

DIVERSITY FRAMEWORK

Policy, Planning and Practice

2012 - 2017

A strategy to meet the needs of clients and carers
with diverse needs and from diverse backgrounds



Home and Community Care (HACC) services provided by RDNS are jointly funded by the Victorian and Australian Governments.

Name of publication: Diversity Framework: Policy, Planning and Practice 2012-2017

Published by: RDNS 31 Alma Road, St Kilda, VIC 3182

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FOREWORD

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 clients and carers with diverse needs and from diverse backgrounds* (Diversity Framework) 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.

Please use this Diversity Framework to embed the principles of diversity in the culture and management systems of RDNS. The RDNS Diversity Conceptual Model is a creative and exciting way of encouraging you to think about the holistic needs of your clients 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 client and stakeholder groups.

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



Stephen Muggleton

Chief Executive Officer



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1.0 DEFINITIONS

Client 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.

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 environment¹.

Diversity is about what makes an individual unique and includes background, personality, beliefs and life experience.

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 wellbeing.

Diversity Conceptual Model supports thinking about diversity at RDNS. It assists RDNS staff 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 improvements to inform and create opportunities for more equitable participation in healthcare and wellbeing through policy, planning and practice.

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 wellbeing.

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 wellbeing and is respectful of their autonomy or right to self determination².

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.³

¹Helman, C. (1994). *Culture, Health and Illness* (3rd edition). Oxford, Butterworth-Heinemann, p.2.

²Department of Human Services. (2008). *Victorian HACC Active Service Model Discussion Paper*. Victoria, Australia. P.11

³Department of Human Services. (2003). *Improving care for older people: a policy for older people*, Melbourne, Victoria.

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 clients and carers 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 Diversity 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 policies include:

- *Carers Recognition Act 2004* (Cth)
- *Aged Care Act 1997* (Cth)
- *Disability Discrimination Act 1992* (Cth).

Examples of Government and service policy referenced in RDNS policies 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)
- NSW Health Policy Directive: Interpreters – Standard Procedures for Working with Healthcare Interpreters, 2006 (NSW).

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 HACC⁴ and Aged Care⁵.

- 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.

2.3 DIVERSITY AT RDNS

RDNS delivers services to a very diverse client and employee population. The Diversity Framework has been designed to recognise and address diversity in its broadest form.

***Diversity** is about what makes an individual unique and includes background, personality, beliefs and life experience.*

RDNS values the diversity and inclusion of all RDNS employees and believes that this contributes to better business outcomes through innovation, creativity and risk management.

The Diversity Framework recognises that diversity can generate disadvantage for clients by contributing to the inequities of access to and use of RDNS and the greater Australian health and aged care system. In order to understand patterns in access and use of RDNS, clients 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 wellbeing.*

There is mounting awareness of inequality of health status and the 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 HACC and Aged Care Programs which are governed by Acts of Parliament.

⁴ Victorian Department of Health (2011). *Diversity Planning and Practice*. Victorian Government, Melbourne.

⁵ Aged Care Act 1997. Sighted December 2011 Commonwealth Consolidated Acts.

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 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 environment⁶.

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. Clients and staff are asked a direct question to self-identify themselves with up to two cultural groups. Sample responses are: Australian Aboriginal; Macedonian; Vietnamese Australian; Italian, Syrian Slovakian (this self-identity was shared by an RDNS staff member) and so on.

Kleinman (1975) argues that 'culture shapes clinical reality'. Following the work of Kleinman, 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.

⁶Helman, C. (1994). *Culture, Health and Illness* (3rd edition). Oxford, Butterworth-Heinmann, p.2.

According to Kleinman, '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'⁷. 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 affected'⁸.

The Diversity Framework's core diversity characteristic commences with cultural identity. This is as 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.

The diversity conceptual model (Figure 1 page 11) provides a visual representation of some of the diversity characteristics of RDNS clients. Client self-perceived cultural identity is presented as the central diversity characteristic from which other diversity characteristics can be considered.

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.*⁹

***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*¹⁰.

The main feature of person-centred health care at RDNS is the concept of partnership. At its foundation, person-centred care has collaborative and respectful partnering between RDNS and the client, 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.

