

SCOPING REVIEW OPEN ACCESS

# Which Cultural Safety Strategies Are Making a Difference? Exploring Hospital Initiatives for First Nations Peoples in Australia. A Scoping Review

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## ABSTRACT

**Aim:** To explore the barriers, facilitators, and outcomes of strategies that have been implemented to improve the experience of cultural safety for First Nations inpatients in the Australian hospital setting.

**Design:** Scoping review.

**Methods:** Guided by the Joanna Briggs Institute scoping review methodology and reported using PRISMA-ScR, six databases were searched with data extracted and synthesised.

**Data Sources:** Cumulative Index to Nursing and Allied Health Literature (CINAHL), Emcare, Informit, Medline, ProQuest and Scopus databases. Searches were undertaken in March 2024.

**Results:** Forty-three articles representing 39 studies were included. Strategies were categorised as governance, service delivery, hospital environment, clinician education, and First Nations workforce. First Nations researchers were co-authors in most studies, and emergent themes were grounded in First Nations priorities, with an emphasis on developing the First Nations health workforce. Findings included (i) First Nations health staff being identified as cultural brokers between First Nations patients and non-First Nations clinicians; (ii) experiences of cultural safety being amplified when First Nations and non-First Nations health staff worked together; and (iii) strong governance being critical to addressing institutional racism and enabling cultural safety.

**Conclusions:** Embedding the voice of First Nations peoples in governance and an organisational commitment to strengthening the First Nations workforce are essential drivers for implementing cultural safety strategies in Australian hospitals.

**Implications for the Profession and/or Patient Care:** Working together respectfully and collaboratively offers a pathway forward for First Nations and non-First Nations health service clinicians and management to deliver culturally safe hospital care.

**Impact:** Culturally safe hospital care is integral to promoting the health of First Nations people. This study maps cultural safety strategies used in the Australian inpatient hospital setting, explores if and how these strategies have improved cultural safety and identifies barriers and facilitators to implementation. Fostering approaches to support understanding and respect between First Nations and non-First Nations clinicians and staff is integral to promoting culturally safe hospital care. Hospital leadership, policymakers and staff can benefit from understanding the drivers of culturally safe hospital care.

**Reporting Method:** Reported using PRISMA-ScR.

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**Patient or Public Contribution:** Guidance on this research was received from Aboriginal leaders at the first author's hospital workplace.

**Protocol Registration:** A research protocol was prepared in advance and registered: [https://osf.io/sfzby/?view\\_only=03c2349ebdae4a7ba95a621d9b7e8bc4](https://osf.io/sfzby/?view_only=03c2349ebdae4a7ba95a621d9b7e8bc4).

## 1 | Introduction

Delivering culturally safe healthcare to reduce health disparities and improve accessibility underpins Australian health policy (Australian Health Minister's Advisory Council 2016; Department of Health 2021; Department of the Prime Minister and Cabinet 2024) and reporting (Australian Institute of Health and Welfare 2023a, 2023b; Bainbridge et al. 2015). Culturally safe healthcare is an experience that centres the patient, their family, and community, requiring their cultural identity and differences to be meaningfully acknowledged throughout their healthcare journey. It also demands that healthcare providers and institutions actively recognise and address existing power imbalances, including the influence of racism (Australian Health Minister's Advisory Council 2016; Clifford et al. 2015; De Zilva et al. 2022; Department of Health 2021; Department of the Prime Minister and Cabinet 2024; Jongen et al. 2017; Thackrah and Thompson 2013). While in some cases it can refer to any cross-cultural care, in Australia it increasingly refers to the care being delivered to First Nations peoples (Clifford et al. 2015; De Zilva et al. 2022; Jongen et al. 2017; Thackrah and Thompson 2013). This review explores cultural safety strategies that have been used in the Australian hospital setting to promote the health and wellbeing of First Nations Australians. The authors respectfully acknowledge the diversity of cultures and identities of 'First Nations' people and use the term First Nations throughout this review to describe Indigenous, Aboriginal, and/or Torres Strait Islander people in Australia (Lowitja Institute 2024).

## 2 | The Review

There is an urgent need to identify strategies to improve the hospitalisation experience for First Nations Australians who experience a shorter life expectancy and entrenched inequality in health outcomes when compared with other Australians (Department of the Prime Minister and Cabinet 2024). A lack of access to culturally safe hospital care has been identified as contributing to this burden of disease (Australian Health Minister's Advisory Council 2016; Department of Health 2021). While improvements have been seen in primary care and public health measures such as immunisation, antenatal care, and health checks, these have not been seen in potentially preventable hospital admissions, which have increased over time (Australian Institute of Health and Welfare 2023a). During 2018–2019, 3 in 10 First Nations Australians did not attend healthcare providers despite having a need (Australian Institute of Health Welfare and National Indigenous Australians Agency 2023). In 2017–2019, First Nations Australians were hospitalised at 1.3 times the rate of other Australians (Australian Institute of Health Welfare and National Indigenous Australians Agency 2023), yet in 2019–2020, 4 in 100 hospitalisations ended in self-discharge, 5.2

times higher than other Australians (Australian Institute of Health and Welfare and National Indigenous Australians Agency 2024). Similar concerns are seen in Emergency Departments (ED), with First Nations Australians 1.5 times more likely to self-discharge than other Australians (Australian Institute of Health and Welfare and National Indigenous Australians Agency 2024). Chronic preventable diseases such as cardiovascular disease, chronic kidney disease, and diabetes have a combined hospital comorbidity for First Nations Australians that is 5.8 times higher than for other Australians, with incidence at younger ages (Australian Institute of Health and Welfare 2023), increasing the impact of these diseases over the lifespan.

To advance First Nations health outcomes and reach health equity, there is a need to improve experiences of cultural safety in hospitals; this is an outcome indicator of the Australian Government's National Agreement on Closing the Gap: transforming government organisations (Department of the Prime Minister and Cabinet 2024). Closing the Gap has been a government policy focus since 2008, yet there is limited evidence on ways hospitals have increased cultural safety or the effect on the experience of First Nations Australians in hospital. Tools to measure cultural safety are limited. Standardised patient feedback forms are one source of measurement but may not be acceptable or appropriate for First Nations people, many of whom may not speak English as a first language (Mithen et al. 2021). Routinely collected hospital administrative data, such as rates of self-discharge, are often used as a proxy to determine if people feel culturally safe. This indirect approach may be impacted by a range of factors related to hospitalisation, providing a limited indicator of cultural safety (Askew et al. 2021; Australian Institute of Health and Welfare 2023a). There is a need to expand understanding of strategies with demonstrated outcomes to guide hospital programmes and planning.

Foundational to the provision of cultural safety in health care settings is a culturally safe health workforce (Australian Health Practitioner Regulation Agency 2020). Representing the largest health discipline in Australia, the Nursing and Midwifery Board of Australia sets out requirements for nurses to ensure culturally safe and respectful practice. These include recognising that only individuals and their families can define what feels culturally safe; respecting diverse identities, beliefs, and experiences of all people, including colleagues; understanding the social, environmental, and cultural influences on health at all levels; practising inclusivity by rejecting bias, discrimination, and assumptions based on identity or background; ensuring a safe and supportive environment for individuals, families, and significant others; and role-modelling respectful behaviour and upholding the dignity, rights, and safety of all people in the workplace (Australian Health Practitioner Regulation Agency Nursing and Midwifery Board 2018). These requirements are comprehensive and may be addressed through a range of strategies in the hospital setting. It is for this reason that our review is encompassing in approach to strategy inclusion; strategies

### Summary

- What does this paper contribute to the wider global clinical community?
  - Opportunities exist to reduce health care disparities through the delivery of culturally safe hospital care.
  - Addressing institutional and individual racism is necessary for change.
  - Involving all staff, organisation-wide, is essential for the delivery of culturally safe hospital care.

were considered if they had the potential to create a supportive environment for First Nations' patients and their families, whether that was through upstream approaches such as policy interventions or downstream activities such as promoting individual staff cultural awareness or enhancing the physical hospital environment.

Previous literature reviews of delivering culturally safe care in acute healthcare settings have provided an overview of the international experience, particularly Canada and New Zealand (Clifford et al. 2015; Mbuji et al. 2017; Tremblay et al. 2023); focused solely on the patient experience (De Silva et al. 2022); or examined First Nations workforce positions (Mackean et al. 2020; Tremblay et al. 2023). Importantly, there is a body of studies that have explored what First Nations people want during their hospital stay, but comparatively few have reported the action arising from that knowledge. Overall, there is a lack of evidence exploring strategies that have actually been implemented to improve the cultural safety experiences of First Nations people in Australian hospitals (McGough et al. 2022).

### 3 | Aim

The aim of this scoping review was to understand strategies that have been implemented to promote cultural safety for First Nations Australians in the inpatient hospital setting. The overarching research question was:

What cultural safety strategies are making a difference to First Nations people in the Australian inpatient hospital setting?

