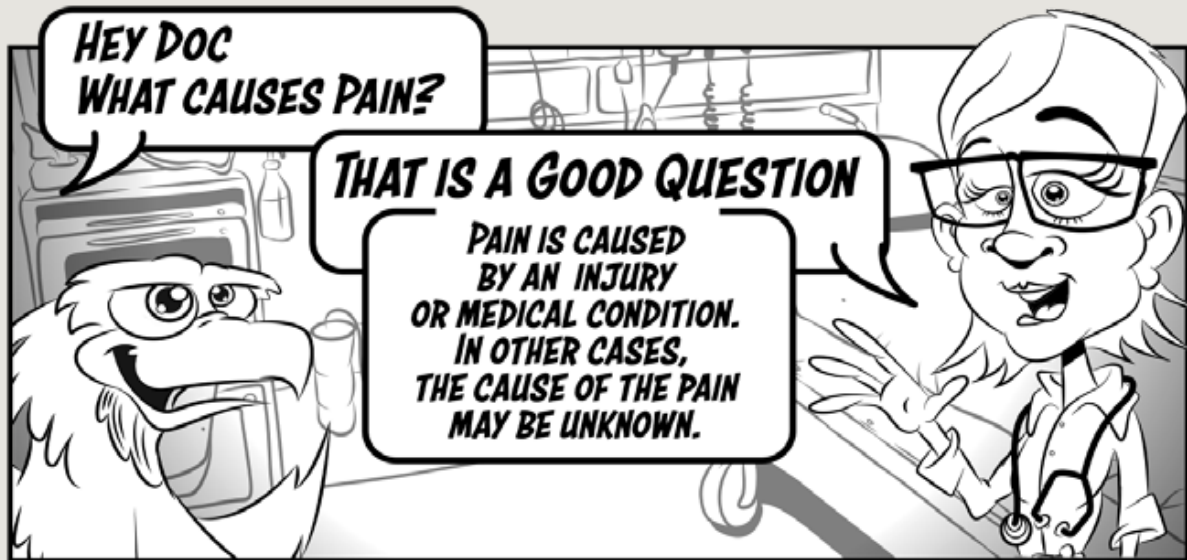






**YOU WILL BE ASKED WHAT PAIN YOU HAVE, WHERE IT IS AND HOW BAD IT IS WHEN YOU GET TO TRIAGE.**  
**THE QUESTIONS HELP THE TRIAGE STAFF UNDERSTAND HOW QUICKLY YOU NEED TO COME INTO THE ED.**  
**IT'S OK TO ASK FOR MEDICATION IF YOU ARE IN PAIN.**  
**TELL THE TRIAGE STAFF AND YOU WILL BE OFFERED PARACETAMOL OR IBUPROFEN**





# PICK THE PAIN

## PAIN IDENTIFIER CHART

### I HAVE ACUTE PAIN

IT FEELS SHARP

IT CAME ON QUICKLY

I HAD AN ACCIDENT OR I HAVE AN INJURY  
(A CUT, A BURN, A MUSCLE SPRAIN, A FRACTURE)

I HAD A MEDICAL PROCEDURE  
- INJECTIONS, DENTAL WORK, SURGERY



### I HAVE CHRONIC PAIN

IT HAS LASTED A LONG TIME

IT COMES AND GOES AND CAN LAST  
FOR MONTHS OR YEARS

I HAVE A HEALTH CONDITION THAT GIVES ME PAIN  
(ARTHRITIS, CHRONIC MIGRAINE, CANCER)

I HAVE MEDICATION I TAKE TO LESSEN THE PAIN  
(IT IS IMPORTANT THAT YOU  
BRING YOUR MEDICATION SO YOU CAN SHOW  
THE DOCTOR)



### I HAVE MENTAL PAIN

I FEEL VERY SAD

I FEEL VERY STRESSED

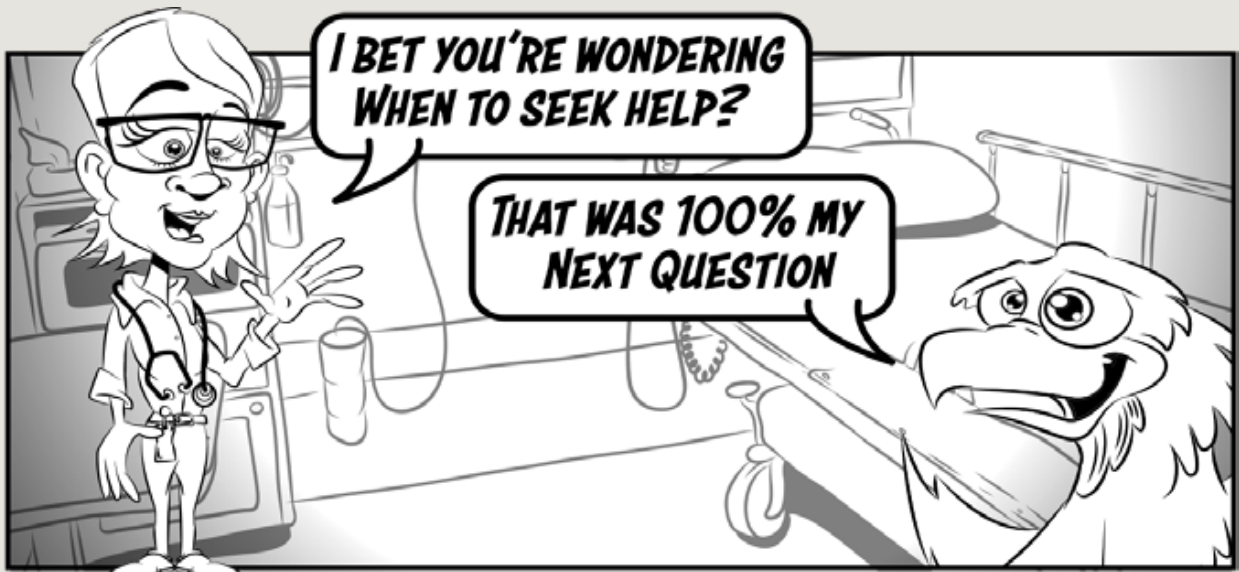
I FEEL VERY LONELY

### I HAVE NERVE PAIN

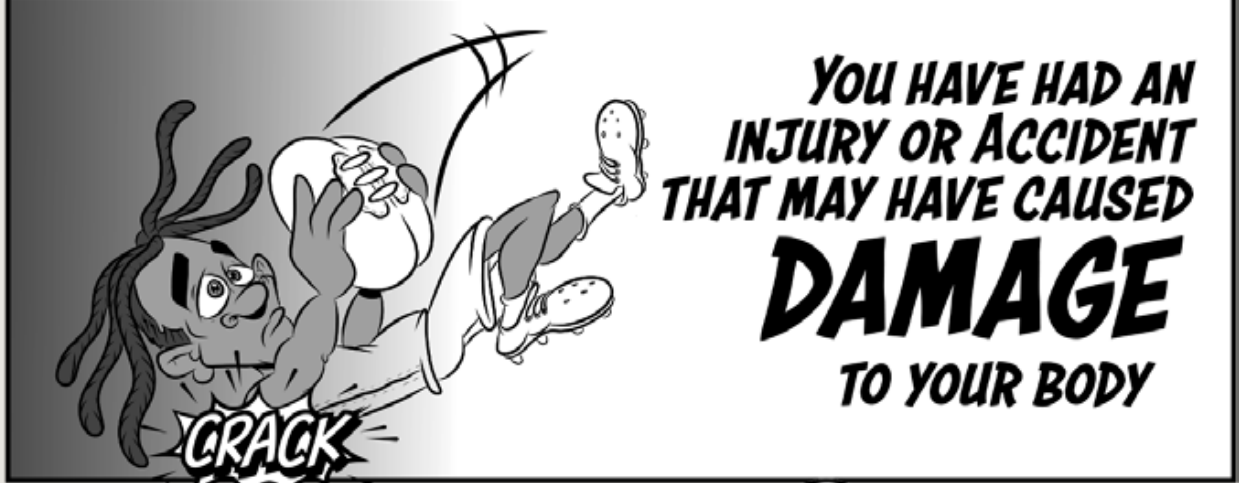
I HAVE SHOOTING, STABBING OR BURNING SENSATIONS

IT FEELS LIKE PINS & NEEDLES

I AM HAVING DIFFICULTY PERFORMING EVERYDAY ACTIVITIES



**SEEK MEDICAL ATTENTION IF:**



**YOU HAVE PAIN ON ANY PART  
OF YOUR BODY WITH OTHER  
SYMPTOMS LIKE**  
**SHORTNESS  
OF BREATH**



DID YOU HURT YOUR  
BACK AGAIN, DAD?