⁷ Kleinman AM (1975). Explanatory models in health care relationships, in *Health of the Family* (National Council for International Health Symp). Washington, D.C., NCIH, 1975, pp. 159-172

⁸ Kleinman AM (1975). Explanatory models in health care relationships, in *Health of the Family* (National Council for International Health Symp). Washington, D.C., NCIH, 1975, pp. 159-172

⁹ Department of Human Services. (2008). *Victorian HACC Active Service Model Discussion Paper*. Victoria, Australia. P.11

¹⁰ Department of Human Services. (2003). *Improving care for older people: a policy for older people*, Melbourne Victoria.

RDNS produced *Local Government Area Community Profiles*, provide information about the diversity of the RDNS client 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 improvements to inform and create opportunities for more equitable participation in healthcare and wellbeing through policy, planning and practice.

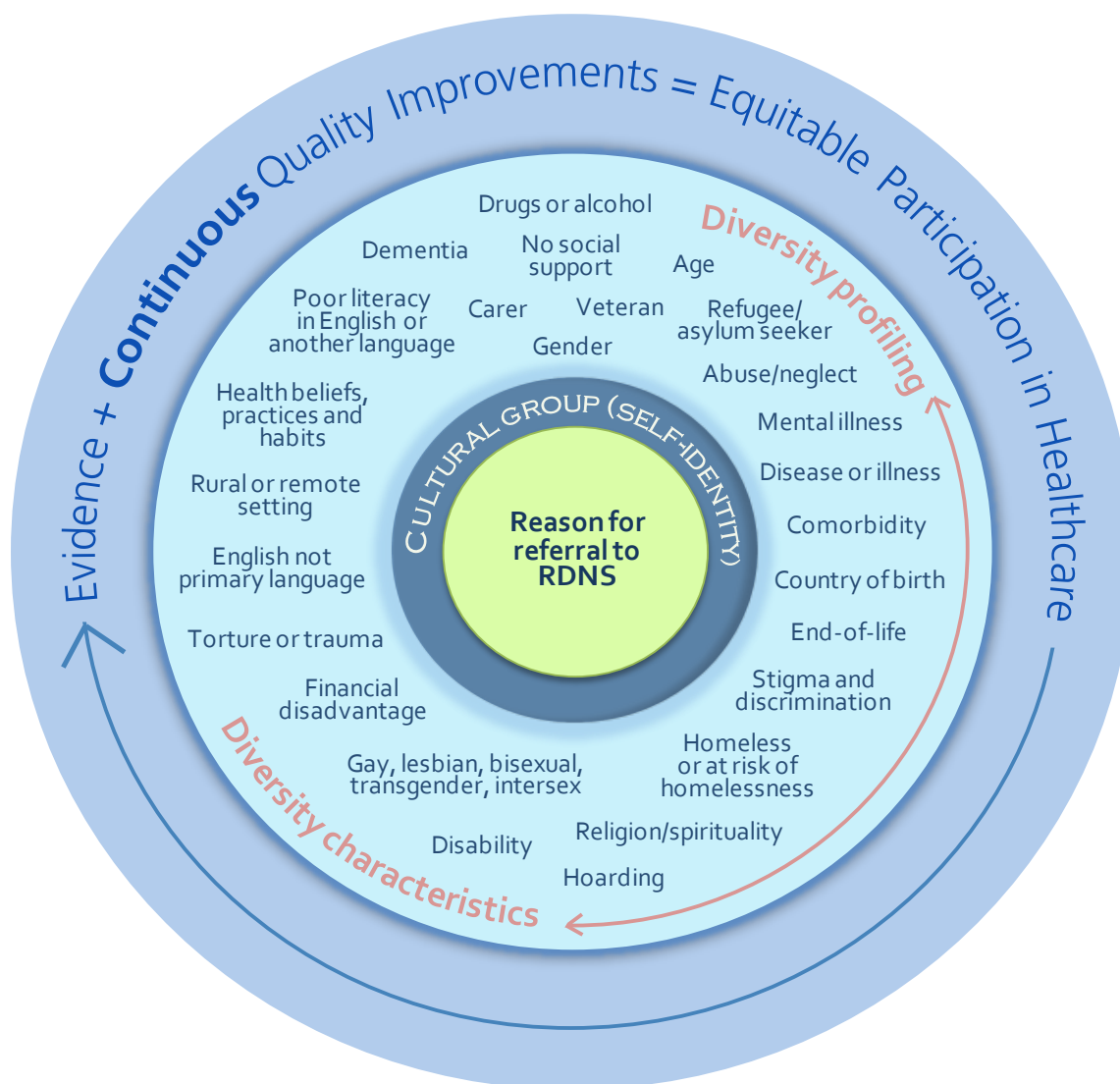


Figure 1, identifies many diversity characteristics of the RDNS client population. Central to this diversity conceptual model is cultural group, as perceived by a person.