*("First Nations of Australia" or aborigin\* or indigenous or "torres strait islander" or "first nation" or "first nations" or "first people" or "first peoples")*

**AND**

*(australia or "new south wales" or victoria or queensland or "northern territory" or Tasmania) AND ("Cultural Safety" or "Transcultural nursing" or "transcultural care" or "cultural competence" or "cultural awareness" or "cultural sensitivity" or "cross cultural care" or "cross-cultural care" or "culturally congruent care" or "cultural bias" or (cultur\* W/2 (care or safe\* or caring or competen\* or sensitiv\* or bias or secur\* or aware\*))*

**AND**

*(patient\* or inpatient\* or hospital\* or "health facility" or "Hospital unit\*" or (hospital\* W/2 (unit\* or department\* or ward\* or patient\* or inpatient\*)))*

**FIGURE 1** | Search terms.

This was explored using four research sub-questions:

**RQ1.** *What strategies have been used to enhance cultural safety for First Nations people in the Australian inpatient hospital setting?*

**RQ2.** *What outcomes have been reported from these strategies?*

**RQ3.** *Have these strategies been assessed or evaluated by First Nations people?*

**RQ4.** *What are the barriers and facilitators to implementing cultural safety strategies for First Nations people in the Australian inpatient setting?*

The objective of this research was to inform the decision-making capacity of hospital organisations, policymakers and health service planners to better support service delivery for First Nations Australians.

## 4 | Methods

### 4.1 | Design

A scoping review was undertaken to identify existing research on cultural safety strategies for First Nations inpatients in Australia. Scoping reviews are useful tools to map and summarise the available evidence, especially in emerging fields of research (Arksey and O'Malley 2005; Peters et al. 2020), and can be used to guide further research and implementation. This scoping review was guided by Joanna Briggs Institute (JBI) methodology for scoping reviews (Peters et al. 2022, 2020) and reported using PRISMA-ScR (Tricco et al. 2018) (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist (Data S1)). A research protocol was prepared in advance and registered: [https://osf.io/sfzby/?view\\_only=03c2349ebdae4a7ba95a621d9b7e8bc4](https://osf.io/sfzby/?view_only=03c2349ebdae4a7ba95a621d9b7e8bc4). Generative artificial intelligence (AI) was not used to formulate this review.

### 4.2 | Search Methods

A comprehensive search strategy was developed with the guidance of a university librarian experienced in First Nations health research (Figure 1). In March 2024, six databases were

searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Emcare, Informit, Medline, ProQuest, and Scopus. Reference lists of reviews identified in the search were examined for additional sources. Articles were imported into EndNote 20.6 (Clarivate Analytics, PA, USA). Duplicates were removed before title and abstract screening against the inclusion criteria, then full texts were retrieved and reviewed against inclusion criteria. The first author (KF) determined which articles met inclusion criteria, and this was verified by the second author (MO). A PRISMA flow chart describes this process (Figure 2).

### 4.3 | Inclusion Criteria

Articles included in this review were peer-reviewed original research articles that involved strategies used to promote the cultural safety of First Nations people in the Australian inpatient hospital setting. Strategies were included if they had the potential to support culturally safe and respectful practice, as described in the Nursing and Midwifery Board of Australia's Code of Conduct for Nurses (Australian Health Practitioner Regulation Agency Nursing and Midwifery Board 2018). Grey literature was excluded as this review aimed to explore the peer-

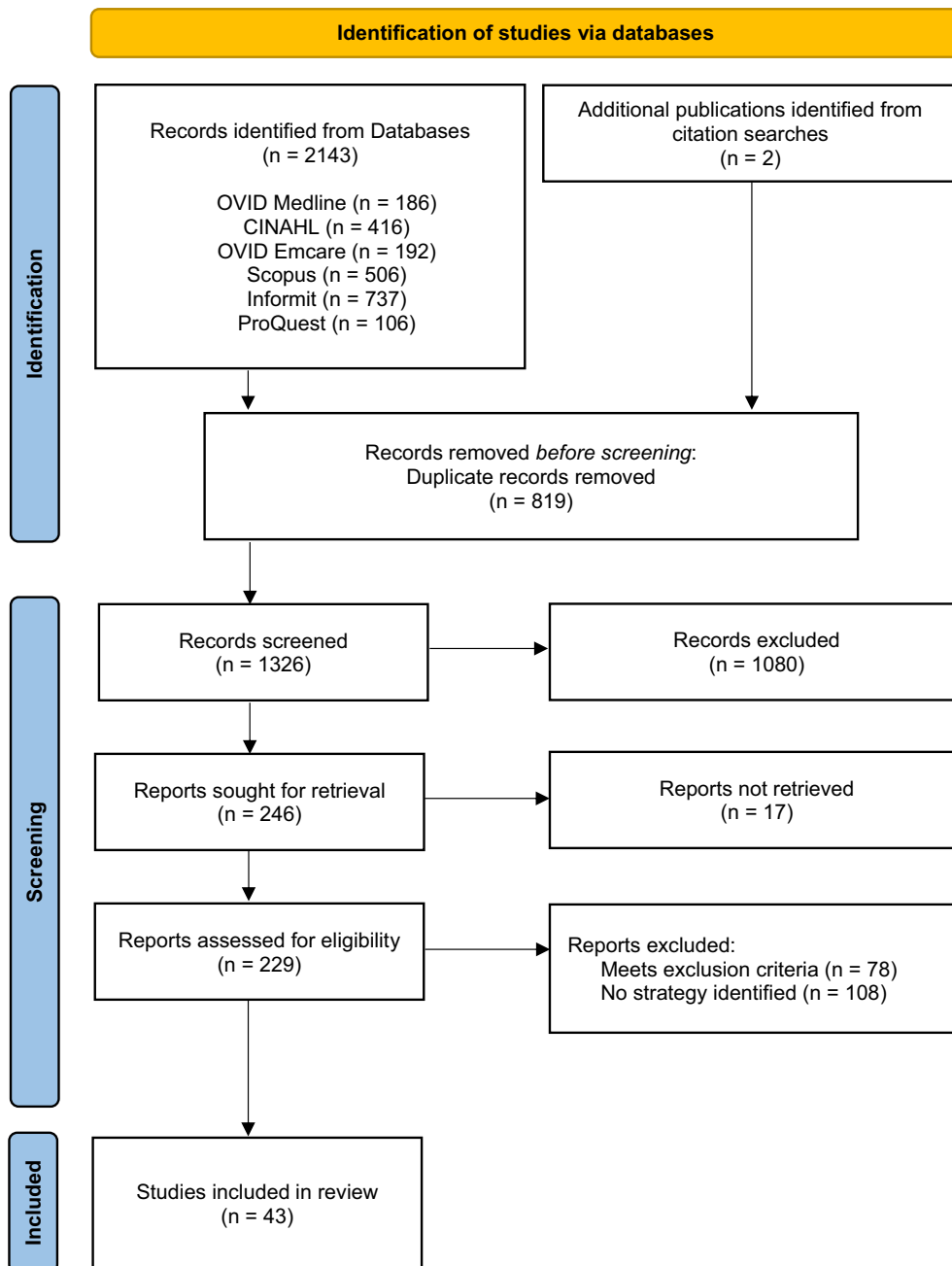


FIGURE 2 | Cultural safety in hospital PRISMA flow diagram. [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com)]

reviewed evidence base, rather than reports of cultural safety

strategies. Literature reviews were also excluded, and there was no restriction on publication date. Articles were excluded if they solely reported on outpatient (including haemodialysis and cancer centres), paediatric, perinatal or psychiatric settings, as these potentially involve a modified hospital environment and patient flow processes that are separate from general medical-surgical inpatient hospital care.

#### 4.4 | Search Outcome

A PRISMA flow chart describes the search outcome (Figure 2).

#### 4.5 | Data Abstraction

Data were extracted from the included studies into a Microsoft Excel data charting form, developed by both authors to identify the variables required to answer the research questions. The first author (KF) charted the data, and the second author (MO) undertook a confirmatory review. Data were extracted for article authors, year, strategy setting and scope, First Nations involvement in research, strategy type and purpose, key findings, outcomes, barriers, and facilitators to implementation.

#### 4.6 | Synthesis

The data was synthesised using a narrative and display approach to identify the range of strategies and reported outcomes (RQ1 and RQ2). As this research focuses on the experience of First Nations people, the involvement of First Nations researchers was recorded. Barriers and facilitators to strategy implementation were organised using a thematic approach (RQ4) (Braun and Clarke 2013).

To illustrate, if First Nations' people had been involved in reporting on strategy outcomes (RQ3), the strategy assessment or evaluation method was broadly identified as qualitative or quantitative, and those involved in assessing or evaluating the strategy were identified. Improvement in cultural safety following strategy implementation was recorded, as reported by the article authors. No assessment of the quality of strategy or evaluation was undertaken, as this is not an integral step in the scoping review design (Peters et al. 2022, 2020; Tricco et al. 2018).

### 5 | Results

Forty-three articles were identified that met the inclusion criteria (Figure 2), representing 39 studies. Strategies were categorised as Governance, Service Delivery, Hospital Environment, First Nations Workforce and Clinician Education, noting some studies were multi-strategic. Many studies included First Nations researchers as co-authors ( $n=29$ ), and one recruited First Nations research assistants within the study. Nine studies did not identify any First Nations researcher involvement (Table 1).

