Diversity Framework
Policy, Planning and Practice
2012 – 2017

A strategy to meet the needs of customers and employees with diverse needs and from diverse backgrounds
At RDNS, diversity in all of its forms is respected and celebrated.

This Diversity Framework: Policy, Planning and Practice 2012-2017. A strategy to meet the needs of customers and employees with diverse needs and from diverse backgrounds is aligned with the RDNS Strategic Plan 2012-2017. The overall purpose of the Diversity Framework is to strengthen and support RDNS in how we respond to the increasing diversity of the population.

RDNS (Royal District Nursing Service) uses this Diversity Framework to embed the principles of diversity in the culture and management systems of RDNS. The Diversity Conceptual Model is a creative and exciting way of encouraging you to think about the holistic needs of your customers and how best to meet these from a policy, planning and practice perspective. This will undoubtedly support organisational change and quality improvements to respond to the diversity of our customer and employee groups.

Thank you to Jaklina Michael and Fiona Hearn for leading the writing of this document; and the many RDNS employees from across the business who participated and provided input during the feedback process, in particular Diversity Resource staff.

Stephen Muggleton
Chief Executive Officer
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1.0 DEFINITIONS

Client or customer is the term used for people receiving service from RDNS.

Client narratives are stories told by clients, their families and carers as to how they perceive, live with and respond to their illness. Narratives provide opportunities for exploration, interpretation and a means to form shared understandings between clients and RDNS.¹

Culture refers to a set of guidelines (both explicit and implicit) which individuals have as members of a particular society and which tells them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment.²

Diversity is about what makes a person unique and different and includes identity, life experience and beliefs. At the same time it is about the shared characteristics and values that connects a person to groups and communities³

Diversity characteristic refers to an individual or population group characteristic such as a condition or situation that can make it difficult for a client or a group of clients to participate in their healthcare and wellbeing⁴

Diversity Conceptual Model supports thinking about diversity. It assists us to think, understand and solve problems associated with customer, employee and population diversity and possible associations with disadvantage. The model encourages use of evidence and continuous quality improvements to inform and create opportunities for more equitable participation and inclusion in healthcare, wellbeing and employment through policy, planning and practice.⁵

⁵ Michael J. Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity. Australasian Journal on Ageing 2016:35(3):210–215
Diversity profiling encourages the use of client narratives to better understand the combination of diversity characteristics which may be contributing to disadvantage, within the context of health and well-being.\(^6\)

Holistic refers to an approach that focuses on each client as a whole person. That is, instead of treating an illness or responding to a physical restriction, holistic care looks at an individual’s overall physical, mental, spiritual, and emotional well-being and is respectful of their autonomy or right to self determination.\(^7\)

Person-centred care is treatment and care provided by health services [that] places the person at the centre of their own care and considers the needs of the older person’s carers.\(^8\)


\(^7\) Department of Human Services. Victorian HACC Active Service Model Discussion Paper. Victoria, Australia. 2008:11

2.0 INTRODUCTION

2.1 PURPOSE

The RDNS (Royal District Nursing Service) Diversity Framework: Policy, Planning and Practice 2012-2017 (Diversity Framework) is an organisational strategy to meet the needs of customers and employees with diverse needs and from diverse backgrounds and is aligned to the RDNS Strategic Plan 2012-2017. Given RDNS’ growth and diversification agenda, the Diversity Framework has been designed for implementation across all services offered by RDNS, in all service jurisdictions and catchments.

The purpose of the Framework is to:
1. Encourage and support RDNS and its employees to value diversity and equity in policy, planning, practice and priority setting;
2. Introduce a diversity conceptual model that can enhance our understanding about diversity and disadvantage;
3. Introduce and extend structures which support the implementation and management of diversity;
4. Identify the diversity priority actions for 2012-2017 and key performance indicators to measure progress and outcomes.

2.2 POLICY CONTEXT

The Diversity Framework recognises RDNS’ obligations to comply with legislation, government policy, standards and service agreements.

Examples of legislation directly referenced in RDNS policy include:
- The Charter of Human Rights and Responsibilities Act, 2006 (Vic);
- Carers Recognition Act, 2004 (Cth);
- Aged Care Act, 1997 (Cth); and
- Disability Discrimination Act, 1992 (Cth).

Examples of Government and service policy referenced in RDNS policy include:
- Australia’s Multicultural Policy, 2011 (Cth);
- National Male Health Policy, 2010 (Cth);
- A Fairer Victoria 2008: Strong People, Strong Communities, 2009 (Vic);
• Cultural Diversity Guide, Victorian Department of Human Services 2004 (Vic); and

RDNS also ensures compliance with quality requirements as per the Australian Council on Healthcare Standards (ACHS), the national Community Care Common Standards and other quality and accreditation requirements such as the Department of Veteran Affairs.

The Diversity Framework is underpinned by the Victorian Department of Health, Strengthening Diversity Planning and Practice Strategy. This strategy supports and encourages Home and Community Care (HACC) services to respect and respond to the characteristics of each person seeking services. The Diversity Framework includes a focus on the needs of the five groups of people with special needs identified in HACC and Aged Care.

