Guidance on assessing standards relating to cultural safety and delivery of culturally safe care

To support the implementation of the *Model Standards for specialist medical college accreditation of training settings*

v1.0

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Australian Medical Council Limited

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The Australian Medical Council (AMC) acknowledges the Aboriginal and/or Torres Strait Islander Peoples as the original Australians, and the Māori People as the tangata whenua, or original Peoples of Aotearoa New Zealand. We acknowledge and pay our respects to the Traditional Custodians of all the lands on which the AMC works, and their ongoing connection to the land, water and sky.

The AMC acknowledges the past policies and practices that impact the health and wellbeing of Aboriginal and/or Torres Strait Islander and Māori Peoples and commits to working together with communities to support healing and positive health outcomes. The AMC is committed to improving outcomes for Aboriginal and/or Torres Strait Islander and Māori Peoples through its assessment and accreditation processes including equitable access to health services.

Introduction

Within this document

This document provides guidance for specialist medical colleges and the training settings that colleges accredit to support the implementation of the *Model Standards for specialist medical college accreditation of training settings* (Model Standards) relating to cultural safety for Aboriginal and/or Torres Strait Islander and Māori trainees and the delivery of culturally safe care.

It is intended that this document is updated periodically to add examples and capture learning.

This document provides:

- example evidence that may be provided to illustrate meeting particular criteria.
- some examples of existing initiatives along the medical education continuum that have been developed locally with strong consultation with Aboriginal and/or Torres Strait Islander and Māori stakeholders, that may assist in meeting particular criteria. *Note: This list of examples is not intended to specify best practice in any way*.

How does this connect to the broader medical education system?

The Model Standards acknowledge the gap in health outcomes of Aboriginal and/or Torres Strait Islander and Māori peoples, the impact of colonising cultures and racism embedded into everyday society, and that existing systems and the institutions in which doctors work were not designed to care for people from other cultures.

The AMC is committed to collaborative continuous improvement of the education and accreditation standards to ensure doctors in training are contributing to a culturally safe workforce and a culturally safe environment for Aboriginal, Torres Strait Islander and Māori trainees, patients, colleagues and communities.

The Model Standards are not isolated in a strengthened approach to cultural safety. The increased focus on cultural safety and on Aboriginal and/or Torres Strait Islander and Māori health is a feature of many standards and requirements already in existence in Australia and Aotearoa New Zealand. Some examples are provided below:

- the Health Practitioner Regulation National Law (Schedule — Part 1, 3A Guiding principles)
- *Standards for Assessment and Accreditation of Primary Medical Programs* (all Domains and Standards)
- the National Framework for Prevocational (PGY1 and PGY2) Medical Training: *National standards for prevocational (PGY1 and PGY2) training programs and terms* (all Standards) and *Prevocational outcome statements* (all Domains and Outcomes)
- *Criteria for AMC Accreditation of CPD Homes* (Criteria 1.4, 2.3 and 3.1)
- *Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes* (all Standards)
- *National Safety and Quality Health Service (NSQHS) Standards* (Second edition) and the *NSQHS Standards User guide for Aboriginal and Torres Strait Islander health*
- *Pae Tū: Hauora Māori Strategy*
- *Ngā paerewa Health and disability services standard*

To note: The AMC is currently undertaking a review of its *Standards for Assessment and Accreditation of Specialist Medical Programs*. The directions for change include significantly strengthened standards related to Aboriginal and/or Torres Strait Islander and Māori health and cultural safety across the standards as a whole. The standards will build on what is expected in primary and prevocational training programs i.e. translating knowledge to specialist level care. Standards identified as related to Aboriginal and/or Torres Strait Islander and Māori health and cultural safety will be led by Aboriginal and/or Torres Strait Islander and Māori people, and all other standards may also be contributed to, as part of this process.

How you can contribute

This is a living document, and additional examples will be added as they arise.

Colleges and training settings are invited to share with the AMC their learnings and examples of how they are implementing the Model Standards relating to cultural safety for Aboriginal and/or Torres Strait Islander and Māori trainees and to the delivery of culturally safe care.

It is important that colleges and training settings consider the local context specific to the region's needs, which will be strengthened through in-depth consultation with Aboriginal and/or Torres Strait Islander and Māori stakeholders in the development of resources.

Please contact specaccred@amc.org.au to share feedback and content.

Model Standards for specialist medical college accreditation of training settings

This section focuses on the criteria requiring training settings to provide a culturally safe workplace for trainees and to support trainees in delivering culturally safe care to patients.

