Chinese patients’ perception of care quality and safety in Australia during acute and critical Illness

By

Ying Yu

Thesis
Submitted to Flinders University
for the partial fulfilment of Master of Nursing (Course work and Research)

Master of Nursing

College of Nursing and Health Sciences
Flinders University
January 2020

CONTENTS

LIST OF FIGURES

LIST OF TABLES

SUMMARY

Quality and safety improvement in the Australian health care system requires up-to-date evidence to measure the performance of care service and inform practice. It is an ongoing challenge in the acute and critical care areas due to the complex patient profile, fast paced decision making and high volume of patient transfer. In recent years, maintaining and improving the quality and safety standards in acute and critical care areas in Australia is further challenged by the increasing number of admissions of Culturally and Linguistically Diverse (CALD) patients. The evidence relevant to health care services for CALD people in Australia is scarce. Therefore, the Chinese population as one of the largest CALD groups in Australia was selected for this study to understand CALD population's hospital experience. The research question was 'what is the Chinese patients and families' perception of care quality and safety in Australia?'

This qualitative study used Gadamer's hermeneutic phenomenology as the methodology. Semi structured face to face interviews and thematic data analysis was used as the method. The interview was conducted in Chinese which is researcher's native language. Thematic analysis commenced with transcribing and colour coding in simplified Chinese to better capture the essence in the original language. Data was grouped into eight main themes including: disorientation, desire for information, desire for comfort, the perception of family involvement in patient's care, communication, reluctance to provide feedback and know how to provide feedback. Communication had two sub-themes including overcoming language barrier and communication issue other than language. Final themes were translated into English for this report.

Overall perceptions of Chinese patients and family members consider the care they received was caring, kind and personalised compared to their experience in China. The study however identified service gaps for Chinese CALD people in the Australian health care service. The result of this study contributes valuable new knowledge to the Chinese CALD patients' quality and safety regarding hospital care. The evidence generated from the study will inform policy improvement and staff education in CALD population care. As well as develop CALD patients' service resources and a specific CALD patients' feedback system review. Further research into CALD population from cultural background other than Chinese and health professionals who provide care to CALD population is needed.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed........Ying Yu..

Date.........10/01/2020...

ACKNOWLEDGEMENTS

The completion of this thesis would not be possible without the help of:

- I would like to thank all participants who contributed their valuable time to this study.
- I also would like to thank my husband Chun Liu for his ongoing support, patience and love.
- I thank Professor Lily Xiao and Associate professor Di Chamberlain for their guidance throughout this study.
- I would like to thank Dr Maurine Redden for her never-ending friendship, cat loving support, encouragement and input through the study.

CHAPTER ONE: INTRODCUTION

This thesis is the report of the Chinese patients and their families' perception of care quality and safety in Australia during their acute and critical illness. This chapter outlines the background and the rationale of this study, the significance of the study, statement of problem and research question. Finally, this chapter includes an outline of the remaining chapters of the thesis.

1.1 Background

Quality and safety in healthcare is often described under three components including the process of the care, the organisational structure guiding the care delivery and patient's outcomes (Hewson-Conroy, Elliott, & Burrell, 2010). Quality care is person centred, efficient, equitable and safe (Chaboyer, 2010; World Health Organization, 2008). Improving quality and safety in acute and critical care settings is an ongoing challenge because of its complex patient profile, fast-paced decision-making process and higher rates of patients' transfers (Rothschild et al., 2005; Walton et al., 2017). The ageing population and increased cultural diversity further challenges acute and critical care quality and safety in Australia (Australian and New Zealand Intensive Care Society, 2016; Australian Institute of Health and Welfare, 2016). It was reported that nearly half of Australians were first- or second-generation migrants and 2% of Australians do not speak English in 2016 (Australia Bureau of Statistics, 2017a). Culturally and linguistically diverse (CALD) patients and their families are exposed to more quality and safety risk factors compared to their non-CALD counterparts due to lack of language proficiency, limited knowledge about the health system and consumer rights, lack of comprehension during decision-making and, in some situations, a reluctance to ask questions and offer feedback on their negative experience (Komaric, Bedford, & Driel, 2012; Suphanchaimat, Kantamaturapoj, Putthasri, & Prakongsai, 2015).

In 2008, an Australian Charter of Healthcare Rights for consumers and healthcare professionals was published and effort was made to improve equitable health care for all cultural groups (Australian Commission on Safety and Quality in Health Care, 2008). Despite this, CALD patients still face barriers to utilize health services and encounter higher hospital costs compared with non-CALD patients (Independent Hospital Pricing Authority, 2015; Komaric et al., 2012). Furthermore, the acute care sector is not adequately prepared to meet the care needs of people from CALD backgrounds. For example, in South Australia, almost 25% of patients who needed an interpreter were not offered this service and only 30% of patients were asked about their cultural and religious beliefs during their hospital admission (Grant, Khan, & Taylor, 2016). Many international and national initiatives were focused on safety rather than quality (Hewson-Conroy et al., 2010). Data reports on the service performance specific to CALD people in Australia was lacking because patient's cultural and language background was not mandatory in routine data collection (The Australian and New Zealand Intensive Care Society centre for outcome and resource evaluation, 2017). Therefore, quality and safety measures in critical and acute care do not fully capture the experience of patients and their families from CALD backgrounds, thereby the data was unable to inform quality and safety improvement specifically related to CALD patients (Harrison et al., 2015; Manias, 2011; Principe, 2015).

Australia is home to 1.2 million population with Chinese ancestry and 82% of this population do not speak English at home (Australia Bureau of Statistics, 2018). In addition to migrants, it was reported that visitors from China were the largest source of overseas arrivals in Australia and accounted for 16% of all visitors in 2019 (Australia Bureau of Statistics, 2019). The different culture, language, political and health care system challenges this group's abilities to utilise the Australian health care service. Currently China remains the top country of birth of Australian residents and arrival of overseas' visitors. Therefore, exploring Chinese population's Australian hospitalisation experience can provide evidence to inform quality and safety improvement specifically related to CALD patients. To achieve this, the research question for the study is 'what is the Chinese patients and their families' perception of care quality and safety during their acute and critical illness in Australia'.

1.1.1 Hospital care in China

All participants recruited in the study were from China and constantly compared their experiences between Australia and China. Therefore, the outline of the hospital acute care and critical care services in China is necessary to help the interpretation of participants' perception of their hospital experiences in Australia. The health delivery system in China mainly depends on hospitals and has relatively high out of pocket cost (Meng, Yang, Chen, Sun, & Liu, 2015). Outpatient departments in each hospital serves as first point of care for any patients (Xu, Gorsky, & Mills, 2019). The disparity of service efficiency between rural and urban hospital is significant with the rural health system being particularly inefficient (Zheng, Gong, & Zhang, 2019).

The quality of health service in China also has some serious problem such as antibiotic misuse, overuse of intravenous therapy and high caesarian section rate (Zhang, Zhou, & Si, 2019). The service satisfaction rate of patients was only 56%, with 6% consider hospital facility was poor and almost 3% consider consultation by the doctor to be poor (Meng et al., 2015). According to the researcher's personal experience and from the evidence, the working environment for nurses in China is different from Australia. Nurses in China are all expected to work full-time on rotating shifts and paid a monthly salary (Tao, Ellenbecker, Wang, & Li, 2015). The hospital service quality measurement in China is decentralized and lacks standardized policies to apply to all hospital across the country (Tao et al., 2015). Higher nurse to patient ratios occurs in acute care (1:8 on day shift) and critical care (1:1 or 1:2) in China compared to Australia 1:4 in acute care and 1:1 in critical care. This difference correlates with nurses burnout, patient safety issues and low patient satisfaction rates in China (You et al., 2013).

1.2 The significance of the study

Australia is the most culturally diverse country in the world (Australia Bureau of Statistics 2017b). Health care services in Australia needs to be continually improved to meet the current population requirements. Exploring hospitalised Chinese CALD patients and their families' perceptions of care quality and safety in Australia is needed to generate evidence for service improvement in the area. This empirical study can be the basis for further research to explore CALD population's unique care needs during their acute and critical illness. The study can identify the barriers affecting the equitability of the health care delivery in Australia. Evidence generated can inform policy development to close the gap in health care disparity. Furthermore, resources for staff education and continuing professional development to improve evidence-based practice and provide culturally competent care can be implemented. A tailored patient education resource can be developed based on findings to empower the CALD population to make informed decisions during their acute illness. Effective CALD patient's education can also decrease adverse events, shorten hospital stays and improve treatment compliance therefore improve cost effectiveness. Findings from this study can also inform the current consumer feedback system by identifying barriers that inhibit CALD population's participation (Health and Community Services Complaints Commissioner (HCSCC), 2019).

1.3 Statement of problem

Acute and critical care is prone to adverse events due to higher acuity patients profile and fast paced decision making (Bion, Abrusci, & Hibbert, 2010). Maintaining quality and safety in this area requires relevant evidence to the Australian health system to measure performance and inform practice. The literature review identified that studies related to CALD patients' in Australian acute and critical care is scarce. The knowledge derived from international studies are not always transferable due to social-economic and health system differences. Lack of relevant evidence to the Australian context impacts on quality and safety improvement. A practical research design that can generate evidence in a timely manner is needed to address this issue. Understanding Chinese CALD population's hospitalisation experience aims to inform policy development, contribute to future quality and safety improvement and hopefully improve recovery, shorten hospital stay and result in reduced hospital cost.

1.4 Research questions

The aim of this study was to explore the acute and critically ill Chinese patients and their families' perception of care quality and safety in Australia.

The specific objectives of this study were to identify:

1) Overall perception of care quality and safety in hospitals in Australia;

2) The care needs and preferences of Chinese patients during acute and critical illness;
3) Chinese patients and their families/carers perspectives of communication;
4) Chinese patients and their families/carers' perspectives in participating in safety and quality improvement activities such as providing feedback.

1.5 Terms and terminologies used in the study

Table 1-1 Terms and terminologies

Terms and terminologies	Definition
Acculturation	Psychological and behaviour change as a result of contact of culture difference people.
Acute care	'Care in which the intent is to perform surgery, diagnostic or therapeutic procedures in the treatment of illness or injury. Management of childbirth is also considered acute care' (Australian Institute of Health and Welfare, 2019,para 6).
Chinese	Chinese in the study were people born in mainland China.
Consumer feedback system	System to enable patients and families to complain, compliment or provide suggestions about their hospital experiences.
Culturally and linguistically diverse (CALD) people	CALD people in this study were defined as adult patients born overseas, in countries other than those classified as "main English-speaking countries" and main language spoken at home is other than English (ABS 2014). The set of main English-speaking countries other than Australia comprises Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom (England, Scotland, Wales, Northern Ireland) and the United States of America (USA) (Australia Bureau of Statistics, 2014, para 19).

Culture	Customs, beliefs and social behavior of group of people.
Intensive Care Unit/Critical Care Unit	'A facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services. Defined as being capable of providing complex, multisystem life support for an indefinite period; a tertiary referral centre for patients in need of intensive care/critical care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role' (Australian Institute of Health and Welfare, 2019, para165).
Private hospital	'A privately (non-government) owned and operated institution catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners' (Australian Institute of Health and Welfare, 2019, para 273).
Public hospital	'A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients' (Australian Institute of Health and Welfare, 2019, para 284).
Quality and safety	'Patient safety is defined as prevention of error and adverse effects associated with health care; and quality is defined as 'the degree to which health services for desired health outcomes and are consistent with current professional knowledge'' (Australian Commission on Safety and Quality in Health Care, 2019, pg 5).

1.6 Thesis outline

The following chapters in this thesis include the literature review in the chapter two. The literature review provided the overview of existing knowledge related to the field. Chapter three presents the research design. The study methodology and method and associated ethical considerations will be discussed. The chapter four will outline the research results. The results will be discussed and analysed in the chapter five. Chapter six will present the limitations and strengths, implications for practice, the researcher’s reflection and the conclusion.

2 CHAPTER TWO: LITERATURE REVIEW

An integrative literature review was conducted to explore publications relating to cultural, linguistic and religious factors affecting quality and safety for hospitalised and critically ill patients to identify existing evidence as well as gaps in knowledge. The literature review was extended to patients from CALD backgrounds due to lack of literature in host countries. The following discussion will provide literature review method, problem identification, search strategy, data evaluation/analysis, present findings and limitations.

2.1 Aim

The aim of this literature review was to critically analyse current studies on cultural, linguistic and religious factors affecting quality and safety for hospitalised and critically ill patients. The review question is 'what is the perception of care quality and safety in CALD patients receiving care during their acute and critical illnesses'.

2.2 Literature review method

An integrative literature review is a method to achieve a holistic view of the topic by critical analysis of both qualitative and quantitative studies (Whittemore & Knafl, 2005). Critical analysis of the selected literature enables identification of the strength and weakness of previous studies as well as justification for the research question and method in future studies. The following five stages of the integrative literature review was used to structure the literature review: 1) Problem identification; 2) Literature search; 3) Data evaluation to measure methodological/theoretical rigour and data relevance; 4) Data analysis using constant comparative method to discover themes and 5) Interpretation and presentation of results (Whittemore & Knafl, 2005).

2.2.1 Problem identification

As advised for this initial stage there was a clear identification of the problem prompting this review. The identification of variables of interest, sampling time frame and types of research ensures that the boundaries and focus of the integrative review were clear (Whittemore & Knafl, 2005). Succinct problem formulation facilitates all stages of the review and assists in the differentiation between applicable information in the data extraction stage. The review question was developed using the Population/type of participants, Context Outcome and Study design (PCOS) framework suggested by Butler, Hall, and Copnell (2016) which was a Modified Population, Intervention, Comparison and Outcome (PICO) (Polit & Beck, 2017).The population /type of participants in the present review was acute and critically ill patients from CALD backgrounds, their carers and health professionals who were involved in caring for this patient population. The context was acute, critical illness and Intensive Care Unit (ICU) care. Outcomes were patient's experience, care quality and safety and health professionals' perception of CALD patients. The study design included qualitative and quantitative studies published within the last 10 years to ensure the research evidence was relevant to the current healthcare system regarding safety and quality performance measures. This approach also enabled findings to identify future research needs and inform the current practice.

2.2.2 Literature search strategies

A comprehensive search for literature published between 2008 and 2018 was conducted using PubMed, The Cumulative Index to nursing and Allied Health Literature (CINAHL), Web of Science, Medical Literature Analysis and Retrieval System Online (Medline), PsycINFO, the Cochrane Library and Scopus electronic databases. Keywords were organised around four areas: cultural and linguistic diversity, acute and critically ill patients, cross-cultural interactions, and quality and safety. The alternatives for each keyword were also identified and documented (see Table 2-1).

Table 2-1 Key words

CALD	Hospital care	Cross-cultural interaction	Quality and safety
Culturally diverse/diversity; linguistically diverse; culturally and linguistically diverse; non-English speaking; migrant; refugee; minority ethnic.	Intensive care; critical care; critical illness Acute care	Cross-cultural interaction; communication; experience; perception	Adverse event; error; mistakes

A Boolean search was conducted by combining the key words (see Appendix A). CALD patients in this review were defined as adult patients born overseas, in countries other than those classified as “main English speaking countries” and main language spoken at home is other than English (Australia Bureau of Statistics, 2014). The set of main English speaking countries other than Australia comprises Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom (England, Scotland, Wales, Northern Ireland) and the United States of America (USA) (Australia Bureau of Statistics, 2014).

Research articles were selected according to inclusion and exclusion criteria (see Table 2-2). These articles included primary studies written in English and were related to cultural and linguistic factors affecting both care quality and safety for critically ill adult patients in hospital settings. These concerned the perspectives of patients, their family members and health professionals. Thus, this literature review fully captured hospitalised CALD patients and family’s experience and the attitude of health professionals towards CALD population that influence the CALD patient’s experiences.

Table 2-2 Inclusion and exclusion criteria

		Inclusion criteria	**Exclusion criteria**
Population/type of participants	Patient	Adult patient, culturally and linguistically diverse, non-English speaking, from minority ethnic group, migrant	Non- CALD patient, single ethnic group without CALD issue, obstetric patient, infant/children
	Family	From CALD background/non-English speaking/migrant whose family members had hospital or ICU admission include parents, children, siblings	Friend, family member of infant/child who admitted to hospital or NICU
	Health care professionals	Hospital or ICU health care professional who provide care to CALD patient and their family members.	Primary health care
Context	ICU admission, Critical illness	Hospital care, Intensive care unit, Critical care unit	Primary health care
Outcomes	Experience, perception, feelings Safety and quality	Experience, views, perceptions, feelings, safety and quality	Treatment, intervention
Study designs	Research paper	Primary research	Discussion paper, literature review, grey literature, textbook

All selected articles were appraised using the Critical Appraisal Skill Programme (CASP) qualitative and quantitative checklist (Critical Appraisal Skill Programme, 2017) the former comprised 10 questions and the latter contained 12. The following equivalents were determined for each question according to the answers ‘yes’ = 2, ‘cannot tell or not applicable’ = 1 and ‘no’ = 0. A higher score was considered as a lower risk for methodological bias. Studies scoring less than a total of 50% were excluded. The selection process of the articles is summarised in Figure 1.

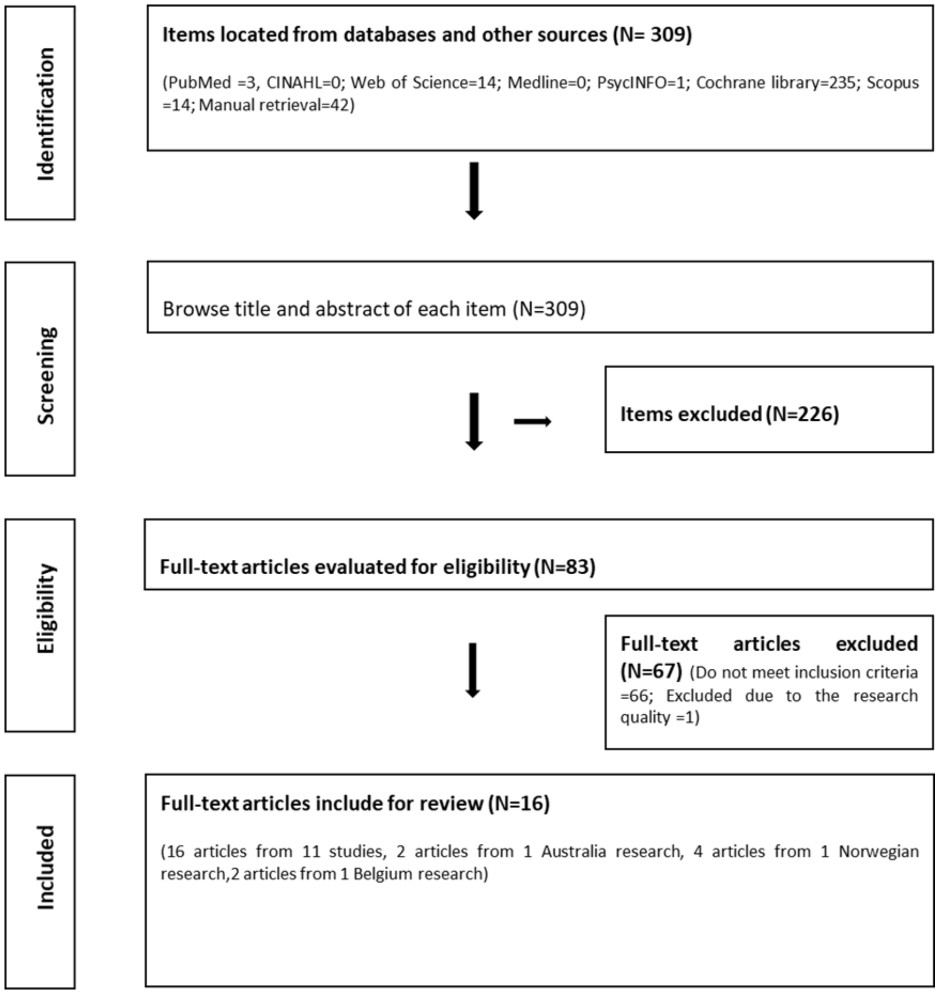


Figure 1 Article selection process

2.2.3 Search result

A total of 267 articles were identified in the keyword search and another 42 articles were identified in the additional manual search of the literature. After removing duplicates and reviewing their titles and abstracts, a total of 83 articles were retrieved and stored in EndNote X8 (see Figure 1). After the critical appraisal of selected articles, a total of 16 articles were included in the final analysis (see Table 2-3). The final analysis contained seven quantitative studies (Douglas, Delpachitra, Paul, McGain, & Pilcher, 2014; Erickson et al., 2011; Lee, Long, Curtis, & Engelberg, 2016; Mendu et al., 2013; Muni, Engelberg, Treece, Dotolo, & Curtis, 2011; Rodriguez et al., 2008; Thornton, Pham, Engelberg, Jackson, & Curtis, 2009) and nine qualitative studies (PW. Garrett, Dickson, Young, & Whelan, 2008b; PW Garrett, Dickson, Lis-Young, Whelan, & Roberto-Forero, 2008a; S. Høye, Kvigne, Åström, Severinsson, & Öster, 2015; Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Sevald Høye & Severinsson, 2010b; Khosla, Washington, Shaunfield, & Aslakson, 2017; Van Keer, Deschepper, Francke, Huyghens, & Bilsen, 2015; Van Keer, Deschepper, Huyghens, & Bilsen, 2017). The nine qualitative studies were conducted in Norway (n=4), Australia (n=2), Belgium (n=2) and the United States (US) (n=1) and were produced from four research projects. Despite multiple articles being published from the same study, each of them reported different aspects of findings. Of the seven quantitative studies, one was conducted in Australia and the remaining originated from the US. Participants of the included studies comprised patients (n=9), family members (n=8) and health professionals (n=5).