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 client.

***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.¹¹*

In order to broaden our understanding of the disadvantage that may be experienced by individuals and population groups, RDNS proposes diversity profiling.

***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 wellbeing.*

Fig 2. (page 14) 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 21).

***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 14) presents a sample client narrative visual using diversity profiling and the diversity conceptual model. Mr P's narrative 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 21).

¹¹ Department of Human Services. (2008). *Victorian HACC Active Service Model Discussion Paper*. Victoria, Australia. P.11

CLIENT NARRATIVE 1

Mr P was born in Turkey and migrated to Australia in 1968. He self-identifies, speaks and understands Assyrian and learned Turkish for 4 years in his local village school. He does not speak English well. He experienced trauma when he was tortured as a Prisoner Of War during World War II.

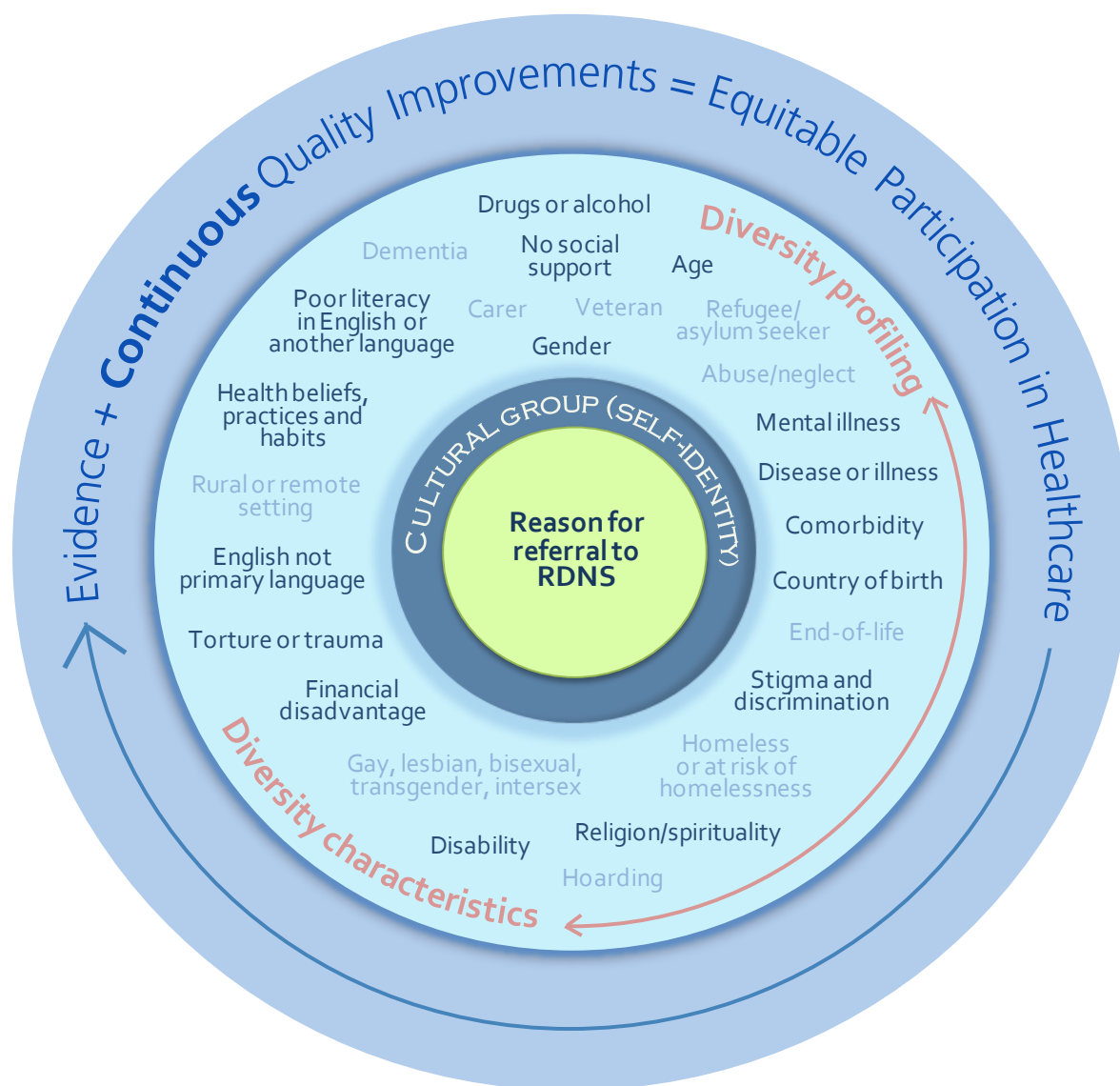
In Australia, he worked in a motor vehicle factory for 20 years. Mr P is 86 years of age, a widower and lives in inner Melbourne. He has two married children; a son in Craigieburn, Victoria and a daughter in Sydney, New South Wales. His wife tragically passed away in a motor vehicle accident 10 years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