**INTERFERING WITH YOUR  
DAY-TO-DAY  
LIFE**

**YOU DON'T NEED TO FEEL SHAME  
AND PUT UP WITH PAIN.  
THIS MOB IS HERE TO HELP  
YOU GET BETTER**



WE REALLY ARE HERE  
TO HELP





**SO DOC, HOW IS PAIN DIAGNOSED?**

**THE TRIAGE STAFF MEMBER WILL BE LOOKING AT YOUR BODY OR YOUR FACE FOR SIGNS OF HOW SEVERE OR URGENT THE PAIN IS. THEY WILL LIKELY ASK YOU THESE TYPES OF QUESTIONS:-**

**WHAT KIND OF PAIN IS IT?**

**WHERE IN YOUR BODY ARE YOU FEELING THE PAIN?**

**DO YOU HAVE OTHER SYMPTOMS?**

**ARE THERE TRIGGERS THAT MAKE THE PAIN WORSE?**

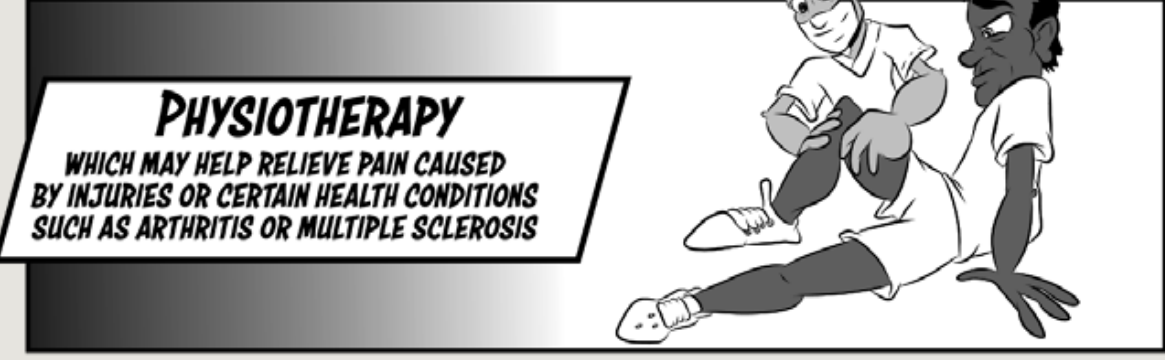
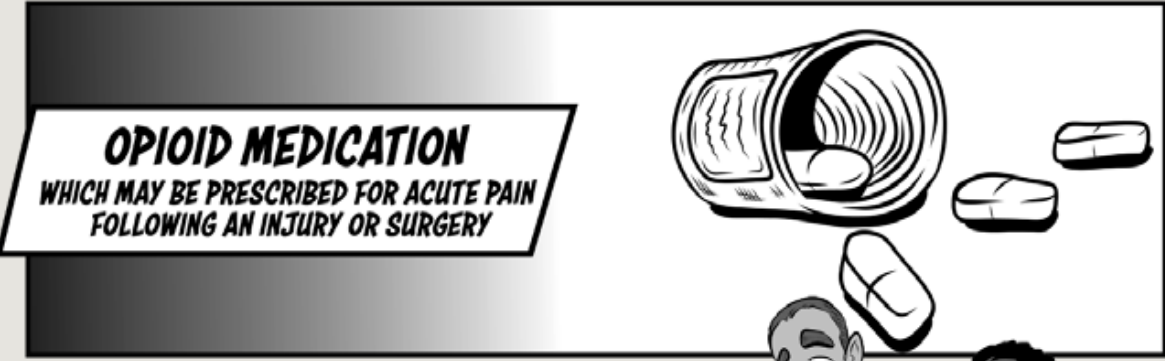
**HAVE YOU BEEN DIAGNOSED WITH HEALTH CONDITIONS? WHICH ONE (S)**

**HAVE YOU HAD ANY RECENT INJURIES OR ILLNESSES?**

**ARE YOU TAKING MEDICATIONS OR SUPPLEMENTS?**

**ON A SCALE OF 1 TO 10 (TEN BEING SEVERE PAIN) WHERE ARE YOUR PAIN LEVELS AT?**

**DEPENDING ON YOUR SYMPTOMS AND MEDICAL HISTORY, THE TRIAGE STAFF WILL MAKE A DECISION ABOUT HOW QUICKLY YOU NEED TO BE SEEN BY THE ED STAFF. WHEN YOU ARE SEEN BY A DOCTOR, THEY WILL EXAMINE YOU AND MAY RUN SOME TESTS OR X-RAYS TO FIND OUT WHAT HAS CAUSED YOUR PAIN**





**NURSES CAN GIVE PARACETAMOL OR IBUPROFEN,  
IT IS REGULARLY OFFERED AT TRIAGE  
BUT THEY WILL NOT BE ABLE TO GIVE YOU SOMETHING  
STRONGER UNTIL THE DOCTOR HAS EXAMINED  
YOU FULLY**



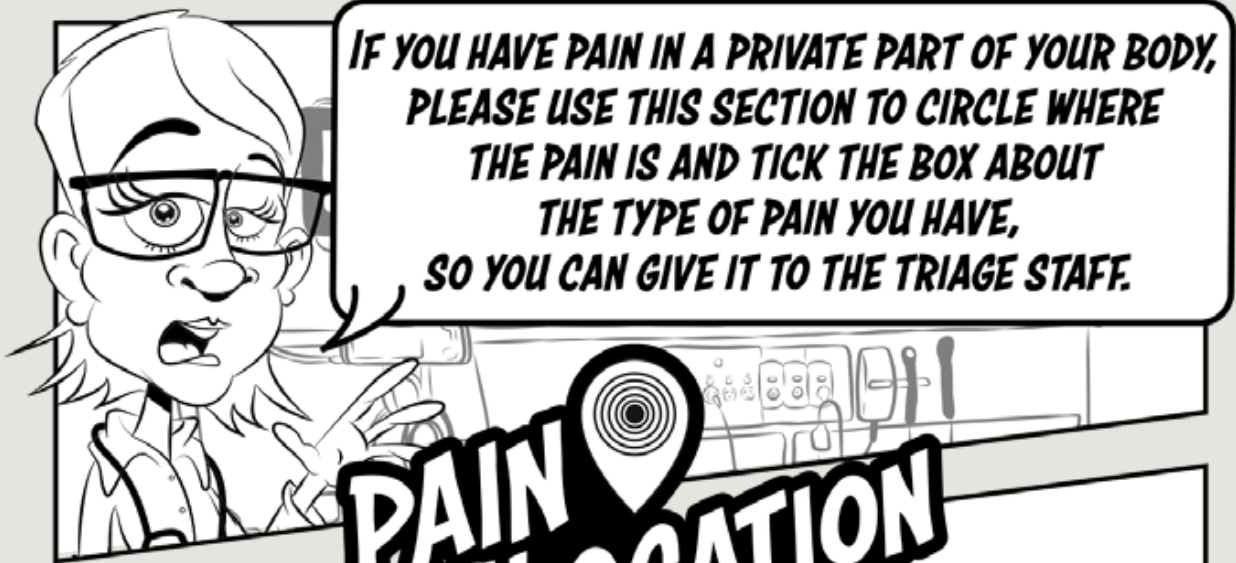
**YOU CAN MANAGE PAIN IN THE WAITING ROOM  
IN THE FOLLOWING WAYS:**

**APPLY A COLD PACK OR ICE TO REDUCE  
PAINFUL SWELLING AND INFLAMMATION**

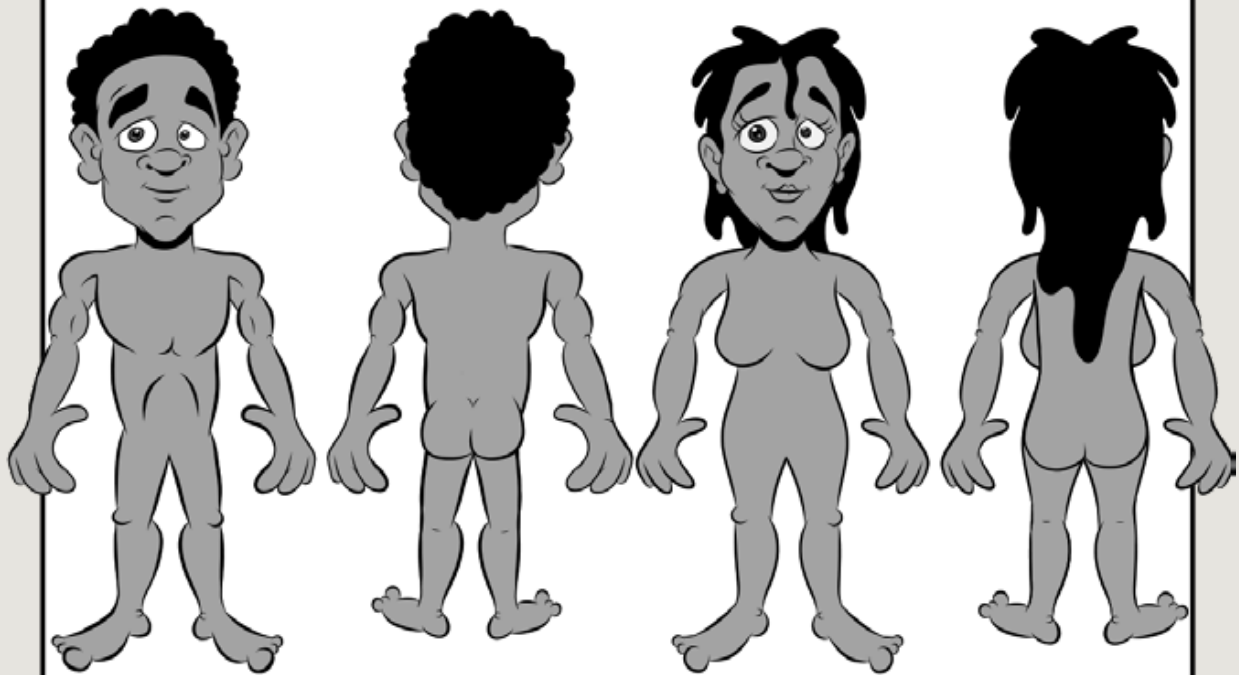
**LIMIT YOUR MOVEMENT**

**YOU CAN ALSO ASK THE NURSE FOR  
IBUPROFEN OR PARACETEMOL AT ANY TIME**





# PAIN LOCATION BODY MAP



## TYPE OF PAIN

- SHARP STABBING PAIN
- BURNING
- ITCHING
- THROBBING PAIN

OTHER \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**IT'S IMPORTANT TO  
REMEMBER THAT  
YOU ARE NOT  
ALONE!**  
**ASK THE TRIAGE STAFF  
IF YOU WANT SOMEONE  
TO SUPPORT YOU ON  
YOUR PATIENT JOURNEY  
LIKE AN  
ABORIGINAL HOSPITAL  
LIAISON OFFICER**

**PLEASE  
REMEMBER  
THAT** **PAIN** **IS A SIGN THAT SOMETHING IS  
WRONG WITH YOUR BODY AND  
YOU NEED HELP**

**SO YOU MOB,  
YOU WILL NEED TO BE ABLE TO SHARE  
YOUR PAIN EXPERIENCE,  
SO GET PREPARED FOR THE ED  
TO ASK QUESTIONS ABOUT YA PAIN  
AND BE READY TO ANSWER THEM**



# Final Word

**Good communication is one of the most important survival skills we have available to us, particularly in life-or-death situations or crisis situations (CDC 2019).**

Human beings are imperfect communicators and, in stressful times, imperfect communication can generate conflict (Howatt 2019). In ED settings, conflict isn't necessarily a bad thing; important ideas and information are often embedded in the experience of conflict and much good can come from the experience. Good communication skills don't develop from avoiding conflict, but they do help avoid unnecessary conflict. During this project, we have tried to address the issue of miscommunication head on and have learned a lot along the way.