Table 2-3 Summary of included articles

Qualitative Research

	Author (country)	Aim/Objectives	Methodology/Method/data type	Samples/Participants	Key findings	Strengths/Limitation
1	Garrett et al., 2008a (Australia)	To conceptualise cultural competency based on non-English speaking patient experiences.	Grounded theory Qualitative focus group interview data	49 patients and 9 carers	– CALD people experienced lack of involvement in healthcare. – Communication barrier led to quality and safety issues. – Service issues included lack of staffing, lack of bilingual staff, lack of family involvement and lack of significant religious liaison people in the hospital. – Family member assumes the role of decision making and filtering of the information. – Patient's cultural belief and spiritual needs were evident.	– Findings are explicit, and recommendations of cultural competency added valuable knowledge to culturally competent care. – It is not directly exploring ICU care, however, some participants were critically ill.

2	Garrett et al., 2008b (Australia)	To explore the experience of non-English speaking patients.	Grounded theory Qualitative focus group interview data	49 patients and 10 carers	– CALD people experienced neglect such as treatment delays and medication errors. – Increased staff workload and pressure. – Lack of information and involvement; medication errors; and diagnostic errors. – Statements indicating fear and powerlessness. – The Happy Migrant Effect--an acceptance of a negative event in healthcare delivery in this population.	– It is not directly exploring ICU care; however, some participants were critically ill.
3	Høyea & Severinsson, 2008 (Norway)	To explore nurses' perceptions of their encounters with multicultural families in ICU in Norwegian hospitals.	Descriptive exploratory qualitative Qualitative multistage focus group interview data	16 ICU nurses	– Increased work stress. – Communication challenge. – Professional status and gender issues. – Culturally related difference in how to respond to crisis.	– Lack of justification of selected methodology – Risk of inconsistency in group members – This article and articles numbered as 4, 5 and 6 were published from the same study.
4	Høyea & Severinsson, 2010a (Norway)	To explore ICU nurses' experiences of conflicts related to practical situations when they encounter CALD patients and carers.	A descriptive and exploratory design Qualitative multistage focus group interview data	16 ICU nurses	– CALD population has culturally based needs to be actively involved in patient care. This challenge the role of ICU nurse. – CALD population's expectation of information sharing and cultural tradition conflict with policy and protocol.	– Lack of justification of the methodology and researcher's position was not evident to reader. – Lack of clarity about interview process. – This article and articles numbered as 3, 5 and 6 were published from the same study.

5	Høyea & Severinsson, 2010b (Norway)	To explore the experiences of multicultural family members in ICU.	Gadamerian hermeneutic study Qualitative multistage focus group interview data	5 family members	– CALD population filtering of information intended to ease patient's anxiety. – CALD population has strong family bonding during crisis. – Ritual and religious needs are evident among some families. – Cultural and tradition play an important part in decision making such as a male family member is the decision maker.	– Lack of justification of the methodology – Small sample size. – Lack of clarity about data saturation. – Lack of clarity about participants linguistic ability – The language issue in cross-cultural research was not addressed. – This article and articles numbered as 3, 4 and 6 were published from the same study.
6	Høye et al., 2015 (Norway)	To explore the comprehension of culture, caring and gender among first and second-generation immigrant women as relatives on their encounters with ICU nurses in Norwegian hospitals.	Discourse analysis Qualitative multistage focus group interview data	3 participants	– Women from CALD backgrounds often assume the role of carer. – Women from CALD backgrounds often need to navigate between two cultures.	– Lack of justification of small sample size and data saturation. – The language issue in cross-cultural research was not addressed. – Lack of clarity about interview process. – This article and articles numbered as 3, 4 and 5 were published from the same study.
7	Khosla et al., 2017 (USA)	To examine communication challenges faced by healthcare providers serving seriously ill South Asian patients and their families and present strategies recommended by providers for	Qualitative descriptive Qualitative focus group interview data	57 health providers	– Passive communication style among South Asian patients. – South Asian family members filtering of information intended to ease patient's anxiety. – Large family members and friends—difficult to identify who is the spokesperson of the family.	– Lack of justification of methodology and method

		effective communication.				
8	Van Keer et al., 2015 (Belgium)	To investigate the factors contributing to conflicts between healthcare professionals and families from ethnic minority groups in a multi-ethnic ICU.	Ethnography study Qualitative data collected from observations	10 patients and their visiting family members	– Conflicts were related to different expectations of care such as care practices, emotional involvement, information exchange and end-of-life decision making.	– Single site study – Limited transferability
9	Van Keer et al., 2017 (Belgium)	To investigate the state of the mental well- being of patients from ethnic minority groups during critical medical situations in hospital.	Ethnography study Qualitative data collected from observations	10 patients and their visiting family	– CALD patients need social contact. – CALD patients desire non-medical information exchange. – CALD patients need comfort. – CALD patients need to participate in end-of-life decision making.	– Single site study – Limited transferability
Quantitative Research						
10	Douglas et al., 2014 (Australia)	To determine whether being a non-English speaker would predict mortality in ICU.	A single-centre, retrospective cohort study Quantitative data extracted from ICU database	- Patients (n=22683) admitted to the ICU between January 1, 2000, and December 31, 2011 in Melbourne; - 5% non-English speaker patients in the study.	– English speaking status was associated with a higher death rate compared to non-English speaking status. – No difference in ICU length of stay between groups. – English speaking patients were associated with a shorter length of hospital stay.	– A single centre study – Limited generalisability due to the under-representation of non-English speaking patients in the study (27% of population speaking a language other than English at home in Australia in the census data (Australia Bureau of Statistics, 2017). – Potentially missing data e.g. Patients without language data were excluded.

						– Only first admission included if there is multiple admission to ICU (patient who re-admitted to ICU can be sicker and have higher mortality rate). – Uncertainty about the clinical implications.
11	Erickson et al., 2011 (US)	To determine whether race or ethnicity is independently associated with mortality or ICU length of stay among critically ill patients after accounting for patients' clinical and demographic characteristics including socioeconomic status and resuscitation preferences.	Historical cohort study Quantitative data extracted from medical records	- A total of 9,518 ICU patients (White n=6,334; Black n=655; Hispanic n=1,917, Asian/Pacific Islander n=612) from 35 Californian hospitals; - 33% minority race/ethnicity in the study.	– Hospital mortality and ICU length of stay did not differ by race or ethnicity after adjustment for severity of illness, resuscitation status, socioeconomic status, insurance status, and admission type. – White patients were most likely to have a Do-Not-Resuscitate advance directive at hospital admission.	– A good representation of non-white minority population – Limited generalisability due to a single state-based study and the under-representation of minority race/ethnicity in the study (40% in the USA Census data (United States Census Bureau, 2018).
12	Lee et al., 2016 (US)	To understand the association of minority race/ethnicity and education with family ratings of the quality of end of life in ICU.	Multicentre cross-sectional survey using structured face-to-face interviews, plus demographic data extracted from medical records	- 15 ICUs participating in a cluster-randomized trial of a palliative care intervention 1290 surveys for 2850 descendants in Seattle;	– Patient and family minority race/ethnicity were both associated with lower ratings of quality of dying. – Neither patient nor family education were associated with quality of dying.	– Health literacy wasn't adjusted. – Cultural preference in end-of life care was not measured. – Risk of missing data due to incomplete documentation. – Limited generalisability due to the under-representation of minority race/ethnicity in the study (40% of the population

				- 14% minority race/ethnicity in the study.	– Minority patients were significantly younger, had lower levels of educational attainment, were less likely to have a living will, and were more likely to die in the setting of full support and associated with lower family ratings of quality of dying. – Findings suggest that lower ratings of quality of dying may be a result of patient and family preferences for more aggressive care at the end of life.	reported in the USA Census data (United States Census Bureau, 2018).
13	Mendu et al 2013 (US)	To investigate the association between primary language spoken and all- cause mortality in critically ill patients.	Cross-sectional survey in two hospitals. Quantitative data extracted from electronic database	- 48 581 patients from 2 hospitals in Boston; - 6% non-English speaker patients in the study.	– Non-English speaking was associated with a lower mortality rate of in-hospital mortality, 30 day-mortality, 90-day mortality and 365-day mortality; – Non-English speaking was associated with a shorter length of hospital stay.	– Health literacy was not adjusted. – Cultural preference in end-of life care was not measured. – Limited generalisability due to the under-representation of non-English speaker patients in the study (19.6% in the UAS Census data described in the article). – Risk of missing data.

14	Muni et al 2011 (US)	To explore the influence of race/ethnicity on the use of ICU at the end of life.	Retrospective cohort study Quantitative data extracted from medical records	- 3138 patients who died in the ICU in Seattle; - 21% minority race/ethnicity in the study.	– Non-white patients were more likely to die with life-sustaining measures. – Restlessness and delirium assessed significantly less frequently for non-white patients.	– Cultural preference in end-of life care wasn't measured. – Risk of missing data due to incomplete documentation. – Severity of illness on admission was not adjusted. – Limited generalisability due to the under-representation of minority race/ethnicity in the study (40% of the population reported in the USA Census data (United States Census Bureau, 2018).
15	Rodriguez et al. 2008 (US)	To determine 1) ICU patients' surrogates' knowledge of their family members' care and resuscitation status; 2) whether characteristics, such as low education level and lack of English language comprehension, are associated with poor ICU care knowledge; 3) surrogates' ratings of ICU team communication; and 4) barriers to this communication.	Cross-sectional survey using structured face-to-face interviews Quantitative data collected from structured interviews	- 81 primary surrogate decision makers (PSDM) participated in a hospital in California; - 67% minority race/ethnicity in the study.	– Non-English speakers were more likely to have poor understanding on objective testing; – Poor communication was associated with not given enough time, explanations too complicated, and too emotionally upset. –	– No indication of ethics approval. – Limited generalisability due to small sample size and the over-representation of minority race/ethnicity in the study. – Qualitative study would be a suitable design for the research questions.

16	Thornton et al., 2009 (US)	To assess clinician-family end of life communication during ICU family conferences involving interpreters and compared it with conferences without interpreters.	Quantitative observational study using a study protocol Quantitative data collected from observations	– 4 hospitals in Seattle; – 39% minority race/ethnicity in the study; – Family members (n=70) and patients (n=10) from interpreted conferences – Family members (n=214) and patients (n=51) from non-interpreted conferences – Different physicians led interpreted conferences (n=9) – Different physicians led non-interpreted conferences (n=36)	– Clinician spend less time, show less emotional support in interpreter conferences.	– A good representation of minority race/ethnicity in the study; Patient’s illness and the severity of condition that might influence the conversation during the conference were not considered as variables. – Qualitative study would be a suitable design for the research questions. – Limited generalisability due to non-random sample and an observational study design.

2.2.4 Quality appraisal

Quantitative studies rated between 14 and 22 points according to the CASP quality appraisal tool. Of the seven quantitative studies, three used a cross-sectional survey design, three applied a retrospective cohort study design, and one was a prospective observational study. There was a lack of justification of research design among the quantitative studies (Douglas et al., 2014; Lee et al., 2016; Rodriguez et al., 2008; Thornton et al., 2009), and sampling bias existed due to the use of a non-random sampling method (Thornton et al., 2009), or single-site study limitations (Douglas et al., 2014). All reviewed studies did not provide information about sample size or the power of the studies. Two studies used a cross-sectional survey method and reported that their sample sizes were small (Lee et al., 2016; Rodriguez et al., 2008). For example there were 81 participants in the survey by Rodriguez et al. (2008). The sample in the observational study conducted by Thornton et al. included 10 patients and 22 family members (Thornton et al., 2009). Therefore, the findings were limited in their generalisability but were included in this review due to the limited number of publications in this area.

The qualitative studies were of higher quality in comparison to the quantitative studies. They also reported ethical approval from their local institutional ethics board whereas this was not apparent in two quantitative studies. Grounded theory, qualitative descriptive research, discourse analysis, Gadamerian hermeneutics and ethnography were the methods and qualitative methodologies employed. There was one Norwegian study that used different methodologies for qualitative analysis and therefore published these as four separate articles (S. Høye et al., 2015; Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Sevald Høye & Severinsson, 2010b). In these studies it was not clear how the recruitment of participants was processed (PW Garrett et al., 2008a), interview procedures lacked clarity (S. Høye et al., 2015; Sevald Høye & Severinsson, 2010a) as were the indicators for data saturation (S. Høye et al., 2015) .

2.2.5 Synthesis of findings

As nine out of the 16 reviewed studies were qualitative and the seven quantitative studies were observational studies, synthesis of findings in this integrated review was achieved by 1) transforming quantitative findings into qualitative descriptions and 2) undertaking a thematic analysis (Sandelowski, Voils, & Barroso, 2006). Transforming quantitative findings into descriptions without numeric findings or statistics was performed by outlining the key findings in Table 5 (see studies 10-16) (Sandelowski, Voils, & Barroso, 2006). A thematic analysis framework described by Braun and Clarke (2006) was applied to the review through five steps. First, researcher read each study carefully and extracted relevant data, organise the data in word documents for coding. Second, meaningful and repeated descriptions in the extracted data were analysed and highlighted using colour codes. Third, initial codes were developed to organise the data. Fourth, the initial codes were further analysed and clustered into categories through comparisons of the content of the data. The final step was to refine the categories into themes based on meanings, importance and relevance to the review objectives. The supervisors also read each article, checked and discussed the initial codes, categories and themes in regular meetings to achieve consensus. The four themes identified in this review were presented as: communication; the expectation of care influenced by cultural and/or spiritual specific needs; end-of-life care; and organisational structure, policy and culture (see Table 2-4).

Table 2-4 Findings from literature review

Category	*Sub-category*	*Codes*
Communication	Patient and family involvement with health professionals	Patient valued positive engagement, compassionate and respectful treatment from health professionals. Health professional reluctant to communicate with CALD patient and family due to language barrier and time pressure. Health professional often disprove family member's care request. Health professionals reluctant to exchange medical information with relatives. Health professional unable to respond to CALD family's express of emotion. Cared by bilingual staff is positive experience however some staff refuse to do so. CALD patient and family reluctant to report negative experience due to their language, cultural and social-economic status. Clinician demonstrated less emotional support and spend less time during interpreted end-of life conference.
	Roles of family member of patient with language barrier	Family feel the need of advocate for patients. Younger generation often act as interpreter for family. Challenge of entrust nurses to care their families. Family consider patient's role is powerless and need vigilant protection due to their language barrier. Patients feel powerless and anxious.
	Communication barrier associated quality and safety issue of care	Being ignored and misinterpreted care needs. Communication barrier cause treatment delays, medication administration without consent and poor compliance of treatment. Patient was not being able to express their daily care needs. Poor understanding of the care due to terminology used and insufficient time during conversation.
Expectations of care influenced by culture, spirituality and religion	Patient and family's culture, spiritual and religious beliefs during illness	Attending sick relatives is an obligation. Need of identifying a spoke person and gender issues among CALD family. Family actively involved in patient's care during hospital stay and Patients want care from family. Family decide what information to pass on to the patient. Family feel the entitlement of the medical information. Family bond need during crisis Different habit in regarding to death and dying between different cultures, e.g. who can withdraw treatment? Seen medical provider as non-questionable. Maintain female modesty during illness, e.g. female patient prefers female care providers. Different culture practice differently during sickness such as Chinese keeping warm. The importance of religious/spiritual symbol and ritual among some CALD families

	Staff's cultural competence	Health professional discover their own lack of knowledge about cultural and religious values. Racism
End-of life care	Health Care disparities/quality and safety issue	Families with limited language proficiency is at risk of receiving less information about their loved one's critical illness as well as less emotional support from their clinicians. Non-verbal care requests were ignored or neglected by healthcare professionals. The inability of the patient with limited language proficiency to understand and negotiate health and welfare services. Restlessness and delirium assessed significantly less frequently for non-white patients.
	Lack of involvement in end-of-life decision making from patient	Family with limited language proficiency were more likely to have poor understanding during surrogate decision-making process during end-of life care. Patient's voice often unheard due to higher hope in western medicine and expectation for cure among family members. Physicians' view of end-of-life decisions as medical decisions. Racial/ethnic minority patients were significantly less likely to have living wills.
Organisational structure, policy and culture	Organisational culture, policy and infrastructure of the hospital	Health professionals only focusing on patient disease unable to satisfy patient needs for social contact. Poor timeliness of treatment, poor staffing, lack of access to bilingual staff and language services. Strict visiting hours and policy. Mix gender ward was seen as negatively among some culture groups. Bilingual staff was seen as a positive in providing culturally and linguistically appropriate care.

2.2.5.1 ***Communication***

Cross-cultural communication issues were evident in twelve articles affecting CALD peoples' experience of hospital care during acute and critical illness (PW. Garrett et al., 2008b; PW Garrett et al., 2008a; S. Høye et al., 2015; Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Sevald Høye & Severinsson, 2010b; Khosla et al., 2017; Muni et al., 2011; Rodriguez et al., 2008; Thornton et al., 2009; Van Keer et al., 2015; Van Keer et al., 2017). There was a lack of understanding and motivation among health professionals to communicate clearly and transparently with patients and families from CALD backgrounds. Further, a failure to interpret or recognise care needs contributed to the negative experiences reported from this group of patients and their carers (S. Høye et al., 2015; Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Thornton et al., 2009; Van Keer et al., 2015; Van Keer et al., 2017). In one ICU, an ethnography study described communication that focussed on tasks rather than person-centred where the psychosocial care needs of CALD patients were largely overlooked (Van Keer et al., 2017). Further, patients' engagement in their own care was affected not only by a lack of interpreting services in the presence of a language barrier, but also insufficient time to discuss treatment with health professionals to clarify any medical terminology used (Rodriguez et al., 2008; Thornton et al., 2009). Miscommunication also contributed to treatment delays, treatment or care without consent and poor compliance of a treatment plan (PW. Garrett et al., 2008b; PW Garrett et al., 2008a; S. Høye et al., 2015; Van Keer et al., 2017). Patients experiencing language barriers often relied on bilingual family members to interpret, advocate and make decisions on their behalf (PW. Garrett et al., 2008b; S. Høye et al., 2015; Sevald Høye & Severinsson, 2010b; Van Keer et al., 2015). A lack of patient involvement with staff in discussing their treatment options made them feel powerless and anxious (PW. Garrett et al., 2008b; PW Garrett et al., 2008a; Van Keer et al., 2017). Relying on family members to act as interpreters impacted on translation filtering and accuracy, for example where family members believed that information should not be passed onto patients (PW Garrett et al., 2008a; S. Høye et al., 2015; Sevald Høye & Severinsson, 2010a; Sevald Høye & Severinsson, 2010b; Khosla et al., 2017; Van Keer et al., 2017).

2.2.5.2 *Expectations of care influenced by culture, spirituality and religion*

Eight articles identified that patients from CALD backgrounds had different expectations of hospital care compared to their counterparts from that country mainstream cultural group. These differences were due to the influence of culture, language use and spiritual or religious beliefs (PW Garrett et al., 2008a; S. Høye et al., 2015; Sevald Høye & Severinsson, 2008, 2010b; Khosla et al., 2017; Van Keer et al., 2015; Van Keer et al., 2017). Disagreements between health professionals, patients and their families were the result of cross cross-cultural misunderstanding. For example, family members, especially women expected to be tasked with a patient's basic care as an obligation and the right way to engage in family bonding during a crisis (PW Garrett et al., 2008a; S. Høye et al., 2015; Sevald Høye & Severinsson, 2008, 2010b; Van Keer et al., 2015; Van Keer et al., 2017). However, this met with disapproval by health professionals in the ICU (PW Garrett et al., 2008a; Sevald Høye & Severinsson, 2010a; Van Keer et al., 2015). Families of CALD patients, from the health professionals perspective, caused additional stress because they did not respect visiting hours, they were noisy, they overcrowded hospital space and demanded information (Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Van Keer et al., 2015; Van Keer et al., 2017). This cultural mismatch of expectations related to hospital processes and care and affected the trust, rapport and therapeutic relationships between the health care professionals and their patients and families. Further, this affected the quality of person-centred care and personal safety where there was a failure to determine and respond appropriately to patients' emotional and psychological distress, and a failure to engage patients' in decision making related to their care (PW Garrett et al., 2008a; Sevald Høye & Severinsson, 2008; Van Keer et al., 2017).

Five studies identified that personal belief systems were an important coping mechanism for some patients and their families, but not others (PW Garrett et al., 2008a; S. Høye et al., 2015; Sevald Høye & Severinsson, 2010b; Van Keer et al., 2015; Van Keer et al., 2017). Patients and families who followed a specific religion or belief often desired environments to support their practices; yet these needs were unmet or overlooked or misunderstood (PW Garrett et al., 2008a; Sevald Høye & Severinsson, 2010b).

2.2.5.3 ***End-of-life care***

Six studies reported patients from CALD backgrounds often died with full life-sustaining treatment and were less likely to have end-of-life directives (Douglas et al., 2014; Erickson et al., 2011; Lee et al., 2016; Muni et al., 2011; Van Keer et al., 2015; Van Keer et al., 2017). Moreover, the voices of patients from CALD backgrounds were less likely to be heard in end-of-life care decision-making processes due to cross-cultural communication barriers, high or unrealistic hope in Western medicine among families and religious beliefs (Erickson et al., 2011; Lee et al., 2016; Muni et al., 2011; Van Keer et al., 2015; Van Keer et al., 2017). Lack of assessment and intervention from health professionals to free this group from pain and distress was also reported (Muni et al., 2011; Van Keer et al., 2017). Disagreements between medical professionals and families during end-of-life care regarding withdrawal from treatment existed (S. Høye et al., 2015; Van Keer et al., 2015).

Three quantitative studies focused on the relationship between ethnicity and mortality in ICU patients or critically ill patients in an attempt to explore the quality of care and showed different results (Douglas et al., 2014; Erickson et al., 2011; Mendu et al., 2013). The study conducted by Douglas et al. in Australia and Mendu et al. in US reported a lower mortality rate in non-English speaking patients compared to the English-speaking patients in ICU (Douglas et al., 2014; Mendu et al., 2013), while the study conducted by Erickson et al. in the US reported no differences of mortality rate between the white patients and the non-white minority patients in ICU (Erickson et al., 2011). All three studies under-represented non-English speaking/non-white minority population in their sample which contributed to the result bias. For example, the Australian study only included 5% of patients from the non-English speaking background which was far below the 27% of the study population who spoke a language other than English at home in Australia (Australia Bureau of Statistics, 2017; Douglas et al., 2014). The study conducted by Mendu et al. in US only included 6% of patients from the non-English speaking background, which was far below the 19.6% of the study population as described by the authors in the article. The sample in Erickson et al. only included 33% non-white minority patients which was also lower than the 40% of the study population reported in the USA census data (United States Census Bureau, 2018).