• people from Aboriginal and Torres Strait Islander backgrounds
• people from Culturally and Linguistically Diverse (CALD) backgrounds
• people with dementia
• people who live in rural and remote areas
• people experiencing financial disadvantage (including people who are homeless or at risk of homelessness)

The Victorian Department of Health Diversity Planning and Practice Strategy, Strengthening Assessment and Care Planning and the Active Service Model are key, interconnected quality improvement initiatives within the Departments’ HACC program. Each of these initiatives strengthens the capacity of RDNS to deliver services that are responsive and person-centred. These quality improvement strategies will be implemented across RDNS, in relevant service jurisdictions and catchments.

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2.3 DIVERSITY AT RDNS

RDNS has very diverse customer and employee populations. The Diversity Framework has been designed to recognise and address diversity in its broadest form.

*Diversity is about what makes a person unique and different and includes identity, life experience and beliefs. At the same time it is about the shared characteristics and values that connects a person to groups and communities*\(^\text{11}\)

Our society is more diverse than ever. RDNS is committed to reflecting the same diversity in our workforce. RDNS values the diversity and inclusion of all RDNS employees and believes that this contributes to better business outcomes through higher levels of innovation, creativity, improved team engagement and risk management.

The Diversity Framework recognises that diversity can generate disadvantage for both customers and employees. Diversity can generate disadvantage for employees and reasonable support needs and adjustments are made to work environments to ensure that employees are able to satisfactorily perform their roles. Diversity can generate disadvantage for customers by contributing to the inequities of access to and use of RDNS and the greater Australian health and aged care systems. In order to understand patterns in access and use of RDNS, customers are clustered into population groups with a diversity characteristic.

*Diversity characteristic refers to an individual or population group characteristic such as a condition or situation that can make it difficult for a client or a group of clients to participate in their healthcare and well-being*\(^\text{12}\)

There is mounting awareness of inequality of health status and inequity of access to services amongst specific population groups. The Diversity Framework includes a focus on the five special needs population groups defined in the Aged Care Programs which are governed by Acts of Parliament. This special needs status is recognition that the following groups may experience particular difficulties in accessing services appropriate to their needs:

- people from Aboriginal and Torres Strait Islander backgrounds
- people from Culturally and Linguistically Diverse CALD backgrounds
- people with dementia
- people living in rural and remote areas
- people experiencing financial disadvantage (including people who are homeless)

\(^{11}\) Michael J. *Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity.* Australasian Journal on Ageing 2016:35(3):210–215

\(^{12}\) Michael J. *Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity.* Australasian Journal on Ageing 2016:35(3):210–215
or at risk of homelessness).
The Diversity Framework recognises that diversity within and across the above 5 special needs groups includes: culture and ethnicity; age; gender and sexual identity; physical and cognitive ability including dementia; emotional; spiritual and religious traditions; backgrounds and beliefs; refugee status and migration experience; language; and socio-economic circumstances and needs including housing insecurity.

2.4 DIVERSITY AND CULTURE

For the purposes of this Diversity Framework, RDNS has adopted the following definition:

**Culture refers to a set of guidelines (both explicit and implicit) which individuals have as members of a particular society and which tells them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment**\(^\text{13}\)

The Australian Standard Classification of Cultural and Ethnic Groups is used for the classification of information relating to a number of topics such as ancestry, ethnic identity, and cultural diversity by the Australian Bureau of Statistics. Although these topics have elements of difference, they will all be presented in this Diversity Framework under the concept of culture. The collection of any cultural identity data by RDNS will be based on a self-perceived group identification approach. Customers and employees are asked a direct question to self-identify themselves with up to 2 cultural groups. Sample responses are: Australian Aboriginal; Macedonian; Vietnamese Australian; Italian, Syrian

Slovakian (this actual self-identity was shared by an RDNS employee) and so on.

Kleinman (1975) argues that ‘culture shapes clinical reality’. Following the work of Kleinman (1975), the Diversity Framework considers cultural group identity as the core diversity characteristic of the diversity conceptual model for all clients for negotiating, planning and providing responsive care.

According to Kleinman (1975), ‘Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanation of sickness, explanations specific to the social positions we occupy and systems of meaning we employ’14. Health behaviour is affected by cultural beliefs. ‘How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate care are all affected15.

The Framework’s core diversity characteristic commences with cultural identity.16 This is a result of the mounting awareness of the inequality of health status amongst individuals and population groups and the inequity of access to services by specific population groups, most notably people from CALD backgrounds and those from Aboriginal and Torres Strait Islander backgrounds. This approach measures the extent to which individual clients associate with a particular cultural group (s) and will assist RDNS with negotiating, planning and providing responsive care. By identifying a connection to a cultural group, the person is only indicating a link or shared value. The level of commitment or adherence to the culture(s) can range from total, uncompromising, through to complete non-concern and/or non-practising association. Early recognition of this connection to cultural group can assist aged care providers to better understand the needs, choices and health behaviour of a consumer.

The Diversity Conceptual Model17 (Figure 1, page 14) provides a visual representation of some of the diversity characteristics of RDNS customers. The Diversity Conceptual Model was developed for customers and many of the diversity characteristics are also applicable to the workforce to better understand how to support employees.

Self-perceived cultural identity is presented as the central diversity characteristic from which other diversity characteristics can be considered.

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RDNS recognises there exists diversity between and within groups with a similar diversity characteristic and is committed to holistic and person-centred care approaches.

**Holistic** refers to an approach that focuses on each client as a whole integrated person. That is, instead of treating an illness, holistic health care looks at an individual's overall physical, mental, spiritual, and emotional wellbeing before recommending treatment. 