Domain: 1. Trainee health and welfare			
Standard: 1.1 Training takes place in a learning environment that supports trainee health and welfare.			
Criterion	**Intent statement**	**Examples of evidence at accreditation** (*e.g. evidence or documentation that an accreditation team could look for that may indicate the standard is met. The type of evidence may differ depending on the size and nature of the training setting*)	**Examples of how criterion *may* be met and useful resources** (*e.g. initiatives developed locally through strong consultation with Aboriginal, Torres Strait Islander and Māori stakeholders. Examples are not intended to specify best practice.*)

1.1.3 There is a positive learning environment that fosters respect, diversity, inclusion, equity and cultural safety for trainees of diverse background.	*Colleges should assess whether there is a positive, supportive, inclusive and equitable learning environment for all trainees that acknowledges and values their diversity. This involves assessing the general environment where trainees carry out their day-to-day duties and identifying factors that may either contribute to, or detract from, a positive and respectful environment.*	***NOTE:** Aboriginal and/or Torres Strait Islander and Māori Peoples are many different and distinct groups, each with their own culture, customs, language, and laws. It is therefore expected that evidence is collected/provided separately in relation to:*
		• *Aboriginal trainees; and*
		• *Torres Strait Islander trainees; and*
		• *Māori trainees,*
		as relevant, to reflect their distinct identities and cultures.
		• Evidence of strategies to enable positive and supportive training environments for (i) Aboriginal trainees, (ii) Torres Strait Islander trainees and for (iii) Māori trainees, as relevant, including:
		  ○ evidence of the implementation of such strategies
		  ○ evidence of promoting strategies to trainees and their supervisors
		  ○ *see also 1.1.6 below for examples of evidence for that criterion*.
		• Evidence of wellbeing and support policies being communicated to (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and to (iii) Māori trainees, as relevant.
		• Evidence ensuring the availability of confidential support and complaint services, including:
		  ○ communications to (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and to (iii) Māori trainees, as relevant, alerting them to these services.
		• Evidence that support and complaint services have been used by trainees.
		• Communications promoting professional development activities on the topics of wellness, appropriate behaviours and cultural safety.
		• Data showing cultural safety training undertaken by all staff.
		• Evidence that the training setting or health service has processes for anonymous or confidential reporting.
		• Data for (i) Aboriginal trainees, (ii) Torres Strait Islander trainees and (iii) Māori trainees, as relevant, at the setting including:
		  ○ how many have commenced training at the setting over the past X years
		  ○ how many have completed their term at the setting over the past X years
		  ○ in which departments/units they have worked over the past X years
		  ○ current number of trainees and in which departments/units they are working.
		Consider the number of (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees at a training setting/health service (i.e. would the trainee be easily identifiable) before asking the following and other questions. Questions such as these need to be optional, and only asked in processes that ensure confidentiality:
		• Would an Aboriginal trainee recommend this training setting to an Aboriginal colleague or patient?
		• Would a Torres Strait Islander trainee recommend this training setting to a Torres Strait Islander colleague or patient?
		• Would a Māori trainee recommend this training setting to a Māori colleague or patient?	

Criterion	Intent statement	Examples of evidence at accreditation (*e.g. evidence or documentation that an accreditation team could look for that may indicate the standard is met. The type of evidence may differ depending on the size and nature of the training setting*)	Examples of how criterion *may* be met and useful resources (*e.g. initiatives developed locally through strong consultation with Aboriginal, Torres Strait Islander and Māori stakeholders. Examples are not intended to specify best practice.*)

1.1.4 Risks to the cultural safety of Aboriginal and/or Torres Strait Islander and Māori trainees are identified, managed and recorded.	*Colleges should have a documented process in place to assess whether training providers identify and manage risks of culturally unsafe, unacceptable, discriminatory or unlawful behaviour at the training setting, relating to Aboriginal and/or Torres Strait Islander and Māori trainees. Management of risks involves eliminating the risk where this is reasonably practicable or if not, minimising the risk insofar as is reasonably practicable. It is expected that training providers will engage with Aboriginal and/or Torres Strait Islander and Māori trainees, local networks and/or colleges' Indigenous networks to support the risk assessment and identify potential mitigating actions, determine organisational processes, and ensure that trainees are supported through this process. The risk assessment should be documented and made available to the college, whether stand alone or integrated into a broader risk assessment.*
	
	Training settings should have mechanisms to identify and respond to individual incidents, as well as ongoing or long term structural or organisational risks. Mechanisms should be appropriate to the size and nature of the training setting and commensurate to the potential harm to trainees. Large settings may have a range of formal policies and procedures in place, whereas small settings may have mechanisms more suited to their size and risk profile.
	