2.2.5.4 ***Organisational structure, policy and culture***

Four articles identified that organisational policies were unable to accommodate patients' care needs associated with their culture, including flexible visiting hours and opportunities for family members to remain with patients during their hospital stay (PW. Garrett et al., 2008b; PW Garrett et al., 2008a; S. Høye et al., 2015; Van Keer et al., 2017). Inadequate cultural competence in health professionals existed and could be the result of lacking professional development opportunities or part of an organisational culture that overlooked the need to engage staff in cultural competence development (Sevald Høye & Severinsson, 2008; Van Keer et al., 2017). Other organisational issues include poor staffing, poor staff attitude and lack of access to bilingual staff or interpreting services to accommodate communication needs for patients (PW Garrett et al., 2008b; PW Garrett et al., 2008a; Rodriguez et al., 2008). Hesitation to provide feedback on the performance of hospital services in patients and their families from CALD backgrounds was also reported as a factor affecting the continuous improvement of care quality and safety (PW Garrett et al., 2008b; Khosla et al., 2017).

2.3 Discussion

The aim of this literature review was to critically analyse current studies on cultural, linguistic and religious factors affecting quality and safety for hospitalised and critically ill patients. The review question was ‘what is the perception of care quality and safety in CALD patients receiving care during their acute and critical illnesses’. Findings from this literature review revealed the unmet care needs and negative experiences of patients from CALD backgrounds during acute and critical illness. Factors that contributed to these situations included the different expectations of care services from CALD patient and their families due to their cultural, religious beliefs and language use. In addition to this, health professionals’ competence in cross-cultural care had a role to play. Furthermore, the design of the health care system is unable to accommodate the CALD patient’s care needs contributed to their negative experience.

Previous studies on hospital care quality for CALD patients reported a lack of mandated documentation about patients’ language proficiency in medical records, a culture of reliance on family members’ presence to communicate with patients instead of utilising interpreting services, and the absence of quality audits on communication (Blay et al., 2018; Paternotte et al., 2017; van Rosse, de Bruijne, Suurmond, Essink-Bot, & Wagner, 2016). This review highlighted a new understanding about the poor cross-cultural end of life care due to lack of engagement with CALD patients in their own decision-making during their acute and critical illness. The lack of advance life care directives, dying with full life-support and uncontrolled pain among CALD patients identified in this review were indicators of inadequate end of life care. Improving cross-cultural communication through education and training for health professionals, the use of professional interpreter services and the provision of culturally and linguistically appropriate information on advance care directives needs to be viewed as a way to promote a dignified end-of-life care for CALD patients.

The quality improvement intervention of the overall health system was viewed as associated with better outcomes compared to interventions of individual health professionals behavioural changes (Barrientos-Trigo, Vega-Vazquez, De Diego-Cordero, Badanta-Romero, & Porcel-Galvez, 2018). This review has identified that a systematic approach to improve quality care for CALD patients to address unmet care needs and poor cross-cultural communication is needed. For example, accommodating family members’ desire to participate in patient care in ICU settings (PW Garrett et al., 2008a; Sevald Høye & Severinsson, 2010a; Van Keer et al., 2015) could be achieved through more flexible visiting hours and considerations that enable family members to engage in some care activities during hospital admission. Moreover, unmet care needs related to patients’ spirituality and religious beliefs as identified in this review (PW Garrett et al., 2008a; Sevald Høye & Severinsson, 2010b) could be addressed through partnerships with family members or CALD communities. In addition, a language barrier in patients and their family members was also identified as a factor in cross-cultural communication (PW. Garrett et al., 2008b; S. Høye et al., 2015; Sevald Høye & Severinsson, 2010b; Van Keer et al., 2015). An easily accessible interpreter service is required to address the language barrier issue. As well a CALD patient friendly feedback system which easily to be located to enable patients and family members to provide feedback in preferred language is needed. The feedback will assist health professionals to improve quality and safety of care for CALD patients.

This review identified only three studies from two projects conducted in Australia that were related to quality of care for CALD patients in hospital setting (Douglas et al., 2014; PW. Garrett et al., 2008b; PW Garrett et al., 2008a). CALD patients in the study by Douglas et al. (2014) on mortality rate in ICU in Australia were under-represented and the findings might not be generalised. In recent years, efforts to improve both quality and safety of care in Australia focused on a range of areas such as critical care practice, clinical handover and developing partnerships with patients' families (Hewson-Conroy et al., 2010). More studies to generate research evidence to inform the quality improvements in these three areas are much needed.

2.4 Limitation

There are some limitations of this review, the first concern is the small number of studies on patients from CALD backgrounds. Although many similarities were reported across the selected studies, the overall evidence was weak. All studies were fundamentally unique due to differences in the sociocultural context making the analysis difficult. Secondly, multiple articles were published from single studies, further limiting the findings, while exclusion of non-English publications and grey literature possibly introduced selection bias. There was also potentially missing literature despite the effort and intention to cover all available evidence.

2.5 Conclusion

Quality and safety for acute and critically ill CALD patients can be influenced by various factors. This integrative literature review has identified that limited studies on the experiences of patients and their family members from CALD backgrounds over the past 10 years. Considerable evidence generated from international studies was not always transferable due to discrepancies in sociocultural context and incompatible healthcare systems. A lack of evidence relevant to an Australia context also may affect the implementation of evidence-based care quality and safety improvements in clinical settings. Thus, research that generates rigorous evidence on factors affecting and approaches to improving the quality and safety of care for CALD patients during acute and critical illness is essential. Such valuable evidence can inform policy and resource development, changes in practice and the overall development of the health care workforce. Further, improved care quality and safety can contribute to the health and wellbeing of this patient population, shortened hospital stays and reduced cost for hospital care.

3 CHAPTER THREE: RESEARCH DESIGN

Maintaining quality and safety standards for acute and critically ill CALD patients in Australia is an ongoing challenge. As discussed previously, lack of evidence relevant to the Australian context impacts on quality and safety improvement. This study adopted the qualitative methodology underpinned by Gadamer's hermeneutic phenomenology and used semi-structured in-depth interviews and thematic data analysis as a method. The following discussion describes the research design to achieve the aims and objectives, methodology and method, ethical considerations and rigour appropriate to the study design.

3.1 Methodology

3.1.1 Research paradigm

Quantitative and qualitative are two main paradigms in nursing research related to how individuals perceive the nature of the world (Borbasi & Jackson, 2016; Polit & Beck, 2017). Each paradigm consists of ontology (nature of existence), epistemology (the relationship between the researcher and those being studied), methodology (the approach taken by the researcher to guide conduct the research) and methods (a process used to conduct research) (Creswell & Poth, 2018; Polit & Beck, 2017). The qualitative paradigm considers there are multiple perspectives of realities and the world is viewed subjectively (Borbasi & Jackson, 2016; Liamputtong, 2017). The epistemological position in the qualitative paradigm is an emic approach where researchers subjectively examine the knowledge and try to get as close as possible to the participants being studied (Creswell & Poth, 2018; Killam, 2013). In contrast, the quantitative paradigm views the world objectively and believe in a single measurable reality using an etic approach to verify hypothesis or seek causal effect (Polit & Beck, 2017). Chinese patients' experience during acute and critical illness is complex and affected by multiple factors such as patient's health literacy, their past experience with the health care system, and staff culture competency. The study therefore requires the researcher to seek detailed information through a close observation or conversation with Chinese patients to understand, interpret and describe the complexity of their lived experience. It neither seeks causal relationship nor test hypothesis, rather an ontologically and epistemologically fit in qualitative paradigm (Creswell & Poth, 2018; Parahoo, 2014).

3.1.2 Justification of chosen methodology

The methodology of qualitative research includes but not limited to grounded theory, ethnography, narrative, case study and phenomenology. Grounded theory and ethnography were not chosen because the study was not intended to generate a theory of Chinese cultural behaviours (Creswell & Poth, 2018). Narrative and case study was avoided due to the limitation of the generalisability and risk of over interpretation of Chinese culture (Ennals & Howie, 2017; Nissen & Wynn, 2014). Gadamer's hermeneutic phenomenology was adopted because this methodology is not to provide a definitive description of a Chinese patients hospital experience but to illuminate the underlying essence from those experiences and seek in-depth understanding of the phenomena (Crowther, Ironside, Spence, & Smythe, 2017; Fleming, Gaidys, & Robb, 2003). As well it enabled the researcher to bring her culture, language and pre-understanding of Chinese patients' experiences to the research design which serves as an advantage in the cross-cultural study (Irvine, Roberts, & Bradbury-Jones, 2008; Liamputtong, 2008).

3.1.3 History of hermeneutic phenomenology

3.1.3.1 *Phenomenology*

Phenomenology is an approach to understand people's lived experience (Polit & Beck, 2017; Van Manen, 2017). Edmund Husserl (1859-1938) influenced by Brentano (1837-1917), developed phenomenology in his work 'Logical investigations' to challenge the then science dominated view on the nature of truth (Dowling, 2007; Moules, McCaffery, Field, & Laing, 2015). Husserl's phenomenology is epistemological and often referred to as descriptive phenomenology (Polit & Beck, 2017). Descriptive phenomenology focuses on the description of human experience in a world of objects (transcendental) and gaining knowledge requires the researcher to eliminate any preunderstanding of the phenomena being studied (bracketing) (Laverty, 2003; Polit & Beck, 2017).

3.1.3.2 *Hermeneutic*

Martin Heidegger (1889–1976), Husserl's student, moved away from Husserl and argued that interpretation/ hermeneutic is a basic characteristic of human understanding (Polit & Beck, 2017). While Husserl focuses on describing human beings and their experience, Heidegger focused on the interpretative meaning of the human being in the world and relationships between each other made understanding possible (Fleming et al., 2003; Polit & Beck, 2017; Van der Zalm & Bergum, 2000). Heidegger critiques Husserl's bracketing as impossible because consciousness is a formation of historical life experience and preunderstanding is the nature of being in the world (Laverty, 2003). According to Heidegger, understanding is through interpretation and the interpretive process achieved from the hermeneutic circle (Annells, 1996). Heidegger's hermeneutic is existential-ontological because of its concerns of human existence (Dyer, 2010; Fleming et al., 2003).

3.1.3.3 *Gadamer's hermeneutic phenomenology*

Hans-George Gadamer (1900-2002), who took up a linguistic and ontological stance from Heidegger, outlined his philosophical hermeneutic based on the question 'how is understanding possible' (Fleming et al., 2003; Moules et al., 2015). Gadamer blended ancient hermeneutics and phenomenology, and was in agreement with Heidegger that language and understanding are inseparable and further developed Heidegger's hermeneutic circle by emphasising text and conversation as a media for interpretation (Converse, 2012; Laverty, 2003). Gadamer acknowledges that one's preconceptions/historical awareness (prejudices) is part of individual's linguistic experience and play an essential role in understanding and interpretation of a phenomena (Annells, 1996; Dowling, 2004, 2007; Dyer, 2010; Fleming et al., 2003; Gadamer, 2004; Peck & Mummery, 2018). According to Gadamer (2004), understanding and interpretation are a continuous dialogic and open-ended process (hermeneutic circle of understanding and linguistics of understanding) and no one reading of the text offer definite interpretation (Dombro, 2007; Fleming et al., 2003). Furthermore, Gadamer asserts that Individual's self-understanding and understanding of others are modified through the dialogue because of the changing of the individual's preconceptions during the process called 'effective history'(Dowling, 2007; Dyer, 2010). Eventually, the person who expresses him/herself and the person who understands are connected by a common human consciousness (fusion of horizon) which makes understanding possible (Dyer, 2010).

Gadamer's hermeneutic phenomenology is the most suitable methodology for the study because it offers the opportunity for in-depth understanding of the Chinese patient's hospital experience in Australia. The process utilises the researchers' culture and language background to facilitate the dialogue described by Gadamer, therefore promotes the understanding of the participants' experience. This methodology also offers no definite conclusion which allow readers of this thesis to achieve their own understanding of the phenomena described as fusion of horizon.

3.2 Method

This study adopted Fleming et al.'s (2003) research process underpinned by Gadamer's hermeneutic phenomenology. The research question was developed to seek in-depth understanding of the hospitalised Chinese patient's experience. The researcher's pre-understanding of this phenomena was thoroughly examined. In-depth Interview as the method was congruent with Gadamer's hermeneutic phenomenology that understanding was only achieved from the dialogue (Fleming et al., 2003; Peck & Mummery, 2018). The notion of the dialogue includes not only a dialogue between the researcher and participants but also a dialogue between the reader and the text (Fleming et al., 2003; Peck & Mummery, 2018). Therefore, semi-structured in-depth face to face interviews were conducted to gain an understanding of participant's experiences. Each Interview was conducted in Mandarin Chinese (researcher and participants' native language) to facilitate better understanding of the phenomena. Interviews were audio recorded and transcribed verbatim in Chinese for data analysis. The transcription was checked by the bilingual supervisor to ensure the accuracy. A reflective journal was maintained to ensure any changes in the preunderstanding was continually examined as the study developed. Field notes that document participants' non-verbal responses were taken to assist with data interpretation. Transcribed data including field notes were analysed in the original language to gain an understanding through the text (Fleming et al., 2003). Participants were given an opportunity to review the transcripts. This process was to complete Gadamer's hermeneutic circle and to gain a shared understanding in relation to their experiences. Sample strategies, participants' recruitment, data collection and data analysis process are discussed in the following section.

3.2.1 Sampling strategy/ Sample size justification

Gadamer’s hermeneutics phenomenology purposely seeks the participants for in-depth understanding of the study topic (Laverty, 2003; Moules et al., 2015). There are many types of sampling strategies and terminologies used in qualitative research includes but not limited to convenient sampling, criterion sampling, snowball sampling (referral sampling), purposive sampling (targeted sampling) and theoretical sampling (Polit & Beck, 2017; Trotter II, 2012). The criterion sampling and snowball sampling strategy was used in this study. Criterion sampling is an approach that select participants according to the predetermined criteria (Polit & Beck, 2017). Compared to convenience sampling, the advantage of criterion sampling is that it allows identification and selection of participants with the most knowledge and experience of the phenomenon (Polit & Beck, 2017). Combined criterion sampling and snowball sampling allowed recruitment from community rather than limited in one hospital (Polit & Beck, 2017).

Gadamer’s hermeneutic phenomenology is not validated by sample numbers but relies on the richness of the data collected (Moules et al., 2015). A small sample size, often 10 or less can reach data saturation which is collected data to illuminate patterns and themes (Guest, Bunce, & Johnson, 2006; Polit & Beck, 2017; Robinson, 2014). The study recruited 10 Chinese patients and their family members. Data collection and analysis was conducted simultaneously to ensure participants’ recruitment and data collection continued until no new information emerged (data saturation). In-depth interviews with participants ensured the richness of the data collected therefore the sample size was sufficient.

3.2.2 Participants recruitment

The study population included adult Chinese patients and their families aged over 18 years who had an acute and critical care admission in Australia. Participants’ inclusion and exclusion criteria is summarised in table 3-1.

Table 3-1 Participants selection criteria

Inclusion criteria	Exclusion criteria
Adult patients aged over 18 years	Circumstances that interfere with the participant’s ability to give informed consent, e.g. cognitively impaired patients without families
Chinese background as defined in the study	
Acute and critical care admission within 3 months of interview	

Chinese patients' family who are the main carer of the patient during their admission	

Participants' information and consent was translated to Chinese and quality checked by the bilingual supervisor. The first four participants were recruited from one metropolitan hospital in South Australia. Potential participants were given a pre-packaged sealed information pack (including participants' information and consent, researcher contacts) at discharge from the hospital. They had two weeks to consider participation. They received a follow up letter after their discharge to improve the participant recruitment rate. Health professionals who provided direct care services for these patients were not involved in participants' recruitment. More participants who met the selection criteria were referred by the first four participants from the Chinese community to the researcher. These referred participants had various private and public hospital admissions in South Australia.

3.2.3 Data collection

A 30-60-minute semi-structured face to face in-depth interview using a pre-developed interview guide (see Appendix B) was conducted after patient discharge (both the patient and their families) to discuss their acute and critical care experiences. The interview was conducted in Mandarin as it was the preferred language among participants. Mandarin is the researcher's native language; therefore, interpreter services were not required. The interview was guided by the overarching question 'what was it like to be in an Australian hospital'. Four open-ended interview questions were developed to address the stated objectives in Chapter one. These questions focused on gathering data that lead to a textual description of the Chinese patient's hospital experience. Probing questions were developed to ensure the flow of the conversation and the focus of the research objectives. Questions and probes were asked in a different order or some omitted or added, depending on the participants' responses. Interviews were audio recorded. A reflective journal was maintained to ensure any change of the preunderstanding is continually examined as the study developed. Field notes that documented participants' non-verbal responses were taken to assist with data interpretation.

3.2.4 Data analysis

This study adapted the steps of thematic analysis suggested by Liamputtong and Serry (2017, p.433) with the emphasis on hermeneutic circles suggested by Fleming and colleague (2003). Data was analysed in original language to ensure the essence of the interview were accurately captured (Chen, Smith Helen, & Liu, 2008; Esfehani & Walters, 2018). The thematic analysis in this study was achieved by identifying themes from coded data (Liamputtong & Serry, 2017). The emphasis on interpretation of data begins with understanding text as a whole, then moving back and forth in reading the text to achieve the hermeneutic circle (Fleming et al., 2003). Six steps of thematic analysis were applied as follows:

1. Raw data preparation and reading through organised data: Audio recorded interviews were transcribed verbatim and checked by the bilingual supervisor after each interview. Field notes and the reflective journal were added. All data were arranged according to the source of information such as from interviews or field notes. The researcher read through data carefully to achieve an overall understanding of the text. This understanding also influenced the researcher's preunderstanding of Chinese patients and families experience.

2. Generating initial codes: The researcher read through interview data again, colour coded and documented. All similar codes were highlighted in the same colour to further examine the linkage.

3. The same coloured codes were re-examined and organised into themes. Researcher's preunderstanding of the Chinese patients and families experience was reflected upon at this stage to assist with interpretation.

4. Re-reading all data again, then gather all related data to each theme to ensure coherence between data and theme.

5. Review/revise themes: a thematic map was developed to check/ensure the themes reflected the meaning of data as a whole. This was the essential element of the hermeneutic circle that understanding was gained through movement back and forth between the part and the whole. The study aims and objectives were continually referred to which ensured the relevant themes were generated.

6. After ongoing analysis and revision of themes in relation to data, each theme was named and described according to the individual theme's narrative. The themes and relevant codes were translated into English and checked by the bilingual supervisor for accuracy at this stage.

Discovery of constitutive pattern/s and identifying the passage that best represents the shared understanding between researcher and participants is the highest level of hermeneutical analysis (Crowther et al., 2017; Fleming et al., 2003; Polit & Beck, 2017). Codes, categories and draft themes were discussed in regular meetings with supervisors. Revision of themes and the selection of excerpts to support the themes were discussed until consensus was reached. The final themes were presented as findings and incorporated into this report. The example of coding is attached in Appendix C.

3.3 Ethical considerations

3.3.1 Vulnerable populations

Participants' information and consent was translated into Chinese to ensure participants fully understand the study. Participants were encouraged to discuss their decision to participate in the study with their family and friends. Health professionals who provided direct care services for patients were not involved in participants' recruitment. Potential participants were assured about maintaining their confidentiality and the right to refuse or withdraw from the study at any stage. They also have the right to refuse to answer any questions. Counselling services were considered for any participant's distress during the interview.

3.3.2 Consent

The written consent form was signed between researcher and participants during the first meeting and before the interview. All participants in this study were Chinese and spoke the same language as the researcher, therefore interpreter services were not required. The researcher thoroughly explained the study aims and process to ensure participants fully understood the study. Participants were informed that they had the right to refuse, pause or withdraw from the study at anytime. They also had the right to refuse to answer any questions during the interview. Participants were also given permission to contact the researcher any time if they changed their mind about participation after they signed a consent form. No participants withdrew from the study.

3.3.3 Confidentiality

Audio recordings of the interviews will be kept for 5 years after transcription. All information was collected in a de-identifiable form. Participants were given a pseudonym and therefore, cannot be individually identified in this report. Data collected for this study remains stored in a locked cabinet in the researcher's office. All electronic data will to be kept on Flinders University computer server, which is password protected. All study-related data is only accessible to the researcher and supervisors.

3.3.4 Reporting negligence

Any negligence that was uncovered during the interview was reported to the appropriate authorities including SA Health using the Safety Learning System and the Australian Health Practitioner Regulation Agency.

3.3.5 Approval and ethical standards guiding study

The study was conducted in full conformance with the principles of the "Declaration of Helsinki", Good Clinical Practice (GCP), the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council (NHMRC), 2007), the Australian Code for the Responsible Conduct of Research (2007) and within the laws and regulations Australia. Ethical approval was obtained from Southern Adelaide Human Research Ethics Committee (see Appendix D).

3.3.6 Site/Governance Review

In accordance with the *SA Health Research Governance Policy Directive,* Site Specific Assessment (SSA) Approval was sought from individual public health sites where the study was being conducted (see Appendix E)

3.4 Rigor appropriate for approach

The trustworthiness in this qualitative research was established by Quality Criteria Framework which refers to credibility, dependability, confirmability, transferability and authenticity (Lincoln, Lynham, & Guba, 2011; Polit & Beck, 2017). The credibility refers to the establishment of truth and therefore confidence of the study (Polit & Beck, 2017). It was established by member checking and accurately presenting the participants perspectives in the final findings by using detailed description (Fleming et al., 2003). The data was analysed in the original language to ensure the participants' perception was truthfully presented. The entire study was reported to supervisors to ensure the consistency between methodology and method was maintained. As well, the participants were provided with the opportunity to review and change transcripts prior to data analysis to ensure the accuracy and credibility of their data and to complete the Gadamer's hermeneutic circle.