#### 5.1 | Organisation and Governance

Strategies that involved changes to hospital organisation and governance were identified. Two studies described comprehensive reorientation of hospitals to better meet First Nations community needs, with both identifying funding and governance restructuring as key components (Carroll et al. 2015; Quilty et al. 2019). Embedding the First Nations' voice in governance included the appointment of First Nations people to leadership roles, First Nations community consultation (Bourke et al. 2018), and an organisational commitment to increasing the First Nations workforce (Bourke et al. 2018; Reeve et al. 2015). Consultation with the First Nations community-identified hospitals delivering culturally safe care that could be used as exemplars to develop future strategies (Chong et al. 2011; Taylor et al. 2021).

Building community trust in health services is essential and will take time, given the historical inequities experienced by First Nations Australians (Barnes et al. 2022; Blignault et al. 2021; Gadsden et al. 2019; Kerrigan et al. 2021b; Quilty et al. 2019). Organisational support, including executive leadership and strong governance, was identified as essential to delivering culturally safe patient care (Barnes et al. 2022; Blignault et al. 2021; Carroll et al. 2015; Chong et al. 2011; Chynoweth et al. 2020; Gadsden et al. 2019; Kerrigan et al. 2024, 2021a; Lethborg et al. 2022; Mitchell et al. 2020; Quilty et al. 2019; Reeve et al. 2015; Taylor et al. 2020). Community-identified strategies were explicitly identified as a driver for organisational change (Carroll et al. 2015).

#### 5.2 | Hospital Environment

The hospital environment contributed to the First Nations inpatient experience of cultural safety. Waiting rooms were re-decorated to provide a more culturally welcoming environment (Barnes et al. 2022; Davison et al. 2024; Gadsden et al. 2019). Artwork and other demonstrations of First Nations culture, such as participating in ceremonies and traditional healers, were valued as evidence of the organisation's commitment to cultural safety by both First Nations patients and staff (de Souza et al. 2023; Parter et al. 2024; Reeve et al. 2015; Taylor et al. 2021). When First Nations artwork was introduced on theatre caps, an increased number of patients self-identified as First Nations (Peake et al. 2024). Cultural identity influenced preferences for hospital room configurations, including the need for a physical space to allow family to be present and having a connection to the outdoors (Nash et al. 2021).

#### 5.3 | Service Delivery

Family inclusion in treatment decisions and discussion was integral to promoting culturally safe service delivery for First Nations patients (Blignault et al. 2021; Chynoweth et al. 2020; Kerrigan et al. 2021a; Lethborg et al. 2022; Parter et al. 2024; Taylor et al. 2021; Wotherspoon and Williams 2019). Changes to service delivery focused on improving care coordination, enhancing communication and strengthening the connection

**TABLE 1** | Characteristics of included articles—study setting, aim, design, First Nations involvement and strategy type.

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First Nations involvement in research and study development	Strategy by type			
					Governance service delivery	Hospital environment	First nations workforce	Clinician education
Barnes et al. (2022)	VIC, single tertiary emergency department	Promote cultural safety by embedding reconciliation as core business in the emergency department.	Guided by strengths-based participatory methodology (participatory action research and appreciative inquiry).	First Nations co-author.	✓	✓	✓	✓
Bernardes et al. (2023)	QLD, multiple sites, pain services	Improve cultural capability and communication between non-First Nations staff and First Nations patients accessing pain management services.	Evaluation of education intervention (pre- and post-questionnaire; and qualitative inquiry), part of a larger research project.	First Nations co-author.	✓			✓
Blignault et al. (2021)	NSW, two tertiary hospitals, statewide	Explore patient, family and provider experiences of the holistic model of care, designed to ensure care is coordinated and safe, for Aboriginal adults with chronic conditions.	Evaluation of multi-site model of care (strengths-based, appreciative inquiry).	First Nations co-author.	✓	✓		✓
Bourke et al. (2018)	QLD, multiple sites, statewide	Examine institutional racism's role in creating health outcome discrepancies for First Nations people, and assess the management of institutional racism in an Australian hospital and health service.	Use of external assessment tool (matrix) to measure institutional racism. Comparison with an earlier case study.	First Nations co-author.	✓			✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research and study development	Strategy by type		
					Governance service delivery	Hospital environment	First nations workforce
Carroll et al. (2015) <sup>a</sup>	WA, single district hospital, statewide	Explore enablers of change following the reorientation of an acute care service to a culturally relevant primary health care service for First Nations people.	Enablers of change to the model of care were explored using qualitative inquiry.	First Nations co-author. Community-guided strategy.	✓		
Chapman et al. (2014)	VIC, single tertiary emergency department	Explore if cultural awareness training affected emergency department staff knowledge and attitudes towards First Nations people.	Evaluation of education intervention (pre- and post-questionnaire).	No First Nations involvement in research identified.			✓
Cheng et al. (2004)	NT, single tertiary perioperative department	Identify barriers and facilitators to improve communication between anaesthetists and First Nations people.	Audit of anaesthetist-patient communication using a questionnaire.	No First Nations involvement in research identified.			✓
Cheok et al. (2023)	NT, single tertiary orthopaedics department	Explore rates of self-discharge by First Nations people following the introduction of Aboriginal Liaison Officers as part of orthopaedic team.	Retrospective cohort study investigating the association between rates of self-discharge and employment of liaison officers.	First Nations co-author.			✓
Chong et al. (2011)	National intervention	Design of a toolkit to improve hospital-wide cultural sensitivity towards First Nations people.	Development and trial of quality improvement framework (toolkit). Informed by hospital case studies. Part of improving the Culture of Hospitals project.	First Nations co-author. Community-guided strategy.	✓		✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research authorship and study development	Strategy by type			
					Governance service delivery	Hospital environment	First nations workforce	Clinician education
Chynoweth et al. (2020)	National intervention	Develop a culturally safe cancer care pathway for First Nations people.	Development of care pathway through synthesis of a literature review and stakeholder input.	First Nations co-author. Community-guided strategy.	✓	✓		
Communicate Study Group (2020) <sup>b</sup>	NT, single tertiary hospital, statewide	Investigating the association between the employment of a First Nations interpreter, interpreter service usage and self-discharge.	Quasi-experimental pilot study. Part of Communicate project.	First Nations co-author.			✓	✓
Davison et al. (2024)	QLD, single tertiary emergency department	Evaluate intervention to promote culturally safe care to reduce the number of First Nations people presenting to ED who 'Take own leave'.	Evaluation of a multi-strategic project involving a pre-post quasi-experimental study design using mixed methods. Included a participatory action research approach to enable process improvements during implementation.	First Nations co-author.	✓	✓	✓	
Daws et al. (2014)	VIC, single tertiary cardiology department	Implement a model of care involving an Aboriginal Liaison Officer and specialist cardiac nurse working together to improve hospital care and attendance at cardiac rehabilitation services for First Nations people.	Development and implementation of a working-together model of care. Guided by a quality improvement framework that included a retrospective medical records audit.	First Nations co-author.	✓		✓	

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	Strategy by type				
				First nations involvement in research authorship and study development	Governance service delivery	Hospital environment	First nations workforce	Clinician education
de Souza et al. (2023)	NT, a single tertiary hospital, statewide	Improve connection to homeland for First Nations people in hospitals.	Case study of nature-based intervention.	First Nations co-author.		✓		
Durey et al. (2017)	WA, two tertiary oncology departments	Evaluate if a workshop can improve the confidence of radiation oncologists in their ability to offer culturally safe healthcare to First Nations people.	Evaluation of education intervention (Pre, post, and 2-month follow-up questionnaire).	First Nations co-author.				✓
Gadsden et al. (2019)	NSW, multiple emergency departments	Investigate if a quality improvement project increased the accuracy of identification of First Nations people in Emergency Department information systems, reduced the proportion of First Nations people who had an incomplete visit and improved the cultural appropriateness of systems and environments.	A Multi-method quality improvement project involving multiple baseline design, secondary data analysis, stakeholder qualitative inquiry and document review.	First Nations co-author.	✓			✓
Haynes et al. (2020) <sup>c</sup>	QLD, multiple sites, statewide	Design a tool to explore First Nations people's perceptions and experiences of healthcare buildings and preferences for specific healthcare settings.	Development and implementation of an online survey tool. Survey instrument informed by qualitative inquiry.	No First Nations involvement in research identified.		✓		