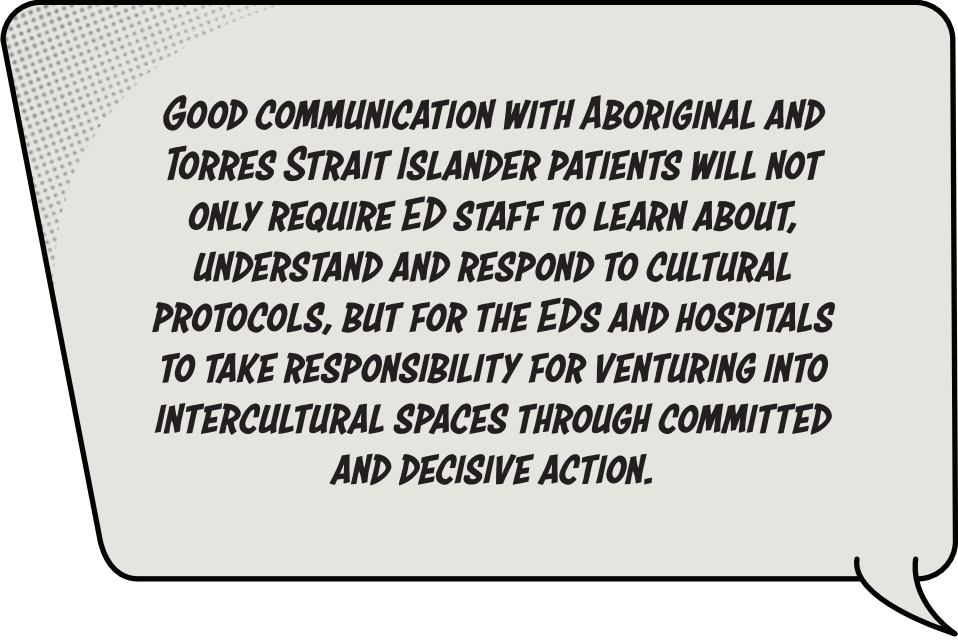
The resultant comics from this project are, for now, confined to this report. We have not yet facilitated the development of distribution channels and referral pathways to give these comics meaning, nor have we developed in-house training opportunities to support emergency staff to meet the needs of Aboriginal and Torres Strait Islander patients and their families and carers through the development of this work. We are yet to identify whether the comics meet the expectations of patients, referral agencies or staff. In future projects, we hope to interrogate whether these do meet the needs of everyone on the patient journey by interacting with the messages contained in the comics themselves.

We all know the importance of catching miscommunications early. Yet in ED settings, particularly in a COVID-19 environment, there is little time or space to consider how the issue can be dealt with, particularly as much of the comics' content is directed toward pre-ED contexts and settings. Effective communication and reducing miscommunication will require the ED to extend its realm of influence into the community it serves.

We also understand that communications easily and inevitably go awry. Spotting miscommunication early, and having a coordinated, regional approach to addressing the miscommunication in ways that benefit staff and patients, are key (Yashadhana et al. 2020). Coordinated approaches enable patients to manage potential resentment, fear and frustration about waiting times and pave the way for going over or preparing for possible points of contention in the patient journey. Inevitably, we want patients to experience empowerment in communicating their needs, and hope that this work will go some way to making that happen.

There are often clues that the ED staff have not communicated to patients in ways that they understand. These clues are often non-verbal and can include unexpected emotional reactions, blank stares or indecisiveness from patients on decisions that need to be made. Staff may also have their own internal sense that they have just spoken into a vacuum, or that patients are saying yes even though the issue (e.g., informed consent for anaesthesia) is not well understood (CDC 2014). We have tried to keep in mind that these communication patterns are clues, not evidence. We also know that when a staff member asks the patient to help communicate well, the quest for clear communication is seen as a collaborative experience (Newell & Jordan 2015). This approach is a fundamental underpinning to 'two-way communication'.

We have identified the many factors that contribute to miscommunication and to communicating effectively. Differences in culture, age, family roles and responsibilities, gender, mood, listening styles and assumptions significantly affect our ability to speak or to listen effectively. In the consultations, we heard stories about staff having mistakenly assumed, for example, that someone who is making eye contact has clearly heard everything that has been said to them. Conversely, someone who avoids eye contact may not be ignoring staff members but are actually listening keenly (Queensland Government 2015).



**GOOD COMMUNICATION WITH ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS WILL NOT ONLY REQUIRE ED STAFF TO LEARN ABOUT, UNDERSTAND AND RESPOND TO CULTURAL PROTOCOLS, BUT FOR THE EDS AND HOSPITALS TO TAKE RESPONSIBILITY FOR VENTURING INTO INTERCULTURAL SPACES THROUGH COMMITTED AND DECISIVE ACTION.**

When miscommunication occurs, we urge on the side of empathy (McKee & Wiens 2017). We would encourage staff and patients to be sympathetic, not accusatory. It helps to remember that the greater duress people are under, the harder it is for them to communicate. We say this because good communication involves more than technique; it also involves attitude. Taking on the work of creating culturally safe and effective communication tools is best achieved through processes – ones that recognise the essence of our family and community relationships and why we present, and facilitate that experience with as much dignity and camaraderie as possible – as part of ED staff commitment to continued quality improvement. Communication remains one of the greatest sources of difficulty and hope in dealing with serious situations (Nancarrow et al. 2013).

We have learned, as we hope that different EDs across Australasia are prepared to learn, that communication takes time to cultivate. It requires deep listening to the needs and desires of people who are often underserved or over-represented in emergency departments to determine what could make their experience better. Good communication with Aboriginal and Torres Strait Islander patients will not only require ED staff to learn about, understand and respond to cultural protocols, but for the EDs and hospitals to take responsibility for venturing into intercultural spaces through committed and decisive action. Not only will this meet the aspirations of people working in EDs to respond to their patients more effectively and empathetically, but it will also activate the *United Nations Declaration on the Rights of Indigenous Peoples* (UN 2007), and other human rights covenants around the globe, which for many people during this pandemic have not been available or have been denied. For them, we must make every effort to address miscommunication, achieve equity and enhance access to EDs the world over.

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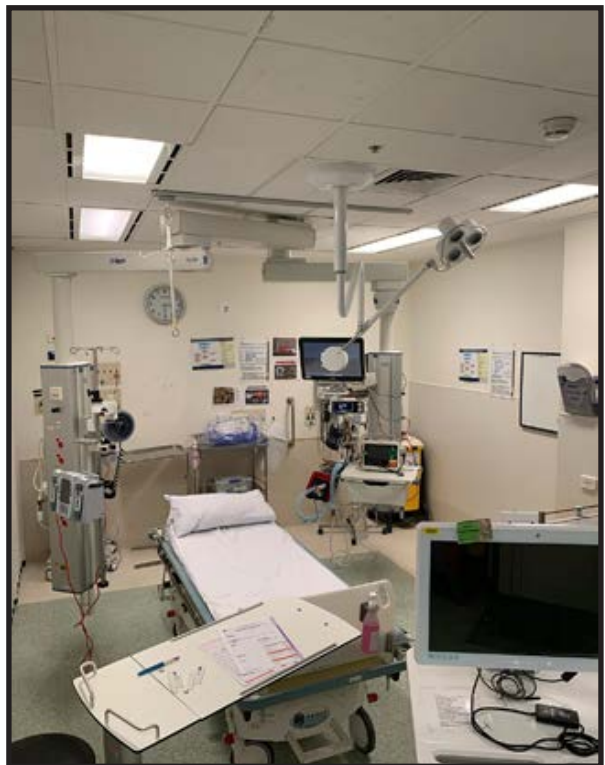
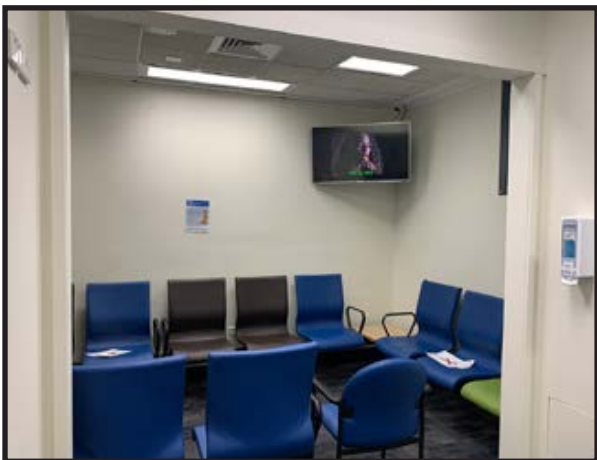
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# Appendices

## Appendix A: Photos from St Vincent's Hospital Melbourne emergency department

The following images are photos of St Vincent's Hospital Melbourne's ED taken by Dr Jennie Hutton, Emergency Department Physician at SVHM. They detail what a patient's journey through the ED looks like. There are images of the ED waiting rooms, the reception area, nurses in PPE and the treatment rooms.