**Person-centred care** is treatment and care provided by health services [that] places the person at the centre of their own care and considers the needs of the older person’s carers.

The main feature of person-centred care at RDNS is the concept of partnership. At it’s foundation, person-centred care has collaborative and respectful partnering between RDNS and the customer, their carer and family.

### 2.5 DIVERSITY AND USE OF DATA

A range of qualitative and quantitative sources of data are used as evidence to inform the direction of RDNS policy, planning and practice about diversity including: population data from the Australian Bureau of Statistics (ABS) Census, reports produced by the Australian Institute of Health and Welfare (AIHW) on the health of specific population groups, incidence and prevalence reports on disease and a range of RDNS administrative data. This helps to identify patterns of health needs and demands of population groups within the RDNS catchment.

RDNS produced *Local Government Area Community Profiles* provide information about the diversity of the RDNS customer population and the general population (ABS census data is used in this product). This product is used by RDNS to support policy, planning and practice at both the organisation and at each local catchment area.

### 3.0 DIVERSITY CONCEPTUAL MODEL

**Diversity Conceptual Model** supports thinking about diversity at RDNS. It assists RDNS to think, understand and solve problems associated with client and population diversity and possible associations with disadvantage. The model encourages use of evidence and continuous quality improvement efforts

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improvements to inform and create opportunities for more equitable participation in healthcare and wellbeing through policy, planning and practice.\textsuperscript{20}

The Diversity Conceptual Model was developed for aged care\textsuperscript{21} but many of the components of the model can also be considered to address the diversity of the employee population.

\textsuperscript{20} Michael J. Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity. Australasian Journal on Ageing 2016:35(3):210–215

\textsuperscript{21} Michael J. Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity. Australasian Journal on Ageing 2016:35(3):210–215
Figure 1 above, identifies many diversity characteristics of the RDNS customer population.

Central to this diversity conceptual model is cultural group, as perceived by a person. Many of the components and diversity characteristics of the model can also be considered to address the diversity of the employee population.

3.1 DIVERSITY PROFILING

RDNS recognises that one diversity characteristic is very narrow and unrealistic and doesn’t help us to understand the holistic needs of a customer.

Holistic refers to an approach that focuses on each client as a whole person. That is, instead of treating an illness or responding to a physical restriction, holistic care looks at an individual's over-all physical, mental, spiritual, and emotional well-being and is respectful of their autonomy or right to self determination.

In order to broaden our understanding of the disadvantage that may be experienced by individuals and population groups, RDNS proposes diversity profiling. Diversity profiling, using the diversity conceptual model, a thinking can be applied to each individual customer that helps us to understand the distinct nature of each diversity characteristic, which in most instances is connected with other diversity characteristics.

Diversity profiling encourages the use of client narratives to better understand the combination of diversity characteristics which may be contributing to disadvantage within the context of health and well-being.

Figure 2 (page 17) is a sample client narrative – Mr. P. It illustrates the distinct nature of each diversity characteristic which in most instances is connected with other diversity characteristics and helps us to consider the context and the multiple needs of an individual client. Additional client narratives are presented in section 6.0 (page 25).

Client narratives are stories told by clients, their families and carers as to how they perceive, live with and respond to their illness. Narratives provide opportunities for exploration, interpretation and a means to form shared understandings between clients and RDNS.

3.2 SAMPLE CLIENT NARRATIVE

Figure 2 (page 16) presents a sample client narrative visual using diversity profiling and the diversity conceptual model. Mr. P's narrative (below) assists RDNS to think, understand and solve problems specific to the identified diversity characteristics that are creating disadvantage. It illustrates the distinct nature of each diversity characteristic which in most instances is connected with other diversity characteristics and helps us to consider the context and the multiple health and wellbeing needs of Mr. P.

Additional client narratives are presented in section 6.0 (page 25). Five of these client narratives have been developed as electronic resources and are used for staff induction and in-service training.

CLIENT NARRATIVE 1

Mr. P was born in Turkey and migrated to Australia in 1968. He self-identifies as Assyrian, speaks and understands Assyrian and learned Turkish for 4 years in his local village school. He experienced trauma and was tortured as a prisoner of war during World War II.

In Australia, he worked in a motor vehicle factory for 20 years. Mr. P is 86 years of age, a widower and lives in inner Melbourne. He has two married children; a son in Craigieburn, Victoria and a daughter in Sydney, New South Wales. His wife tragically passed away in a motor vehicle accident 10 years ago and has little contact with his children.

Mr. P has mobility issues and uses a walking stick. He is member of the Holy Apostolic Catholic Church of the East and the priest visits him often. He has no superannuation and relies on his aged care pension. He lives alone in a rental unit. He does not speak English well.

Mr. P has diabetes and has developed complications including vision impairment and peripheral vascular disease. These further reduce his capacity to be self-caring. He receives support from RDNS to manage his insulin therapy, blood glucose monitoring and oral medications.

He is a heavy smoker and continues to drink alcohol-against advice, throughout the day, as he believes it helps him with his appetite. Mr. P also suffers from anxiety and depression and takes medication to manage these conditions.
Figure 2 below, is Mr. P’s conceptualized client narrative. Diversity characteristics, starting from cultural group, are considered when planning and delivering holistic and person-centred health and wellbeing services.