Dependability refers to the reliability and replicability of the findings, while confirmability is about the accuracy of the data (Polit & Beck, 2017). The researcher maintained comprehensive field notes throughout the study and utilised member checking to enhance the dependability and confirmability of the study. The data was analysed in the original interview language and checked/ rechecked by the bilingual supervisor to ensure the accuracy further enhanced the confirmability of the study. Data was collected from patients and family members to validate information enhanced the understanding of their experience through different angles and perspectives. This enhanced dependability by using data collection triangulation to minimise the intrinsic bias that comes from a single-method (Nowell, Jill M. Norris, Deborah E. White, & Moules, 2017; Polit & Beck, 2017).

Transferability means the extent that findings can be applied to another settings or group of people, and authenticity refers to the report that truthfully represent the participants' lived experience (Polit & Beck, 2017). Transferability and authenticity of the study was promoted by member checking and providing detailed description of the participants' perspectives in this report. Participants hospital experience included both public and private hospital admissions which enhanced the transferability of this study.

3.5 Conclusion

This study of Chinese patients and families' experience during acute and critical illness sought deep understanding of the CALD populations experience. The qualitative paradigm with Gadamer's hermeneutic phenomenology was chosen to enable the researcher to bring her culture, language and pre-understanding of Chinese patients' experiences to the research design using interactive conversations. The research methodology and rigour of the research design also enabled the researcher to generate new, valid and rich evidence to inform the hospital quality and safety improvement.

4 CHAPTER FOUR RESULTS

This chapter presents the study results after thematic data analysis. As Methodology and method were discussed in the previous chapter, thematic analysis with the emphasis on hermeneutic circles was applied to data analysis. The researcher's preunderstanding of Chinese patients and families experience during their hospital admission was examined. The following discussion describes the participants' demographic characteristics and findings to address the study objectives as described in chapter 1.

4.1 Participants' demographic characteristics

A total of 10 participants were recruited in this study. Of those participants, five were patients (n=5) and five were family members (daughter of the patient n=3, husband of the patient n=1, wife of the patient n=1). All participants were born in mainland China and spoke Mandarin at home. Participants' age ranged from 30 to 65 years old. Two participants (n=2) were on a visitor's visa for visiting their only child. Three participants (n=3) held a permanent residency and migrated to Australia with their only child. All other participants (n=5) were first generation migrants. The first-generation migrants in the study had further tertiary or post graduate education in Australia. Patient's hospital experience ranged from private and public hospital admissions, multiple emergency department (ED) presentations, elective and emergency surgical procedures and ICU admissions. None of the participants had religious beliefs at the time of the study. All participants in this study were given a pseudonym to maintain their confidentiality. The participants' background was summarised in table 4-1.

Table 4-1 Participants demographic characteristics

Patient/carer pair	Participants' code	Gender/Age	Patient/carer relationship	Hospital	Reason for admission	Immigrant status	Time in Australia	Language
1	Zhao - P1	M/60-70		Public	ICU admission post urology surgery	Migrant's parent (visiting visa)	1 year	Chinese
	Qian - C1	F/30-40	Daughter			First generation migrant	10 years	Chinese
2	Sun - P2	M/60-70		Public	Cardiac patient, multiple admissions to different public hospitals	Migrant's parent (permanent resident)	4 years	Chinese
	Li - C2	F/60-70	Wife			Migrant's parent (permanent resident)	4 years	Chinese
3	Zhou – P3	F/60-70		Private and public	Surgery, recovery, chemotherapy and radiotherapy	Migrant's parent (permanent resident)	4 years	Chinese
	Wu – C3	F/30-40	Daughter			First generation migrant	12 years	Chinese
4	Zheng – P4	F/30-40		Public	Obstetric ICU admission	First generation migrant	15 years	Chinese
	Wang – C4	M/30-40	Husband			First generation migrant	15 years	Chinese
5	Feng - C5	F/30-40	Daughter			First generation migrant	5 years	Chinese

	Chen - P5	F/50-60		Private	Gynaecological surgery	Migrant’s parent (visiting visa)	2 months	Chinese

P=Patient; C= Carer

4.2 Results

A total of eight themes were identified from the data analysis that addressed Chinese patients and their families' hospital experiences during their acute and critical illness. To address objective 1, patients and their families expressed acceptance of the hospital care they received. Objective 2 was addressed by their display of the need for orientation as they were disoriented, desire for comfort and desire for information. The perception of family involvement in patient's care was also expressed. Objective 3 revealed communication to be a main theme with two sub-themes: 1) overcoming language barrier and 2) communication issue other than language. Lastly, objective 4 highlighted two themes in relation to providing feedback 1) reluctance to provide feedback and 2) lack of awareness of how to provide feedback. These themes and sub-themes addressed the study objectives in chapter 1 listed in figure 2.

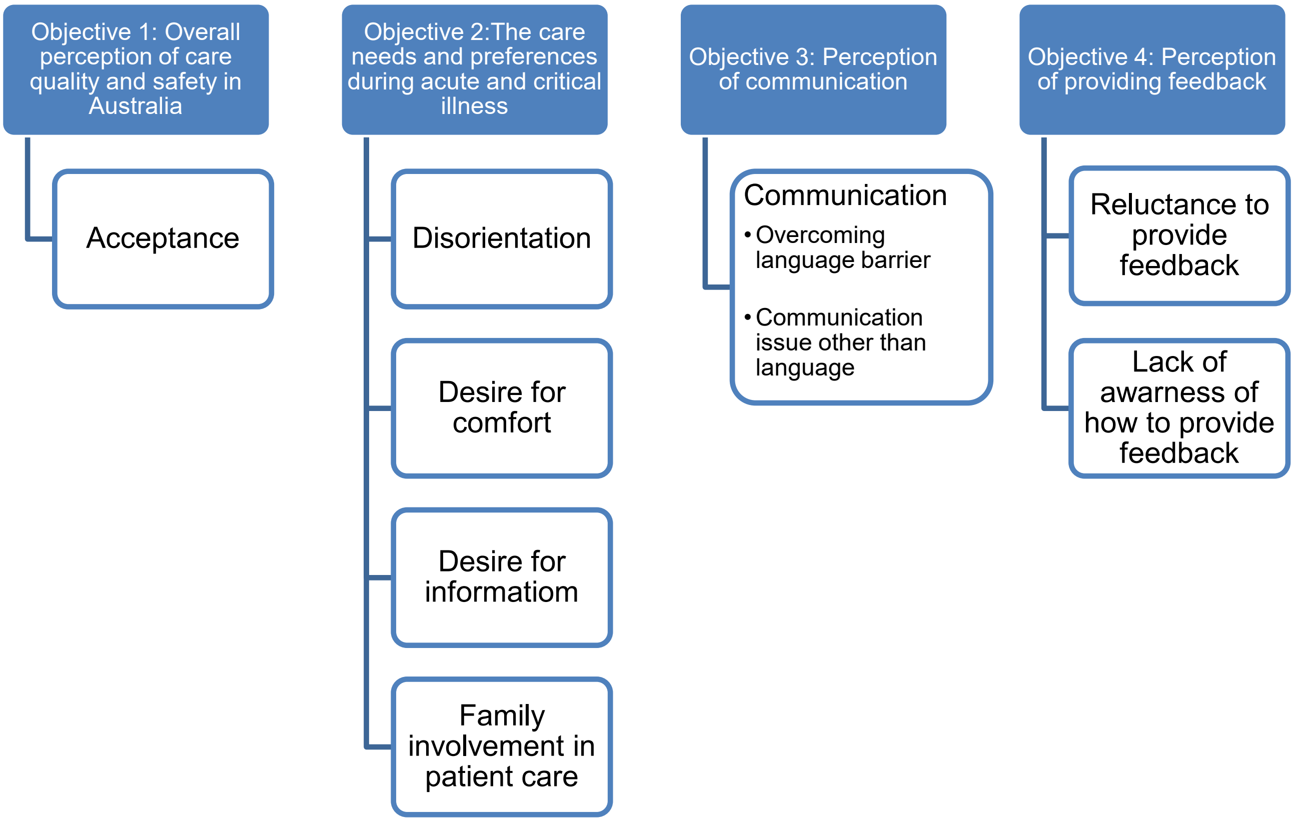


Figure 2 Study objectives and themes

4.2.1 Theme one: Acceptance

Participants constantly compared their hospital experience to their previous experience in China. Their perception of the quality and safety in Australia hospital was caring, personalised and respectful when compared to the hospital service in China. Most participants had limited knowledge of the Australian health system. Participants accepted the given care despite experiencing concerns during their hospital admission in Australia.

Zhao was on a visiting visa and required urology surgery for cancer before he was due to return to China. He was admitted to ICU post-surgery. His perception of nurses in China were not very nice. Zhao's perception of the ICU service in Australia was excellent although he has no previous admission experience in Australia or in China.

> *I have no ICU experience or hospital experience; I have no idea about the process. But I feel the service was very good from the care from the first nurse… (Zhao-P1)*

Zhao woke up to a non-Chinese speaking nurse and no interpreter was utilised to enable communication. However, the perception of care quality was not affected by the language barrier.

> *A male nurse was very caring although he could not speak Chinese. He would attend you anytime when you start to move (Zhao-P1).*

It was evident that the non-verbal and caring behaviour from the nurse reassured the patient that he was in a good care. There was no complaint from Zhao about any communication difficulty.

Acceptance of care services was also related to the participants' view that they were the foreigners in this country, and they needed to overcome difficulties or adapt to this care system.

> *For us foreigners, inability to communicate (in the dominant language of the host country) is common/normal and we need to overcome this ourselves. They have done their best to look after me. It was my problem that I could not speak English, but it won't be a problem for the people like you… (Zhao-P1).*

In this example, the acceptance of communication barriers without extra assistance from hospital services might be attributed to the lack of awareness of patients' rights to have interpreter service and communicate with health professionals in the language of their choice.

Older migrants demonstrated their satisfactions with hospital care services in Australia by comparing their experiences in China. For example, Sun and his wife Li migrated to Australia with their single child. He and his wife has been in Australia for about four years. They live with their daughter and look after their grandchildren at home. He had multiple hospital admissions to different metropolitan hospitals. He stated:

> *I have no unrealistic expectations because I have never been to hospital other than in China. Everything is so personalised compare to China. They have done a great job. For example, nurse check on you regularly… (Sun-P2)*

Comparison of the two countries' services were also evident in Zhao's interview.

> *In China, Patient is the weak party compare to doctor. The doctor has issues with the accountability and communication because it is all money orientated. Nurses in China got attitude (not very nice), but all of you in Australia are very diligent and nice, the environment is very important. (For example), the nurse who administer chemo explained everything again when I went in, it was very different from China (Zhao-P1)*

Both Sun and Zhao were over 60 years of age. The acceptance of the Australian health service was also based on the comparison with their previous experience in China. The older participants expressed the willingness to accept or compromise in this new country because the service is better than their previous experienced in China.

In contrast, younger migrants showed high expectations of hospital care services. Wu, the daughter of Zhou has been in Australia 12 years and worked in the hospital and explained her concerns with a deemphasised tone:

> *It was a little problem. Some nurses didn't check on my parents like they did for other patient. This might because they think my parents could not understand them (Wu-C3).*

This perception was not shared by Zhou which might be attributed to a lack of awareness of the expected care standards, patient's rights and entitlement. Disparity in nursing services were also reported by Zheng, a younger participant who was in ICU for three days. She stated:

> *Some nurses would sit there won't do any extra or didn't want to talk to you… experienced nurse and newly graduate nurse was different. Newly graduated nurse might be too anxious and worried about making mistakes; therefore, they won't do anything extra…Experienced nurse were also depending on who they are…some of them are good but not all of them…(Zheng-P4).*

Both Wu and Zheng have been in Australia more than 10 years. The younger participants' expectations were higher because they had a better understanding of the Australian health system and service standards.

The service has its deficit, however, most participants praised majority of nurses for their caring and kindness. Zheng also stated:

> *Some nurses will come to visit you although they didn't look after you on the shift make you feel they were very kind…I could not remember their names, but I can recognise their voice… (Zheng-P4).*

Chen was on visiting visa when she was admitted to the private hospital. She shared the same view. She stated:

> *The service makes me feels like my daughter was around although my daughter was not there. (Chen-P5).*

Some services were considered as excellent and personalised although those services were common to Australian. Chen was interested in all the details that she experienced in the Australian hospital. Her eyes were filled with appreciation and admiration when she described the recovery layout and how nurses treated her.

> *They gave me a warm blanket because the room was cold, then replaced with another one when this one getting cold…TV and magazines in the waiting room was great…I also checked their toilet, all toilet was fitted with hand bars for people to hold on and patient can have a shower in there… we cannot achieve this in China because we have too many people in China…(Chen-P5).*

There is a big difference between Australia and China in relation to meals in the hospital. Patients in

China need to provide their own meals and normally provided by family. Zhou had her surgery in the private hospital while all other treatment was done in the public hospital. She was given a menu to choose from in the hospital which made her feel the hospital service was like a hotel.

> *They give us a menu to choose from for our meal, this is like in the hotel…(Zhou-P3).*

The choice of the meal satisfied participants. Chen stated:

> *Nurse asked me if I would like something to eat. I understood she said 'sandwich' and ' coffee'. I asked for a warm water… (She didn't described how did she achieved this with limited English)…the details were so personalised…(Chen-P5).*

In this example, the participants accepted the meal quality and considered it excellent compared to China where no meal is provided in the hospital.

In addition to the hospital infrastructure and nurses' services, doctors' services were trusted and praised by all participants. The trust among some participants appeared to be implicit. For example, Zhao believed he should do whatever he was asked by doctor without question. He stated:

> *I did whatever I was told to do…I have to…(Zhao-P1).*

Zhou shared the same opinion. He stated:

> *Doctor asked my opinion, I said I follow all doctor's orders. I trust them…(Zhou-P3).*

Sun's trust in Australian doctors was because they patiently explained things as he stated:

> *Doctor explained things very patiently and in details. I would insist conservative management if I was in China. The doctor drawn a heart picture and explained all positive and negative aspects of the procedure. This was why I agreed to have the procedure done (Sun-P2).*

Sun's wife Li agreed with him:

> *Doctor explain things well. Therefore, we trust them (Li-C2).*

Although Sun did not explain why he would insist a conservative management of his condition in China, the comparison between two countries by him was evident. Participants trusted in Australian doctors because of their communication style and respectful gesture. There was some degree of powerlessness sensed in their tone as well. This was potentially because they depend on their families to navigate the health system and the lack of autonomy.

Non-verbal gestures that are considered common in Australia to enhance communication, for example kneeling to enable eye contact during communication was perceived as respectful and caring behaviour by the participant.

> *Doctors were one knee on the floor when they spoke to me (to make eye contact). I was really moved by their gesture (Chen-P5).*

This example revealed that Australian and Chinese culture perceived communication skills differently. Good non-verbal communication skills in Australian culture was perceived as respectful behaviour in Chinese culture.

4.2.2 Theme Two: Disorientation

Disorientation was reported among participants who had experiences in ICU. Others who had family company or staff able to speak Chinese after waking from anaesthesia did not report disorientation. Despite the feeling of disorientation, the perception of the hospital experience was positive among most of the participants.

Zhao woke up after surgery and didn't know the day and time, he could not communicate with the nurse at the time. He stated:

> *I woke up and I didn't know what really happened. I think I lost a day. I could not ask nurse because he could not speak Chinese (Zhao-P1).*

Timely reorientation was lacking due to communication barrier although patients did not express any concerns. His daughter Qian stated her concerns because she was not there when her dad woke up not because of communication barrier or lacking reorientation. She stated:

> *My dad didn't know the time of the day when he woke up. He didn't sleep because he thought it was daytime, in fact it was midnight, I could be there if I know they would extubate him right after I left (Qian-C1).*

Disorientation was not only happened to elder patients. Zheng was younger also recalled her experience.

> *I was under the influence of heavy medication. I have no idea what the time during the day was. I was not sure what did they say to me or could not really understand. You only have equipment around you. Many people came talk about me without talking to me (Zheng-P4).*

Reorientation was never expressed although disorientation was reported. Lack of timely reorientation might be attributed to the communication barrier. However, participants did not express any concerns regarding disorientation. Zhao perceived his care experience as positive due to one to one nursing in ICU.

> *I feel the service was very good from the care by the first male nurse…one to one nursing was really good (Zhao-P1).*

Zheng shared the same view. She stated:

> *ICU care is better because it is one to one nursing…but ICU is more painful…I can feel the environment include who was looking after me. Some nurses were very kind because they visited me although they were not allocated as my nurse (Zheng-P4).*

This example indicated that one to one nursing provided patients with sense of security although they were disorientated. The allocated nurse could respond quickly to patients by observing their body language and facial expression. This might be why the participants were not concerned.

Other participants woke-up to their family members or a Chinese speaking staff member that might have helped with re-orientation. Zhou didn't experience disorientation after her surgery because her daughter was allowed entry into recovery.

> *My daughter was there when I woke-up from surgery…(Zhou-P3).*

While others like Chen woke up to a Chinese speaking doctor and nurse.

> *My surgeon can speak Chinese. I woke-up to a nurse who can speak Chinese was also really helpful (Chen-P5).*

This example indicated that removing any communication barrier potentially can eliminate the risk of disorientation/post-operative delirium which is more sustainable than one to one nursing. Patients and family were more concerned about a sense of security that one to one nursing could offer instead of the care quality they received.

4.2.3 Theme Three: Desire for comfort

Pain, anxiety and discomfort was a common perception during hospital admission among the participants. Participants described their uncomfortable feeling vividly during the interview. Nurses were perceived as good in providing pain relief and comfort care.

Zhao repeatedly described that his mouth was very dry during the hospital admission.

> *My mouth was so dry, and I only can ask for ice chips (Zhao-P1).*

Nurses were very good in providing ice-chips in this example. However, there was no other method explored to relieve Zhao's dry mouth.

Anxiety was also reported in some participants especially before the surgery. Zhou had partial mastectomy in a private hospital. She stated:

> *I was very anxious before the surgery then I didn't know anything once they give me anaesthetic (Zhou-P3).*

Chen was also anxious before her surgery, but the environment helped her to relax. Chen stated:

> *I was anxious before the surgery, but the care and respect from doctors and nurses really helped me overcome this. The environment was so relaxing and welcoming. All the details such as TV, food, warm blanket and warm massage chair made such a big difference in my feeling (Chen-P5).*

There was no indication that either of the participant expressed their anxious feelings to anyone include health professionals. This might because of their language barrier prohibited them to seek or receive reassurance at the time.

Pain was another issue during the hospital stay. Most of participants still felt uncomfortable when they described the pain they experienced. Zheng expressed that her feeling in ICU was ‘painful’ despite the good care she received. Zheng was admitted to ICU post-partum haemorrhage. She stated:

> *I paid more attention to how to be more comfortable than how long could I live at the time. I felt ICU was more painful…I always ask if it is painful before they do anything to me…I want pain relief all the time…I don’t know why I felt so painful, I felt lots of pain even when they just touch my skin (Zheng-P4).*

This example might indicate inadequate analgesia for this type of pain. However, this study did not explore how the pain was assessed to determine the cause.

Zhou experienced pain from surgery through to discharge. She stated:

> *It was very painful after surgery. I keep asking for pain relief…I still feel uncomfortable now (Zhou-P3).*

Zhou expressed her pain level by using a pain scale card pre-made by her daughter. Although she experienced significant pain, she still considered nurses assessed her pain regularly and provided pain relief in a timely manner. Zhou stated:

> *They (nurses) came regularly to check on me and give me pain relief…(Zhou-P3).*

Zheng shared a similar view to Zhou although she experienced pain all the time. She stated:

> *They (nurse) always explain to me and give me pain relief before they do anything… (Zheng-P4).*

Most nurses were perceived as very good in providing comfort care and pain relief although they experienced pain all the time. It is unsure how the effect of the pain relief was evaluated in these examples. The pain that participants experienced during the hospital admission appears to have a long-term effect on them even after their discharge.

4.2.4 Theme Four: Desire for information

Patients and families in this study all have the desire for information sharing. However, they did not want to be perceived as bothersome because they felt doctors and nurses were very busy. Waiting for information became a difficult part of the hospital experience.

Wu had experience with both her father and mother admitted to hospital. Waiting for the doctor’s ward round became a daily routine.

> *The main worry was language. I could not stay in hospital 24 hours, have to wait for doctor’s ward round, have no idea when it would be, difficult if there was no Chinese nurse (Wu-C3).*

The same feeling was expressed by Qian while her father was in the hospital.

> *They were very happy to help us to find doctors to answer questions, but when can they come was another question (Qian-C1).*

This indicated that families are willing to participate in patient's treatment plan by join the ward round. However, it was difficult for the participants because the time of ward rounds were unpredictable.

Some participants can only wait to be cared for by Chinese nurses to gain information. Zhao woke up to a non-Chinese speaking nurse. He did self-assessment because he could not communicate with the nurse and had to wait to the next morning to get more information. Zhao stated:

> *I really wanted to know if I lost lots blood during surgery. I could not ask because the nurse could not speak Chinese. I looked at my hand because I only could assess my own hand. I saw my hand only four fingers were pink, from joint to palm was very pale, I know I have lost lots blood… I asked the Chinese female nurse next day (about my blood loss) …(Zhao-P1).*

His daughter expressed similar concern with the understanding of the business of the staff.

> *Nurses and doctors were very busy. It was difficult to find the doctor to ask questions… Sometimes nurses didn't explain much unless they were Chinese nurses. We did not want to bother them because they were busy. They always tried to allocate Chinese nurse to look after my father which was good (Qian-C1).*

Participants preferred to be cared for by a bilingual nurse or a doctor to allow communication. However, there was no demand for interpreter services to eliminate communication barriers possibly because participants were unaware of their entitlement.