Mr P has mobility issues and uses a walking stick. He is a 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.

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, 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 conceptualised client narrative assists us to **think** about a client's holistic needs, beyond the reason for referral. By focusing on the client as a whole person we can better understand an individual's overall physical, mental, spiritual, and emotional wellbeing. We can also identify any associations with disadvantage which may contribute to a client's inability to participate in their healthcare. This analysis can support RDNS 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 and communication help to support RDNS 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 clients from diverse backgrounds and diverse needs, and its implementation and management is supported by the following organisational structures:

- **Diversity Resource Staff** will operate at each site and department to support the implementation of the Diversity Framework across the organisation
- **Diversity Resource Group** will meet four times a year and membership includes Diversity Resource staff and the Manager, Diversity
- **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 organisation 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 clients from diverse backgrounds with diverse needs.

4.3 DIVERSITY RESOURCE STAFF

Diversity Resource staff are integral to addressing the local diversity needs of RDNS and clients.

During the period 2012-2017 each RDNS site and department will have an identified staffing resource of 2 hours per week. The position is open to all RDNS staff and staff are recruited and supported by the relevant Client Services or Department Manager. Orientation to the role is facilitated by the RDNS Manager, Diversity.

A position statement identifies key aspects for the role which include: assisting staff with problem solving, disseminating information, attending and facilitating staff attendance at relevant training, participating in projects and public relations activities, orientating new site staff, attending quarterly diversity group meetings and assisting the Client Services or Department Manager to develop an annual local operational plan for diversity and implementing the identified priority areas (refer to section 5.0).

An Electronic Statistical Staff Visit Report (ESSVR) indirect code *Diversity (Administration)* is used to collect information on time spent with administrative tasks related to diversity. Time spent in the role will be measured against local and organisational outcomes.

4.4 DIVERSITY RESOURCE GROUP

The Diversity Resource Group holds quarterly meetings in March, June, September and December to discuss issues, share successes, develop ideas and learn from each other and guest speakers.

This group receives specialist training to implement the Diversity Framework at each local level and to help lead the process of change. It is made up of a nominated Chairperson, the Diversity Manager, Diversity Resource staff from each RDNS site and department, and other relevant RDNS staff. The group operates according to a terms of reference and minutes of meetings are sent to Executive General Managers, General Managers, Operational Managers and Client Services and Department Managers.

4.5 DIVERSITY PLANNING PROCESSES

Diversity planning processes at local RDNS sites, departments and divisions are informed by the *Department of Health (2011). Strengthening Diversity Planning & Practice – A guide for Victorian Home and Community Care Services (2011). State of Victoria* and other relevant Commonwealth and State policies and practice guides.

These planning processes occur within the context of the RDNS organisation strategic plan and resulting division and site 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 client population

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

PRIORITY ACTION 3: Work with clients, their families and carers and other service providers to enhance RDNS services and products, to meet the needs of a diverse client 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 staff to reflect local population demographics and to maximise on staff cultural and language skills and knowledge

PRIORITY ACTION 6: Improve the knowledge, awareness, skills and behaviour of all staff to meet the needs of a diverse client 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 client satisfaction surveys, focus groups and others.