## Appendix B: Example of designing illustrations

### Design process for Comic 1: Focusing on what to expect at SVHM's ED

As we know from findings in *Traumatology Talks*, one of the most common causes of patients leaving the ED without being seen is because of the long waiting period they commonly have to experience. Thus, when developing Comic 1, we decided to focus on explaining the process of being triaged and admitted. There is an expectation by most patients who come into the ED that they will be seen by a doctor quickly or in the order in which they arrived. When this expectation is not met, this can lead to frustration because patients do not know the process of the ED, and staff are usually too busy to provide support. Developing an illustration that shows patients what happens on the ED journey will help them be better informed of, and prepared for, what to expect.

### Explaining the ED process

Extensive work has been carried out across Australia and internationally to improve patient flow through the ED as a way of optimising care. When patients present to the ED, their first point of contact is usually triage where they will be placed in a category according to the Australasian Triage Scale (ATS) from 1–5. The ATS is a ‘clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient’ (ACEM n.d.). This tool ensures that patients are treated in order of their clinical urgency, ranging from Category 1 (an immediately life-threatening condition requiring immediate treatment) to Category 5 (a chronic or minor condition which is treated within two hours) (ACEM 2016).

**Table 1: Australasian Triage Scale**

Australasian Triage Scale Category	Treatment Acuity (Maximum waiting time for medical assessment and treatment)	Performance Indicator Threshold
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

Patients' arrival time will be recorded when the triage assessment starts. The Performance Indicator Threshold illustrates the percentage of patients who commence assessment and treatment within the relevant waiting time. Once patients are triaged (and if they do not require immediate treatment), they will usually see an administration staff member who will take down their details, such as Medicare number, address, phone number and next-of-kin. Patients will then be directed to wait in an appropriate waiting area. If the patient's condition changes or worsens while waiting, the patient should be re-triaged.

At SVHM, during the COVID-19 pandemic, patients will first see a concierge who will check them in, give them a mask and take their temperature. Patients will then proceed to triage. Once triaged, they will visit a clerk who will take down their administrative details. Patients will then be directed to one of the waiting areas. All patients who identify as Aboriginal and/or Torres Strait Islander will be automatically triaged as a Category 3 or more urgent.

There are various patient models of care in EDs in Australasia. Some examples of newer models outlined in ACEM's ED Design Guidelines include:

- ▶ **Rapid Assessment Team:** This is a dedicated team made up of medical, nursing and ancillary staff who carry out an assessment of patients (usually those deemed acute/major) at triage, on arrival. This team may be mobile in the acute area of the ED or based in a dedicated area. Although this is a resource intensive model, it is recognised as an 'efficient way of early assessment and investigation/therapeutic instigation' (ACEM 2014:9). This is the patient model of care implemented at SVHM.
- ▶ **Medical led triage:** This is where patients are assessed on arrival by a doctor (ideally senior) instead of a triage nurse. This assessment may take place in the waiting room, at reception or within the triage area of the ED.
- ▶ **Medical led triage and nursing assessment team:** This model involves a senior Emergency Physician working alongside the triage nurse(s) and/or Clinical Initiatives Nurse to 'augment the triage process with early disposal decisions and investigation instigation' (ACEM 2014:9). This team is based in the triage and ambulance assessment area.

- ▶ **Dedicated Assessment Areas:** Some EDs have a dedicated area for acute/major patients who may have been brought in via ambulance or have self-presented, and have been streamed to this area. These areas may be purpose built to accommodate for multi-disciplinary teams or they may be a re-allocation of existing treatment spaces. Dedicated Assessment Areas 'should be staffed for a rapid turnover of patients with suitable appropriate outflow areas' (ACEM 2014:9).

The next step in the ED process is for patients to be transferred to the most appropriate area for further medical and nursing assessment, treatment and investigation. This may include pathology testing, medical imaging and dispensing of medicines. Patients may be seen and treated by other relevant medical or allied health professionals, and Hospital in the Home Services may be arranged. Once this has taken place, patients will either be admitted to an appropriate ward, assessment unit or short stay unit, taken to a transit lounge, discharged or, in the event of death, taken to the mortuary (ACEM 2014).

To assist the illustrator in developing the comic about the ED process for patients, the following key activities should be considered:

- 1 Speak to triage nurses and other ED staff to understand the range of questions patients are asked at triage and how staff interpret patient presentations in allocating different triage categories (e.g., experience of pain, broken bones, mental health).
- 2 Understand how and where patients will be waiting – particularly in COVID-19 environments.
- 3 Explain the roles and responsibilities of key staff in the ED.
- 4 Describe the different places patients will be waiting until they are seen.
- 5 Identify the different communication strategies that are needed to support patients in communicating their issues, particularly if they have 'private concerns' that cannot be shared in public.
- 6 Stage photos and do audio recordings of waiting rooms and EDs.

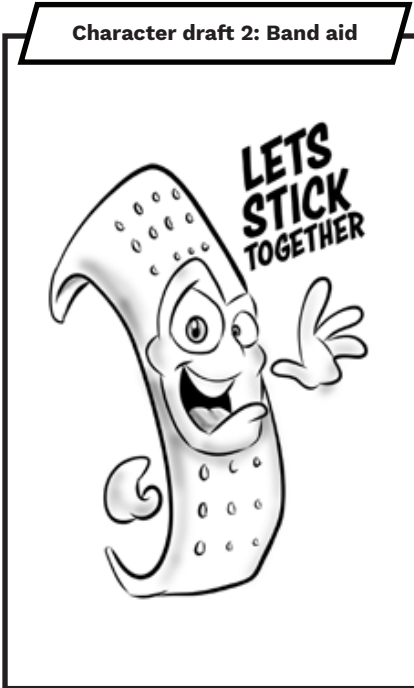
**Figure 2: Pathways that a patient may follow on arrival at the Emergency Department (ACEM 2014)**



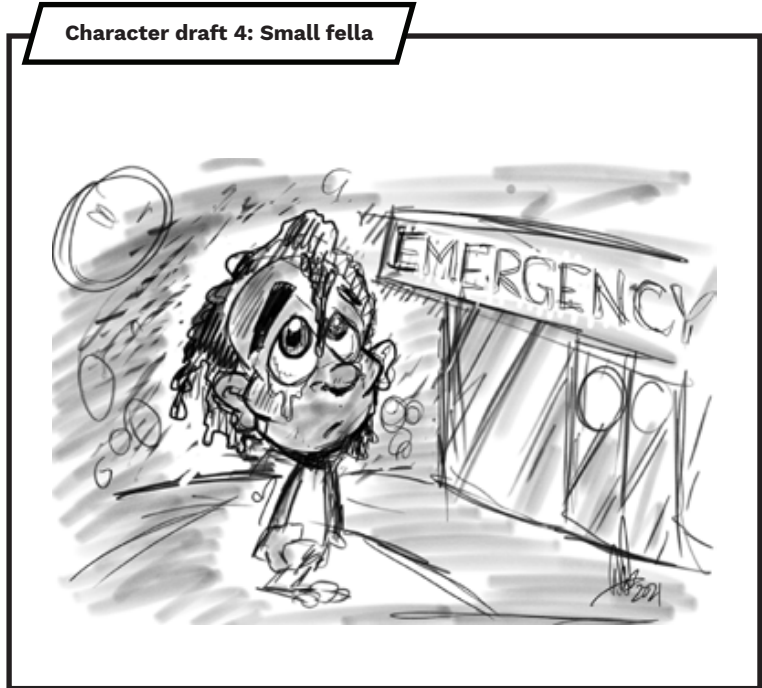
## Character development

Examples of other characters developed for Comic 1:

Character draft 2: Band aid



Character draft 4: Small fella



Character draft 3: Kookaburra



Character draft 3A



Character draft 3B



Character draft 3C

Appendices (cont.)

Character 5: The Captain



Character draft 5A



Character draft 5B



## Appendix C: Sample of scripts

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### Script for process: What to expect at the emergency department at St Vincent's Hospital Melbourne

Emergency Departments (EDs) are busy, noisy, chaotic places to visit, especially when you are stressed or accompanying a patient. They are open 24 hours a day and are available to anyone who needs them.

At different times through the week and the year, there will be different reasons why people come to an ED. Sometimes after a sports day, people will come with broken bones, head injuries or concussion. During holidays, there may be car, swimming, or skiing accidents. Some seasonal changes mean people come to the ED with asthma or pneumonia. Some people experience homelessness and want shelter and support. In big cities, people will always come in with heart attacks, drug overdoses or mental health issues. Now, people are in the ED because of COVID-19. It is important to wear a mask in the ED so you and your family can be safe.

The busiest time in an ED is night time. There are lower levels of staff than during the day. It is during these busy times where you can be expected to wait. Sometimes you can wait a long, long time. Waiting is hard, especially if you have children with you or you are scared, worried and feeling more and more frustrated. It is important to know if you feel unsafe, unseen and not listened to you can ask any staff member to see or call an Aboriginal Hospital Liaison Officer to keep you company, or to be your advocate.

You will be hearing people having conversations – some might swear or be in pain, some may ramble, and others will be crying. Staff will be coming into the waiting room in the ED calling out people's names. You may hear screams from inside the ED or feel shame hearing someone explain private matters to a triage nurse. It is a very emotional time for patients and their carers and can sometimes be scary if you are alone or in pain.

If you have been using illegal drugs and see a police officer, you might feel afraid they will take you away. You need to know that all people in the ED respect your need to access health. You cannot be taken away from

the waiting room by police. But, if you or someone in the waiting room or ED becomes violent, security guards can have you removed, or remove others from the waiting room.