	Note: It is not intended that colleges assess how a training provider has managed a single isolated incident of unlawful or unacceptable behaviour (although colleges and training providers may have other duties in this regard). However, multiple and ongoing instances of unlawful or unacceptable behaviour may indicate that risks are not being identified, investigated, managed and/or recorded which would be relevant to the assessment of this criterion and would be an indicator of concern.
		• Evidence of risk identification processes, including:
		  ○ documented processes used or audits conducted to assess the environment and identify potential cultural safety risks for (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees
		  ○ culturally safe engagement with (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees, their local networks and/or colleges' Indigenous networks to support risk assessment
		  ○ evidence showing how feedback from this engagement has been used to identify and mitigate risks.
		• Evidence of risk management processes, including:
		  ○ documented protocols/procedures for addressing and managing risks, including response timelines, roles of staff and escalation pathways.
		  ○ evidence showing how feedback has been gathered in a culturally safe way from (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees, their local networks; and/or colleges' Indigenous networks, and how these approaches have been reviewed with them
		  ○ evidence showing how the feedback received has been considered and used to inform decisions, improvements, and/or actions, including examples of outcomes
		  ○ evidence showing how trainees have been supported throughout the process when risks are identified, including through engagement with trainees and Indigenous networks to inform appropriate responses and to ensure the matter is managed in a manner consistent with the principles of self-determination
		  ○ evidence showing that decisions, improvements, and/or actions have been communicated back to trainees in a culturally safe way
		  ○ consideration of data showing cultural safety training undertaken by all staff (*see evidence relating to criterion 1.1.3 above)*
		  ○ consideration of data relating to the number of (i) Aboriginal trainees, (ii) Torres Strait Islander trainees and (iii) Māori trainees (*see evidence relating to criterion 1.1.3 above*).
		• Evidence of a register or system to record, monitor and follow up on risks or incidents related to cultural safety of (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees.
		• Evidence of evaluation of the risk identification and management processes to assess their effectiveness and inform ongoing improvement.
		
		Consider the number of (i) Aboriginal trainees, (ii) Torres Strait Islander trainees, and (iii) Māori trainees at a training setting/health service (i.e. would the trainee be easily identifiable) before asking the following and other questions. Questions such as these need to be optional, and only asked in processes that ensure confidentiality:
		• Would an Aboriginal trainee recommend this training setting to an Aboriginal colleague or patient?
		• Would a Torres Strait Islander trainee recommend this training setting to a Torres Strait Islander colleague or patient?
		• Would a Māori trainee recommend this training setting to a Māori colleague or patient?	

1.1.6 Trainees can access leave arrangements, including leave to fulfil community cultural obligations, in accordance with employment and/or appointment conditions.	*Colleges should assess whether trainees can reasonably access the leave entitlements, including cultural leave, that are set out in their employment and/or appointment conditions. It involves assessing whether reasonable leave is being denied on an ongoing basis and if this has adversely impacted trainees' ability to meet their training program outcomes and/or their health and welfare. Colleges should assess whether certain trainees are disadvantaged such as parents of younger children, trainees with carer's responsibilities or trainees with cultural obligations.*
	
	Note: It is not intended that colleges regulate whether training providers meet industrial obligations, but to consider outcomes for trainees working at the training setting, for example, whether trainees are actually taking leave to which they are entitled, whether leave is being consistently denied to trainees or a particular group of trainees. It is not intended that training providers be required to grant all leave requests, as many contingencies must be managed in relation to trainee leave.
		• Evidence demonstrating that leave policies are clearly accessible to trainees e.g on the website or within induction programs.
		• Evidence of communications alerting trainees to leave policies, including recognising the cultural loading of Aboriginal and/or Torres Strait Islander and Māori staff.
		• Evidence of implementation of leave policies, including:
		  ○ Are trainees, supervisors/workforce teams aware that this leave is available?
		  ○ Are trainees taking this leave?
		  ○ Do trainees feel safe and supported to use this leave without negative repercussions?
		  ○ What are the perceptions of this leave among supervisors/workforce teams/staff and colleagues more broadly?
		  ○ What strategies are in place to promote awareness and understanding of these policies?
		  ○ How are leave policies communicated to staff? Is it explained to staff why cultural leave is important and needed?
		  ○ Are there any examples of disputes over this leave?
		• Examples for Australia: Trainees are able to take leave to attend, for example, Sorry Business, ceremonial obligations, and community and cultural activities.
		• Examples for Aotearoa New Zealand: Trainees have the ability to take leave to attend Tangihanga, Iwi or Hapu meetings, Te Matatini Festival and preparations, Hononga, Kawe mate to discharge other cultural obligations.	