The information gained from a conceptualized client narrative assists us to think about a customer’s holistic needs, beyond the reason for referral. By focusing on the customer as a whole person we can better understand an individual’s overall physical, mental, spiritual, and emotional well-being. We can also identify any associations with disadvantage which may be contributing to a customer’s inability to participate in their healthcare. This analysis can support us to solve problems, specific to identified diversity characteristics during screening, assessment, care planning and service delivery processes.

Policy improvement, continuous staff education and a range of resources targeting diversity characteristics such as literacy, health beliefs, communication etc. help to support us to provide person-centred care.
4.0 DIVERSITY POLICY, PLANNING AND PRACTICE AT RDNS

4.1 BACKGROUND

The Diversity Framework is an organisational strategy for planning and providing responsive services to customers and employees from diverse backgrounds and diverse needs, and its implementation and management is supported by the following organisational structures:

- **Diversity Manager** provides leadership on issues relating to Diversity, ensuring highly professional coordination of the Diversity program.
- **Diversity Coordinators** are dedicated staffing positions with a regional/local focus.
- **Diversity Planning Processes** will be incorporated into existing local and organisational structures and continuous quality improvement cycles across the organisation.

4.2 DIVERSITY FRAMEWORK 2012-2017

RDNS first developed a Cultural Diversity Planning Framework in 2000 in response to the cultural planning requirements of the HACC Program. The RDNS Cultural Diversity Planning Framework was revised and updated in 2003, 2006 and 2009 to reflect Government, industry and organization priorities.

The Diversity Framework 2012-2017 presents a transition from cultural planning to a broad diversity approach. The Diversity Framework is an organisational strategy for planning and providing responsive services to customers and employees from diverse backgrounds and diverse needs.

4.3 DIVERSITY COORDINATORS

Diversity Coordinators are integral to addressing the regional and local needs of customers and employees.

Diversity Coordinators:
- Support the organisation with person centred care to customers in partnership with the carer and the family.
- Facilitate and support the implementation of regional Diversity Actions Plans and partnership activities with external stakeholders.
- Support the business goals in the most efficient, effective and qualitative manner.
- Provide leadership on issues relating to Diversity as agreed with Manager Diversity.
4.4 DIVERSITY PLANNING PROCESSES


These planning processes occur within the context of the RDNS organisation strategic plan and resulting division and regional plans.
5.0 DIVERSITY PRIORITY ACTIONS 2012-2017

Existing organisational planning structures will be extended to include objectives for each of the following six priority actions:

PRIORITY ACTION 1: Introduce or improve policy, services or products to meet the needs of a diverse customer and employee population

PRIORITY ACTION 2: Increase the development and use of language services to support effective communication between employees and customers, their families and carers

PRIORITY ACTION 3: Work with customers, their families and carers and other service providers to enhance services and products, to meet the needs of a diverse customer population

PRIORITY ACTION 4: Increase the take up of RDNS service by people from the five identified special needs groups, considering diversity characteristics that exist across and within these groups

PRIORITY ACTION 5: Increase the diversity of employees to reflect local population demographics and maximize on staff cultural and language skills and knowledge

PRIORITY ACTION 6: Improve the knowledge, awareness, skills and behaviour of all employees to meet the needs of a diverse customer population

RDNS will use both quantitative and qualitative data to measure progress and outcomes of each of the above priority actions. Qualitative data will include data from employee and customer satisfaction survey, focus groups and others.
The following set of quantitative key performance indicators (KPI) for each priority action area will be implemented. These KPIs will assist RDNS to benchmark against other like organisations.

**PRIORITY ACTION 1**: Introduce or improve policy, services or products to meet the needs of a diverse customer population

**KEY PERFORMANCE INDICATORS**

<table>
<thead>
<tr>
<th>1.1 KPI</th>
<th>Number of policies, services or products introduced or improved to meet the needs of a diverse customer population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of policies, services or products introduced or improved</td>
</tr>
</tbody>
</table>

**PRIORITY ACTION 2**: Increase the development and use of language services to support effective communication between employees and consumers

**KEY PERFORMANCE INDICATORS**

<table>
<thead>
<tr>
<th>2.1 KPI</th>
<th>Number of CALD customers identified as requiring an interpreter and who receive an accredited interpreter service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of customers identified as requiring an interpreter service</td>
</tr>
<tr>
<td></td>
<td>Comment: Adapted from Cultural responsiveness framework(^{23})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 KPI</th>
<th>Number of on-site interpreters used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of customers identified as requiring an interpreter service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.3 KPI</th>
<th>Number of telephone interpreters used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of customers identified as requiring an interpreter service</td>
</tr>
<tr>
<td></td>
<td>Comment: Inclusive of AUSLAN interpreters</td>
</tr>
</tbody>
</table>

PRIORITY ACTION 3: Work with customers, their families and carers and other service providers to enhance services and products, to meet the needs of a diverse client population

KEY PERFORMANCE INDICATORS

| 3.1 KPI | Number of customers with targeted diverse needs and diverse backgrounds who participated in service or product development or research  
| Total number of customers who participated in service or product development or research  
| Comment: Consider a range of diversity characteristics of population groups |

PRIORITY ACTION 4: Increase the take up of RDNS service by people from the five identified special needs groups, considering diversity characteristics that exist across and within these groups