The detailed information provided by nurses or doctors was always welcomed and played an important role in participants' decision making. Sun's decision of cardiac stent insertion for his cardiac event was based on his doctor's detailed and patient explanation. He stated:

> *Doctor explained things very patiently and in details. I would insist conservative management if I was in China. The doctor drawn a heart picture and explained all positive and negative aspects of the procedure. This was why I agreed to have the procedure done (Sun-P2).*

More information sharing would also answer more questions and eliminate participants' anxiety. Zhao repeatedly asked the researcher to clarify treatment provided for his surgery and chronic condition during the interview.

> *The other drain was removed a few days later, but I still feel it was removed earlier… I am worry about my foot getting cold because I have type 2 DM… I just worry the recovery may take almost half a year. I always think about this (Zhao-P1).*

This example possibly indicated Zhao needed reassurance for his care and treatment. More information related to his condition would be helpful.

The feeling of powerlessness was acutely sensed by some participants during the information sharing because they were not in control.

Zheng stated:

> *I have no control over my body or decision making because I could not do anything. I did not feel I have the right to say no. Because you have no idea what things were for, I could not comprehend despite they explained to me. I felt they were professional, and they must wish good for me. I felt powerless physically and mentally (Zheng-P4).*

Zheng also questioned the transparency of information in the ICU.

> *Information in ICU was not transparent. I did not feel I have the right to say no. Because you have no idea what things are for, I could not comprehend despite they explained to me. I feel they are professional, and they wish good for me…(Zheng-P4).*

She believed that more information would help her to feel secure and safe but expressed the conflict in her feeling.

> *It would be better for me or made me feel secure if they explained more to me…. but I would not know what to do either if I was asked…I really don't know…I didn't really care… I feel they are professional, and they would do well for me (Zheng-P4).*

This example indicated that information sharing is important for participants. However, their vulnerability needed to be acknowledged and addressed by health professionals.

Participants tended to recall their previous experience in an attempt to understand current situation. When they perceived their condition as less severe, they appeared to be less anxious. Zheng continuously compared her experience as a patient to when her father in law was in the same ICU.

> *They told you they have tried their best; you have to hope for the best. My condition was not that serious like my father in law. He was in comma for many days…(Zheng-P4).*

The attempts to comprehend the information provided also made some participants seek a second opinion from non-professional family and friends.

> *My daughter asked someone at her work. A relative of my son in law has got the same condition, we also asked him through my son in law. My son in law explained for us (after asking him) because some of the terminology we don't understand (Zhao-P1).*

It was not explored whether the participants received any Chinese information from health professionals to help them understand the condition.

Family members also found it was difficult when conflicting information was given. Qian still regrets that she was not at her father's bedside when he was extubated because of the conflicting information she received. She stated:

> *I was told dad would be sedated and will be on the ventilator overnight. I visited next day and realised they extubated him just after I left. I was very disappointed because I was not there when he woke up (Qian-C1).*

Wu had a similar experience, she stated:

> *Many nurses did not know the treatment plan, always provided different information. This made things difficult for us (family members) (Wu-C3).*

These examples explain why family members want to participate in doctor's ward round to eliminate any errors and confusion during information exchange.

4.2.5 Theme Five: Family involvement in patient's care during hospital stay

Participants had different perception of family involvement in the patient's care during their admission. Traditionally the Chinese family member would provide physical care to the patient during their illness. Treatment decisions were made by family members no matter if patients are capable. In Australia, nurses provide the physical care to patients and patients make their own treatment decisions if they are capable.

Sun had multiple visits to different metropolitan hospitals for cardiac events. He would like his daughter to make all decisions for him. This request was declined by the medical staff.

> *I want my daughter to make decision for me, but it was not allowed here, they communicate with patient directly (Sun-P2).*

Similarly, when Zhou was diagnosed with cancer, her daughter Wu did not want to tell her. The request was refused by surgeon.

> *Initially I really did not want mum to know she has got cancer because our culture thinks this will cause stress to patient. But I was told cannot do this in Australia. I was so worried that mum cannot cope with truth. I have to prepare mum before seeing the surgeon (Wu-C3).*

Wu later expressed that respect for patient's right to know their diagnosis is more beneficial than detrimental. She stated:

> *After the treatment, I found that let patient know their diagnosis has more benefit than risk. The risk was mum feel stressed about her prognosis. The benefit was mum actively involved in treatment and care for herself. As family, I did not need to worry how to cover up her diagnosis (Wu-C3).*

These examples indicated that some participants are unaware of the Australian regulations and standards of care by expressing their own cultural preference, however, they were quick to adapt to the Australian norm and accepted the process.

Older participants expressed the wish for family members to remain with them during hospitalisation such as Sun. He stated:

> *I felt it would be better if there was family with me at the night of admission, but I used to it because no one has family there (Sun-P2).*

His wife Li thought differently in this situation.

> *I feel it was really good that hospital does not need family to stay. It has been a burden when we were in China. The whole family have to take days off from work to care for one patient… (Li-C2).*

The younger generation also had different feelings about family involvement in the care. Most of them prefer to leave the care to professional staff. Qian was trying to be helpful and applied pressure on her father's drain, later she was educated by the nurse. In reflection, she thought she should not do it because she did not understand the concept and could be dangerous. She also concluded:

> *Family should not provide care because we are not professional (Qian-C1).*

Feng was not in the hospital when her mum had surgery.

> *I was not there when Mum had her surgery. I only went to pick her up (Feng-C5).*

Her mum Chen was also happy about it. Chen stated:

> *Hospital was doing such a good job and did not need family around (Chen-P5).*

Previous Australian hospital experiences gave some participants confidence in the treatment and care that was all provided by doctors and nurses. Wang's wife was in ICU for three days. He also recalled the experiences of his father's ICU admission. He was calm and confident when he described his feeling.

> *I was told she will get better. I trust hospital very much. They are professional and must provide better care than me…My father was in the same ICU a few years ago…(Wang-C4).*

Family involvement can add pressure to the younger patient. Zheng's parents caused her more emotional stress when they were present, let alone provide patient care. Zheng stated:

> *I was worried to see my family at the time. I didn't want to see my parents. They were so worried and cry a lot when they visited me. I could not sleep if they stay with me. I could not sleep if children were around (Zheng-P4).*

The shift from Chinese traditional values to Australian cultural values among Chinese patients was evident in the study. The younger participants showed quicker integration to the Australian culture than older participants.

4.2.6 Theme Six: Communication

Language barrier was reported repeatedly among the participants although their experiences were not always negative. Different strategies were used to help participants overcome the language barrier such as using interpreters; body language and prewritten words. The communication issue other than language barrier however had more impact on participants' hospital experience.

4.2.6.1 *Sub-theme one: Overcome language barrier*

An interpreter was commonly used to help with the communication between the doctor and the patient during consultation. It was often initiated by the doctor before the surgery/procedure when decisions needed to be made by the participants. Zhao stated:

> *Surgeon could not speak Chinese. He organised an interpreter and recorded…(Zhao-P1).*

In some situations, a professional interpreter was preferred over translating by a family member. Sun stated:

> *Hospital provided an interpreter when surgeon could not speak Chinese. He would not let my daughter to translate either…(Sun-P2).*

The interpreting service was available to people on visiting visa if they had correct insurance cover. Feng's mum and mother in law had hospital admissions during their Australian visit. An interpreter service was provided and covered by their insurance. She stated:

> *They provided interpreter service despite my mum was on visiting visa. It was covered by the insurance (Feng-C5).*

The interpreter service was not utilised after the hospital admission. Notably nurses or doctors did not utilise interpreter services during day to day patient care. Many participants used pre-written bilingual cards made by the family to communicate with non-Chinese speaking nurses.

> *My daughter wrote down some key words such as pain and toilet on the card. I can point at the word when I need something (Zhao-P1).*
>
> *I used card which was written by my daughter before she left. I can communicate with nurse by pointing on the word (Zhou-P3).*

Qian also believed that interpreter services only can be requested by health professionals.

> *I did not think they would organise interpreter if my dad requested. It must be requested by doctors (Qian-C1).*

Participants did not report use of interpreter services during their hospital admission. Lack of awareness of the service and entitlement was evident in the above examples.

The encounter with the interpreter was not always positive either. Feng recalled her mother in law had an impatient interpreter, which might be the reason that her mum Chen did not request an interpreter prior to her procedure.

Doctors and hospitals had different approaches to the use of interpreter services. Wu's experience was different in two metropolitan hospitals. She stated:

> *Doctors won't let me translate before the surgery because I am the family member. They have to have a third person interpret. But in the other hospital, they just let me translate and sign the consent straight way. They all do things differently (Wu-C3).*

Wu also described her and her mum's experience when utilising interpreter. Some interpreter's lacked medical knowledge making interpretation difficult. In one incident, the interpreter's translation lacked specification because she did not know how to translate 'ductal carcinoma in situ (DCIS)', this was witnessed by Wu who has medical background. In another situation the interpreter became impatient towards patient and family during the consultation.

> *I always go to consultation with mum, but they won't let me interpret because I am family member. Sometimes mum would ask me to translate again when she felt the interpreter did not translate clearly. Some interpreter was not happy with this, one of them told me to stop directly without considering our feeling. Another time my mum asked questions, interpreter told my mum to stop asking questions and let doctor to talk (Wu-C3).*

The interpreter's accent can also cause issues. There are many dialects in China, and it is common for some people to speak Mandarin with an accent. This impacted on patient's understanding.

> *Some interpreter especially those from south east Asia has very strong accent when they speak Mandarin. Some of them were not good Mandarin speaker. It was difficult for Mum to understand. They also use different word to describe things such as radiotherapy, they translate as ' dian liao', while we translate as 'fang liao' (Wu-C3).*

In this example, the quality of the interpreter service impacts on patients and their families experience.

Chinese speaking nurses and doctors made communication easier for participants when there was no interpreter. It remained the preferred communication method possibly because of convenience.

> *I could not communicate in English but there was a doctor can speak Chinese…we also asked nurse who can speak Chinese to translate for us…(Sun-P2).*
>
> *Nurse could speak Chinese was really helpful…(Feng-C5).*

Other times body-language was used among participants to help with overcoming language barrier. Li felt that language barrier made it very difficult for her and her husband. Apart from using an interpreter and asking their daughter to translate, using body language to communicate was common. Despite of the difficulty, they have no demand for interpreter service. In contrast, they believed that they should learn English instead.

> *We sometimes use body-language to communicate…Other time I ask my daughter to translate, it was difficult, we should learn English (Li-C2).*

Zhao shared the same feeling. He believed it was his problem when could not communicate and he should be the one should try to overcome this issue, not the health professional or health system.

> *For us foreigners, cannot communicate is common/normal and we need to overcome this ourselves. They have done their best to look after me. It was my problem that I could not speak English, but it won't be a problem for the people like you… (ZHAO-P1).*

Chen's anaesthetist communicated with her using body language instead of an interpreter. It might be because her surgeon can speak Chinese therefore no need for an interpreter.

> *Anaesthetist was a non-Chinese speaking doctor. He used body-language to talk to me. For example, he posed a sleeping position to tell me he will put me to sleep…(Chen-P5).*

Technology was also used among some participants and made participants feel independent.

> *My dad and I felt a lot better after he was transferred to the ward because he could use his translation app on his phone to communicate. He felt more independent (Qian-C1).*
>
> *I used translation apps on my phone to communicate with nurses. It worked well (Sun-P2)*

In this example, under use of technology or restrictions of using mobile phones during the admission disadvantaged some participants considering technology is readily available, convenient and easy to use. Participants accepted the service and had no demand for any additional support from hospital.

4.2.6.2 ***Sub-theme two: communication issue other than language barrier***

Communication is more than speaking the language. There were other communication issues other than language barriers identified such as inadequate communication or unwillingness to communicate. Lack of communication with the patient and family was reported by the participants.

Qian felt that she was not involved in the conversation of her father's treatment during doctor's ward round. Qian stated:

> *Some doctors only communicated with nurse, rarely talk to patient or family (Qian-C1).*

Zheng was a patient and she shared similar feelings about doctors' ward round. She stated:

> *Many people came talk about me without talking to me (Zheng-P4).*

Lack of involvement with the patient and family members was evident in these examples. This might be because of the doctor's busy schedule, underestimation of the willingness of patient's participation or lack of communication skills.

In some situations, it was uncertain who should take the responsibility to initiate a conversation. Zhao needed to extend his visa on medical grounds. It was brought to the attention of the ICU social worker but three days later, they were told to talk to the ward social worker because he had been discharged from ICU. The problem was quickly resolved by a ward doctor later who could provide required documentation. Qian shared this story with the researcher but did not feedback to the hospital. She stated:

> *There were nothing done during three days admission by a social worker…then we were told we need to talk to the social worker in the ward because we were discharged from the ICU, then a medical officer solved problem for us…why made it so complicated when it was so simple (Qian-C1).*

Qian was happy because the problem was solved eventually. However, the process could be communicated better to ease her family's stress. It was not explored whether a large workload or lack of awareness of current regulations among the social workers was the cause.

Reluctance to provide information among some staff was also reported. Both patient and family experienced some resistance in information sharing.

> *It was very difficult to get information from one nurse… The information given by nurse was different from the documentation… There was no explanation of why transfusion was needed or not needed (Qian-C1).*
>
> *Other nurses would sit there won't do any extra or didn't want to talk to you. I gain understanding of people through their body language (Zheng-P4).*

Miscommunication caused confusion with some participants such as being provided with conflicting information among the treating doctors and the nursing team. Qian was disappointed because she was not at the bedside to reorientate her father due to the miscommunication.

> *I was told they will keep my father on the machine overnight. I left about 11 o'clock at night. But I found out my dad was extubated right after I left. I was very disappointed I was not there. He didn't know the time and could not speak English. I could stay if they told me they will extubate him. It also might be me didn't fully understand… (Qian-C1).*

A similar situation also happened to Wu in another hospital. Wu recalled that the nurses were often not familiar with her father's plan and provided conflicting information. She stated:

> *Many nurses did not know the treatment plan, always provided different information among each other…(Wu-C3).*

The communication issue other than language barrier might be attribute to staff's attitude, competence, communication skills and awareness of the available service. It might also relate to the organisational culture in terms of staff development.

4.2.7 Theme Seven: Reluctance to provide feedback

Reluctance to provide feedback was a major theme merged. Elder participants were happy with the service because compared to Chinese health system, Australian health system is perceived as personalised. They also believed feedback is only for complaints as Zhao highlighted during his interview:

> *I didn't feedback to them because they have done a great job (Zhao-P1).*

Sun stated that he wishes that he could see doctors quicker in Australia because no appointment is needed in China. Despite this, he still happy with the service and did not provide feedback. He stated:

> *I didn't provide feedback because I am happy with the service (Sun-P2).*

Younger participants were more passive and would not provide feedback unless they were asked. Qian believed whatever happened was in the past and there was no need to mention it unless someone want to know.

> *I would not provide feedback unless they come to ask me directly (Qian-C1).*

Qian and her father Zhao did not provide any feedback to the ICU and the ward after discharge. Qian also believed everyone worked very hard and small issues during their admission was not worth escalating or providing feedback. She stated:

> *These were little things and all of them worked very hard. I may tell people if someone asked me, otherwise I won't say it. It past and I did not want to mention it. My dad was quite weak that was why he did not say anything either…(Qian-C1).*

Reluctance to provide feedback was common among participants. Zheng also did not provide any feedback to ICU and the ward after discharge. All she remembered was saying goodbye to the staff. Zheng's husband Wang mentioned that he wishes the discharge process could be fast tracked, however, he did not feedback to the hospital. He explained that he was not an expert in the field, therefore, did not feel it was appropriate to criticise. Wang stated during the interview:

> *I am not an expert in the field, I cannot criticise in case they may think it is wrong or be offended (Wang-C4).*

Wang was not the only one that concern feedback may offend the health professionals. Wu did not feedback was also because she did not want to offend anyone.

> *I didn't feedback because don't know who I should talk to. And I don't want to offend anyone. There was no third party that I can speak to either (Wu-C3).*

These examples revealed that participants believed feedback was not warranted because staff were trying their best to provide care. They also believed that negative feedback could upset the staff which they did not want to see.

4.2.8 Theme Eight: Lack of awareness of how to provide feedback

Majority of participants did not provide feedback because they were unsure of the process to provide feedback. Li had experience in public and private hospitals. She did not provide any feedback to either hospital and was surprised when asked whether she has provided any feedback.

> *I didn't provide feedback because no one asked. Do they want feedback? (Li-C2)*

Others want to provide feedback to a third party but did not know how. Wu did not know if there was such a feedback system for them to use. She discussed her feelings during the interview:

> *I didn't feedback because don't know who I should talk to. And I did not want to offend anyone. There was no third party that I can speak to either (Wu-C3).*

Uncertainty about the feedback process was also expressed as not having an opportunity among the participants. Although they want to let the hospital know how well they were cared for. Chen did not provide feedback because she was discharged quickly, and she felt she did not have opportunity to do so. She stated:

> *I didn't provide feedback because there was no opportunity (Chen-P5).*

Zheng shared the same view following discharge from ICU and did not provide any feedback, she stated:

> *I didn’t provide feedback. I just left. There was no follow up from ICU or hospital (Zheng-P4).*

Most participants reported they were unfamiliar with the health service feedback system. There was no report that staff encouraged patients or family to participate in any quality service improvement activity either.

5 CHAPTER FIVE: DISCUSSION

The aim of the study was to explore the Chinese people's perception of care quality and safety in Australian hospitals during their acute and critical illness. The findings were discussed in the previous chapter. Eight themes emerged from the study including acceptance, disorientation, desire for comfort, desire for information, family involvement in patient's care, communication, reluctance to provide feedback and lack of awareness of how to provide feedback. This chapter presents the discussion on these findings. The discussion was under the overarching research question 'what was the Chinese people's perception of care quality and safety in Australia'.

5.1 Happy Migrant Effect on patients' experiences

The acceptance of any given hospital care services including substandard services experienced by the participants in the study might be attributed to the Happy Migrant Effect (PW. Garrett et al., 2008b). Garrett et al. (2008b) described the Happy Migrant Effect as willingness to compromise in the host country while constantly comparing to the country of origin. The Happy Migrant Effect reflects on powerless, social desirability, politeness and self-reflected not having English proficiency (PW. Garrett et al., 2008b). Using country of origin as a point of reference was common in migrants (Luiking et al., 2019). The participants in the present study were grateful for services they received when compared to the health system they experienced in China. Although their knowledge of the Australian health system, patient's rights and entitlements was limited. This supports the Happy Migrant Effect.

This Happy Migrant Effect could be attributed to limited health literacy related to the Australian Health System. The average time participants in the study spent in Australia was seven years and they had different exposure to the Australian health system. Most of the patients in the study fully depend on family members to navigate the health system. Poor health literacy can affect the participants' ability to understand the expected care services, their rights and entitlement when using the care services and to participate in evaluating the service they received (Renzaho & Nidhi Dhingra, 2016). Similarly, participants who spent a longer time in Australia and were exposed to hospital system were more critical about the service compared to others. Limited information provision in patients' language of choice about health care services, care standards might have played a role in the low health literacy of this patient cohort. Patients and their family members might have the ability to search information about the disease in the languages of choice via internet sources, however, the information about the health care system and care standards were not always available in different languages.

In the present study, the participant's culture might have also contributed to the Happy Migrant Effect pertinent to their hospital experience. The root of Chinese Confucianism believes in harmony which means tolerance and moderation when they interact with others (Chang, 2001). The tolerance and acceptance of substandard care services was evident in this study and may reflect the Chinese

Confucianism. For example, most participants accepted a communication barrier and had no demand of support from health providers. Deemphasising the negative experience and tolerance to the adverse event without reporting may put this population at the risk of unmet care needs, missed opportunity to achieve early detection of deterioration and lack of feedback from the patients or their family members to improve care services.

5.2 Acculturation

Acculturation was defined as psychological and behaviour change as a result of contact with people from different cultures (Schwartz, Unger, Zamboanga, & Szapocznik, 2010).The authors stated that elder migrants experience the most difficulty in adapting to new cultures. Acculturation could take place in up to 4 years where migrants felt confident in navigating the health system (Terry, Ali, & Le, 2011). The same study also stated that major health events speed the acculturation process. In the present study, most participants especially elder participants considered themselves as foreigners, an indicator of the lack of integration to the mainstream culture. Most Chinese parents only stayed at home to care for children and grandchildren. Social isolation might impact on their opportunities to interact with local Australians, learn and adapt to the Australian culture and have a sense of belonging to a new country. In a study by Lai, Li, Lee, and Dong (2019), the sense of the community belonging can improve older migrants social activity which is lacking among the older participants in the present study. Lack of involvement in social activities also leads to limited knowledge of their rights and entitlements which was evident in the study. Being fully dependent on their family members for navigating the health system during illness adds extra burden to their family members who may also have a limited sense of community belonging.

In the present study, elder participants uphold their Chinese heritage and tradition while younger participants tended to adapt to Australian culture and were more assertive to seek better hospital care. The difference was evident by the belief of who should care for the sick family members. Participants who were younger in this study believed that care should be provided by professional staff instead of family members. This finding was very different from Chinese tradition which consider filial obligation as a central value which is to unconditionally care for one's parents including during their illness (Poškaitė, 2014). This shift from participating in all physical care traditionally to only accompanying the patient was also different from other overseas studies (S. Høye et al., 2015; Sevald Høye & Severinsson, 2008; Sevald Høye & Severinsson, 2010a; Sevald Høye & Severinsson, 2010b; Van Keer et al., 2015). The findings are consistent with the study conducted by Guo, Kim, and Dong (2019) that younger generation's acculturation level is associated with the sense of filial obligation. The younger participants in the present study had less sense of filial obligation compared to traditional Chinese. Due to the influence of acculturation on family members, individualised assessment of their expectations of the hospital care is needed. In the present study, elder participants expressed the acceptance of no family carer stay in the ward overnight. The shared ward experience during their illness helped them to adapt to this new cultural norm where no family member remained with them overnight at the hospital bedside.