Domain: 2. Supervision, management and support structures			
Standard: 2.2 Trainees receive appropriate and effective supervision.			
Criterion	**Intent statement**	**Examples of evidence at accreditation** (*e.g. evidence or documentation that an accreditation team could look for that may indicate the standard is met. The type of evidence may differ depending on the size and nature of the training setting*)	**Examples of how criterion *may* be met and useful resources** (*e.g. initiatives developed locally through strong consultation with Aboriginal, Torres Strait Islander and Māori stakeholders. Examples are not intended to specify best practice.*)

2.2.5 Supervisors are supported in meeting their education and training responsibilities, including in providing culturally safe supervision and contributing to a culturally safe environment.	*Colleges should assess whether supervisors are supported by the training provider to perform their dual roles of delivering healthcare services and supervising/supporting trainees and that they have adequate time to carry out education and assessment functions, such as conducting workplace-based assessments. Monitoring the performance of supervisors is also relevant to this criterion, including opportunities for trainees, the Director of Training (or equivalent), and other relevant people to provide feedback to supervisors.*
	
	Colleges should assess whether the training provider supports supervisors in professional development opportunities related to appropriate workplace behaviour, cultural safety, cultural competence and, in Aotearoa New Zealand, Hauora Māori.
	
	The support provided should be appropriate to the size and nature of the training setting and commensurate to the potential harm to trainees. Support may be formal or informal, including professional development activities, provision of time to undertake supervision and supervisor forums.
	
	Note: Colleges also have a role to play in supporting supervisors through formal supervisor training, feedback and evaluation.
		• Data showing training undertaken by supervisors, including what percentage of supervisors have undertaken what training.
		  ○ What are the training and professional development opportunities that are made available?
		  ○ Is supervisor training in cultural safety tracked?
		  ○ What proportion of supervisors have undertaken training within the last 12 months?
		  ○ Are there any trends in attendance or uptake of training opportunities, what can that tell you?
		  ○ Are supervisors supported to attend training sessions/professional development, forums, conferences and events where appropriate?
		  ○ Are supervisors asked for feedback on training, workshops etc?
		  ○ Is there a quality assurance/improvement process for the training?
		  ○ Are supervisors encouraged to undertake further learning, courses and conferences? This may include those delivered by groups such as:
		  ▪ *In Australia:* Leaders in Indigenous Medical Education (LIME), the Australian Indigenous Doctors' Association (AIDA), the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), and the Australian Indigenous Psychologists Association (AIPA).
		  ▪ *In Aotearoa New Zealand:* Te ORA, or Universities of Auckland, Otago or Whare Wananga.
		  ○ Do supervisors know what networks they can be using?
		  ○ Do supervisors know where they can look for national or local training?
		• Data showing trainee feedback is routinely sought on their supervision, including on the cultural safety of their supervisors.
		  ○ Is there a meaningful quality improvement process on the basis of this feedback?
		  ○ How is feedback encouraged?
		  ○ Is the data collected in a way that allows for robust, honest, de-identified feedback?
		  ○ For trainees who have negative feedback, what agency do they have in the process that follows and how has the setting considered cultural safety within that process?	

Standard: 2.3 Trainees are supported in delivering quality patient care, including culturally safe care.			

2.3.1 Trainees are supported in delivering quality patient care, including culturally safe care, to patients of diverse backgrounds.	*Colleges should assess whether trainees are exposed to the full diversity of patients and clients treated at the training setting where this is clinically appropriate. Diversity of patients means patients of diverse cultures, religious beliefs, gender, age, disability, language, rurality and geography or other such factors. This includes assessing whether trainees are supported to understand the needs of diverse patients and informed of how diverse patients are supported at the setting, including the provision of culturally safe care.*
	