KEY PERFORMANCE INDICATORS

| 4.1 KPI | Number of customers who self-identify as Aboriginal or Torres Strait Islander  
| Total number of customers |
| 4.2 KPI | Number of customer born overseas  
| Total number of customers |
| 4.3 KPI | Number of customers who speak a language other than English at home  
| Total number of customers |
PRIORITY ACTION 5: Increase the diversity of employee to reflect jurisdiction and local population demographics and to maximize on staff cultural and language skills and knowledge

KEY PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Number of employees born overseas</td>
</tr>
<tr>
<td></td>
<td><strong>Total number of employees</strong></td>
</tr>
<tr>
<td></td>
<td><em>Comment: Includes English and non-English speaking countries</em></td>
</tr>
<tr>
<td>5.2</td>
<td>Number of employees who self-assess as competent in using language skills in everyday work and/or public relations</td>
</tr>
<tr>
<td></td>
<td><strong>Total number of employees</strong></td>
</tr>
</tbody>
</table>

PRIORITY ACTION 6: Improve the knowledge, awareness, skills and behaviour of all employees to meet the needs of a diverse customer population

KEY PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Number of employees who attend diversity training provided by RDNS</td>
</tr>
<tr>
<td></td>
<td><strong>Total number of employed employees</strong></td>
</tr>
<tr>
<td></td>
<td><em>Comment: Adapted from Cultural Responsiveness framework</em></td>
</tr>
<tr>
<td>6.2</td>
<td>Number of employees training workshops inclusive of diversity provided by RDNS</td>
</tr>
<tr>
<td></td>
<td><strong>Total number of employees training workshops provided by RDNS</strong></td>
</tr>
</tbody>
</table>

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6.0 CLIENT NARRATIVES

CLIENT NARRATIVE 1

Mr. P was born in Turkey and migrated to Australia in 1968. He self-identifies as Assyrian, speaks and understands Assyrian and learned Turkish for 4 years in his local village school. He experienced trauma and was tortured as a prisoner of war during World War II.

In Australia, he worked in a motor vehicle factory for 20 years. Mr. P is 86 years of age, a widower and has two married children; a son in Craigieburn, Victoria and a daughter in Sydney, New South Wales. His wife tragically passed away in a motor vehicle accident 10 years ago and he has little contact with his children.

Mr. P has mobility issues and uses a walking stick. He is member of the Holy Apostolic Catholic Church of the East and the priest visits him often. He has no superannuation and relies on his aged care pension. He lives alone in a rental unit. He does not speak English well.

Mr. P has diabetes and has developed complications including vision impairment and peripheral vascular disease. These further reduce his capacity to be self-caring. He receives support from RDNS to manage his insulin therapy, blood glucose monitoring and oral medications.

He is a heavy smoker and continues to drink alcohol—against advice, throughout the day, as he believes it helps him with his appetite. Mr. P also suffers from anxiety and depression and takes medication to manage these conditions.
Mr B is a 58 year old Aboriginal man who lives in Melbourne. His only living family is a brother, who lives interstate. He had limited education opportunities in his early life on his country in Queensland. He is not able to read English well, as this is not his first language.

Mr B and his partner rent a house in the outer suburbs. It is run down and had the power disconnected when they were unable to pay their electricity bills. They use a gas lamp for lighting. They also try to stay warm in winter by keeping the gas oven on, with the door open. Both Mr B and his partner have recently experienced health problems and this makes it hard for them to find work.

Mr B was recently referred to RDNS from hospital. He had been admitted for unstable diabetes and chronic obstructive pulmonary disease. He was withdrawn and mostly silent in hospital. This led some staff to become concerned about his capacity to understand and make decisions regarding his health. The Aboriginal Hospital Liaison Officer became involved for support while Mr B was in hospital and on discharge. Other medical and allied health staff remained worried about how he would cope at home. The lack of power and refrigeration for insulin and food storage was a major concern. The hospital therefore suggested residential care be considered. Mr B did not want to be separated from his partner and discharged himself from hospital against medical advice.

RDNS was referred to provide daily monitoring of insulin, blood glucose levels and medicines. Once RDNS staff were able to develop a trusting relationship, he was willing to discuss his health and other needs. With their consent, they were referred to a local Aboriginal Health Service. He and his partner were supported in finding more appropriate accommodation and with financial counselling. They also got help with nutrition, podiatry and ongoing support. Mr B agreed for a local pharmacy to store insulin supplies, until more suitable arrangements could be made.

Mr B’s diabetes management was stabilised and his general health and nutrition improved.
Mr. P is a war veteran who resides in small rural town, on the edge of Ballarat, Victoria. He is a 95 year old gold card veteran who lives in a community rental unit operated by a not for profit organisation which is cement cladded, cold and in need of a renovation.

RDNS supports Mr. P with his personal care because of vertigo. To maintain his independence RDNS only assist with showering and dressing, when required. Mr. P also receives home care cleaning services and support with hanging out his washing, on a weekly basis. He cooks his own meals and does the grocery shopping.

Shopping trips require him to drive his car to the city of Ballarat. He bought the car only a few years ago, from money he received from veteran affairs. Mr. P relies solely on his aged care pension. He receives no other payments.

Mr. P attends a local physiotherapy service to maintain strength and participate in exercises to control his vertigo. He drives to these weekly sessions, as he is not able to use the bus because of his mobility problems. A taxi service does not run from his town. His doctor and podiatrist are also local however he needs to drive to Ballarat for all other medical needs.

Mr. P has a son in Ballarat who is not able to assist on a daily basis because of work commitments.