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research authorship and study development	Strategy by type			
					Governance service delivery	Hospital environment	First nations workforce	Clinician education
Kelly et al. (2016)	SA, multiple nephrology departments	Map patient journeys to enhance the coordination and quality of First Nations people's hospital renal care experiences.	Participatory action research involving patient journey mapping and qualitative inquiry. Part of the Managing Two Worlds Together project.	No First Nations involvement in this stage of the larger project (First Nations engagement in other stages documented).	✓			
Kerrigan et al. (2020)	NT, multiple hospitals, statewide	Assessment of First Nations cultural awareness training by health professionals.	Evaluation of education intervention (post-only questionnaire). Strengths-based approach. Part of the Communicate Study Partnership.	First Nations co-author.				✓
Kerrigan et al. (2024)	NT, single tertiary endocrine and nephrology departments	Health professionals' assessment of intercultural communication skills training to improve First Nation cultural safety.	Evaluation of education intervention (post-only questionnaire). Part of the Communicate Study Partnership (participatory action research).	First Nations co-author.				✓
Kerrigan et al. (2021a) <sup>d</sup>	NT, single tertiary nephrology department	First Nations language-speaking patients' and interpreters' experiences and perspectives of hospital care when access to interpreter-mediated communication is consistent.	Qualitative inquiry guided by critical theory. Part of the Communicate Study Partnership (participatory action research).	First Nations co-author.	✓	✓		✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research authorship and study development	Strategy by type		
					Governance service delivery	Hospital environment	First nations workforce
Kerrigan et al. (2021b) <sup>d</sup>	NT, single tertiary nephrology department	Document the process of self-reflection, and subsequent changes undertaken by renal doctors and interpreters when First Nations interpreters were embedded in the renal team.	Qualitative inquiry guided by critical theory. Part of the Communicate project (participatory action research).	First Nations co-author.	✓	✓	✓
Lawrence et al. (2010)	SA, single tertiary cardiothoracic department	Explore how improved travel arrangements to and from major metropolitan hospitals enhance the experience and outcomes for remote-dwelling First Nations people requiring cardiac surgery.	Quality improvement action research case study and patient journey mapping. Pilot of Remote Area Nurse Liaison Service.	No First Nations involvement in research identified.	✓		
Lethborg et al. (2022)	VIC, single tertiary oncology department	Report on the development, trial and evaluation of a consumer-codesigned, culturally informed model of supportive cancer care for First Nations people.	Develop, trial and evaluate a model of cancer care. Appreciative inquiry.	First Nations co-author.	✓	✓	✓
Mitchell et al. (2020)	QLD, single tertiary cardiology department	Describe the development, implementation and review of a culturally sensitive approach to a hospital-funded discharge medicine subsidy for First Nations people.	Develop, trial and evaluate a model of pharmaceutical care. Case Study. Part of the Better Cardiac Care project.	First Nations co-author.	✓		✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	Strategy by type				
				First nations involvement in research and study development	Governance service delivery	Hospital environment	First nations workforce	Clinician education
Mithen et al. (2021) <sup>b</sup>	NT, single tertiary hospital, sitewide	Validate a survey exploring First Nations peoples' experiences of hospital care; and document advice from First Nations interpreters on strategies to improve service delivery.	Medical records audit. Patient experience survey. Qualitative inquiry. Established baseline for the Communicate project.	First Nations part of research team. ✓	✓		✓	
Nash et al. (2021) <sup>c</sup>	QLD, multiple sites, sitewide	Identify design changes to the physical hospital environment to mitigate stress and support the recovery of First Nations people.	Questionnaire and qualitative inquiry, involving in-depth interviews following a survey.	First Nations research assistants were used during recruitment. ✓				
O'Connor et al. (2021) <sup>b</sup>	NT, single tertiary hospital, sitewide	Investigate the relationship between First Nations interpreter usage and First Nations peoples' hospital self-discharge rates, using a cultural safety lens.	Evaluation of complex intervention. Intervention mapping. Quantitative exploration of hospital data. Evaluation of education intervention (pre, post and 6–8 month follow-up questionnaire). Part of the Communicate Study Partnership.	First Nations co-author. ✓			✓	✓
Parter et al. (2024) <sup>d</sup>	NT, single district hospital, sitewide	Provide an exemplar of how hospital services for First Nations people can implement the cultural determinants of health into clinical practice.	Case example (qualitative).	First Nations co-author. ✓	✓		✓	

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	Strategy by type				
				First nations involvement in research and study development	Governance service delivery	Hospital environment	First nations workforce	Clinician education
Patel (2015)	National, statewide	Report on the pilot of an online cultural competency self-assessment tool, designed for pharmacists to measure their cultural responsiveness and communication skills, and followed up with a workshop to improve skills.	Pilot of an online self-assessment tool in a workshop environment. Included facilitated discussions.	No First Nations involvement in research identified.				✓
Peake et al. (2024)	NT, single tertiary perioperative department	Assess the acceptability and benefit of Indigenous art-themed caps, for operating theatre staff, on the First Nations' patient experience.	Evaluation of intervention (pre- and post questionnaire). Audit of strategy adherence.	No First Nations involvement in research identified.	✓			
Preis et al. (2022)	NSW, single tertiary emergency department	Explore why First Nations people were leaving before receiving care in the emergency department, and to design a programme to improve care delivery.	Evaluation of the ED model of care (pre- and post-dataset analysis).	First Nations co-author.	✓		✓	
Quilty et al. (2019) <sup>d</sup>	NT, single district emergency department	Identify First Nations people who are frequent attenders at hospitals and enrol them into community-based collaborative case management to improve their wellbeing and redirect them to a more preventative care approach.	Interim findings (at 10 months) of a prospective cohort study. Evaluation (pre and post) using multiple linked health and related datasets.	First Nations co-author, Community-guided strategy.	✓		✓	

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	Strategy by type				
				First nations involvement in research and study development	Governance service delivery	Hospital environment	First nations workforce	Clinician education
Reeve et al. (2015) <sup>a</sup>	WA, single district hospital, statewide	Evaluation of a single-governance structure involving reorientation of health services from an acute to a comprehensive primary health care approach in a remote First Nations community.	Evaluation of the health service partnership model of care using dataset analysis. Cultural safety strategies were identified but not directly measured.	First Nations co-author, Community-guided strategy.	✓	✓	✓	✓
Reilly et al. (2018)	SA, multiple oncology departments	Explore how care coordination influences First Nations people's experiences of cancer treatment.	Qualitative inquiry. Part of the CanDAD – Cancer Data and Aboriginal Disparities project.	First Nations co-author, community-guided strategy.	✓		✓	
Sinnott and Wittmann (2001)	QLD, multiple hospitals, statewide	Evaluation of awareness training for new doctors to enhance their understanding of First Nations people's culture and health.	Evaluation of intervention. Pre (survey) and post (interview) of LOs, directors of clinical training and medical education officers. Post-only survey of intern doctors.	No First Nations involvement in research identified.			✓	✓
Stanford et al. (2019)	NSW, two regional hospital's cardiology departments	Explore perspectives of coronary care health professionals regarding patient-practitioner communication with First Nation's people, and evaluate the acceptability and value of culturally focused educational videos.	Qualitative inquiry. Part of the Better Cardiac Care project.	First Nations co-author.				✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research authorship and study development	Strategy by type		
					Governance service delivery	Hospital environment	First nations workforce
Taylor et al. (2021) <sup>e</sup>	QLD single tertiary & WA single district oncology departments	Explore the experiences of First Nations cancer patients and their families with services identified as providing high-performing culturally safe care.	Case studies (qualitative inquiry). Part of Discovering Indigenous Strategies to Improve Cancer Outcomes Via Engagement, Research Translation and Training (DISCOVER-TT).	First Nations co-author, community-guided strategy.	✓	✓	✓
Taylor et al. (2020) <sup>e</sup>	QLD single tertiary & WA single district oncology departments	Explore the perspectives of hospital staff on services identified as providing high-performing, culturally safe care for First Nations people.	Case studies (qualitative inquiry). Part of Discovering Indigenous Strategies to Improve Cancer Outcomes Via Engagement, Research Translation and Training (DISCOVER-TT).	First Nations co-author, Community-guided strategy.	✓	✓	✓
Taylor et al. (2009)	WA, a single tertiary cardiology department	Explore the impact of a First Nations health worker on inpatient care and outpatient cardiac rehabilitation utilisation.	Evaluation of the health worker role involving qualitative inquiry, health data analysis and document audit.	First Nations co-author.	✓		✓
Welch et al. (2022)	National, sitewide	Identify the roles of, and specific services provided by, Australian hospital pharmacists/pharmacy departments in providing medicine management services to First Nations people admitted to Australian hospitals.	Explanatory sequential mixed methods, involving survey and qualitative inquiry.	No First Nations involvement in research identified.	✓		✓

(Continues)

TABLE 1 | (Continued)

Author (year)	Study setting, including location, hospital, department/sites	Study aim, including relationship to enhancing cultural safety	Study design	First nations involvement in research authorship and study development	Strategy by type		
					Governance service delivery	Hospital environment	First nations workforce education
Williams et al. (2021)	QLD, single tertiary perioperative department	Develop a culturally appropriate pre-surgery screening tool to ensure First Nations people are appropriately prepared to undertake surgery.	Development of a screening tool. Evaluation using concurrent mixed methods, involving health data analysis and qualitative inquiry.	First Nations co-author.	✓		✓
Wotherspoon and Williams (2019)	VIC, multiple hospitals, statewide	Compare the inpatient experiences of First Nations and non-First Nations people in a mainstream metropolitan hospital.	Cross-sectional patient survey.	No First Nations involvement in research identified.	✓	✓	✓

<sup>a</sup>Same hospital, research undertaken at different times.

<sup>b</sup>All articles from the same research project. O'Connor et al. (2021) will be used for both this and the Communicate Study Group (2020), while Mithen et al. (2021) are reported separately as they are a separate part of the same project.