5.3 Unmet care needs

5.3.1 Care and assessment

Post-operative delirium is a common complication of critically ill patients (Chaiwat et al., 2019). Disorientation is one of the signs of delirium (Cunningham & Kim, 2018). A timely assessment and reorientation are essential to identify post-operative delirium in order to manage this syndrome effectively. Similarly, pain assessment and management during the hospital admission is essential for patient's experience. It was evident that despite participants' belief that they received excellent care during their admission, effective reorientation and pain management was lacking in this study. There was insufficient information in this study to suggest how cognitive and pain assessments were conducted with a language barrier. The known fact was no interpreter was utilised in daily care. Inadequate cognitive and pain assessment for CALD population can lead to unrecognised deterioration and delayed treatment. This finding was similar to some overseas studies (Muni et al., 2011; Van Keer et al., 2017). The present study also found that some participants received less attention compared to non-CALD patient in the same ward. Misinterpreted patient's needs could also exist due to a language barrier. For example, Zhao experienced ongoing dry mouth and asked for ice chips regularly. Nurses could offer him a mouth care product if nurses recognised his request was for his dry mouth not for thirst. In addition, their culture of tolerance and concern for being perceived as bothersome put CALD patients at a risk of delayed support and assistance.

In the present study, participants trust doctor's expertise and believe the position of the patient is to follow doctors' orders without questioning. This finding is consistent with the study by Shaw, Zou, and Butow (2015). Family members also play an important role in decision making regarding CALD patient's treatment. For example, allowing family to make treatment decisions or enabling the family to decide what information patient was allowed to know was also consistent with the previous study (Khosla et al., 2017; Mitchison et al., 2012; Shaw et al., 2015). The trust in the doctors and family members revealed the vulnerability of the CALD patients. The health professional's moral and ethical obligation, as well as the ability of advocating for this population is the best safeguard for quality and safety. A personalised patient consultation to promote family involvement in the decision making as well empowering patients is necessary. The present study also highlighted that a fully informed patient can be proactive in their own treatment which was more beneficial.

5.3.2 Ineffective communication

5.3.2.1 ***Language barrier***

Ineffective communication is multi-faceted issue. Language barrier was one of the important factors that impacted on CALD people's hospital experiences according to the literature review. In this study, lack of English proficiency among Chinese migrants contributed to ineffective communication during their hospitalisation which is similar to another overseas study (Tsoh et al., 2016). Body language and use of electronic devices are a commonly employed in situations where limited verbal communication occurs (Freeman-Sanderson, Morris, & Elkins, 2019). In the present study, patients and family members were proactive with overcoming language barriers using a pre-made bilingual cue card or an electronic device to overcome language barriers. There were no resources supplied or initiated by the hospital staff for participants in this study. Provided technology is readily available and easily accessed in the current climate, underutilising this method is inefficient and unjustified. The issue has only become apparent in this study. Use of technology can potentially prevent inadequate assessment and recognition of deterioration earlier. The present study however was not able to determine the reason for underutilisation of available resources to support CALD patients to overcome the language barrier.

5.3.2.2 ***Underused interpreter services***

Underuse of the interpreter service due to time restraint and unaware of the impact on care quality was not new phenomena (Diamond, Schenker, Curry, Bradley, & Fernandez, 2009). In the present study, no interpreter was used regularly. Ineffective communication resulted from underuse of Interpreter services and in one incident, the quality of the interpreter used was highlighted. The discrepancy between the service availability and utilisation by the staff in the present study was reported previously (Tschurtz, G. Koss, Nancy J. Kupka, & Scott C. Williams, 2011). It was established that use professional interpreter associated with improved clinical care (Karliner, Jacobs, Chen, & Mutha, 2007). Underutilised interpreter services potentially impact on quality and safety of the patient care.

The quality of the interpreter was reported as a factor for the refusal of this service in a previous study (Steinberg, Valenzuela-Araujo, Zickafoose, Kieffer, & DeCamp, 2016). In the present study, bilingual health professionals were preferred over interpreter services by participants possibly because their previous negative experience. Interpreters play an important role in how doctors respond to patient’s emotional cues (Krystallidou, Bylund, & Pype, 2019). The same study reported that large numbers of emotional expressions were not passed on to the doctor during the consultation by the interpreter (Krystallidou et al., 2019). Similar lack of interpretation accuracy and empathy from the interpreter was also reported in the present study. The quality and accuracy of the interpretation service potentially jeopardise the quality and safety by delaying responses to the patients’ needs, affecting patient’s understanding and decision-making process.

5.3.2.3 ***Staff competency in cross cultural communication***

Ineffective communication was shown as staff reluctance to interact with Chinese patients and families in this study. Conflicting information or no information provided to patients and family members was also identified. Unwillingness to communicate with the Chinese CALD population in this study was similar to the overseas study (Van Keer et al., 2017). Lack of communication and emotional support for CALD patients compared to their non-CALD counterparts was also reported previously (Sevald Høye & Severinsson, 2008; Muni et al., 2011; Thornton et al., 2009). This potentially indicated a lack of staff confidence and competence in communicating with CALD patient. It may also reflect over stretched staff workload.

The present study reported that doctors often failed to involve patients and family members during ward rounds possibly due to not recognising the impact on family and patient's experience. This result supports previous research findings that health care providers always underestimate the family's interest in participating in the ward round (Au, Roze des Ordons, Soo, Guienguere, & Stelfox, 2017). Family and patient involvement in the ward round can provide opportunity for treatment decision making, promote accurate information sharing and reduce family stress.

5.4 Organisational culture

The present study identified that most hospitals employed bilingual staff. All patients in this study had experience with Chinese speaking nurses and doctors. Dependence on bilingual staffing or use of a family member instead of utilising interpreter services was apparent in this study. This finding supports previous research results (Diamond et al., 2009; PW. Garrett et al., 2008b; PW Garrett et al., 2008a; Tschurtz et al., 2011). It should be noted bilingual doctors and nurses by default were used as part of interpreter services. This was not recognised as part of their workload. The CALD patients experience may not be equitable because it is unrealistic to employ staff from all individual backgrounds due to the Australian cultural diversity.

All hospitals in this study were flexible with the visiting hours and one participant was even granted entry to the recovery which is uncommon. This finding contrast with another overseas study by S. Høye et al. (2015). Participants in the present study have no close family members in Australia therefore visiting causes less disturbance to other people. Despite the flexible visiting hours, no extra support was offered to this population in this study.

5.5 Providing feedback

The findings of reluctance to provide feedback among the Chinese participants in this study was similar to the previous study (Doherty & Stravropoulou, 2012). Doherty and Stravropoulou (2012) reported that the language barrier and staff encouragement were factors that impede patient's participation in safety improvement. This finding is similar to the present study that language barrier experienced by elder participants might have prevented them from providing feedback. Insufficient follow up from the hospital potentially indicates lack of willingness to encourage this population to feedback especially those who are culturally passive in receipt of instructions. In addition to this, the present study also discovered that lack of awareness of how to provide feedback and fear of upsetting the staff were among reasons for reluctance to provide feedback. Lack of awareness of available services was not a new issue for migrants (Renzaho & Nidhi Dhingra, 2016).Tolerance and deliberately deemphasising negative experience could also be due to the Chinese culture of conflict avoidance to achieve social coherence and harmony. Participants in the present study believed that it was not necessary to provide feedback because in their view the service was excellent. This potentially indicate a lack of patient's education regarding hospital quality improvements and consumer feedback system.

5.6 The comparisons of patients care in Australia and China

Participants in the study perceived that hospital care in Australia was better than that in China notably the better hospital infrastructure (better environment; disability access and supply of meals) and different communication style. The better hospital service quality is reflected in higher patient's satisfaction rate (Thawesaengskulthai, Wongrukmit, & Dahlgaard, 2015). The present study indicated that all participants were satisfied with the care they received in Australian hospitals except for non-emergency consultation waiting times and complicated discharge process compare to China. The main difference between Australian and Chinese hospital care quality possibly relates to the following factors such as staff to patient ratio and staff education.

Better service quality in Australia compared to China might due to the relatively lower workload, higher proportion of staffing level which is proven to directly affect service quality and patient safety, hence patient's satisfaction rate worldwide (Amiri & Solankallio-Vahteri, 2019; Liu et al., 2018; Shin, Park, & Bae, 2018). The average nurse to patient ratio during the day shift in a general ward was one nurse to seven patients in Guangdong Province in China (Liu et al., 2018). The difference is significant compared to one nurse to four patients in a general ward and one to one in ICU in the South Australian public sector (Government of South Australia, 2016). Australia also has the highest level of trained nurses per capital in developed countries which also contribute to higher hospital service quality (Amiri & Solankallio-Vahteri, 2019).

The difference in nursing education and registration could also contribute to the difference in the service quality and patient satisfaction between two countries. Lack of capacity to train high quality graduated nurses in China is complex and multi-faceted including unqualified teaching, out-dated teaching approaches, nursing practice that focus on treatment rather than person centred care, shortages of the clinical placement and lack of capacity to train post graduate level nurses (C. C. Wang, 2016; Y. Wang et al., 2013). The single level nursing registration system in China does not distinguish between levels of nursing education they received compared to Australia three tier registration. For example, nurses from a diploma course or baccalaureate course would all be registered as registered nurses once they pass the Chinese National Nurse Licence Exam despite their different education pathway (C. C. Wang, 2016). This single level of the registration in China does not promote the development of nursing expertise or inspire nurses to stay in the profession. This contributed to nursing shortages and low retention rates in China which impacts on the service quality. Lack of mandatory continuing professional development and standardised regulation in China compared to Australia may also contribute to the quality of nursing workforce.

5.7 Summary

Overall Chinese patients and family members perceived Australian hospital care as caring, kind and personised despite the deficits they experienced. Acculturation played a role in patients and family members' perception. The unmet care needs identified in the study include lack of patient assessment and pain management, lack of communication due to language barriers and staff cross-cultural communication skills. Organisational culture and lack of follow up system for consumer feedback were discussed. This positive perception of Australian hospital care is a result of comparison to the Chinese hospital care they have experienced. Chinese culture of harmony and tolerance also played a role in patients' perceptions in this study.

6 CHAPTER SIX: CONCLUSION

This qualitative study of Chinese patients and families' experience in Australia during acute and critical illness provided in-depth understanding of their hospital experience. This chapter discuss the limitations of the study and implications for practice. The researcher also reflected on the research process for further professional development in research skills. The conclusion provided an overview of the study and summation of the thesis.

6.1 Limitations and strengths

There were various limitations associated with the study design. Firstly, Gadamer's hermeneutic phenomenology offers a methodology rather than a strategic method (Carpenter, 2017; Van der Zalm & Bergum, 2000). Lack of an established research guide in Gadamer's hermeneutic phenomenology presented a challenge. The flexibility of the methodology not only allowed the researcher to produce her conclusion, but also has openness for interpretation by others. However, this richness of the information has potential for expansion of understanding which serves as a strength. Using the interview as a method was the second limitation because potentially participants may not fully disclose their feelings to the researcher. However, comprehensive field notes to document participants non-verbal responses were used to assist with accurate data analysis.

Thirdly, the time required to read and re-read the transcript to facilitate the change of pre-understanding of Chinese patient's experience and then to complete the hermeneutic circle is another limitation. This also only allowed for one interview of each participant. Gadamer asserts that understanding depends on the historical situation therefore speaking to participants more than once facilitates a change of the preunderstanding is recommended (Fleming et al., 2003). However, the researcher was conscious of this limitation in the design, therefore, participants were given the opportunity to review the transcribed verbatim data. Member checking was debated by Crowther et al (2017) who argue that it was not congruent with Gadamer's hermeneutic phenomenology because what was shared in an interview maybe interrelated differently at a later reading. The participants reviewed their transcribed data however this was not only to complete Gadamer's hermeneutic circle to gain richer data but to ensure the credibility of the data collected. The thematic analysis was conducted in Chinese enhanced accuracy of presenting the participants perception. The risk of inconsistency in thematic analysis was addressed by bilingual member checking.

The fourth limitation was that the results may not be generalised due to the nature of qualitative study design. Only 10 Chinese participants were recruited in this study potentially limiting the transferability. This study's results may not represent patient's perceptions whose cultural background is other than Chinese from mainland China, however, the hospital service deficit identified can still inform service improvements is a strength.

6.2 Implications for practice

The present study identified the areas for CALD patient’s services improvement in current health system. Resource development could explore available technology to facilitate better communication when interpreter service is not used. For example, electronic device use for translation between health professionals and patients. Promoting the available resources such as interpreter services, bilingual cue cards or electronic devices in hospitals to improve their usage is required. The necessary culture change regarding appropriate use of the technology such as smart phones at the bedside should be considered.

Policy and protocol development should consider how to facilitate better CALD patient’s assessment during their acute and critical illness. Current assessment methods risk inaccurate results where a language barrier exists because it may depend on patient’s verbal response and interaction with the staff. For example, lack of comprehension due to a language barrier has similarities to confusion and the inability to follow commands. This further supports the use of the available resources suggested above.

In addition to this, further development of hospital’s consumer feedback system to enhance CALD people’s quality improvement participation is also needed. The current hospital consumer feedback system is available in English but difficult to locate. For the CALD population, this creates a further barrier for them to participate. Incorporating consumer feedback with hospital discharge will reassure CALD population that their feedback is valued. This process also overcomes the difficulty of CALD population to locate the feedback system and encourage participation.

Staff education focusing on cross-cultural communication and involvement in CALD patients and family during daily ward rounds is necessary. Ongoing professional development should emphasise advocacy for CALD population to improve hospital care equitability. A program or campaign that promotes the awareness of the available resources should be implemented. Culturally competence care through education and training is much needed.

Further research to explore the health professional’s perception of care for CALD patients would help understand the reason of underutilised available resources. Research involving more CALD patients in addition to Chinese could add further evidence to this field.

6.3 Reflection

It was important to note that the researcher’s cultural and linguistic background and critical care nursing qualification serves as an advantage in cross-culture nursing research. It allowed the researcher to build a therapeutic relationship with the Chinese community and hospital which enhanced the participant recruitment. The original study planned to recruit participants from four cultural groups (Greek, Italian, Chinese and Vietnamese). However, unexpected barriers were experienced. The planning process to recruit participants after their hospital discharge by leaving an information package in their file proved to be very difficult. In reflection, the researcher believed that no direct contact or conversation with potential care providers and participants was a recruitment barrier. This process prohibited the researcher/critical care nurse to build rapport and trust with potential participants/patients, therefore limited recruitment numbers. The lengthy and complicated Ethics application put a severe strain on the timeframe to complete this thesis.

The research process also provided the researcher an opportunity to re-examine the preunderstanding of Chinese patients and family needs in Australia. The researcher's own experience as a first-generation migrant, a nurse, a patient and a family member allowed her to fully understand participants experiences and this understanding developed over the time of the research. The conversation between the researcher and the participant facilitated understanding as described by Gadamer's hermeneutic phenomenology. The understanding further developed during the reading and re-reading of the transcripts. Thematic analysis in Chinese allowed the themes to develop in the original language to capture the true meaning of the transcript. The researcher's ability of speak, read and write in Chinese and English served as an advantage in the study to eliminate the interpreter bias.

6.4 Conclusion

Quality and safety improvement in Australia health care requires updated evidence to inform policy development and guide practice. Lack of the data relating to the CALD population relevant to Australian health system was evident in literature review. The study aimed to explore the acute and critically ill Chinese patients and their families' perception of care quality and safety in Australia. There were four objectives: 1) Overall perception of care quality and safety in hospitals in Australia; 2) The care needs and preferences of Chinese patients during acute and critical illness; 3) Chinese patients and their families/carers perspectives of communication; 4) Chinese patients and their families/carers' perspectives in participating in safety and quality improvement activities such as providing feedback. The present study used Gadamer's Hermeneutic phenomenology in order to illuminate the essence of perception of the Chinese people as largest CALD group in Australia, as well as using the researcher's cultural background as an advantage in cross-culture research. In-depth interviews were conducted in the participants and researcher's native language (Chinese) to eliminate interpretation bias.

The thematic analysis was conducted in Chinese to ensure the true meaning was captured to form eight themes then translated to English. The eight themes include: 1) acceptance; 2) disorientation; 3) desire for comfort; 4) desire for information; 5) family involvement in patient care; 6) communication; 7) reluctance to provide feedback and 8) lack of awareness of how to provide feedback. The theme of communication has two sub-themes 1) language barrier and 2) communication issue other than language barrier. The results highlighted valuable new information of Chinese patients' perception which was often overlooked by hospital's consumer feedback system.

The thesis discussed following areas related to the results: 1) Happy Migrant Effect on patient's experience; 2) acculturation; 3) unmet care needs; 4) ineffective communication; 5) organisational culture; 6) providing feedback and 7) the comparisons of patients care in Australia and China. This discussion added valuable insights into the complexity of Chinese patients' Australian hospital experience.

The implication for practice allowed the researcher to make the following recommendations: 1) resources development; 2) policy and protocol development; 3) staff education; 4) culture competency training and 5) areas for further research. The researcher believed the study's aim was met and objectives were clearly addressed. The reflection of study barriers and enablers has enriched the researcher's knowledge. The detailed description of this study's data also provided the opportunity for readers to reach their own conclusion (fusion of horizon) which is a way to complete Gadamer's hermeneutic circle.

BIBLIOGRAPHY

Amiri, A, & Solankallio-Vahteri, T. (2019). Nurse-staffing level and quality of acute care services: Evidence from cross-national panel data analysis in OECD countries. *Int J Nurs Sci, 6*(1), 6-16. doi:10.1016/j.ijnss.2018.11.010

Annells, M. (1996). Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing, 23*, 705-713.

Au, S. S., Roze des Ordons, A., Soo, A., Guienguere, S., & Stelfox, H. T. (2017). Family participation in intensive care unit rounds: Comparing family and provider perspectives. *J Crit Care, 38*, 132-136. doi:10.1016/j.jcrc.2016.10.020

Australia Bureau of Statistics. (2014). 6250.0 - Characteristics of Recent Migrants, Australia, Nov 2013. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/6250.0Glossary1Nov%202013?opendocument&tabname=Notes&prodno=6250.0&issue=Nov%202013&num=&view=

Australia Bureau of Statistics. (2017). Census reveals a fast changing, culturally diverse nation. Retrieved from https://www.abs.gov.au/Ausstats/abs@.nsf/dd0ca10eed681f12ca2570ce0082655d/05dee7dfca9c2e00ca25814800090fb2!OpenDocument

Australia Bureau of Statistics. (2017a, 30/03/2017). Migration, Australia, 2015-16. Cat.no 3412.0. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3412.0

Australia Bureau of Statistics (2017b, 1/09/2017). Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/2024.0Main%20Features12016?opendocument&tabname=Summary&prodno=2024.0&issue=2016&num=&view=

Australia Bureau of Statistics. (2018, 15 February 2018). MEDIA RELEASE: ABS reveals insights into Australia's Chinese population on Chinese New Year. Retrieved from https://www.abs.gov.au/Ausstats/abs@.nsf/dd0ca10eed681f12ca2570ce0082655d/d8cae4f74b82d446ca258235000f2bde!OpenDocument

Australia Bureau of Statistics. (2019, 11/11/2019). 3401.0 - Overseas Arrivals and Departures, Australia, Sep 2019. Retrieved from https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3401.0Main%20Features3Sep%202019 opendocument&tabname=Summary&prodno=3401.0&issue=Sep%202019&num=&view=

Australian and New Zealand Intensive Care Society. (2016). *Centre for Outcome and Resource Evaluation Adult Patient Database (APD) Activity Report 2015-2016*. Retrieved from ANZICS Melbourne: http://www.anzics.com.au/Downloads/APD%20Activity%20Report%202015-16.pdf

Australian Commission on Safety and Quality in Health Care. (2008). *Australian Charter of Healthcare Rights*. Australian Commission on Safety and Quality in Health Care (ACSQHC), Sydney NSW

Australian Commission on Safety and Quality in Health Care. (2019). *The state of patient safety and quality in Australian hospitals 2019*. Sydney NSW

Australian Institute of Health and Welfare. (2016). *Admitted patient care 2014–15: Australian hospital statistics.Health services series no. 68. Cat. no. HSE 172.* Canberra: AIHW

Australian Institute of Health and Welfare. (2019). Glossary. Retrieved from https://www.aihw.gov.au/reports-data/myhospitals/content/glossary

Barrientos-Trigo, S., Vega-Vazquez, L., De Diego-Cordero, R., Badanta-Romero, B., & Porcel-Galvez, A. M. (2018). Interventions to improve working conditions of nursing staff in acute care hospitals: Scoping review. *Journal of Nursing Management, 26*(2), 94-107. doi:10.1111/jonm.12538

Bion, J. F., Abrusci, T., & Hibbert, P. (2010). Human factors in the management of the critically ill patient. *British Journal of Anaesthesia, 105*(1), 26-33. doi:10.1093/bja/aeq126

Blay, N., Ioannou, S., Seremetkoska, M., Morris, J., Holters, G., Thomas, V., & Bronwyn, E. (2018). Healthcare interpreter utilisation: analysis of health administrative data. *BMC Health Services Research, 18*. doi:10.1186/s12913-018-3135-5

Borbasi, S., & Jackson, D. (2016). *Navigating the maze of research: Enhancing nursing and midwifery practice*. Sydney Australia: Elsevier.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology *Qualitative Research in Psychology, 3*(2), 77-101.

Butler, A. E., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews Evid Based Nurs, 13*(3), 241-249. doi:IO.IIII/WVN.12134

Carpenter, C. (2017). Phenomenology and rehabilitation research. In P. Liamputtong (Ed.), *Research method in health, Foundation for evidence-based practice* (3rd ed.). Australia: Oxford.