Information is limited, the seats are uncomfortable and while there is a television in the waiting room, sometimes it is easier to wait outside near the pond. You need to let people know where you are and keep coming back in to check when your turn is coming.

Inside the waiting rooms and in the ED, there are some things you can see, and others you can't see. You can see a triage nurse and you will see other people in the waiting room. Some of them might even be called up before you to see a doctor, even though they arrived later than you. That is because the triage nurse has taken their vital signs and they have been assessed as having more clinical urgency to see a doctor.

You can't see the ambulances lining up at the back of the ED bringing in patients, you can't see police and prison officers bringing in people who need treatment and care, and you can't see how many doctors and nurses will be working on a patient to help them stay alive. You can't see if a machine has broken down, or if a staff member is sick on the roster and everything else backs up. The things you can't see will affect your time at the ED. There is no way to bypass the system.

Let's remember what is important for you in the ED:

- 1** The hospital and staff have a duty of care in triage, in the waiting room and in the ED. You have a right to have your health needs met.
- 2** Everyone should be asked if they identify as Aboriginal and/or Torres Strait Islander. This is a positive question to be asked, to make sure you can access the best care and resources.
- 3** You are going to get asked the same questions time and again, by different people on your way through your ED journey (Name, DOB, Allergies). There are about 5 or 6 questions that you will be asked to answer for yourself, or on behalf of a child or a person in your care. People ask you these because it is part of the ED's duty of care. You should feel very empowered to answer these questions.

## Appendices (cont.)

Some of the staff you will meet along the way are:

- ▶ Triage nurses
- ▶ Concierge
- ▶ Security guards
- ▶ Rapid Assessment Team
- ▶ Aboriginal Hospital Liaison Officers
- ▶ Doctors and nurses
- ▶ Assessment, Liaison & Early Referral Team.

You will meet a triage nurse. They are going to ask you direct questions in public spaces about why you are coming to the ED. There are lots of questions they may ask you that you may feel uncomfortable about or you may feel too rushed to answer. It is important to be clear about why you are arriving at the ED. This is the person who will be making an assessment about what category of sickness you have and how long you will have to wait. They may ask questions such as:

- ▶ Why have you come today?
- ▶ Do you have pain?
- ▶ Where do you have pain?
- ▶ On a scale of 1–10, how is your pain?
- ▶ Are you on medication?

You might have a couple of problems you are presenting with; they are looking for the **priority problem**. Which problem is the worst one for you? Another way to think about this is what can you tell them, in the shortest amount of time, that can get you seen sooner rather than later?

Sometimes you will give an answer to a triage nurse, or you have asked for ibuprofen or paracetamol to manage the pain before going to the waiting room. It could happen that they will go away from the desk while you are still standing there, sometimes for up to 15 minutes! They are not being rude or have forgotten you, they have had to go to their supervisor to make sure that they are able to give you pain relief or they have to talk with a colleague to get a second opinion. Trust us on this one, they will come back to you. It is part of the process to keep you safe.

There will also be a security guard. Their job is to support a positive relationship with staff and clients. They are employed by the hospital and have an obligation to create a trusting environment while always maintaining confidentiality. They have a role and responsibility in emergencies as well as performing other tasks. These positions are essential for safety.

There is a concierge who is not a health professional but who can be an advocate for patients in a waiting room. This person can support you by checking on you, making sure your vital signs are checked and any other non-medical information needed for you to have a positive experience. They can make phone calls for you and can refer you to other people in the hospital system that can help you.

Doctors and nurses in the waiting rooms usually introduce themselves as the Rapid Assessment Team. They may ask you to come to a cubicle or a room to do another assessment. This is usually a quick assessment where you might be asked to go back to the waiting room.

The Rapid Response Team is a group of doctors that respond to medical emergencies around the hospital. This team is activated when someone deteriorates and is there to coordinate transportation to other parts of the hospital including the Intensive Care Unit, Operating Theatres or Radiology.

There is also an ALERT (Assessment, Liaison & Early Referral Team) who are there to assist with providing coordinated care for patients who have social barriers to accessing care. Just explain your situation – e.g., you are unwell, and you have children at home who can't be cared for by anyone else, you are experiencing homelessness and have nowhere to be discharged to, you have been removed from a family violence environment and need to take yourself and your family to safety. This team usually operates between 8.30am–9.00pm, 7 days a week. You can ask the concierge to see the ALERT to help you make the best decisions for your situation.

There are not often Aboriginal or Torres Strait Islander staff members in EDs. You can ask the triage nurse or someone in the waiting room to call the Aboriginal Hospital Liaison Officers (AHLOs) for you. You can also ask to see an AHLO after you have identified as Aboriginal or Torres Strait Islander. 'Do you identify as an Aboriginal or Torres Strait Islander person?' 'Yes... and can I please speak to the AHLO?' You can speak to the AHLO, or ask for them to come and see you if:

- ▶ You need to arrange aftercare
- ▶ You feel like leaving the ED rather than staying
- ▶ Your kids are getting tired and hungry in the ED
- ▶ You have a child with you who is well, but can't come with you when you go into the ED.

There are many reasons why our mob gets triggered in an ED and in a waiting room. You may see prisoners (in shackles) or see someone having a mental health episode, or someone might have to be restrained by the security guard. Just know that you do not have to leave without being seen, there are lots of ways you can be supported.

You will be moving through ED services all the time. It is important to know that you will be in different places on your journey through the ED.

The first place is the Triage Desk – where you will be asked why you have come to the ED and what sort of priority issue you have.

You will also be waiting in different areas of the ED, some will be outside (the pond), others will be in the main waiting room, or in a cubicle (a bed with a curtain) or in a closed room.

You may need to move in between these places and spaces to see different professionals, who will all ask you the same questions. If you are worried or experience anxiety about any places where you have been asked to wait, let someone know. Just sing out, or ask to see an AHLO, a nurse or the concierge who will be able to help.

You will be seen, there is no doubt about it. Just answer the questions to the best of your ability, ask people for help along the way, and if you need to discuss something in private, make sure you ask for someone to listen in ways that you feel comfortable. People have a duty to look after you, and to help them help you, use your big voice, answer questions honestly and be proud that you are taking care of yourself, or those you care about on your journey through the ED.

### **Script for content: How to communicate pain**

#### **What kind of pain do you have? Can you tell someone about your pain?**

Pain is an uncomfortable sensation in your body. Pain can range from annoying to crippling. It may feel like a sharp stab or dull ache. Pain can also be described as throbbing, pinching, stinging, burning or sore.

You will be asked questions about your experience of pain when you get to triage. The questions help the triage staff understand if you need to see a doctor immediately or if you can wait in the waiting room. It is important for you to know how to let emergency department staff know what pain you have and where. There are different kinds of pain:

- ▶ Chronic pain – with ongoing sensations that last for months or years
- ▶ Pain that stops and starts
- ▶ Acute pain – a sudden pain that only lasts a short period of time.

Pain may affect a specific part of your body, like a toothache or a stomach cramp, or it could be an all over feeling such as the body aches you can get with the flu.

Pain lets us know when something is wrong. Some pain is easy to diagnose and can be managed at home. Other types of pain are signs of serious health conditions that require medical attention to treat. If you are worried about being overheard when you have pain in private parts of your body, look over this guide to see how you can share your experience of pain without being shame! The better you can tell the staff at the ED about your pain experience, the better they will be able to help you.

## Appendices (cont.)

### What causes pain?

Pain is clearly caused by a specific injury or medical condition. In other cases, the cause of the pain may be less obvious or unknown.

Some common causes of pain include headaches, toothaches, sore throats, stomach pain, muscle cramps, cuts, burns or bruises or bone fractures. You may develop other symptoms as well and these may include fatigue, swelling, nausea, vomiting or mood changes.

It's possible to experience more than one type at the same time. If you're in pain, identifying the type of pain may help the triage staff give advice to the emergency staff.

If you are asked: What kind of pain do you have?  
You can say one of the following:

- ▶ I have **acute pain**. To describe this type of pain, you can say:
  - It feels sharp
  - It came on quickly
  - I had an accident, or I have an injury (a cut, a burn, a muscle sprain, a fracture)
  - I had a medical procedure – injections, dental work, surgery.
- ▶ I have **chronic pain**. To describe this pain, you can say:
  - It has lasted a long time
  - It comes and goes and can last for months or years
  - I have a health condition that gives me pain (arthritis, chronic migraine, cancer)
  - I have medication I take to lessen the pain (sometimes it is good to bring your medication with you so you can show the doctor).

- ▶ I have **physical pain**. There are a couple of ways to describe physical pain:
  - I have pain because of damage caused to the skin, muscles, bones, or other tissue (injury)
  - I have pain that shoots down my arms, or legs, or through my back. I have a burning sensation in my body. I have feelings of pins and needles, weakness, tingling, burning or freezing, stabbing pain or electric shocks through my body.
- ▶ I have **pain from a medical condition** – you can say the medical condition you have and the types of pain you can have. Something like this:
  - I have diabetes which causes pain and numbness in my legs and feet, stomach problems, urinary tract infections, blood vessels and heart
  - I have irritable bowel syndrome, which causes abdominal pain
  - I have heart trouble, which causes chest pain or pain down my arms.

### When to seek help

Seek medical attention for your pain if it's:

- ▶ the result of an injury or accident that may have caused substantial damage to your body, including severe or uncontrollable bleeding, broken bones or a head injury
- ▶ an acute and sharp internal pain, which may be a sign of a serious problem such as a ruptured appendix
- ▶ located in your chest, back, shoulders, neck, or jaw and accompanied by other potential signs or symptoms of a heart attack, such as pressure in your chest, shortness of breath, dizziness, weakness, cold sweats, nausea or vomiting
- ▶ interfering with your day-to-day life, including your ability to sleep, work, or take part in other activities that are important to you.