When Mr. P is unwell he is unable to drive which limits his independence and social outings. Social isolation because of age, transport and mobility is becoming a big problem for Mr. P.
CLIENT NARRATIVE 4

Evan is a 67 year old transgender man. He was referred to RDNS for wound care following surgery and radiation treatment for lung cancer. During his school years Evan wanted to dress in boy’s clothing and was seen by the other children as a lesbian.

He was assigned female at birth but transitioned from female to male during his late teenage years. He experienced persistent trauma and discrimination because of his appearance. Like most transmen Evan was prescribed testosterone, a male hormone, but has no male genitals.

On the referral Evan’s gender was recorded as male but there was a note that stated that he was transgender. He had many tattoos and a beard and looked completely male in appearance. The nurse incorrectly assumed after meeting him that he was male wanting to transition to female. Evan explained that he had no contact with his family and that his neighbour Alex provided important daily support to him. Evan stated Alex was often ignored as a carer by health care workers even though he was the most central and important person in his life.

Evan’s anxiety was greatest when having people visit him at home. This increased when he needed to expose his body for wound care. He was also worried about needing help to go to the toilet as he didn’t know how people would react to his body.

The nurse learned not to make assumptions about a person’s physical appearance. The nurse was careful not to rush and got to know Evan’s individual needs and preferences. This assisted in reducing his anxiety about having his body exposed to provide wound care. The nurse asked “what would assist you now?” which allowed Evan to direct his care and suit his needs. Evan’s carer was also fully involved in all discussions and planning about his care. This acknowledged the important relationship that he had with his carer.
CLIENT NARRATIVE 5

Mr. S is 77 year old male from a Macedonian speaking background, with Type 2 Diabetes, was commenced on insulin twice daily. He lived with his son and daughter in law. The hospital referred the client to RDNS Liaison for RDNS to administer insulin at home.

The Liaison assessment with a hospital interpreter revealed the following:-

- Client had only 2 single teeth which inhibited a normal diabetic diet
- Client’s goal was to ‘eat properly’ as his daughter in law had been mashing foods at home.

In order to understand Mr. S’s needs in a holistic way, the Liaison asked the client what else is important to him. Mr. S responded that he wanted to go away with his son and daughter for a few days. This was something he had done for many years, but he was now scheduled to go to another family member’s house to be “close to the hospital” and to be home for the RDNS nurse to visit twice a day. Liaison discussed insulin injections with Mr. S who kept changing the subject from the insulin to food which indicated to Liaison the importance of him achieving his goal of “wanting to eat properly”.

RDNS recognised that he had the ability to improve his capacity. A collaborative working relationship with his carer and family was necessary. Liaison phoned the daughter in law to discuss the issues of eating properly (hence new teeth of which she would need to be involved with appointments etc) and going away for a few days - liaison approached the issue with sensitivity as the family may have wanted respite instead but the family confirmed they would like to take him on a holiday. Liaison discussed and documented this with relevant hospital staff, including the issue of nutrition, false teeth and the option of daily Lantus and diabetes management education.

Liaison also highlighted that his poor dental hygiene may be contributing to gum disease and therefore uncontrolled diabetes.

Referral was made by the hospital to the dental hospital for removal of teeth and dentures. The client was educated using daily Lantus. Liaison arranged RDNS daily visits for seven days for ongoing education in the community to both the client and family members.

The client had returned to the Diabetes outpatient clinic, very happy at the prospect of new teeth being fitted soon and the upcoming holiday with his son and daughter in law. The daughter in law is supervising Mr. S administering his own insulin and he is still being seen by RDNS 2x week, but with the view that he will be able to self-manage his diabetes.
Ms R is a 43 year old Australian born woman with a five year old daughter. She has an extensive history of homelessness, substance and alcohol use, transient violent relationships, depression, hypertension and asthma. The family is currently residing in a friends lounge room. The family has been transient for over a year, moving every few weeks from friends to low cost hotels and private rooming houses. Often these environments have been violent, unsafe or prohibitively expensive. Multiple services have been involved with the family, however owing to the family’s transient lifestyle and the constant moving across Melbourne’s geographical areas has led to service breakdown and has impacted on the family’s wellbeing.

The Department of Human Services-Child Protection-(DHS) became involved with the family, however Ms R demonstrated to DHS that she is a loving, caring, nurturing mother to her daughter and the DHS discharged the family from their service.

Ms R was referred to the RDNS Homeless Persons Program (HPP) by her General Practitioner (GP) – the only professional who has been consistent and available to the family’s needs. RDNS HPP assessed the family, and with discussion with Ms R, a flexible care plan was put in place as Ms R was cautious about another service assisting her, in particular, having to disclose her history once more and Ms R did not wish to be let down by professionals. Outreach, liaison, health education, orientation and referral to health, housing and a range of children’s services was planned and implemented. Material aid was provided thus relieving some of the financial burden, and providing nutrition, medication assistance, clothing and some recreational needs to Ms R’s daughter.

Despite the family’s ongoing housing challenges HPP continues to provide consistency, advocacy, support, maintaining links with Ms R and services and a flexible approach, thereby alleviating Ms R and her daughter further anxiety and pressure and improving their health outcomes.
Mrs. L is an 89 year old pensioner who arrived in Australia in 1983 from Hong Kong. She speaks Cantonese and has limited English. Mrs. L lives with her son. She is Roman Catholic but is no longer able to attend church services, due to mobility issues. Mrs. L is also no longer able to visit her close friend, who lives nearby.