Chaboyer, W. (2010). Quality, safety and critical care nursing. *Australian Critical Care, 23*(3), 106-108. doi:10.1016/j.aucc.2010.03.005

Chaiwat, O., Chanidnuan, M., Pancharoen, W., Vijitmala, K., Danpornprasert, P., Toadithep, P., & Thanakiattiwibun, C. (2019). Postoperative delirium in critically ill surgical patients: incidence, risk factors, and predictive scores. *BMC Anesthesiol, 19*(1), 39. doi:10.1186/s12871-019-0694-x

Chang, H.-C. (2001). Harmony as Performance: The Turbulence Under Chinese Interpersonal Communication. *Discourse Studies, 3*(2), 155-179. doi:10.1177/1461445601003002001

Chen, J., Smith Helen, J., & Liu, X. (2008). Language and rigour in qualitative research: Problems and principles in analyzing data collected in Mandarin. *BMC Medical Research Methodology, 8*(1), 44. doi:10.1186/1471-2288-8-44

Converse, M. (2012). Philosophy of phenomenology: how understanding aids research. *Nurse Researcher, 20*(1), 28-32.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative Inquiry and Research Design, Choosing Among Five Approaches*. California: SAGE publications, Inc.

Critical Appraisal Skill Programme. (2017). CASP (qualitative research) Checklist. Retrieved from http://www.casp-uk.net

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting Stories in Hermeneutic Phenomenology Research: A Methodological Device. *Qualitative Health Research, 27*(6), 826-835. doi:10.1177/1049732316656161

Cunningham, J., & Kim, L. D. (2018). Post-operative delirium: a review of diagnosis and treatment strategies. *Journal of Xiangya Medicine, 3*, 8-8. doi:10.21037/jxym.2018.01.03

Diamond, L. C., Schenker, Y., Curry, L., Bradley, E. H., & Fernandez, A. (2009). Getting by: underuse of interpreters by resident physicians. *J Gen Intern Med, 24*(2), 256-262. doi:10.1007/s11606-008-0875-7

Doherty, C., & Stravropoulou, C. (2012). Patients's willing ness and ability to participate actively in the reduction of clinical errors: A systematic literature review. *Social Science & Medicine, 75*, 257-263. doi:10.1016/j.socscimed.2012.02.056

Dombro, M. (2007). Historical and philosophical foundation of qualitative research. In P. L. Munhall (Ed.), *Nursing research, a qualitative perspective* (4 ed., pp. 99-122). Canada and UK: Jones and Bartlett Publishers International.

Douglas, J., Delpachitra, P., Paul, E., McGain, F., & Pilcher, D. (2014). Non-English speaking is a predictor of survival after admission to intensive care. *J Crit Care, 29*(5), 769-774. doi:10.1016/j.jcrc.2014.03.037

Dowling, M. (2004). Hermeneutics: an exploration. *Nurse Researcher (through 2013), 11*(4), 30-39.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*, 131-142. doi:10.1016/j.ijnurstu.2005.11.026

Dyer, J. (2010). Hermeneutics. In P. Peterson, E. Baker, & B. McGaw (Eds.), *International Encyclopedia of Education (Third Edition)* (pp. 413-418): Elsevier Ltd.

Ennals, P., & Howie, L. (2017). Narrative Enquiry and Health Research. In Pranee Liamputtong (Ed.), *Research Methods in Health Foundations for Evidence-based Practice* (3rd ed., pp. 106-120). Australia and New Zealand: Oxford.

Erickson, S. E., Vasilevskis, E. E., Kuzniewicz, M. W., Cason, B. A., Lane, R. K., Dean, M. L., . . . Dudley, R. A. (2011). The effect of race and ethnicity on outcomes among patients in the intensive care unit: A comprehensive study involving socioeconomic status and resuscitation preferences. *Critical Care Medicine, 39*(3), 429-435.

Esfehani, M. H., & Walters, T. (2018). Lost in translation? Cross-language thematic analysis in tourism and hospitality research. *International Journal of Contemporary Hospitality Management, 30*(11), 3158-3174. doi:10.1108/IJCHM-10-2017-0701

Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing: developing a Gadamerian-based research method. *Nursing Inquiry, 10*(2), 113-120.

Freeman-Sanderson, A., Morris, K., & Elkins, M. (2019). Characteristics of patient communication and prevalence of communication difficulty in the intensive care unit: An observational study. *Aust Crit Care, 32*(5), 373-377. doi:10.1016/j.aucc.2018.09.002

Gadamer, H.-G. (2004). *Truth and Method,2nd, revised Edition, translation revised by Joel Weinsheimer and Donald G. Marshall*. London: Continuum.

Garrett, P., Dickson, H., Young, L., & Whelan, A. (2008b). The Happy Migrant Effect'': perceptions of negative experiences of healthcare by patients with little or no English: a qualitative study across seven language groups. *Quality & safety in health care, 17*(2), 101.

Garrett, P., Dickson, H. G., Lis-Young, Whelan, A. K., & Roberto-Forero. (2008a). What do non-English-speaking patients value in acute care? Cultural competency from the patient's perspective: a qualitative study. *Ethnicity & Health, 13*(5), 479-496.

Government of South Australia. (2016). NURSING/MIDWIFERY (SOUTH AUSTRALIAN PUBLIC SECTOR) ENTERPRISE AGREEMENT 2016. Retrieved from https://www.sahealth.sa.gov.au/wps/wcm/connect/f3c512004fec0ab4806dcd5fa07ddff7/NursingMidwifery+%28South+Australian+Public+Sector%29+Enterprise+Agreement+2016.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f3c512004fec0ab4806dcd5fa07ddff7-mMA1nDc

Grant, J., Khan, J., & Taylor, A. (2016). *Measuring Consumer Experience. SA Public Hospital Inpatients Annual Report, April 2016.* Population Research & Outcome Studies, Adelaide, SA.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods, 18*(1), 59-82.

Guo, M., Kim, S., & Dong, X. (2019). Sense of Filial Obligation and Caregiving Burdens Among Chinese Immigrants in the United States. *J Am Geriatr Soc, 67*(S3), S564-S570. doi:10.1111/jgs.15735

Harrison, R., Walton, M., Manias, E., Smith–Merry, J., Kelly, P., Iedema, R., & Robinson, L. (2015). The missing evidence: a systematic review of patients' experiences of adverse events in health care. *International Journal for Quality in Health Care, 27*(6), 424-442. doi:10.1093/intqhc/mzv075

Health and Community Services Complaints Commissioner (HCSCC). (2019). For consumers. Retrieved from https://www.hcscc.sa.gov.au/making-a-complaint/

Hewson-Conroy, K. M., Elliott, D., & Burrell, A. R. (2010). Quality and safety in intensive care—A means to an end is critical. *Australian Critical Care, 23*(3), 109-129. doi:10.1016/j.aucc.2009.12.001

Høye, S., Kvigne, K., Åström, S., Severinsson, E., & Öster, I. (2015). Encounters between multicultural family members and the nurses in the context of intensive care. *Clinical Nursing Studies, 3*(1), 89-99.

Høye, S., & Severinsson, E. (2008). Intensive care nurses' encounters with multicultural families in Norway: An exploratory study. *Intensive and Critical Care Nursing, 24*, 338-348.

Høye, S., & Severinsson, E. (2010a). Professional and cultural conflicts for intensive care nurses. *Journal of Advanced Nursing, 66*(4), 858-867. doi:10.1111/j.1365-2648.2009.05247.x

Høye, S., & Severinsson, E. (2010b). Multicultural family members' experiences with nurses and the intensive care context:

A hermeneutic study. *Intensive and Critical Care Nursing, 26*, 24-32.

Independent Hospital Pricing Authority. (2015). *Culturally and linguistically diverse patient costing study report*. Retrieved from Independent Hospital Pricing Authority: https://www.ihpa.gov.au/sites/g/files/net636/f/publications/culturally_and_linguistically_diverse_patient_costing_study.pdf

Irvine, F., Roberts, G., & Bradbury-Jones, C. (2008). The Researcher as Insider Versus the Researcher as Outsider: Enhancing Rigour Through Language and Cultural Sensitivity. In P.

Liamputtong (Ed.), *Doing Cross-Cultural Research, Ethical and Methodological Perspectives* (pp. 35-48): Springer.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res, 42*(2), 727-754. doi:10.1111/j.1475-6773.2006.00629.x

Khosla, N., Washington, K. T., Shaunfield, S., & Aslakson, R. (2017). Communication Challenges and Strategies of U.S. Health Professionals Caring for Seriously Ill South Asian Patients and Their Families. *JOURNAL OF PALLIATIVE MEDICINE, 20*(6), 611-617. doi:DOI: 10.1089/jpm.2016.0167

Killam, L. A. (2013). *Research terminology simplified: Paradigms, axiology, ontology, epistemology and methodology.*: Laura Killam, 2013.

Komaric, N., Bedford, S., & Driel, M. L. v. (2012). Two sides of the coin: patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. *BMC Health Services Research, 12*(322), 1-14.

Krystallidou, D., Bylund, C. L., & Pype, P. (2019). The professional interpreter's effect on empathic communication in medical consultations: A qualitative analysis of interaction. *Patient Education and Counseling*. doi:10.1016/j.pec.2019.09.027

Lai, D. W. L., Li, J., Lee, V. W. P., & Dong, X. (2019). Environmental Factors Associated with Chinese Older Immigrants' Social Engagement. *J Am Geriatr Soc, 67*(S3), S571-S576. doi:10.1111/jgs.15899

Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Method, 2*(3), 21-35.

Lee, J. J., Long, A. C., Curtis, J. R., & Engelberg, R. A. (2016). The Influence of Race/Ethnicity and Education on Family Ratings of the Quality of Dying in the ICU. *Journal of Pain and Symptom Management, 51*(1), 9-16.

Liamputtong, P. (2008). Doing Research in a Cross-Cultural Context: Methodological and Ethical Challenges. In P. Liamputtong (Ed.), *Doing cross-cultural research, ethical and methodological perspectives* (pp. 3-21): Springer.

Liamputtong, P. (2017). The Science of Words and the Science of Numbers. In P. Liamputtong (Ed.), *Research method in health,foundations for evidenced-based practice* (3 ed., pp. 3-49). Australia and New Zealand: OXFORD university press.

Liamputtong, P., & Serry, T. (2017). Making sense of qualitative data. In P. Lamputtong (Ed.), *Research Method in Health, Foundation for evidence-based practice* (3rd ed., pp. 422-435). Australia: Oxford.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging conflunces, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4 ed., pp. 97-150). California: SAGE.

Liu, X., Zheng, J., Liu, K., Baggs, J. G., Liu, J., Wu, Y., & You, L. (2018). Hospital nursing organizational factors, nursing care left undone, and nurse burnout as predictors of patient safety: A structural equation modeling analysis. *Int J Nurs Stud, 86*, 82-89. doi:10.1016/j.ijnurstu.2018.05.005

Luiking, M. L., Heckemann, B., Ali, P., Dekker-van Doorn, C., Ghosh, S., Kydd, A., . . . Patel, H. (2019). Migrants' Healthcare Experience: A Meta-Ethnography Review of the Literature. *J Nurs Scholarsh, 51*(1), 58-67. doi:10.1111/jnu.12442

Manias, E. (2011). Measuring safety and quality in health care: Classic methods paper. *International Journal of Nursing Studies, 48*(3), 356-358. doi:10.1016/j.ijnurstu.2010.12.002

Mendu, M. L., Zager, S., Moromizato, T., McKane, C. K., Gibbons, F. K., & Christopher, K. B. (2013). The association between primary language spoken and all-cause mortality in critically ill patients. *J Crit Care, 28*(6), 928-934. doi:10.1016/j.jcrc.2013.07.057

Meng, Q. Y., Yang, H., Chen, W., Sun, Q., & Liu, X. (2015). *People's Republic of China Health System Review*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/208229/9789290617280_eng.pdf;jsessionid=3D29277625475FE503D9FB659E97522E?sequence=1

Mitchison, D., Butow, P., Sze, M., Aldridge, L., Hui, R., Vardy, J., . . . Goldstein, D. (2012). Prognostic communication preferences of migrant patients and their relatives. *Psychooncology, 21*(5), 496-504. doi:10.1002/pon.1923

Moules, N. J., McCaffery, G., Field, J. C., & Laing, C. M. (2015). *Conducting hermeneutic research, From philosophy to practice* (Vol. 19). New York: Peter Lang publishing.

Muni, S., Engelberg, R. A., Treece, P. D., Dotolo, D., & Curtis, J. R. (2011). The Influence of Race/Ethnicity and Socioeconomic Status on End-of-Life Care in the ICU. *Chest, 139*(5), 1025-1033.

National Health and Medical Research Council (NHMRC). (2007, 2019). The National Statement on Ethical Conduct in Human Research. Retrieved from https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#toc__15

Nissen, T., & Wynn, R. (2014). The clinical case report: a review of its merits and limitations. *BMC Research Notes, 7*(264), 1-7. doi:doi:10.1186/1756-0500-7-264

Nowell, L. S., Jill M. Norris, Deborah E. White, & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods, 16*, 1-13. doi:10.1177/1609406917733847

Parahoo, K. (2014). Qualitative research. In K. Parahoo (Ed.), *Nursing research: principles, process and issues* (3 ed., pp. 55-77). Basingstoke: Palgrave Macmillan.

Paternotte, E., van Dulmen, S., Bank, L., Seeleman, C., Scherpbier, A., & Scheele, F. (2017). Intercultural communication through the eyes of patients: experiences and preferences. *International Journal of Medical Education, 8*, 170-175. doi:10.5116/ijme.591b.19f9

Peck, B., & Mummery, J. (2018). Hermeneutic Constructivism: An Ontology for Qualitative Research. *Qualitative Health Research, 28*(3), 389-407. doi:10.1177/1049732317706931

Polit, D. F., & Beck, C. T. (2017). *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (10th ed.): Wolters Kluwer.

Poškaitė, L. (2014). Filial Piety (xiao 孝) for the Contemporary and Global World:A View from the Western and Chinese Perspectives. *Asian Studies, 2*(1), 99-114. doi:10.4312/as.2014.2.1.99-114

Principe, I. (2015). *Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds. A scoping Study for the Health Performance Council*. Retrieved from https://www.hpcsa.com.au/reports#X-201609291459291

Renzaho, A. M. N., & Nidhi Dhingra. (2016). *Assessing the impact of post migration lifestyle changes on migrant settlement trajectories*. Retrieved from Sydney:

Robinson, O. C. (2014). Sampling in Interview-Based Qualitative Research: A Theoretical and Practical Guide. *Qualitative Research in Psychology, 11*(1), 25-41. doi:10.1080/14780887.2013.801543

Rodriguez, R. M., Navarrete, E., Schwaber, J., McKleroy;, W., Clouse, A., Kerrigan, S. F., & Fortman, J. (2008). A prospective study of primary surrogate decision makers' knowledge of intensive care. *Crit Care Med, 36*(5), 1633-1636. doi:10.1097/CCM.0b013e31816a0784

Rothschild, M. J., Landrigan, P. C., Cronin, W. J., Kaushal, W. R., Lockley, H. S., Burdick, M. E., . . . Bates, W. D. (2005). The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care. *Critical Care Medicine, 33*(8), 1694-1700. doi:10.1097/01.CCM.0000171609.91035.BD

Sandelowski, M., Voils, C., & Barroso, J. (2006). Defining and Designing Mixed Research Synthesis Studies. *Research in the Schools, 13*(1), 29-40.

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the concept of acculturation: implications for theory and research. *Am Psychol, 65*(4), 237-251. doi:10.1037/a0019330

Shaw, J., Zou, X., & Butow, P. (2015). Treatment decision making experiences of migrant cancer patients and their families in Australia. *Patient Educ Couns, 98*(6), 742-747. doi:10.1016/j.pec.2015.01.012

Shin, S., Park, J. H., & Bae, S. H. (2018). Nurse staffing and nurse outcomes: A systematic review and meta-analysis. *Nurs Outlook, 66*(3), 273-282. doi:10.1016/j.outlook.2017.12.002

Steinberg, E. M., Valenzuela-Araujo, D., Zickafoose, J. S., Kieffer, E., & DeCamp, L. R. (2016). The "Battle" of Managing Language Barriers in Health Care. *Clin Pediatr (Phila), 55*(14), 1318-1327. doi:10.1177/0009922816629760

Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W., & Prakongsai, P. (2015). Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens. *BMC Health Services Research, 15*(390), 1-14.

Tao, H., Ellenbecker, C. H., Wang, Y., & Li, Y. (2015). Examining perception of job satisfaction and intention to leave among ICU nurses in China. *International Journal of Nursing Sciences, 2*(2), 140-148. doi:10.1016/j.ijnss.2015.04.007

Terry, D., Ali, M., & Le, Q. (2011). Asian migrants' lived experience and acculturation to Western health care in rural Tasmania. *Aust J Rural Health, 19*(6), 318-323. doi:10.1111/j.1440-1584.2011.01229.x

Thawesaengskulthai, N., Wongrukmit, P., & Dahlgaard, J. J. (2015). Hospital service quality measurement models: patients from Asia, Europe, Australia and America. *Total Quality Management & Business Excellence, 26*(9-10), 1029-1041. doi:10.1080/14783363.2015.1068596

The Australian and New Zealand Intensive Care Society centre for outcome and resource evaluation. (Ed.) (2017). Carlton South, VIC, Australia.

Thornton, J. D., Pham, K., Engelberg, R. A., Jackson, J. C., & Curtis, J. R. (2009). Families with limited English proficiency receive less information and support in interpreted intensive care unit family conferences. *Crit Care Med, 37*(1), 89-95. doi:10.1097/CCM.0b013e3181926430

Trotter II, R. T. (2012). Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives. *Preventive Medicine, 55*, 398-400. doi:10.1016/j.ypmed.2012.07.003

Tschurtz, B. A., G. Koss, Nancy J. Kupka, & Scott C. Williams. (2011). Language Service in Hospital Discordance in Availability and Staff Use. *Journal of Healthcare Management, 56*(6), 403-418.

Tsoh, J. Y., Sentell, T., Gildengorin, G., Le, G. M., Chan, E., Fung, L. C., . . . Nguyen, T. T. (2016). Healthcare Communication Barriers and Self-Rated Health in Older Chinese American Immigrants. *J Community Health, 41*(4), 741-752. doi:10.1007/s10900-015-0148-4

United States Census Bureau. (2018). Race and Hispanic Origin. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045218

Van der Zalm, J. E., & Bergum, V. (2000). Hermeneutic-phenomenology: providing living knowledge for nursing practice. *Journal of Advanced Nursing, 31*(1), 211-218.

Van Keer, R. L., Deschepper, R., Francke, A. L., Huyghens, L., & Bilsen, J. (2015). Conflicts between healthcare professionals and families of a multi-ethnic patient population during critical care: an ethnographic study. *Critical Care, 19*. doi:10.1186/s13054-015-1158-4

Van Keer, R. L., Deschepper, R., Huyghens, L., & Bilsen, J. (2017). Mental well-being of patients from ethnic minority groups during critical care: a qualitative ethnographic study. *BMJ Open, 7*(9). doi:10.1136/bmjopen-2016-014075

Van Manen, M. (2017). Phenomenology in Its Original Sense. *Qualitative Health Research, 27*(6), 810-825. doi:10.1177/1049732317699381

van Rosse, F., de Bruijne, M., Suurmond, J., Essink-Bot, M. L., & Wagner, C. (2016). Language barriers and patient safety risks in hospital care. A mixed methods study. *International Journal of Nursing Studies, 54*, 45-53. doi:10.1016/j.ijnurstu.2015.03.012

Walton, M., Harrison, R., Kelly, P., Smith-Merry, J., Manias, E., Jorm, C., & Iedema, R. (2017). Patients' reports of adverse events: A data linkage study of Australian adults aged 45 years and over. *BMJ quality & safety, 26*(9), 743-750. doi:10.1136/bmjqs-2016-006339

Wang, C. C. (2016). Closing the gap in nursing education: Comparing nursing registration systems in Australia and China. *Chinese Nursing Research, 3*(1), 1-6. doi:10.1016/j.cnre.2016.03.001

Wang, Y., Wei, S., Li, Y., Deng, S., Luo, Q., & Li, Y. (2013). Challenges and a response strategy for the development of nursing in China: a descriptive and quantitative analysis. *J Evid Based Med, 6*(1), 21-33. doi:10.1111/jebm.12016

Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553.