### How is pain diagnosed?

If you seek medical attention for your pain, be prepared to describe the pain specifically, including when it started, when it is most intense, and whether it is mild, moderate or severe.

The triage staff member will be looking at your body or your face for signs of how severe or urgent the pain is. They will likely ask you these types of questions:

- ▶ Is pain the reason you are presenting today?
- ▶ How is the pain affecting you right now?
- ▶ What kind of pain is it? (Sharp, dull, all over, specific part, private part)
- ▶ Where in your body are you feeling the pain?
- ▶ Do you have other symptoms?
- ▶ Are there triggers that make the pain worse?
- ▶ Have you been diagnosed with health conditions? Which one(s)?
- ▶ Have you had any recent injuries or illnesses?
- ▶ Have you recently changed your diet or exercise routine?
- ▶ Are you taking medications or supplements?
- ▶ On a scale of 1 to 10 (with 10 being severe pain) where are your pain levels at?

Depending on your symptoms and medical history, the triage staff will make a decision about how quickly you need to be seen by the emergency department staff. They will be noting signs to show how much pain you are experiencing. They may be looking at your face to see if you have been crying, they can look at your hands to see if you are holding a part of your body, they may watch how you walk up to the counter to be served and check your mobility, you may have elevated breathing or be wincing in pain.

### How is my pain treated in an ED?

If you have pain that's caused by an injury, you might need medication, surgery, or other medical attention.

If your pain is caused by an infection, you might need medication or other treatments.

If you have a chronic health condition such as arthritis, cancer or chronic migraine, your doctor might prescribe medication, surgery, or other therapies to help treat it.

Staff in the ED might also recommend treatments to ease the pain itself. For example, they may recommend or prescribe:

- ▶ Over the counter pain relief such as Panadol, aspirin or ibuprofen
- ▶ prescription anti-inflammatory drugs
- ▶ opioid medication which may be prescribed for acute pain following an injury or surgery
- ▶ physical therapy, which may help relieve pain caused by injuries or certain health conditions such as arthritis or multiple sclerosis.

Triage nurses and other emergency department staff will need to consult a doctor before giving you a treatment of any kind. Even for a dose of Panadol. They will not be able to give you something stronger until a full assessment is complete. You can manage pain in the waiting room in the following ways:

- ▶ apply a cold pack or ice to reduce painful swelling and inflammation caused by injuries or chronic conditions such as arthritis
- ▶ apply heating pads to ease muscles stiffness, soreness or cramps
- ▶ limit or avoid certain activities or triggers that make your pain worse.

## Appendices (cont.)

### The takeaway

As always, you are able to ask the triage staff to have access to someone to support you on your patient journey, an Aboriginal Liaison Officer, the Patient Experience Officer and or the Rapid Assessment Team.

If you are worried about privacy issues, you can ask to speak to someone in private, or hand them the picture of what is happening for you. If you have pain in a private part of your body, please use this section to circle where the pain is and tick the box about the type of pain you have, so you can give it to the triage staff.

Pain is a sign that something is wrong in your body.

You need to be able to share your pain experience, so have a look at the questions and have an answer ready for them!

### Script for experience: Bringing children to the Emergency Department

Sometimes when we have an emergency, we must make the decision about whether we should bring our kids along with us. Some carers might need to leave their children at home then come in late at night when they are sleeping in the hopes they can be seen quickly. Others will leave their kids at home and then leave the hospital without being seen, because they want to get back home to them. Some people don't want to bring their kids in for fear they will be taken away from them, or they know the kids will muck up in the waiting room. There are lots of reasons why Booris will be in the waiting room:

- ▶ They are feeling unwell
- ▶ Their brothers or sisters are sick, and they are there as a family
- ▶ Maybe their parent or carer is sick
- ▶ Maybe someone is getting palliative care and they are on their way to the Dreamtime
- ▶ Some may have experienced family violence and they are in the waiting room to be safe.

Some kids will be scared, overwhelmed or their emotions will be running high because they are terrified of the place, and they are worried for the person needing treatment. Sometimes we don't tell kids what is going on, and we forget to involve them in knowing what is happening.

Don't worry, though, here are some handy tips for you to help our kids in the waiting room:

- ▶ First, we know that you cannot bring a child into the emergency room with you if you are needing treatment, but there are ways to make sure kids in your care are OK while they are waiting.
- ▶ If you know you are going to be there for a while, make sure the kids have something they can use to entertain themselves. Try colouring books, pencils and children's shows they can watch on your phone.
- ▶ Try to bring snacks from home. Cafeteria snacks can get expensive!
- ▶ Bring a pillow and a blanket or a toy they like so they can have something to hold onto. It gives them a sense of security. Make sure you can go for a walk around outside to get rid of some extra energy.

If you are unwell and don't have any support to help you with your kids, here's a few things to help you on your way:

- ▶ Kids can wait with the nurses in the nursing station. They might get bored though, so it is always good to have something with them to keep them entertained.
- ▶ You can ask to speak to the AHLO when you arrive. You can explain to them that you need support to care for your kids while you are at the hospital.
- ▶ They can work with you to make the phone calls you need to make sure your kids are safe, and then the person who needs the help can get help.
- ▶ Tell the triage nurse you are an Aboriginal or Torres Strait Islander person. At SVHM, they have changed the waiting time for our mob, to get us in and out as fast as they can.

If you need to leave because you haven't got access to child care, tell the triage nurse or the Patient Experience Officer or someone else on the team. It is important for you to let us know so we can find other ways of helping you and helping our Boori feel safe!

## Appendix D: Key stakeholders identified

Category	Organisation	Individuals
Service providers	ACEM	Indigenous Health Committee
	ACEM	Reconciliation Action Plan Steering Group
	SVHM	Deborah Barnes
	SVHM	Dr Jennie Hutton
	SVHM	Indigenous Health Equity Working Group
	The Royal Children's Hospital Melbourne	Selena White
	Western Health	Tanya Druce
	VACCHO	Moira Rayner
	VAHS	Emmie Lidis
	VAHS	Christine Ingram
	St Johns Ambulance NT	Kaitlyn Krahe
	Cairns and Hinterland Hospital and Health Service	Tileah Drahm-Butler
	VACCA (Victorian Aboriginal Child Care Agency)	Kerry Brogan
Aboriginal and Torres Strait Islander community members	cohealth	Rhonda Di Blasi
	Birrarung Council	Jesse Pottage
	Birrarung Council	Fiona McConachie
	Nairn Marr Djambana	Kerry Strickland
	Nairn Marr Djambana	Leanne Pearson
	Mullum Mullum Indigenous Gathering Place	Elke Smirl
	Aboriginal Housing Victoria	Shaun Middlebrook
	Aboriginal Housing Victoria	Samantha French
	Women's Housing Limited	Lindy Parker
	Deaf Indigenous Community Consultancy	Jody Barney
	Watnanda Consulting	Judith McDonald
	University of Melbourne	Catherine Chamberlain

## Appendices (cont.)

### Appendix E: List of consultation participants

#### Co-develop content of the illustrations

Roundtable	Attendees	Role and Organisation
<b>Roundtable 1</b> 3/11/21	Dr Glenn Harrison	Aboriginal FACEM, Co-Chair of Indigenous Health Committee, ACEM/The Royal Melbourne Hospital
	Simone Soderlund	Associate Nurse Manager in ED, SVHM
<b>Roundtable 2</b> 8/11/21	Indigenous Health Equity Working Group members	SVHM

#### Feedback of draft illustrations

Roundtable	Attendees	Role and Organisation
<b>Roundtable 1</b> (Service Providers) 25/1/22	Tanya Druce	Manager of Aboriginal Health, Policy and Planning (Wilim Berrbang), Western Health
	Moira Rayner	Senior Project Officer, VACCHO
	Tileah Drahm-Butler	Social Worker, Cairns and Hinterland Hospital and Health Service
<b>Roundtable 2</b> (Community members) 28/1/22	Elke Smirl	CEO, Mullum Mullum Indigenous Gathering Place
	Jody Barney	Director, Deaf Indigenous Community Consultancy
	Elizabeth Temple	Translator for Jody
	Judy McDonald	Watnanda Consulting
<b>Roundtable 3</b> 31/1/22	Indigenous Health Equity Working Group members	SVHM
<b>Phone call</b> 1/2/22	Dr Liz Mowatt	FACEM, Co-chair of ACEM's Reconciliation Action Plan Steering Group and Emergency Physician at Cairns Hospital



## Appendix F: Feedback received from consultations

Three workshops were held to obtain feedback on the draft comics both from ED service providers (including those involved in the referral pathway) and from Aboriginal and Torres Strait Islander community members. We also received written and verbal feedback from service providers such as ED nurses, doctors and paramedics who were unable to attend the workshops.

This section is structured to present the feedback received from each stakeholder group. The common themes and variations that can be seen from each group are presented in a table format for ease of comparison. We were able to obtain feedback by page with some stakeholder groups, whereas others provided general feedback on the comics.