<sup>c</sup>Articles from the same study. Nash et al. (2021) referenced in narrative.

<sup>d</sup>Articles exploring different perspectives from the same research project.

<sup>e</sup>Articles exploring different perspectives from the same research project.

with primary health care. Reorientation of acute health service delivery towards a comprehensive primary health care approach resulted in a reduction in ED presentations and unplanned readmission rates (Quilty et al. 2019); co-designed models of culturally safe care promoted adherence to co-designed care plans (Lethborg et al. 2022); and the development of a culturally appropriate screening tool administered by First Nations staff resulted in a reduction of patient-initiated surgical cancellations (Williams et al. 2021). Following the introduction of a multi-strategic model of care that involved improvements to coordinated care on discharge, subsidised medication supply, family involvement, and primary-care follow-up, an improvement in First Nations patient identification and a decrease in unplanned readmissions was qualitatively reported (Blignault et al. 2021). Further strategies designed to improve access to discharge medications were identified as an important foundation to strengthen care delivery and support culturally safe healthcare for First Nations patients (Lethborg et al. 2022; Mitchell et al. 2020; Preisz et al. 2022; Welch et al. 2022). Supporting First Nations patients through their journey to an urban tertiary setting was explored in two studies (Kelly et al. 2016; Lawrence et al. 2010), with one finding that enabling people to maintain their sense of self led to improved outcomes for the remote-living First Nations patient (Lawrence et al. 2010).

Barriers to culturally safe strategy implementation were related to the demanding hospital environment. These included the impact of bed pressure on the time and ability to deliver culturally appropriate patient-centred care (Blignault et al. 2021; Cheng et al. 2004; Kelly et al. 2016; Kerrigan et al. 2024, 2021b; Taylor et al. 2009); First Nations people (both staff and patients) having difficulty navigating complex hospital buildings and systems, leading them to feel unwelcome (Kerrigan et al. 2021b; Taylor et al. 2020; Wotherspoon and Williams 2019); and health funding models that disadvantage First Nations people (Carroll et al. 2015; Mitchell et al. 2020; Welch et al. 2022), especially those who must cross state borders to access treatment (Lawrence et al. 2010).

Supporting the cultural safety of First Nations people was problematic when hospital records did not support First Nations people's perspectives. Inaccuracies in Indigenous identification in hospital administrative records were recognised as potentially leading to the exclusion of First Nations people from planned strategies designed to enhance cultural safety (Blignault et al. 2021; Davison et al. 2024). Importantly, mixed methods exploration revealed that nearly half of patients (45%) who were documented as 'take own leave' in the dataset stated they left the ED because they believed their care needs had been met (Davison et al. 2024).

## 5.4 | First Nations Workforce

Having a First Nations person as a hospital staff member had a uniformly positive impact on First Nations inpatients (Cheng et al. 2004; Cheok et al. 2023; Davison et al. 2024; Daws et al. 2014; Lethborg et al. 2022; Mitchell et al. 2020; O'Connor et al. 2021; Preisz et al. 2022; Taylor et al. 2009; Williams

et al. 2021) with measurable outcomes reported including a reduction in First Nations patients self-discharging before treatment was completed (Cheok et al. 2023; Gadsden et al. 2019; O'Connor et al. 2021; Preisz et al. 2022); an improvement in the accurate identification of First Nations patients (Gadsden et al. 2019); and an increase in referrals to and attendance of cardiac rehab programmes post-discharge (Daws et al. 2014; Taylor et al. 2009). The role of a First Nations Care Coordinator was explored (Reilly et al. 2018), and new ways for existing First Nations staff to operate were identified, particularly those in health worker and liaison officer roles (Blignault et al. 2021; Cheok et al. 2023; Davison et al. 2024; Daws et al. 2014; Lethborg et al. 2022; Mitchell et al. 2020; Preisz et al. 2022; Taylor et al. 2009; Williams et al. 2021).

When First Nations patients interacted with First Nations staff, they felt reassured and able to communicate openly (Blignault et al. 2021; Kerrigan et al. 2021a; Mithen et al. 2021; Reilly et al. 2018; Taylor et al. 2021; Wotherspoon and Williams 2019). Concurrently, First Nations staff felt pride in advocating for First Nations patients, identifying that they act as an interface or bridge between patients and the hospital system (Blignault et al. 2021; Kerrigan et al. 2021b; Mithen et al. 2021; Reilly et al. 2018; Taylor et al. 2020).

Hospitals identified as delivering culturally safe care encouraged the professional development of their First Nations workforce (Chong et al. 2011; Taylor et al. 2020). Funding of positions and paid non-clinical time was a meaningful demonstration of organisational support to grow the First Nations workforce (Barnes et al. 2022; Bourke et al. 2018; Chapman et al. 2014; Chong et al. 2011; Daws et al. 2014; Kerrigan et al. 2020, 2024; Taylor et al. 2020).

First Nations workforce strategies with clearly defined role descriptions supported First Nations staff to feel part of the larger team (Kerrigan et al. 2021b; Mithen et al. 2021; Taylor et al. 2020). Cultural safety was supported when First Nations and non-First Nations staff worked respectfully alongside one another to deliver culturally safe care to the First Nations patient (Blignault et al. 2021; Cheok et al. 2023; Daws et al. 2014; Kerrigan et al. 2021b; Lethborg et al. 2022; Taylor et al. 2020). When First Nations staff worked alongside Non-First Nations staff, it created opportunities for the latter to observe the positive impact on patients and develop greater cultural awareness, leading to Non-First Nations staff incorporating culturally safe practices in their work, such as clinical yarning (Kerrigan et al. 2021b; Taylor et al. 2020, 2009).

The value of having First Nations and non-First Nations working together was demonstrated by rapid improvements to patient outcomes when changes were implemented (Preisz et al. 2022; Taylor et al. 2009). When shifts in organisational culture were sustained over time, the First Nations community had the potential to gain trust in the hospital, and First Nations staff reported viewing the hospital as a culturally safe employer (Blignault et al. 2021; Taylor et al. 2020). This was described as a virtuous cycle whereby the cultural safety of a hospital was enhanced by a stronger First Nations workforce (Taylor et al. 2020).

Strong relationships between First Nations and non-First Nations staff and patients and the wider First Nations community enabled opportunities to improve cultural safety for First Nations hospital patients (Blignault et al. 2021; Carroll et al. 2015; Chong et al. 2011; Chynoweth et al. 2020; Gadsden et al. 2019; Lawrence et al. 2010; Preisz et al. 2022; Quilty et al. 2019; Reeve et al. 2015; Taylor et al. 2020). However, many First Nations positions were only operational during business hours, limiting opportunities for culturally safe care outside of hours (Blignault et al. 2021; Cheok et al. 2023; Preisz et al. 2022; Quilty et al. 2019). Some First Nations roles were understaffed, and there was difficulty reported in retaining First Nations staff (Blignault et al. 2021; Lethborg et al. 2022; Taylor et al. 2009), particularly for more complex roles such as First Nations interpreters (Cheng et al. 2004; Communicate Study Group 2020; Kerrigan et al. 2021b; Williams et al. 2021). Factors influencing First Nations staff recruitment included cultural responsibilities, their own burden of disease, feeling unwelcome in the hospital workplace (Kerrigan et al. 2021b), and challenging application processes (Taylor et al. 2020).

## 5.5 | Interpreters

The use of interpreters provided opportunities to enhance inpatient cultural safety in the hospital setting (Cheng et al. 2004; Kerrigan et al. 2021b; Mithen et al. 2021; O'Connor et al. 2021; Parter et al. 2024). A need for trained First Nations interpreters to facilitate culturally safe communication of complex clinical scenarios was explored across four studies (Cheng et al. 2004; Kerrigan et al. 2021b; Mithen et al. 2021; O'Connor et al. 2021), with one study describing how First Nations patients were only able to clearly articulate their concerns when an interpreter could assist them (Mithen et al. 2021). The influence of having First Nations interpreters included in clinical rounds was described as 'transformative' to the delivery of culturally safe care by both patients and clinicians (Kerrigan et al. 2021a) and reduced rates of self-discharge (O'Connor et al. 2021).

Despite there being agreement on the importance of using First Nations interpreters, this role was underutilised in the hospital setting (Cheng et al. 2004), and a lack of appropriately trained interpreters in the diverse range of First Nations languages was acknowledged. Employing a First Nations interpreter coordinator was significantly more effective in promoting interpreter uptake than championing the strategy or training clinicians to work alongside interpreters (O'Connor et al. 2021). Strategies such as the use of plain English, 'teach-back', and describing clinical concepts using metaphors were described as ways to improve culturally safe communication when interpreters were not available (Kerrigan et al. 2024; Parter et al. 2024; Patel 2015; Taylor et al. 2021).

## 5.6 | Clinician Education

The influence of education strategies to increase the capacity of non-First Nations clinicians to deliver culturally safe healthcare was explored (Bernardes et al. 2023; Chapman et al. 2014; Durey et al. 2017; Kerrigan et al. 2020, 2024;

O'Connor et al. 2021; Sinnott and Wittmann 2001). Some studies identified access to cultural awareness training within the context of wider strategies (Barnes et al. 2022; Gadsden et al. 2019; Mitchell et al. 2020; Reeve et al. 2015), and two acknowledged the role of education in improving cultural safety (Patel 2015; Welch et al. 2022).