The following set of quantitative key performance indicators (KPIs) for each priority action area will be implemented. These KPIs will assist RDNS when benchmarking against other similar organisations

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

KEY PERFORMANCE INDICATORS

1.1	Number of policies, services or products introduced or improved to meet the needs of a diverse client population
	Total number of policies, services or products introduced or improved

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

KEY PERFORMANCE INDICATORS

2.1	Number of CALD clients identified as requiring an interpreter and who receive an accredited interpreter service
	Total number of clients identified as requiring an interpreter service Comment: Adapted from cultural responsiveness framework ¹²

2.2	Number of on-site interpreters used
	Total number of clients identified as requiring an interpreter service

2.3	Number of telephone interpreters used
	Total number of clients identified as requiring an interpreter service Comment: Inclusive of AUSLAN interpreters

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

KEY PERFORMANCE INDICATORS

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

¹²Victoria Department of Health. (2009). *Cultural responsiveness framework. Guidelines for Victorian health services*. Rural and Regional Health and Aged Care Services, Victoria Government, Department of Health, Melbourne, Victoria.

PRIORITY ACTION 4: Increase the take up of RDNS service by people from the five identified special needs groups (refer page 8), considering diversity characteristics that exist across and within these groups.

KEY PERFORMANCE INDICATORS

4.1	Number of clients who self-identify as Aboriginal or Torres Strait Islander
	Total number of clients

4.2	Number of clients born overseas
	Total number of clients

4.3	Number of clients who speak a language other than English at home
	Total number of clients

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

KEY PERFORMANCE INDICATORS

5.1	Number of staff born overseas
	Total number of staff Comment: Includes English and non-English speaking countries

5.2	Number of staff who self-assess as competent in using language skills in everyday work and/or public relations
	Total number of staff

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

KEY PERFORMANCE INDICATORS

6.1	Number of staff who attend diversity training provided by RDNS
	Total number of employed staff Comment: Adapted from Cultural Responsiveness framework ¹³

6.2	Number of staff training workshops inclusive of diversity provided by RDNS
	Total number of staff training workshops provided by RDNS



¹³ Victoria Department of Health. (2009). *Cultural responsiveness framework. Guidelines for Victorian health services. Rural and Regional Health and Aged Care Services*, Victoria Government, Department of Health, Melbourne, Victoria.

6.0 CLIENT NARRATIVES

CLIENT NARRATIVE 2

Ms S is a 58 year old Aboriginal woman who moved to Melbourne 15 years ago. Her only remaining sibling is a brother who lives in the country. Ms S has little formal education and is illiterate in English. She and her partner, Mr T, were living in private rental housing in the outer suburbs which was dilapidated and had no power supply. Lighting was by means of an outdoor gas lamp or torchlight and they were keeping warm in winter by running the gas oven. Mr T has limited formal education and has recently experienced deterioration in his health preventing him from finding work.

When referred to the Hospital Admission Risk Program (HARP) and RDNS, Ms S had the following health problems:

- Type 2 diabetes requiring insulin therapy
- Chronic obstructive pulmonary disease

Her admission to hospital was due to unstable diabetes. Although usually communicative in her home environment, Ms S was withdrawn, shy and non-communicative as an inpatient. Her cognitive assessment (MMSE) score was 6/30 on the ward. Staff expressed concern about her capacity to make decisions regarding her health and about the home situation, due to no power resulting in lack of refrigeration for insulin storage, food access and safety of the home environment. In hospital it was suggested residential care be considered for her due to the perceived risks. Ms S became concerned about the potential for separation from her long term partner and discharged herself from hospital against medical advice.

RDNS undertook daily monitoring of insulin, Blood Glucose Levels, medications and nutrition. RDNS also provided support and expert advice through the RDNS Homeless Persons Program (HPP). HARP referral from the hospital for a Diabetes Educator/Care Facilitator was arranged to visit the home. The Diabetes Educator established a relationship and trust with both the client and carer, acted as care coordinator and arranged with the local pharmacy to store insulin supplies. Ms S and Mr T consented to being referred and subsequently linked to a local housing worker. Ms S's diabetes management was stabilised and her nutrition improved. Both she and her partner accessed local Aboriginal Health Services including diabetes education and podiatry for ongoing support. They were also successful in relocating to more appropriate housing through the support of the housing worker.

CLIENT NARRATIVE 3

Mr P resides in a small rural town, on the edge of Ballarat, Victoria. He is a 95 year old gold card war veteran. Mr P lives in a community rental unit which is cement cladded. This unit is cold and in need of a renovation, and is operated by a not-for-profit organisation.

RDNS supports Mr P with his personal care because he suffers from vertigo. To maintain his independence RDNS only assist with showering and dressing, when required. Mr P also receives homecare 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.

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

Mr S is 77 year old male from a Macedonian speaking background, with Type 2 Diabetes commenced on insulin twice daily. He lives 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:

- Mrs S had only 2 single teeth which inhibited a normal diabetic diet
- The 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.