### Comic 1 draft: What to expect at St Vincent’s Hospital Melbourne Emergency Department

Stakeholder groups	General comments
Workshop 1 Service providers	<p>Considerations should be made around disabled communities, those with hearing/vision impairments, mental health issues, and low reading/literacy levels so the comic includes everyone and not just the mainstream population. These factors would likely impact access to the resources. Maybe there is potential to create different volumes of the comics to cater to different groups?</p> <p>If using/referencing specific totems, permission needs to be sought from local land councils/ Traditional Owners.</p> <p>Need to cut down on wording and specify in the front of the comics that the resources are specific to SVHM.</p> <p>It would be good to see more female representation and diverse representation in the comics (female doctors).</p> <p>It is important to reflect the diversity of SVHM’s staff (different looks, colours etc.).</p> <p>Resources can be made downloadable on the SVHM/ACEM website and distributed widely around Victorian ACCHOs. They can also be tailored to become resources for the Aboriginal health care workforce to support their mob in a hospital setting.</p> <p>There is opportunity for staff training in this space.</p> <p>The chaos of the ED is reflected well.</p> <p>The comics are fantastic resources and capture the ED experience in a realistic way. A lot of the comic content is readily transferable to the ‘pre-ED/pre-hospital setting’.</p> <p>If a patient requires urgent or emergent care, there may not be time for these resources to be disseminated and read, and it may not be appropriate.</p> <p>Considerations around providing these resources to an older person, would they feel infantilised by being given a comic?</p>

## Appendices (cont.)

Stakeholder groups	General comments
<p><b>Workshop 2</b> Community members</p>	<p>Need to involve ACCHOs who have a direct pathway to SVHM in the consultation process.</p> <p>Smaller rural hospitals (e.g. in Wodonga–Albury) have AHLO Transition Officers, is there a similar position at SVHM?</p> <p>The current iteration of the comic doesn't reflect the COVID-19 environment in the ED.</p> <p>Include cleaners when describing the ED environment.</p>
<p><b>Workshop 3</b> SVHM IHEWG</p>	<p>Comic needs to be illustrated by an Aboriginal artist.</p> <p>The comic is quite detailed and busy, patients who are in distress or unwell may not be able to comprehend the information. The comic needs to be simple, mainly visual and grab attention quickly.</p> <p>The comic is too wordy and won't be attractive to Aboriginal people to pick up.</p> <p>It is a good resource to have in the community.</p> <p>There is scope to have more content if the comics become an animation, but there is not much use with paper resources in the ED, it often ends up on the floor.</p> <p>Some patients are illiterate, it would be good to include more pictures and less words.</p> <p>There needs to be clarity around how it will be used and distributed.</p> <p>There are a lack of ethnicities and gender represented. There are also concerns about how Aboriginal people are depicted.</p> <p>Queries around anatomical correctness (characters are drawn with 3 fingers and a thumb).</p> <p>The resource should be applicable outside of COVID-19 environments so that if a patient picks it up in 6–12 months' time, it will still be largely accurate and applicable. Could potentially develop a COVID-19 applicable sheet that can be inserted into the main comic.</p> <p>The purpose of the comics needs to be clarified, i.e. for ACCHOs or EDs to disseminate; this will assist with prioritising which content remains in the comics.</p> <p>Hospital processes change rapidly, so for a tool to be sustainable it would be better to take a broader approach to the content.</p>

Page	Stakeholder groups	Comments
Page 1		



**Workshop 1**  
Service providers  
Change use of ‘me’ in ‘Let old mate wedge tail take you under me wing’ to ‘my’.

**Workshop 2**  
Community members  
Have the Wedge-tailed Eagle referred to as Bunjil (otherwise it doesn’t resonate with Aboriginal people, knowing how important Bunjil is).

Probably need to seek Traditional Owners/ Wurundjeri Council and First Nations groups and Elder endorsement (artwork needs copyright).

**Workshop 3**  
SVHM IHEWG  
The Eagle isn’t very Aboriginal-specific. Using Bunjil would make it more appropriate.

Page 2		
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**Workshop 1**  
Service providers  
This page is a little content-heavy, might be good to remove references to each of the roles/re-word.

Mention/portray security guards early on – they can be intimidating and may follow patients throughout their journey. They also advocate for patients at times. Make them look friendly and approachable.

Make it clear that ED stands for Emergency Department (maybe use E.D. for example), can remove ‘or as the locals call it’.

**Workshop 3**  
SVHM IHEWG  
Concerns that this page might set people up with an expectation of services that cannot be delivered. Described as ‘promisy’ – staff can’t sit in waiting rooms with patients and there are no volunteers to help out.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 3		
	<p><b>Workshop 1</b> Service providers</p>	<p>It is a good idea to include the words that everyone will get their turn.</p>
	<p><b>Workshop 3</b> SVHM IHEWG</p>	<p>The picture of the woman banging her head is insensitive and stereotypical. There are better ways of depicting someone with mental health issues.</p>
Page 4		
	<p><b>Workshop 1</b> Service providers</p>	<p>Remove 'big' in 'use your big voice' and change to 'use a loud voice.'</p> <p>Also emphasise that while staff have a duty of care to patients, patients also have rights and responsibilities in terms of treating staff respectfully – 2-way street.</p>



**Workshop 1**  
Service providers

The questions asked are confronting for Indigenous patients (probing). Many patients won't answer truthfully. People get embarrassed and don't want to tell the whole room. It would be good to acknowledge that the questions are difficult/confronting, and may make you feel a bit 'shame', but that it's OK to answer them truthfully.

It's important to include the different categories of triage – if people are waiting, staff can tell them which category they are and what that means.

**Workshop 2**  
Community members

Queries about the first point of contact (reception or triage nurse).


It would be good to have an Aboriginal concierge available.

**Workshop 3**  
SVHM IHEWG

In a COVID-19 environment, the process is that patients will see the concierge first, then triage, then clerk to get their details. Everyone gets a mask and gets sent to different waiting areas. Patients who need to check in, will receive masks and hand sanitizer. More steps need to be added to the comic.

Suggest to clarify why people are waiting in separate rooms to avoid discrimination issues.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 6		
	<p><b>Workshop 1</b> Service providers</p>	<p>Social workers need to be represented as they play an important role (in the ED in Queensland).</p> <p>It is not necessarily true that patients can trust that the hospital is only concerned about their health. If someone is drug affected, there is a duty of care to notify child protection services right away – there are circumstances where children are then removed. We don’t want to portray a false sense of security. Unless clinically relevant, some staff would prefer patients don’t disclose drug use to avoid these situations. Although medical professionals are only there to look after your health, they still have a duty of care to notify you.</p> <p>Change ‘but trust me you mob, this place is only concerned about you and your health’ to ‘but you mob, this place should only be concerned about you and your health’.</p> <p>Change ALOs to AHLO (Aboriginal Hospital Liaison Officers) as this is used in SVHM.</p> <p>Include the hours when AHLOs are available and on site (as done with ALERT team). They are available 8.30am–5pm Mondays – Fridays.</p>
	<p><b>Workshop 2</b> Community members</p>	<p>Specify when AHLOs are available.</p>
	<p><b>Workshop 3</b> SVHM IHEWG</p>	<p>Patients will have seen the concierge by the time they see the comic, and suggest removing the concierge.</p> <p>Patients can see the AHLO at any time; times should be given to manage expectations.</p> <p>Remove the inclusion of taking drugs, freaking out, seeing police.</p> <p>Social workers aren’t separately called, just the ALERT team.</p> <p>Clerks should be included as heroes.</p>

Page	Stakeholder groups	Comments
Page 7		



**Workshop 3**  
SVHM IHEWG

Rapid Response Teams aren't relevant to the ED.

Doctors and nurses are doing clinical care in the ED, they need to be referenced.

Page 8		
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**Workshop 3**  
SVHM IHEWG

The ALERT team and Care Coordinators are the same team. Almost all of the ALERT team are women at SVHM. Need to consult with the ALERT team to specify how they want to be depicted.

There should also be input from the security team. The security guard looks intimidating and looks like his hand is on his holster. Change the uniform to make him look less militaristic.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 9		



**Workshop 1**  
Service providers

Make the concierge's badge more prominent so that patients know who to approach.

Put the superheroes in order of when patients can expect to see them.

Mixed feelings regarding health care workers being referred to as heroes. The main concern would be that this kind of language could be interpreted as reinforcing perceived power dynamics between patients and health professionals (reinforces authority of health care workers). This could potentially manifest in a number of ways including patients being less likely to contradict the ED staff and patients more likely to agree with the staff to maintain politeness.

**Workshop 3**  
SVHM IHEWG

There is room for the heroes to be streamlined as there is duplication and some information isn't accurate.

Some information within the roles is inaccurate (e.g. role of the concierge).

Page 10



**Workshop 3**  
SVHM IHEWG

The help strips give an impression that it can be used by all Aboriginal and Torres Strait Islander patients at hospitals.

The intention behind the help strips is good and would be helpful to be implemented across EDs but it is still too wordy.



HELP STRIPS

SIMPLY TEAR ONE OUT AND HAND IT TO ONE OF THE SUPERHEROES OF HELP



I AM AN ABORIGINAL AND/OR TORRES STRAIT ISLANDER PERSON. CAN SOMEONE PLEASE GET ME IN TOUCH WITH THE ABORIGINAL LIAISON OFFICER? IF THEY ARE NOT HERE, CAN I SEE SOMEONE ELSE?

---

I HAVE A PROBLEM THAT MEANS I NEED TO LEAVE THE ED. I HAVEN'T SEEN ANYONE YET. CAN I TALK TO ANYONE ABOUT MY PROBLEM TO GET HELP? I WANT TO STAY.

---

I AM FEELING SCARED AND WORRIED. CAN I HAVE SOMEONE SIT WITH ME SO I CAN HAVE COMPANY?.

---

I HAVE NOWHERE TO GO WHEN I LEAVE HERE.

---


I NEED HELP TO GET ME BACK TO MY PLACE.

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I NEED HELP WHEN I GO HOME.