Successful educational strategies had shared characteristics: they were presented by local Elders, delivered information specific to the region, included interactive case studies and real-life experiences, included adequate time for self-reflection, and contained practical application tailored to the audience (Bernardes et al. 2023; Durey et al. 2017; Kerrigan et al. 2020, 2024).

All the educational strategies were assessed by asking the strategy participants. First Nations staff found cultural safety education beneficial in one study (Kerrigan et al. 2020). Only two educational strategies were not considered to be beneficial (Chapman et al. 2014; Sinnott and Wittmann 2001); these both had limited positive effects on the participant attitudes, although the earlier of these (Sinnott and Wittmann 2001) was positively assessed by the First Nations staff who delivered the education. This study was also notable as the only one where those delivering the education were asked to assess its effectiveness (Sinnott and Wittmann 2001).

## 5.7 | Racism, Culture and Communication

Institutional and individual racism was identified as a barrier to cultural safety (Barnes et al. 2022; Blignault et al. 2021; Bourke et al. 2018; Kerrigan et al. 2021b; Welch et al. 2022). Lack of access to culturally appropriate communication was linked to behavioural difficulties and patients being labelled as 'non-compliant' (Kerrigan et al. 2024). First Nations patients reported that non-First Nations staff sometimes made unchecked assumptions about language skills, asked family to interpret complex medical terminology, and expressed frustration if the patient was unable to understand (Kerrigan et al. 2021a; Reilly et al. 2018; Taylor et al. 2009). Microaggressions towards First Nations people were identified in several studies (Kerrigan et al. 2021b; Mithen et al. 2021; Nash et al. 2021; Reilly et al. 2018; Wotherspoon and Williams 2019), and it was acknowledged that this can be especially prevalent in parts of Australia where non-First Nations and First Nations communities are more segregated (Kerrigan et al. 2021b). In some studies, First Nations patients and staff identified instances where patients experienced overt racism, either through consenting to major operations without access to informed consent (Kerrigan et al. 2021a) or comments made by non-First Nations staff (Reilly et al. 2018).

For non-First Nations staff, a lack of cultural knowledge was a barrier to effective communication with First Nations patients. Some staff reported they avoided engaging with First Nations patients as they did not know how to appropriately ask questions and feared causing offence (Cheng et al. 2004; Kerrigan et al. 2024, 2021a; Mithen et al. 2021; O'Connor et al. 2021; Taylor et al. 2009); and some clinicians identified a lack of access to culturally appropriate educational materials (Lethborg et al. 2022; Stanford et al. 2019; Welch et al. 2022). However, when non-First Nations staff were

supported to undertake critical self-reflection, they became proactive in challenging implicit and organisational racism and taking on the onus of transformational change (Barnes et al. 2022; Durey et al. 2017; Kerrigan et al. 2024, 2021b; Parter et al. 2024). This capacity was further enhanced through sustained education strategies (Kerrigan et al. 2024), and when First Nations and non-First Nations staff worked together within a team.

## 5.8 | Measuring Strategy Outcomes

Strategy outcomes were measured using quantitative and qualitative approaches, and most involved First Nations patients and/or staff. Twenty-four studies quantitatively measured the impact of the cultural safety strategy. Some used routinely collected hospital administrative data to demonstrate the impact of the strategy on the hospital experience of First Nations patients ( $n=10$ ), while other studies directly collected data to assess their strategy ( $n=7$ ), created or accessed surveys of hospital patients and staff ( $n=8$ ), or reviewed hospital documents ( $n=2$ ). Qualitative assessment was predominantly drawn from participant interviews ( $n=13$ ) involving First Nations patients ( $n=7$ ), First Nations staff ( $n=8$ ), and non-First Nations staff ( $n=2$ ). Some studies used free text in surveys undertaken by First Nations patients ( $n=2$ ) and non-First Nations staff ( $n=2$ ) (Table 2). Notably, in every study where both First Nations patients and staff assessed a strategy outcome ( $n=5$ ), the two groups agreed with each other.

Two studies facilitated culturally appropriate communication to enable First Nations patients to complete patient experience surveys. In both studies, patients identified a perceived lack of respect and experiences of racism related to their hospital visit (Mithen et al. 2021; Wotherspoon and Williams 2019). In some studies, the effect of the strategy was measured without any engagement with First Nations people (Bernardes et al. 2023; Chapman et al. 2014; Cheng et al. 2004; Durey et al. 2017; Kelly et al. 2016; Kerrigan et al. 2024; Parter et al. 2024); although two of these are part of larger research projects with extensive First Nations engagement (Kelly et al. 2016; Kerrigan et al. 2024). In six studies, the effect of the strategy on cultural safety in the First Nations inpatient experience was not assessed (Barnes et al. 2022; Chong et al. 2011; Chynoweth et al. 2020; de Souza et al. 2023; Patel 2015; Welch et al. 2022).

## 6 | Discussion

There is a growing body of evidence translating research into practice in ways that can practically enhance the cultural safety of the First Nations hospital patient. It is essential that First Nations people are central to this process. Priorities identified in this review align with national policy frameworks that are written both for and with the First Nations community to guide health delivery to First Nations people in Australia (Australian Health Minister's Advisory Council 2016; Department of Health 2021). These include the Cultural Respect Framework 2016–2026 (Australian Health Minister's Advisory Council 2016) that describes six domains and the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Department of Health 2021), which has 12 priorities. This review used an

inductive approach and identified First Nations researchers as co-authors in most studies, with many studies measuring the strategy outcomes using datasets that involved First Nations patients or by directly querying First Nations peoples' perspectives (Domains 5, 6; Priorities 1, 11, 12); the necessity for strong organisational leadership and commitment to improving cultural safety (Domains 1, 4; Priorities 1, 8); the value of investing in and developing the First Nations health workforce, with a focus on the role of health workers and interpreters to demystify clinical and diagnostic processes for patients (Domain 3; Priority 3); the need for non-First Nations health staff to engage with First Nations patients in a culturally safe way (Domain 3); and the requirement to include family, both physically by welcoming them into the hospital environment and emotionally at the centre of treatment decisions and discussions (Domain 4; Priority 9). These findings demonstrate that existing research about the First Nations inpatient experience of cultural safety in the hospital setting is predominantly grounded in the priorities and values of the First Nations community.

Respect for First Nations staff and culture is foundational to creating a bridge between First Nations patients and the mainstream hospital's culture (Taylor et al. 2020). For the non-First Nations staff, a deepened understanding of the cultural and social contexts of First Nations patients has the potential to support a more holistic approach to care (Bainbridge et al. 2015). Enhancing clinicians' cultural competency requires more than educational initiatives—it involves fostering a commitment to lifelong cultural learning (Johnson and Withers 2018). Studies in this review demonstrated that when a strong organisational commitment to supporting cultural safety existed in a hospital setting, non-First Nations staff were encouraged to challenge institutional racism by introducing culturally safe practices such as clinical yarning during ward rounds, including traditional healers in treatment plans, and traversing institutional barriers to facilitate family inclusion in First Nations patient care.

Building organisational capacity to deliver culturally safe care is essential (Australian Institute of Health and Welfare 2023b; Tremblay et al. 2023), and this review identified the importance of First Nations and non-First Nations health staff working respectfully together. When cultural safety changes were sustained over time, the hospital's reputation improved in the First Nations community, and this encouraged uptake of employment by First Nations staff (Taylor et al. 2020), thereby strengthening the First Nations workforce and providing opportunities to further support cultural safety in the hospital setting.

Contemporary approaches to health service delivery rely on accurate patient datasets (Australian Institute of Health and Welfare 2023b), and inaccuracies in Indigenous identification in hospital administrative datasets have been noted in this review and other studies (O'Loughlin et al. 2020). Misidentification may lead to a wide range of impacts, including the potential exclusion of First Nations people from culturally safe initiatives in hospitals. With limited existing outcome measures of cultural safety strategies (McGough et al. 2022), there is a reliance on existing metrics such as rates of self-discharge and take one's own leave (Australian