The 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 twice a week, but with the view that he will be able to self-manage his diabetes in the near future.

CLIENT NARRATIVE 5

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 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 consistently been 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. Ms R was cautious about another service assisting her, in particular, having to disclose her history once more. Ms R did not wish to be let down by another organisation. 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 RDNS HPP continues to provide consistency, advocacy, support, maintaining links with Ms R and services all with a flexible approach. This service alleviates Ms R and her daughter further anxiety and pressure therefore improving their health outcomes.



CLIENT NARRATIVE 6

Mrs L is an 87 year old widow with a diagnosis of bi-polar disorder. She lives with her adult son and also has a married daughter who lives nearby, who is her primary carer. However it is her son who receives a carer's pension. Mrs L arrived in Australia from Greece in the early 1950's and speaks fluent English when physically and mentally well. However when Mrs L has acute episodes of depression, she reverts to being only able to speak Greek.

RDNS has been visiting Mrs L for wound care. Her primary nurse referred Mrs L to the RDNS social worker, after Mrs L's daughter expressed concerns that her mother was getting very forgetful and that she feels her brother is taking advantage of this resulting in him financially exploiting her mother.

The RDNS social worker tried to arrange a home visit to see Mrs L and her family, but her son refused to be involved in this. Instead with her consent Mrs L and her daughter were seen at her daughter's home. Mrs L identified that her son had gambling issues and that he had been accessing and using her credit card without her consent to gamble online. Mrs L also stated that when she had confronted her son about this, he had said that she was imagining things and that she was getting too old and confused to manage her own finances. He then showed her a copy of a Power of Attorney (Financial) which she had apparently signed at her solicitor's office, giving her son authority to manage her financial affairs. Mrs L was worried as she had no recollection of organising this and therefore felt that her son may be right that she needed his help with her finances.

Mrs L and her daughter were provided information about Mrs L's rights and of support services available to her. Mrs L made a decision to return to her solicitor and revoke the Power of Attorney (Financial) made out to her son and instead appointed her daughter to assist her to manage her financial affairs.

Mrs L was also referred by RDNS for a review with her psychiatrist and to the local Cognitive, Dementia and Memory Service to try and identify the reasons for Mrs L's memory issues and treat as appropriate. These services were also advised by RDNS that Mrs L may require an interpreter at her appointments, depending upon her health status at the time.

The family were provided with information on a range of other local and other community services available to them should they choose to self-refer in the future including gambling support, Senior Rights Victoria and Aged Care Assessment Services.

CLIENT NARRATIVE 7

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 settled with a Burmese acquaintance. The family was asked to leave the acquaintance after an altercation and rendered homeless. The family was directed to a housing service and referred to the RDNS Homeless Persons Program (HPP) for health issues and care.

The family were assessed by RDNS 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 were 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 Type 2 Diabetes, Post Traumatic Syndrome Disorder and poor dental and 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.

CLIENT NARRATIVE 8

Mx B is a 38 year old intersex person⁵ who contracted HIV following a sexual assault. Mx B was referred to RDNS when starting treatment with antiretrovirals for support and education.

Mx 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. Mx B preferred the title Mx or Mix (which has been adopted by some intersex people and is recognised by the Australian Federal government). Mx B requested the use of the pronouns sie, hir (instead of 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.

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

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

Mx B tolerated antiretroviral's well, remains healthy and has returned to work as a teacher. With RDNS support, Mx B's brother also came to learn that HIV transmission to his children was not a risk through contact with Mx 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).

CLIENT NARRATIVE 9

Mr J is a Vietnamese born gentleman in his 80's living with his second wife and his teenage son.

Mr J has advancing dementia first diagnosed in 2006, he now presents with significant cognitive impairment and disorientation resulting 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 homecare 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 two 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 homecare but also to spend time with Mr J and engaging him in social activities.

However the family situation was deteriorating 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 has begun linking Mr J's son to specific services to improve the relationship between him and his mum and also arranged additional respite services for Mr J. This enabled 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 healthcare 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.

CLIENT NARRATIVE 10

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 two year old son. Her seven year old daughter remained in Sudan.

Five years ago Ms N fell pregnant and was diagnosed HIV positive during routine antenatal screening. Her husband and two year old son were subsequently diagnosed with HIV. She was provided with antiretrovirals throughout her pregnancy and her new 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 undergoing 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 two 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 only two 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.