No comments

IT'S EVERYONES AIM TO HAVE YOU FLYING OUT OF HERE IN NO TIME



ST, VINCENTS LOGO AND CONTACT INFO

No comments

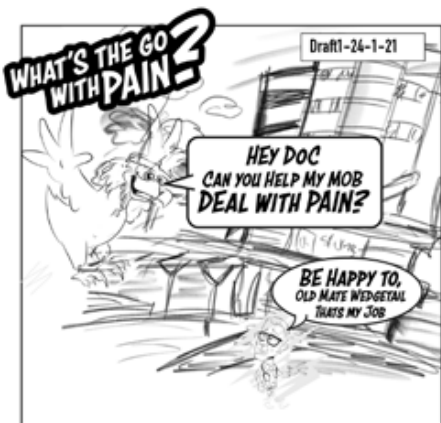
## Appendices (cont.)

### Comic 2 draft: How to communicate pain

#### General comments from community members

- ▶ The comics are busy and reflect the busy environment of the ED, but it would be good to separate the information across multiple pages to reduce confusion.
- ▶ Each page needs to be less busy.
- ▶ Considerations should be made for when people will receive this info – what will they comprehend when in crisis mode at the ED?
- ▶ Waiting rooms in ACCHOs have TVs, is there a possibility of making the screen an animation instead of a comic strip or an app?
  - For example, Albury–Wodonga has puppets with skits about language, visual and hearing
  - TV could even quickly advertise across the moving screen that there is a booklet available.
- ▶ Suggestions to launch/advertise the comic with Victorian Aboriginal Health Service (VAHS) and other ACCHOs (e.g. Aboriginal Housing Victoria), and to use radio shows to promote the comic (e.g. 3KND).
- ▶ Promotion in VAHS and VACCHO, this will filter out to regional areas (important for regional people to know if visiting too).
- ▶ Comics can be a blueprint for other hospitals.
- ▶ There is potential to turn these comics into a resource package.
- ▶ Considerations should be made for the low sight vision community, deaf community, Elders etc.
- ▶ Experiences of ED presentations might be different for different demographics, etc.
- ▶ Could have messages from notable people in the community (to be used as champions).
- ▶ Triage staff need training for this and cultural safety training – all staff need cultural awareness overhaul.
- ▶ There needs to be more representation from female Elders and pregnant women.

Page	Stakeholder groups	Comments
Page 1	<p><b>Workshop 1</b> Service providers</p>	<p>Change ‘crazy’ to ‘chaotic’ or ‘busy’.</p>



Page	Stakeholder groups	Comments
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Page 2



**Workshop 1**  
Service providers

Add 'tearing' to descriptions of pain.

Patients will be asked to rate their pain on a scale of 1-10, which needs to be made more clearly.

It is OK to ask for medication if a patient is in pain, they will be given paracetamol or ibuprofen (do not mention brand names).

The hand only has three fingers and a thumb. This is not anatomically correct.

Page 3



**Workshop 1**  
Service providers

Remove 'some pain is easy to diagnose and can be managed at home'. It is dangerous to encourage people not to come to the ED and for people to triage themselves. This contrasts to some government campaigns (e.g. Queensland Health) which are telling people not to come to the EDs.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 4	<p><b>Workshop 1</b> Service providers</p>	<p>The word ‘fatigued’ is a very medical concept, suggesting an amendment to ‘overwhelming tiredness’ to ensure everyone understands.</p> <hr/> <p>Other signs of severe pain can be feeling sweaty, good to include that in the comic.</p> <hr/> <p>Patients’ understanding of pathogenesis can exist outside of a Western biomedical model of disease. Using this model and ill-health to conceptualise patients’ discomfort and distress may not be consistent with their understanding, making the care provided culturally unsafe. It is important to hold space for a patient’s way of knowing even (and especially) when they appear to conflict with the clinician’s understanding of disease which is limited by the parameters of Western biomedical framework.</p> <hr/> <p>There might be potential that patients had accessed traditional medicines or healing prior to coming to the ED. It is good for clinicians to ask whether any traditional medicines/healing were utilised and for clinicians to document this as any other treatment. It is also important to consider that patients may not disclose certain practices to clinicians as they do not feel safe to share this information with non-Indigenous people.</p>



Page	Stakeholder groups	Comments
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Page 5



**Workshop 1**  
Service providers

It would be beneficial to include a depiction of mental pain.  
 In chronic pain, it is vital for patients to bring their medication with them (remove sometimes – it’s all the time).

Page 6



**Workshop 1**  
Service providers

Remove specific examples of diseases/ health conditions to avoid patients from self-diagnosing.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 7		



**Workshop 1**  
Service providers

Remove specific examples of diseases/ health conditions to avoid patients from self-diagnosing.

Page 8



**Workshop 1**  
Service providers

Include a discussion about triage categories and how staff triage patients.

Text needs to be cut down.

Doctors will run tests on patients to find out the cause of their pain, this should be included.

Page	Stakeholder groups	Comments
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Page 9



**Workshop 1**

Service providers

Patients should be told that hospitals have brokerage to help patients get medicine upon discharge (refer to SVHM’s clinical guidelines around medication).

Is it necessary to have examples of different medications? Rare to get opioids in the ED. Can guarantee patients will be offered paracetamol and ibuprofen (refer to SVHM’s clinical guidelines around medication).

Page 10



**Workshop 1**

Service providers

Triage nurses have nurse-initiated medication and don’t [always] need to consult with doctors.

Patients’ concept of full assessment can be different to physicians. This should be considered.

## Appendices (cont.)

Page	Stakeholder groups	Comments
Page 11		
	<p><b>Workshop 1</b> Service providers</p>	<p>Remove the abbreviation RAT to describe Rapid Assessment Team as this can be confused with Rapid Antigen Tests.</p>



## Script 3 draft: Bringing children into the emergency department

Due to the overall change in scope of the project and time constraints, a comic strip was not developed for this script.

### Script 3

Sometimes when we have an emergency, we must make the decision about whether we bring our kids along with us. Some carers might need to leave their children at home then come in late at night when they are sleeping in the hopes they can be seen quickly. Others will leave their kids at home and then leave the hospital without being seen, because they want to get back home to them. Some people don't want to bring their kids in for fear they will be taken away from them, or they know the kids will muck up in the waiting room. There are lots of reasons why Boori's will be in the waiting room:

- They are feeling unwell,
- Their brothers or sisters are sick, and they are there as a family
- Maybe their parent or carer is sick
- Maybe someone is getting palliative care and they are on their way to the Dreamtime
- Some may have experienced family violence and they are in the waiting room to be safe.

Some kids will be scared, overwhelmed or their emotions will be running high because they are terrified of the place, and they are worried for the person needing treatment. Sometimes we don't tell kids what is going on, and we forget to involve them in knowing what is happening. Don't worry, though, here are some handy tips for you to help our kids in the waiting room.

First, we know that you cannot bring a child into the emergency room with you if you are needing treatment, but there are ways to make sure kids in your care are ok while they are waiting.

If you know you are going to be a while, make sure the kids have something they can use to entertain themselves. Try colour books, pencils and children's shows they can watch on your phone.

- Try to bring snacks from home. Cafeteria snacks can get expensive!
- Bring a pillow and a blanket or a toy they like so they can have something to hold onto. It gives them a sense of security. Make sure you can go for a walk around outside to get rid of some extra energy.

If you are unwell and don't have any support to help you with your kids, here's a few things to help you on your way.

- Kids can wait with the nurses in the nursing station. They might get bored though, so it is always good to have something with them to keep them entertained.
- You can ask to speak to the AHLO when you arrive. You can explain to them that you need support to care for your kids while you are at the hospital.
- They can work with you to make the phone calls you need to make sure your kids are safe, and then the person who needs the help can get help.
- Say to the Triage Nurse you are an Aboriginal or Torres Strait Islander person. At St. V's they have changed the waiting time for our mob, to get us in and out as fast as they can.

If you need to leave because you haven't got access to childcare, tell the Triage nurse or the Patient Experience Officer or someone else on the team. It is important for you to let us know so we can find other ways of helping you and helping our Boori's feel safe!

## Appendices (cont.)

Stakeholder groups	General comments on script 3
<b>Workshop 1</b> Service providers	<p>People already work this out for themselves. They only bring kids in if they have to.</p> <p>A lot of hospitals have specific places for people with TV, toys etc. Should be a model for best practice.</p> <p>Some hospitals have free wi-fi, check with SVHM if that is the case with them.</p> <p>Social workers get called in when kids don't have anywhere to go, often they and nurses look after kids. Hospitals don't have facilities but make do.</p> <p>Patients might be coming late at night, and some staff don't understand why, so it is more important to have staff education around this and why children are brought in.</p> <p>There is a bit of confusion around who the target audience is. At times it sounded like it was aimed at patients, and at other times it was health professionals.</p> <p>Resources (pens and papers) are generally provided by the ED, at least in some EDs.</p> <p>The fear/trauma of having their children taken away from them may also impact parents' decision to call for an ambulance.</p> <p>Ideally paramedics should also be asking patients whether they would like to speak to an AHLO and what their preferred language is (if relevant) so that this can be handed over to the receiving clinician as part of clinical handover and hopefully expedite the process.</p> <p>Pre-ED perspective: When there are dependants at a residence or scene, paramedics always ask whether children are able to be left home with family/friends or whether the caregiver would like them to attend hospital as escorts if there is no one else to care for them at home. Paramedics have a responsibility (and duty of care) to ensure that children and young people are safe. Navigating these questions can evoke feelings of shame and/or have triggered a past trauma.</p> <p>Generally speaking, dependants can absolutely travel in the ambulance (where appropriate, depending on the condition of the patient) or we can arrange for another resource to transport dependants to hospital where other care cannot be arranged and the dependants cannot be transported in the ambulance.</p>
<b>Workshop 2</b> Community members	<p>Would be useful for parents before they get to ED.</p> <p>There needs to be some mechanism by hospitals to alleviate stress for parents (e.g. resource packs, etc.). Hospitals receive money to do this (WESE money).</p> <p>Prep needs to be done within health service and within the community – could be a project through VAHS to prepare the community.</p>





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