**TABLE 2** | Cultural safety strategies used in hospitals—description, outcome and outcome assessment.

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	Asking first nations staff	
Barnes et al. (2022)	Development of a working group of ED clinicians and members of the hospital's Aboriginal Health Unit to improve the cultural safety of the emergency department in response to high rates of self-discharge. Strategy involved: regular forums with First Nations guest speakers, education to improve identification of First Nations patients, completion of online education on cultural safety, development of an information hub, redecoration of the waiting room with First Nations signage and language, information on waiting times and priority assessment of First Nations patients.	Outcomes not measured.				✓	
Bernardes et al. (2023)	Several one-day workshops on clinical yarning delivered at a range of sites to improve non-First Nations staff's communication skills. First Nations patients helped develop resources for use in workshops that were facilitated by First Nations and non-First Nations people.	Outcome: positive reception with staff requesting more.	✓			✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				
			Quantitative assessment	Qualitative assessment			Outcome not assessed
				Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Blignault et al. (2021)	Created an Aboriginal Transfer of Care team (ATOC) of First Nations Liaison Officers (LOs) and Patient Flow RNs to facilitate coordinated care on discharge, in response to high rates of unplanned readmissions. The model includes subsidised medication supply, family involvement, primary-care follow-up and linkages with external agencies. Strategy sustained over 3 years.	Outcome: increased First Nations patient identification, decreased unplanned readmissions/ED presentations, stronger partnerships between services, increased First Nations community trust in health service.	✓	✓	✓	✓	
Bourke et al. (2018)	Audit of a health service that had been working to reduce institutional racism and to identify key indicators of change. Identified improvements included creating First Nations community consultation body and appointing First Nations staff to leadership positions, improved reporting on routinely collected data on First Nations patients, First Nations traineeship program.	Outcome: a reduction in institutionalised racism.	✓				
Carroll et al. (2015)	Following a community-led decision to change health system delivery, a district hospital partnered with a local ACCHO to integrate cultural, clinical, primary and preventative health service partnerships. Health department approval is required as usually under different funding models.	Outcome: A community-led organisation that meets community needs and attracts staff.		✓	✓	✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Quantitative assessment	Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Chapman et al. (2014)	Cultural awareness training for staff was held as three workshops delivered over 6 weeks, facilitated by a local First Nations educator.	Outcome: no change in attitude statements and a small effect on familiarity statements about First Nations people.	✓				
Cheng et al. (2004)	After the First Nations Interpreter Service commenced, a survey of anaesthetists to was conducted to identify if they recognised language barriers to consent and used interpreters when necessary.	Outcome: underutilisation of First Nations interpreters even when language issues are identified, despite the positive effect when the service is accessed. Non-First Nations patients had better access to interpreters.	✓				
Cheok et al. (2023)	Embedded Aboriginal Liaison Officers in speciality rounds and multidisciplinary teams to reduce rates of self-discharge.	Outcome: reduction in First Nations patient self-discharge rates, with no effect on non-First Nations patient outcomes.	✓				
Chong et al. (2011)	Hospitals identified through First Nations community consultation as providing culturally safe care was examined to develop a quality improvement framework for hospitals to use when implementing changes aimed at increasing cultural safety. Included training First Nations staff in quality improvement processes.	Outcomes not measured.				✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	Asking first nations staff	
Chynoweth et al. (2020)	Development of an optimal cancer care pathway and care framework to promote the delivery of culturally appropriate care to First Nations patients. Extensive First Nations community and clinical consultation was undertaken. A framework has been developed that has been endorsed by all Australian health ministers.	Outcomes not measured.					✓
Communicate Study Group (2020) & O'Connor et al. (2021)	(2020 and 2021): Introduced a package of measures to improve First Nations interpreter use and thereby improve First Nations patient outcomes. Creation of the Aboriginal Interpreter Coordinator (AIC) position, training non-First Nations staff to champion interpreter use and teaching non-First Nations staff how to work with interpreters.	<p>Outcome (2020): that the AIC was the most important intervention of the package.</p> <p>Outcome (2021): the AIC was the most important intervention of the package, and a reduction in self-discharge rates for First Nations patients correlated with interpreter bookings. The AIC role increased to include orientation and mentoring of interpreters.</p>	✓				
Davison et al. (2024)	In response to high self-discharge, developed an alternate pathway into ED for First Nations patients, including ED information packs, follow-up after presentation by a First Nations nurse navigator, and increased linkages to community services.	<p>Outcome: an increase in self-discharge rates, possibly linked to a surge in overall presentations, but increased patient satisfaction with service was identified. Some patients self-discharged because they felt treatment had been completed by components of the pathway.</p>	✓				✓

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Quantitative assessment	Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Daws et al. (2014)	Introduction of the Care Coordination model with an Aboriginal Liaison Officer and specialist RN to improve cardiac rehabilitation engagement for First Nations patients. Facilitated attendance at rehabilitation by negotiating enrolment rules.	Outcome: increased referrals and attendance at cardiac rehabilitation.	✓				
de Souza et al. (2023)	Creation of outdoor spaces to reduce hospital building temperatures and provide green shaded spaces. Certain plants are chosen in consultation with local Elders to welcome First Nations patients to hospital and support ceremonial practices. Signage in the local language of the cultural significance of plants.	Outcome: Environmental impacts measured. The outcome of cultural strategies is not measured.					✓
Durey et al. (2017)	A one-day workshop for radiation oncologists on cultural awareness delivered at two sites, facilitated by a First Nations researcher using case studies and group discussion. Focus on identifying behaviours that demonstrate institutional racism to improve communication with First Nations patients.	Outcome: increased confidence in non-First Nations staff to deliver culturally safe care maintained 2 months post-intervention. Increased awareness in non-First Nations staff of First Nations cultural and social contexts, able to reflect on institutional and unconscious bias.	✓				✓

(Continues)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	Asking non-first nations staff	
Gadsden et al. (2019)	Emergency departments implemented initiative to improve First Nations patient identification, reduce self-discharge rates and improve the cultural safety of the systems and environments. Working groups of project officers, local First Nations community members and ACCHO staff and key hospital staff supported implementation.	Outcome: although some isolated improvements in First Nations patient identification and rates of self-discharge were seen, no programme effect was seen overall. Other improvements identified included improved referrals to First Nations community organisations and mandatory cultural awareness education for hospital staff.	✓	✓	✓	✓	
Haynes et al. (2020) & Nash et al. (2021)	(2020): Investigating patient preferences for health clinic vs. hospital and design components of hospital patient areas such as single/shared rooms, inclusion of window/balcony, and type of view using a survey tool with paired images. (2021): Explores patient preferences for design components of hospital patient areas such as single/shared rooms, inclusion of window/balcony and type of view.	Outcome (2020): preference for health clinics over hospitals, and for shared over single rooms, especially for those with long-term health issues and less education. Outcome (2021): Access to outside strengthens connection to Country. Private rooms allow family to visit, but shared rooms with another First Nations patient facilitate companionship. Fear of not being accepted by non-First Nations patients/families. The need for social inclusion and recognition underpin preferences. Stress increased when appropriate social interactions were absent.	✓	✓	✓		

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff		
Kelly et al. (2016)	Journey mapping against models of care to identify gaps and share knowledge between experienced specialist nurses with a high First Nations caseload.	Outcome: a template for patient mapping developed, a checklist for rapid transfer of palliative patients, use outcomes to develop an educational tool for other nurses.				✓	
Kerrigan et al. (2020)	Multiple one-day workshops on cultural awareness were delivered at multiple sites across a health service, delivered by a local First Nations educator.	Outcome: overwhelmingly positive feedback from participants, including First Nations staff. Requests for training to be broken up to allow discussion and reflection. Requests for intercultural communication training and interactions with Elders from diverse First Nations communities. Local information was appreciated.	✓	✓		✓	
Kerrigan et al. (2024)	The podcast was developed to be listened to alongside weekly hour-long workshops where guest First Nations 'specialists' facilitated discussion across 8 weeks. The aim was to develop critical thinking and facilitate behaviour change, especially in communication. Pilot study in two departments with engaged leadership.	Outcome: participants demonstrated engagement with the material, expressed confidence to make changes in their practice to deliver more culturally appropriate care.	✓				

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				
			Qualitative assessment				
			Quantitative assessment	Asking first patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	Outcome not assessed
Kerrigan et al. (2021a) & Kerrigan et al. (2021b)	(2021a): Embedded First Nations interpreters with a single specialty for clinical rounds—two languages represented. This article focussed on the experience of First Nations patients and First Nations interpreters. (2021b): Embedded First Nations interpreters with a single specialty for clinical rounds—two languages represented. This article focussed on the experience of First Nations interpreters and non-First Nations doctors.	Outcome (2021a): Patients were able to clearly communicate their unmet needs and understand treatment and decisions. The First Nations interpreter's presence shifted the power dynamic in the patient favour. Significant changes to patient treatment and care. Some patients had not understood the implications of operations due to a lack of an interpreter. Outcome (2021b): Doctors lengthened rounds to allow time for improved communication and found the experience rewarding while identifying barriers to systemic change, including overt and institutional racism. Challenges for First Nations hospital interpreters outlined.	✓	✓	✓	✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff		
Lawrence et al. (2010)	Journey mapping the transition of remote patients to a tertiary hospital for major surgery and subsequent piloting of a Remote Nurse Liaison Service to support that transition to ensure culturally safe patient care.	<p>Outcome: identified the transition leads to a loss of cognitive control for the First Nations patient.</p> <p>Cognitive control maintains the patient's worldview and self-determination. This was maintained when the Liaison Service was piloted, as patients were better supported and informed prior to transition for surgery, with improved physical and psychosocial patient outcomes.</p>	✓				
Lethborg et al. (2022)	Codesign with First Nations consumers to develop a model of care for oncology patients. Involved First Nations staff from local health services, LOs, clinicians, social workers and consumer representatives. From this, LOs and social workers developed model to assess First Nations patients within 48 h of presentation and develop a care plan to meet cultural and clinical needs.	<p>Outcome: all participants were seen in the timeframe and had individualised support plans developed.</p> <p>Development of care plans ensured family involvement in decisions, referrals to community services were made, certain patient costs were negotiated, and medications were subsidised. Some patients had cultural ceremonies enabled while in hospital.</p>	✓				