	For non-patient facing roles (for example pathology, other diagnostics), trainees should be supported in their role of indirectly delivering quality patient care, including culturally safe care, to patients of diverse backgrounds.
		• Evidence showing the training setting demonstrates a commitment to an ongoing approach to a variety of personal development opportunities.
		• Evidence of providing alternative opportunities for trainees to demonstrate meeting the training program outcomes.
		  ○ What are the training opportunities that are made available? How are they promoted? Does the training setting have evidence that training opportunities map to the training program outcomes?
		  ○ Evidence of encouraging trainees to undertake further learning, courses and conferences. This may include those delivered by groups such as:
		  ▪ *In Australia: Leaders in Indigenous Medical Education (LIME), the Australian Indigenous Doctors' Association (AIDA), the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), and the Australian Indigenous Psychologists Association (AIPA).*
		  ▪ *In Aotearoa New Zealand: Te ORA, or the Universities of Auckland, Otago or Whare Wananga.*
		• Data showing trainee feedback is routinely sought on support received, including on the cultural safety of their supervisors.
		  ○ Is there a meaningful quality improvement process on the basis of this feedback?
		  ○ How is feedback encouraged?
		  ○ Is the data collected in a way that allows for robust, honest, de-identified feedback?
		  ○ For trainees who have negative feedback, what agency do they have in the process that follows?	

Criterion	Intent statement	Examples of evidence at accreditation (*e.g. evidence or documentation that an accreditation team could look for that may indicate the standard is met. The type of evidence may differ depending on the size and nature of the training setting*)	Examples of how criterion *may* be met and useful resources (*e.g. initiatives developed locally through strong consultation with Aboriginal, Torres Strait Islander and Māori stakeholders. Examples are not intended to specify best practice.*)

2.3.2 Trainees are supported in developing specific knowledge and skills to deliver quality patient care, including culturally safe care, to Aboriginal and/or Torres Strait Islander and Māori people.	*Colleges should assess whether the training provider supports trainees in developing knowledge and skills to provide quality patient care using a patient-centred approach. This approach should recognise that Australian communities are diverse and patients will have different preferences, needs and values about their health care.*
	
	Colleges should assess whether the training provider has engaged with Aboriginal and/or Torres Strait Islander and Māori clinicians, communities and medical education experts to identify clinical experiences that support trainees to develop the skills and reflective practice that support culturally safe care for Aboriginal and/or Torres Strait Islander and Māori patients. In Aotearoa New Zealand, this includes developing Hauora Māori professional standards for doctors.
	
	In ensuring opportunities for all trainees to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander and Māori people, it is recognised that Aboriginal and/or Torres Strait Islander and Māori people seek and are provided care in all healthcare settings, not only in community-controlled health settings.
	
	In smaller training settings, support could include trainees being able to attend other centrally delivered sessions.
	
	For non-patient facing roles (for example, pathology, other diagnostics), trainees should be supported in developing specific knowledge and skills to deliver quality indirect patient care, including to Aboriginal and/or Torres Strait Islander and Māori people.
		• Evidence that the training setting demonstrates a commitment to an ongoing approach to a variety of personal development opportunities specific to Aboriginal peoples' and/or Torres Strait Islander peoples', or Māori peoples' health at all levels (e.g. networks, workshops, interprofessional learning opportunities, training etc.)
		• Evidence of providing alternative opportunities for trainees to demonstrate meeting the training program outcomes.
		  ○ What are the training opportunities that are made available? How are they promoted? Does the training setting have evidence that training opportunities map to the training program outcomes?
		  ○ Evidence of encouraging trainees to undertake further learning, courses and conferences may include those delivered by groups such as:
		  ▪ *In Australia: Leaders in Indigenous Medical Education (LIME), the Australian Indigenous Doctors' Association (AIDA), the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), and the Australian Indigenous Psychologists Association (AIPA).*
		  ▪ *In Aotearoa New Zealand: Te ORA, or Universities of Auckland, Otago or Whare Wananga.*
		• Data showing training undertaken by trainees.
		• Data showing trainees are meeting the training program outcomes regarding (i) Aboriginal peoples', (ii) Torres Strait Islander peoples', and (iii) Māori peoples' health, as relevant.
		• What are the culturally safe networks available to (i) Aboriginal trainees/staff, (ii) Torres Strait Islander trainees/staff, and (iii) Māori trainees/staff, to support those asked to provide development opportunities for colleagues?
			• Lowitja Institute: Deficit Discourse and Strengths-Based Approaches – Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing (2018) Link
			• Australian Commonwealth Department of Health, disability and Ageing: Aboriginal and Torres Strait Islander Health Curriculum Framework (2012) Link