The only aged care service Mrs. L receives is home nursing for her diabetes and wounds. During a wound assessment with an onsite interpreter, Mrs. L said she had authorised her son to withdraw money from her account to pay bills. She recently has received a letter about an overdue electricity bill. Mrs. L accepted the nurse’s suggestion to discuss this with an RDNS Social Worker.

During the social work visit with an on-site interpreter a number of possible options were discussed to assist to resolve these issues. Mrs. L advised the Social Worker that she could not allow her son to get into trouble with any authorities or to lose face. She stated she wanted to be able to sort out the issues herself.

Mrs. L was advised she could contact the Social Worker, if she ever changed her mind, by using the National Language Line. This would connect her to a telephone interpreter. Mrs. L was shown how to use this service. Six weeks later, the social worker received a call from Mrs. L. She was distressed as she had received a disconnection notice from her electricity provider. The Social Worker took her to a meeting at her bank where a telephone interpreter was used. Mrs. L made the decision to revoke the authority for her son to withdraw money from her account. Instead, she set up direct debits for bill payments.

During follow up visits, the social worker also linked Mrs. L to other aged care services, including weekly visits to a local Chinese planned activity group. Mrs L. was also referred for a Home Care Package. Mrs. L now has a Cantonese speaking home care worker who takes her to church and to visit her friend regularly.
Ms K, her husband and their five year old daughter arrived in Melbourne as refugees from Burma, in 2009. On arrival in Melbourne, the family was settled with a Burmese acquaintance. The family was asked to leave the acquaintance after an altercation and was rendered homeless. The family was directed to a housing service and were referred to the RDNS Homeless Persons Program (HPP) for health issues and care.

The family was assessed by HPP and referred to health services in the area. They attended numerous general practitioners and were confused over the lack of consistent care. Intensive outreach, orientation, discussion, health promotion and education was planned with the family, often with the assistance of interpreting and cultural services, in view of navigating, understanding and accessing services. RDNS HPP referred the family to a Family Support Worker and a shared care plan was implemented.

Refugee health assessments were completed by the Community Health Service. Ms K was diagnosed with Diabetes Type 2, Post Traumatic Syndrome Disorder, dental and poor vision. Her husband had experienced intensive gastric pain, Post Traumatic Syndrome Disorder, dental problems and poor vision. They were referred to specialist hospital/community clinics and refugee services and care, management, and treatment was commenced.

The family are devout Evangelical Christians and RDNS HPP referred them to a local church. RDNS HPP continues to provide intensive support and assistance as the family continue to face settlement challenges.
B is a 38 year old intersex person\(^5\) who contracted HIV following a sexual assault. B was referred to RDNS when starting treatment with antiretrovirals for support and education.

B was born in Australia of Australian Irish heritage. He had been raised as a boy but at age 19 no longer identified as male or female but as intersex. At the initial assessment visit, the RDNS Clinical Nurse Consultant (CNC) realised the limitations of the RDNS database and demographic categories. There was a category for 'intersex', but no suitable title. B preferred the title Mx or Mix (which has been adopted by some intersex people and is recognised by the Australian Federal government). B requested the use of the pronouns sie, hir (instead or she or he/her or his) in documentation. In establishing a therapeutic relationship the client required that this terminology be acknowledged and respected. RDNS staff contacted the RDNS informatics department to request appropriate system changes.

B revealed being estranged from hir parents as they did not accept B’s identification as ‘intersex’ nor hir HIV status. B has a close relationship with hir sister and a helpful network of friends in the Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) community. B’s brother believed sie was ‘gay’ and refused to let B interact with his children for fear of HIV transmission, which caused great distress to B.

RDNS assisted with education before B began treatment and provided symptom management and care coordination. RDNS HIV CNCs and social worker assisted in linking hir in with HIV legal services and counselling prior to the sexual assault court proceedings.

B tolerated antiretrovirals well, remains healthy and has returned to work as a teacher. With RDNS support, B’s brother also came to learn that HIV transmission to his children was not a risk through contact with B and their relationship has improved dramatically.

\(^5\) Intersexed person is an individual “whose internal and/or external morphology has characteristics not specific to just one of the official sexes, but rather a combination of what is considered ‘normal’ for ‘female’ or ‘male’.” (Organisation Intersexe Internationale 2010).
Mr. J is a Vietnamese born gentleman in his 80’s who lives with his wife in second marriage and his teenage son.

Mr. J has an advancing dementia first diagnosed in 2006, he now presents with significant cognitive impairment and disorientation which results in him requiring direction and prompting in most tasks of daily living.

Mr. J was referred to the Aged Care Assessment Team (ACAS) by an Alzheimer's Australia Counsellor and assessed eligible for an Extended Aged Care At Home Dementia (EACH D) package. When RDNS made contact with the family, support with home care was already in place provided by the local council. Mr. J’s wife explained to the RDNS Case Manager that she was hesitant to accept the EACH D package as her husband did not respond well to care workers and wanted to be left in peace. When the Case Manager explored this further it became obvious that none of the care workers involved spoke Mr. J’s first language. Although Mr. J used to be fluent in 2 other languages including English, he lost these skills with the progression of his cognitive impairment.