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Quantitative assessment	Qualitative assessment			
				Asking first patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Mitchell et al. (2020)	Public hospital administration staff, LOs, pharmacists and clinicians registered patients for closing the Gap programme and supported their transition to primary care when discharged by providing subsidised discharge medications and arranging GP follow-up. The project team attended cultural training.	Outcome: over half of First Nations patients received subsidised medications, and there was an increase in attendance at GP appointments. The organisation renewed the trial.	✓				
Mithen et al. (2021)	Audit of patient charts to determine if the First Nations language spoken was correctly identified and if interpreters were used. Also undertook a patient experience survey facilitated by First Nations interpreters.	Outcome: most hospital documents did not identify the First Nations language spoken. Only two interpreters were documented attending. First Nations patients found the standardised surveys confusing. Themes of their hospital experience included loneliness and lack of respect and some experiences of racism.	✓	✓			
Parter et al. (2024)	Using radio interviews of hospital staff, it investigates how a hospital that was culturally unsafe, worked to improve their service and be responsive to the First Nations community.	Outcome: increased inclusion of cultural practices such as bush medicine, understanding kinship structures, the role of family and being on Country to First Nations patients, and increased use of interpreters were all contributing factors. The hospital took organisational responsibility for change.			✓		

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Quantitative assessment	Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Patel (2015)	Hospital pharmacists completed a self-assessment tool of cultural competency and then attended a workshop. The workshop aim was to develop plans to improve individual cultural competence. First Nations Elders facilitated discussion on worldviews, and plain English techniques were explored.	Outcome: while many pharmacists adapt processes to support First Nations patients, it is rarely documented, and approaches are not systematic. Workshop outcomes not measured.				✓	
Peake et al. (2024)	Introduced optional caps for perioperative staff with First Nations artwork and names and roles prominently displayed.	Outcome: patients felt more comfortable and increased First Nations self-identification when caps were introduced.	✓				
Preis et al. (2022)	In response to high rates of self-discharge, they developed an alternate pathway into ED for First Nations patients, where all non-urgent First Nations patients are referred to the 'Flexiclinic' team of ED clinician and First Nations health worker. Patients can leave as needed with no influence to care. Assessment, referrals and discharge medications prioritised. Follow-up by First Nations health worker within 48 h.	Outcome: significant reduction in self-discharge rates 3 months after strategy implemented.	✓				

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Quantitative assessment	Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Quilty et al. (2019)	Introduced case management of frequent attenders—collaboration between hospital, ACCHO and community organisations. Addresses underlying determinants of health while improving health service utilisation to reduce frequent attendance rates. Funding and some governance from the health department.	Outcome: significant reduction in ED presentations and increased engagement with primary health.	✓				
Reeve et al. (2015)	Assessment of effect of service reorientation to comprehensive primary-care model on health indicators following formal partnership.	Outcome: significant improvements in appropriate service provision, increasing numbers of First Nations workforce, and increased access to culturally safe services, including family presence in hospital, cultural ceremonies and traditional healers.	✓				
Reilly et al. (2018)	First Nations Cancer Care Coordinators were introduced to help First Nations patients navigate the health system.	Outcome: Introduction of the coordinator had many positive effects on the cultural safety of the patient. Acted as a cultural broker, patient advocate and support person. Participants recounted experiences of overt racism but felt supported by the coordinator. Trial extended.		✓	✓		

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Quantitative assessment	Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	
Sinnott and Wittmann (2001)	A range of delivery options to educate new clinicians on the role of the LO in hospitals.	Outcome: limited effect seen on clinician attitude and behaviour. All LOs believed the strategy had been beneficial.	✓	✓	✓		
Stanford et al. (2019)	Specialist clinicians evaluating educational video series on cardiac care designed for patients of Aboriginal descent, featuring First Nations actors talking about cardiac procedures to demystify them.	Outcome: videos considered a valuable addition to practice.		✓	✓		
Taylor et al. (2020) & Taylor et al. (2021)	Perspectives on hospital cancer services, identified through community consultation as meeting the needs of First Nations people, were explored by staff (2020) and First Nations patients and families (2021) to understand how culturally safe care is being delivered.	Outcome (2020): staff feel well supported by colleagues and organisation. The LO role is clearly defined, part of the MDT. Strong executive leadership including the Aboriginal Health Strategy unit, Reconciliation Action Plan, is part of a wider culture of respect for the First Nations people. Organisation's good reputation in the First Nations community increases First Nations workforce. Cultural markers displayed, including, flags and artwork, and cultural occasions. Outcome (2021): patients feel culturally safe through communication and support of family networks, clinician advocacy, working with LOs, and inclusion of traditional medicine in treatment.	✓	✓	✓	✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment				Outcome not assessed
			Qualitative assessment				
			Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff	Asking non-first nations staff	
Taylor et al. (2009)	Introduction of a First Nations health worker to provide education and support to First Nations cardiac patients while engaging them to attend post-discharge rehabilitation. Provided telephone follow-up.	Increased follow-up but limited rehabilitation engagement due to a brief (6-month) trial period. Increased informal identification of First Nations patients by drawing on kinship networks. Clinicians felt they learnt how to deliver culturally appropriate care by working alongside First Nations health worker. The trial was to be extended but the First Nations health worker left the organisation.	✓	✓	✓	✓	
Welch et al. (2022)	National survey of unpublished pharmacy and organisational interventions to improve cultural safety for First Nations patients. Strategies identified: Use of cultural champions, LOs, interpreters, cultural advisory committees. Strategies to subsidise medication. Prioritising pharmacist reviews of First Nations patients, supporting medication management including simplified dosing, liaising with primary care/community pharmacy. Involving family in care, using culturally specific medication resources. Mentoring First Nations students. Noted that institutional racism is seen in many pharmacy processes.	Outcomes not measured.				✓	

(Continues)

TABLE 2 | (Continued)

Author (Year)	Strategy description	Outcome of strategy	Method of outcome assessment			
			Quantitative assessment	Qualitative assessment		
				Asking first nations patients and/or family/carers	Asking first nations staff	Asking non-first nations staff
Williams et al. (2021)	To reduce First Nations patient-initiated cancellation of elective surgery, culturally appropriate screening tool developed and trialled. First Nations staff administered screening tool.	Significant reduction in inpatient-initiated cancellations. Concerns and issues were raised and mitigated prior to the procedure; these included confusion about procedural preparation and lack of knowledge about the planned procedure.	✓			
Wotherspoon and Williams (2019)	Standard patient experience surveys were modified to include free text about improving the First Nations inpatient experience.	First Nations patients reported a poorer inpatient experience than non-First Nations patients, including issues of privacy, inadequate access to interpreters and LOs, lack of family inclusion and an unwelcoming hospital environment. First Nations patients expressed a need to interact with First Nations staff who share their heritage and advocate for them and help connect them to their family. Helps them overcome fear and improves their understanding of their care. Experiences of microaggressions detailed.	✓	✓		

Institute of Health and Welfare 2023b); however, this review reported on differences in the patient perception of the conclusion of a care episode and the recorded data. Further research is needed to better understand First Nations people's perceptions of the hospital care journey and to accurately document their experiences.

## 7 | Strengths and Limitations

Strengths of this review included using a systematic approach that followed a prescribed methodology, with clear inclusion and exclusion criteria. Not limiting strategy inclusion by date or an evaluation requirement captured a wide range of strategies.

Although assessing studies on their methodological quality is not a requirement of a scoping review, not assessing for risk of bias is a recognised limitation of the review method (Arksey and O'Malley 2005; Peters et al. 2022). Future research that assesses study quality is indicated to strengthen the evidence base.

First Nations researchers were not part of the author team. This is a limitation to any research pertaining to First Nations people. To somewhat address this concern, efforts were made to seek a First Nations perspective on the findings of this review. The Director of Aboriginal Health Strategy at the first author's hospital workplace appraised this research and provided feedback that contributed to the development of the final manuscript.

## 8 | Conclusions

A wide range of strategies has been implemented in Australian hospitals with the intent to enhance the experience of cultural safety for the First Nations patient. It is encouraging that many of these studies were grounded in First Nations priorities and co-authored by First Nations researchers.

This review identified that the experience of cultural security is amplified when non-First Nations and First Nations hospital staff work together respectfully and collaboratively. Addressing institutional racism requires organisational commitment combined with cultural and clinical leadership across all levels of the organisation, from the executive level to the bedside of the First Nations patient. This approach offers a pathway for First Nations and non-First Nations hospital staff, at every level, to work together to improve the cultural safety of hospital care for First Nations Australians.

### Author Contributions

**Kate Fowler:** conceptualisation, data curation, formal analysis, investigation, methodology, project administration, software, resources, validation, visualisation, writing – original draft, writing – review and editing. **Mary O'Loughlin:** conceptualisation, data curation, formal analysis, investigation, methodology, project administration, software, resources, supervision, validation, visualisation, writing – review and editing.

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### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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### Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** jocn70111-sup-0001-DataS1.docx.