The RDNS Case Manager was able to source a Care Worker who spoke Vietnamese, not only to assist with home care but also to spend some time with Mr. J and engage him in social activities.

However the family situation was not well as Mr. J’s son had developed behavioural issues that impacted severely on Mr. J’s wife and her ability to look after them. The Case Manager started to link Mr. J’s son into specific services to improve the relationship between him and his mum and also arranged additional respite services for Mr. J to enable his wife to have breaks and dedicate time to spend with her son.

The Case Manager also arranged specific services to improve Mr. J’s health care such as an RDNS Clinical Nurse Consultant (Diabetes Educator) and a referral to a dietician.

The Case Manager continues to support Mr. J and his wife. Mr. J’s wife is aware that she can contact the Case Manager if she has any concerns or issues and she can also use the RDNS language line (telephone interpreter system) at any time.
Ms. N is a 33 year old woman of Sudanese ethnicity who has lived in Australia since 2005 after fleeing to Egypt from Sudan. She arrived with her husband and 2yo son. Her 7yo daughter remained in Sudan.

Five years ago Ms. N was diagnosed HIV positive during routine antenatal screening. Her husband and 2 year old son were subsequently diagnosed with HIV. She was provided with antiretrovirals throughout her pregnancy and her baby was treated post birth and tested HIV negative. Her daughter, now 12, was reunited with her family in 2008.

Ms. N’s marriage broke down in 2010 due to family violence. Her husband resides in Perth. Ms. N is fearful of disclosure and alienation from her community. Her son is unaware of his own diagnosis, though he is on treatment.

When Ms. N was referred to RDNS she was living in a Woman’s Refuge. She had fled a small country town concerned that her husband would return to remove her children. Ms. N arrived with 2 suitcases and no clothes for winter. She did not know where to find medical care. Her English and literacy skills are poor. She had no money and 2 days worth of food. Crisis services were contacted to provide the family with food vouchers. They were immediately linked into appropriate medical services for ongoing care.

RDNS found the family now aged 12, 6 and 4 a single room with communal living areas and alternate accommodation was arranged. Ms. N feared the HIV medications in the fridge would disclose the family secret. She was reassured that it was safe for medications to be stored in her room.

RDNS worked with the family to achieve safe housing, adequate clothing, emergency food and introduction to necessary health and allied support services. RDNS continues to support and assist the family in accessing schools, education related to HIV and specialised medical care.
Mrs D is a 68 year old with Maori ancestry, who was born in Christchurch, New Zealand. She was living with her elderly parents and her younger brother and his wife, when an earthquake occurred. Their house was completely destroyed and they were left without a home.

When Mrs D’s brother found a job in Melbourne, her family decided to migrate as well. Five members of her family are currently settled in a small unit in the south-eastern suburbs of Melbourne near extended family.

Mrs D’s family are members of the local Catholic church and they attend services each week. She helps her extended family care for her father, who was recently diagnosed with stomach cancer.

Mrs D is 160cm tall, is morbidly obese (135Kg) and has type 2 diabetes. She also has a leg ulcer.

The family speaks Maori at home. Mrs D had limited opportunities for schooling and finds it difficult to read English. She had problems with self-managing her diabetes and her wound, so receives support from RDNS to manage these. All support provided by RDNS is demonstrated and discussed rather than given to her in written form.

Mrs D is unable to reach down to wash her legs or put on her compression stockings. RDNS staff provide assistance with this.

Mrs D’s family also uses traditional Maori medicine to complement the service provided by RDNS.

Migration to Australia has further disadvantaged Mrs D. As well as experiencing isolation and settlement issues, she is also facing greater financial disadvantage. She cannot afford the wound care products and as a newly-arrived migrant to Australia, she is not eligible for any benefits. In New Zealand, wound care products are provided free of charge. RDNS however, has helped Mrs D to pay for products through a restricted-purpose fund.

Mrs D’s management of her diabetes has improved immensely and her wound is currently healed.
Ms. T is an Australian born 67 year old transgender woman. She transitioned from male to female at age 62, following the death of her wife. She has been on hormones for 5 years. She has not yet undergone gender reassignment surgery meaning that she still has male sexual organs.

Ms. T lives alone and has no contact with her family. She now relies on the aged care pension. Due to her tight budget she cut down the amount of hormone medication she needs and is unable to afford treatments for facial hair removal.

Ms. T has and continues to feel anxious when accessing health services. She has experienced discrimination due to her gender identity and struggles with depression.

Ms. T was recently admitted to hospital because she was having problems with passing urine due to an enlarged prostate. Her medical management in hospital included the insertion of a catheter. On discharge from hospital she was referred to RDNS for continence and catheter care. On the referral form Ms. T was listed as male.

At the first home visit, the nurse was surprised that the client had a female appearance. After some respectful discussion, Ms. T started to share her gender history with the nurse. She told the nurse that she was happy for this information to be shared at RDNS, but not to anybody else. The nurse explained the importance of confidentiality of personal and health information at RDNS and recorded the correct self-identification of Ms. T’s gender.

Before the next home visit the nurse looked for more information from the ‘Guidelines for working with transgender and gender diverse people at RDNS’ to better understand Ms. T’s needs and choices.

During the next home visit the nurse taught Ms T about her catheter and discussed the catheter change procedure that will be used by the nurse. Ms T’s information was also communicated via the RDNS client records to ensure that other staff are aware of Ms T’s correct catheter equipment and procedures.