World Health Organization. (2008). Guidance on developing quality and safety strategies with a health system approach. *Management for health services delivery.* Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0011/96473/E91317.pdf?ua=1

Xu, J., Gorsky, M., & Mills, A. (2019). Historical roots of hospital centrism in China (1835-1949): A path dependence analysis. *Soc Sci Med, 226*, 56-62. doi:10.1016/j.socscimed.2019.02.025

You, L. M., Aiken, L. H., Sloane, D. M., Liu, K., He, G. P., Hu, Y., . . . Sermeus, W. (2013). Hospital nursing, care quality, and patient satisfaction: cross-sectional surveys of nurses and patients in hospitals in China and Europe. *Int J Nurs Stud, 50*(2), 154-161. doi:10.1016/j.ijnurstu.2012.05.003

Zhang, Y., Zhou, Z., & Si, Y. (2019). When more is less: What explains the overuse of health care services in China? *Soc Sci Med, 232*, 17-24. doi:10.1016/j.socscimed.2019.04.018

Zheng, D., Gong, J., & Zhang, C. (2019). Efficiency of medical service systems in the rural areas of Mainland China: a comparative study from 2013 to 2017. *Public Health, 171*, 139-147. doi:10.1016/j.puhe.2019.04.003

APPENDICES

Appendix A Selected Search Strategies

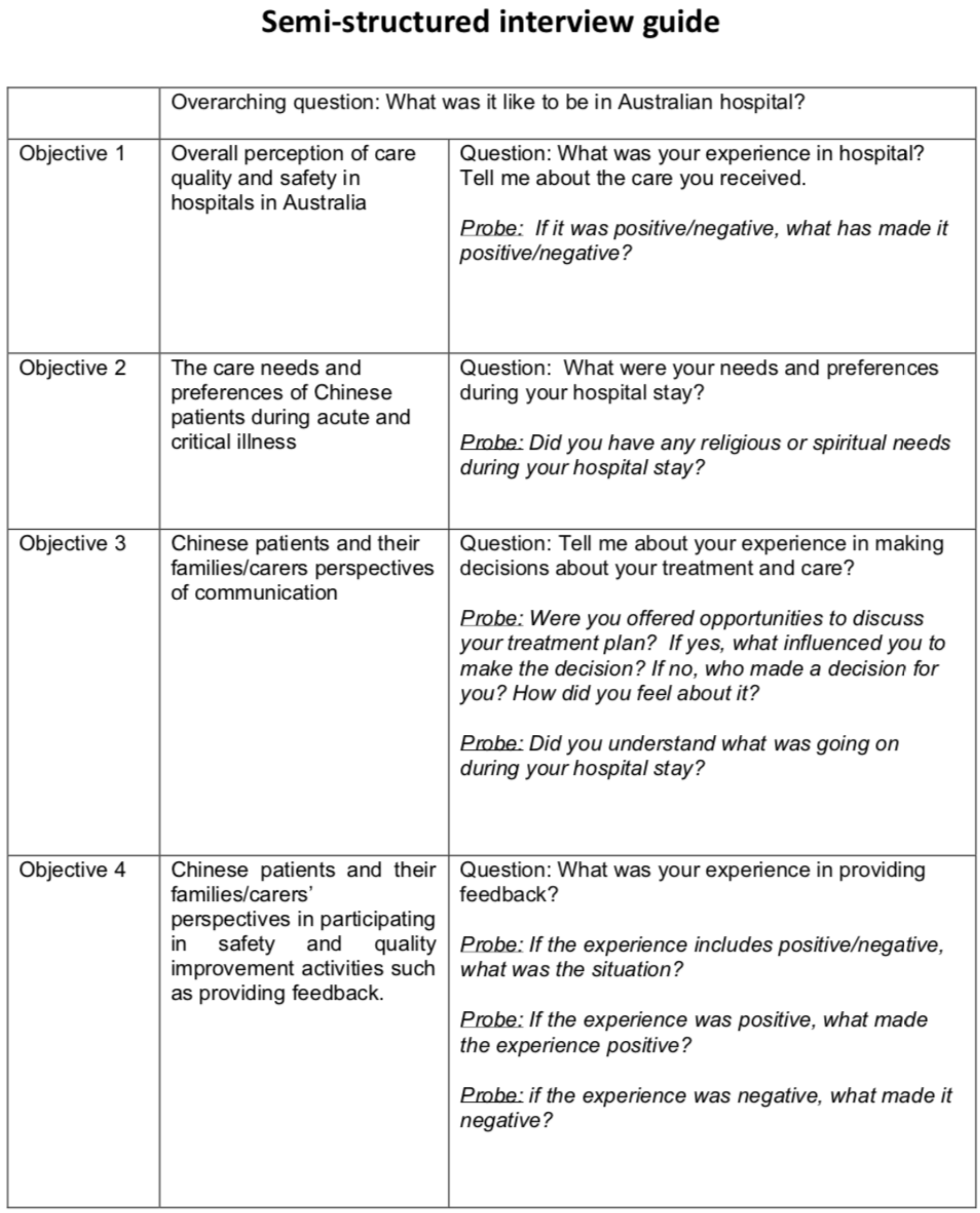
PubMed		**Result**
#1	(((((((("culture"[MeSH Terms] OR "culture"[All Fields] OR "cultural"[All Fields]) AND diverse[All Fields]) OR ("cultural diversity"[MeSH Terms] OR ("cultural"[All Fields] AND "diversity"[All Fields]) OR "cultural diversity"[All Fields])) OR (linguistically[All Fields] AND diverse[All Fields])) OR (("culture"[MeSH Terms] OR "culture"[All Fields] OR "culturally"[All Fields]) AND linguistically[All Fields] AND diverse[All Fields])) OR ("transients and migrants"[MeSH Terms] OR ("transients"[All Fields] AND "migrants"[All Fields]) OR "transients and migrants"[All Fields] OR "migrant"[All Fields])) OR (non-English[All Fields] AND speaking[All Fields])) OR (("minority groups"[MeSH Terms] OR ("minority"[All Fields] AND "groups"[All Fields]) OR "minority groups"[All Fields] OR "minority"[All Fields]) AND ("ethnic groups"[MeSH Terms] OR ("ethnic"[All Fields] AND "groups"[All Fields]) OR "ethnic groups"[All Fields] OR "ethnic"[All Fields]))) OR ("refugees"[MeSH Terms] OR "refugees"[All Fields] OR "refugee"[All Fields])	72395
#2	(("critical care"[MeSH Terms] OR ("critical"[All Fields] AND "care"[All Fields]) OR "critical care"[All Fields] OR ("intensive"[All Fields] AND "care"[All Fields]) OR "intensive care"[All Fields]) OR ("critical care"[MeSH Terms] OR ("critical"[All Fields] AND "care"[All Fields]) OR "critical care"[All Fields])) OR ("critical illness"[MeSH Terms] OR ("critical"[All Fields] AND "illness"[All Fields]) OR "critical illness"[All Fields])	422868
#3	(((((cross-cultural[All Fields] AND (“Interaction”[Journal] OR “interaction”[All Fields])) OR (“Interaction”[Journal] OR “interaction”[All Fields])) OR (“communication”[MeSH Terms] OR “communication”[All Fields])) OR experience[All Fields]) OR (“perception”[MeSH Terms] OR “perception”[All Fields])) OR (cross-cultural[All Fields] AND (“communication”[MeSH Terms] OR “communication”[All Fields]))	2219187
#4	(((“Qual Saf Health Care”[Journal] OR “BMJ Qual Saf”[Journal] OR (“quality”[All Fields] AND “and”[All Fields] AND “safety”[All Fields]) OR “quality and safety”[All Fields]) OR (adverse[All Fields] AND event[All Fields])) OR error[All Fields]) OR mistake[All Fields]	240407
#5	#1 And #2 and #3 and #4	7
#6	Limited #5 to English, Human and 2008-2018	3

CINAHL		
#1	"cultural diverse OR cultural diversity OR linguistically diverse OR (culturally and linguistically diverse) OR migrant OR Non-English speaking OR minority ethnic OR refugee" OR (MH "Cultural Diversity") OR (MH "Organizational Culture")	27561
#2	(MH "Critical Care Nursing") OR (MH "Critical Care") OR (MH "Intensive Care Units") OR "intensive care OR critical care OR critical illness"	38477
#3	(MH "Transcultural Care") OR "cross-cultural interaction OR interaction OR communication OR experience OR perception OR cross-cultural communication"	1359
#4	(MH "Adverse Health Care Event") OR (MH "Adverse Drug Event") OR (MH "Health Care Errors") OR "(quality and safety) OR adverse events OR (errors or mistakes)"	16094
#5	#1and #2 and #3 and #4	0
Web of Science		
#1	ALL FIELDS: (cultural diverse) *OR* ALL FIELDS: (cultural diversity) *OR* ALL FIELDS: (linguistically diverse) *OR* ALL FIELDS: (culturally and linguistically diverse) *OR* ALL FIELDS: (migrant) *OR* ALL FIELDS: (non-English speaking) *OR* ALL FIELDS: (refugee) *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=All years*	105910
#2	ALL FIELDS: (intensive care) OR ALL FIELDS: (critical care) OR ALL FIELDS: (critical illness) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=All years	412515
#3	ALL FIELDS: (cross-cultural interaction) OR ALL FIELDS: (interaction) OR ALL FIELDS: (communication) OR ALL FIELDS: (experience) OR ALL FIELDS: (perception) OR ALL FIELDS: (cross-cultural communication) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=All years	5835825
#4	ALL FIELDS: (quality and safety) OR ALL FIELDS: (error or mistake) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=All years	1153049
#5	#4 AND #3 AND #2 AND #1 Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=All years	18
#6	(#4 AND #3 AND #2 AND #1) *AND* LANGUAGE: (English) *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=2008-2018*	14

Medline		
#1	(((cultural diverse or cultural diversity or linguistically diverse or culturally) and linguistically diverse) or migrant or non-English speaking or minority ethnic or refugee).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	105910
#2	(intensive care or critical care or critical illness).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	203720
#3	(cross-cultural communication or crosscultural interaction or interaction or communication).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	1044828
#4	((quality and safety) or adverse event or error or mistake).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	263967
#5	1 and 2 and 3 and 4	0
PsycINFO		
#1	(((cultural diverse or cultural diversity or linguistically diverse or culturally) and linguistically diverse) or migrant or non-English speaking or minority ethnic or refugee).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	13368
#2	(intensive care or critical care or critical illness).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	9788
#3	(cross-cultural communication or crosscultural interaction or interaction or communication).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	465861
#4	((quality and safety) or adverse event or error or mistake).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	78895
#5	1 and 2 and 3 and 4	1
Cochrane Data Base		

#1	cultural diverse in All Text OR cultural diversity in All Text OR linguistically diverse in All Text OR culturally and linguistically diverse in All Text OR migrant or non-English speaking or minority ethnic or refugee in All Text - (Word variations have been searched)	1395
#2	intensive care or critical care or critical illness	45945
#3	cross-cultural interaction or interaction or communication or experience or perception or cross-cultural communication	91249
#4	quality and safety or adverse event or error or mistake	51491
#5	#1 and #2 and #3 and #4	235
Scopus		
#1	cultural AND diverse OR cultural AND diversity OR linguistically AND diverse OR culturally AND linguistically AND diverse OR migrant OR non-English AND speaking OR minority AND ethnic OR refugee	2731
#2	intensive AND care OR critical AND care OR critical AND illness	133239
#3	cross-cultural AND interaction OR interaction OR communication OR experience OR perception OR cross-cultural AND communication	115236
#4	quality AND safety OR adverse AND event OR error OR mistake	300831
#5	#1 and #2 and #3 and #4	14

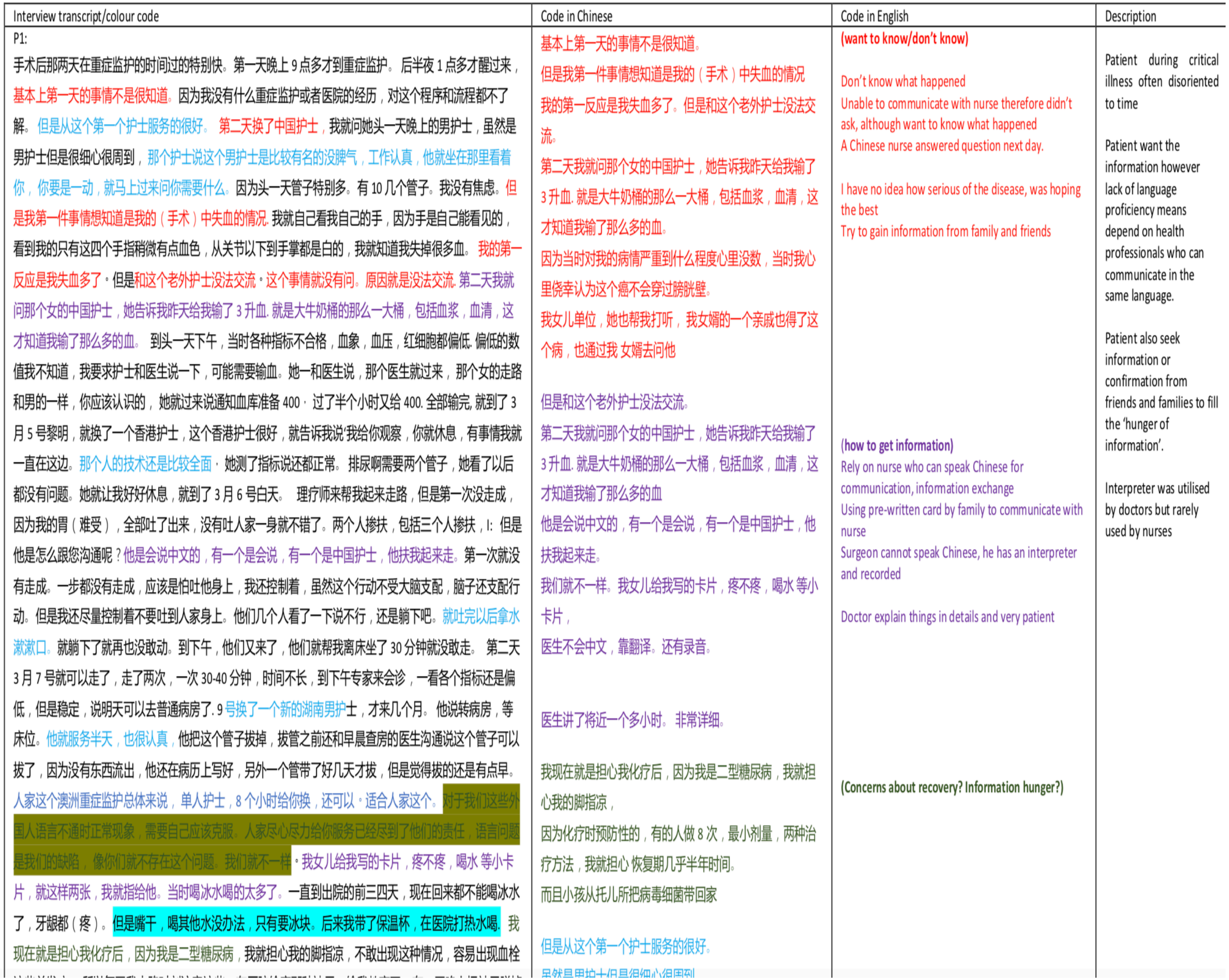
Appendix B Semi-structured interview guide



Semi-structured interview guide

	Overarching question: What was it like to be in Australian hospital?	
Objective 1	Overall perception of care quality and safety in hospitals in Australia	Question: What was your experience in hospital? Tell me about the care you received. *Probe:* *If it was positive/negative, what has made it positive/negative?*
Objective 2	The care needs and preferences of Chinese patients during acute and critical illness	Question: What were your needs and preferences during your hospital stay? *Probe:* *Did you have any religious or spiritual needs during your hospital stay?*
Objective 3	Chinese patients and their families/carers perspectives of communication	Question: Tell me about your experience in making decisions about your treatment and care? *Probe:* *Were you offered opportunities to discuss your treatment plan? If yes, what influenced you to make the decision? If no, who made a decision for you? How did you feel about it?* *Probe:* *Did you understand what was going on during your hospital stay?*
Objective 4	Chinese patients and their families/carers' perspectives in participating in safety and quality improvement activities such as providing feedback.	Question: What was your experience in providing feedback? *Probe:* *If the experience includes positive/negative, what was the situation?* *Probe:* *If the experience was positive, what made the experience positive?* *Probe:* *if the experience was negative, what made it negative?*

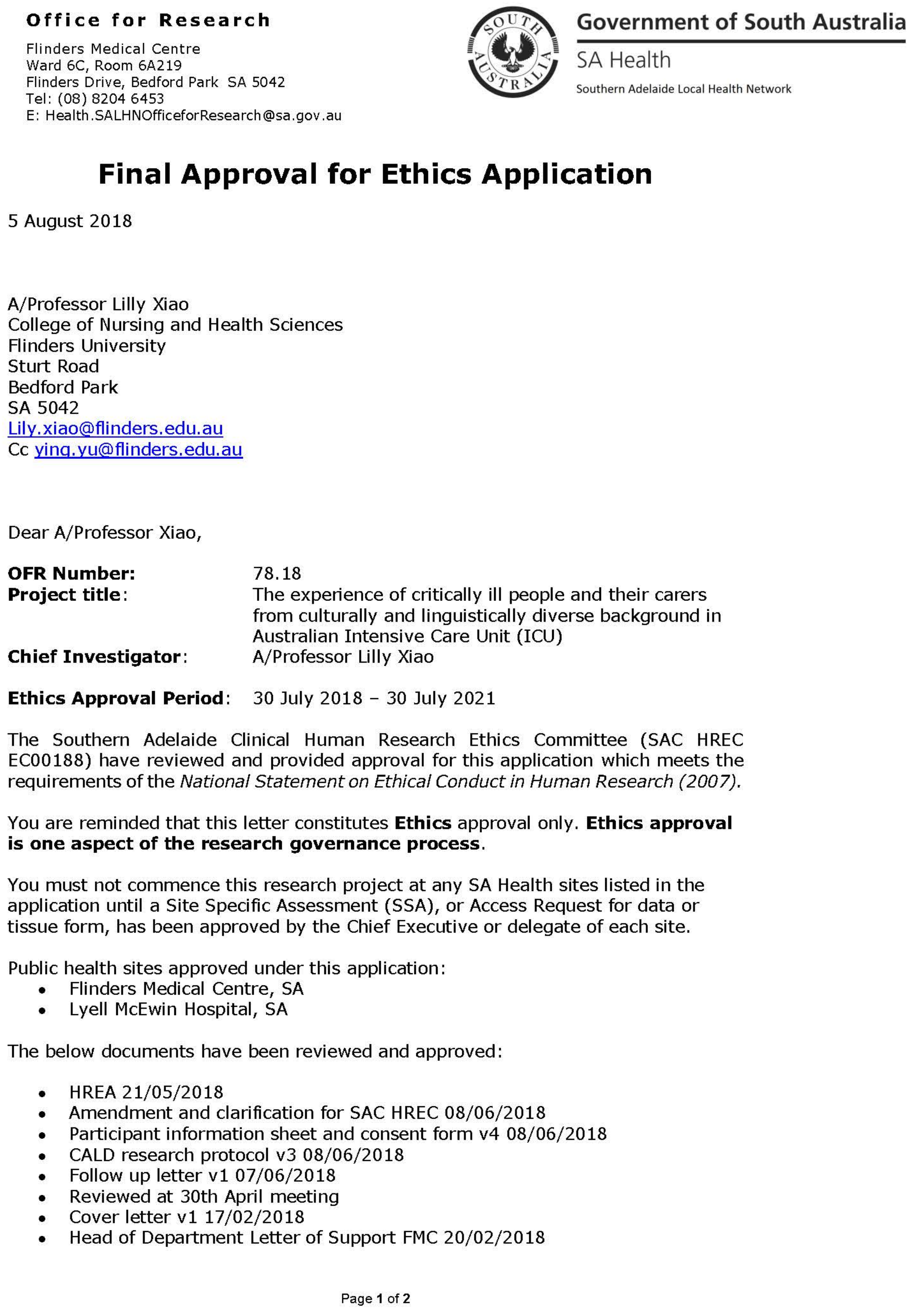
Appendix C Example of interview coding



Interview transcript/colour code	Code in Chinese	Code in English	Description
P1: 手术后那两天在重症监护的时间过的特别快。第一天晚上 9 点多才到重症监护。 后半夜 1 点多才醒过来，基本上第一天的事情不是很知道。因为我没有什么重症监护或者医院的经历，对这个程序和流程都不了解。 但是从这个第一个护士服务的很好。 第二天换了中国护士，我就问她头一天晚上的男护士，虽然是男护士但是很细心很周到，那个护士说这个男护士是比较有名的没脾气，工作认真，他就坐在那里看着你，你要是一动，就马上过来问你需要什么。因为头一天管子特别多。有 10 几个管子。我没有焦虑。但是我第一件事情想知道是我的（手术）中失血的情况. 我就自己看我自己的手，因为手是自己能看见的，看到我的只有这四个手指稍微有点血色，从关节以下到手掌都是白的，我就知道我失掉很多血。 我的第一反应是我失血多了。但是和这个老外护士没法交流。这个事情就没有问。原因就是没法交流. 第二天我就问那个女的中国护士，她告诉我昨天给我输了 3 升血. 就是大牛奶桶的那么一大桶，包括血浆，血清，这才知道我输了那么多的血。 到头一天下午，当时各种指标不合格，血象，血压，红细胞都偏低. 偏低的数值我不知道，我要求护士和医生说一下，可能需要输血。她一和医生说，那个医生就过来， 那个女的走路和男的一样，你应该认识的， 她就过来说通知血库准备 400. 过了半个小时又给 400. 全部输完, 就到了 3 月 5 号黎明，就换了一个香港护士，这个香港护士很好，就告诉我说'我给你观察，你就休息，有事情我就一直在这边。那个人的技术还是比较全面. 她测了指标说还都正常。 排尿啊需要两个管子，她看了以后都没有问题。她就让我好好休息，就到了 3 月 6 号白天。 理疗师来帮我起来走路，但是第一次没走成，因为我的胃（难受），全部吐了出来，没有吐人家一身就不错了。两个人搀扶，包括三个人搀扶，I: 但是他是怎么跟您沟通呢？他是会说中文的，有一个是会说，有一个是中国护士，他扶我起来走。第一次就没有走成。一步都没有走成，应该是怕吐他身上，我还控制着，虽然这个行动不受大脑支配，脑子还支配行动。但是我还尽量控制着不要吐到人家身上。他们几个人看了一下说不行，还是躺下吧。就吐完以后拿水漱漱口。就躺下了就再也没敢动。到下午，他们又来了，他们就帮我离床坐了 30 分钟就没敢走。 第二天 3 月 7 号就可以走了，走了两次，一次 30-40 分钟，时间不长，到下午专家来会诊，一看各个指标还是偏低，但是稳定，说明天可以去普通病房了. 9 号换了一个新的湖南男护士，才来几个月。 他说转病房，等床位。他就服务半天，也很认真，他把这个管子拔掉，拔管之前还和早晨查房的医生沟通说这个管子可以拔了，因为没有东西流出，他还在病历上写好，另外一个管带了好几天才拔，但是觉得拔的还是有点早。人家这个澳洲重症监护总体来说，单人护士，8 个小时给你换，还可以. 适合人家这个。对于我们这些外国人语言不通时正常现象，需要自己应该克服。人家尽心尽力给你服务已经尽到了他们的责任，语言问题是我们的缺陷， 像你们就不存在这个问题。我们就不一样. 我女儿给我写的卡片，疼不疼，喝水 等小卡片，就这样两张，我就指给他。当时喝冰水喝的太多了。一直到出院的前三四天，现在回来都不能喝冰水了，牙龈都（疼）。但是嘴干，喝其他水没办法，只有要冰块。后来我带了保温杯，在医院打热水喝. 我现在就是担心我化疗后，因为我是二型糖尿病，我就担心我的脚指凉，不敢出现这种情况，容易出现血栓	基本上第一天的事情不是很知道。 但是我第一件事情想知道是我的（手术）中失血的情况 我的第一反应是我失血多了。但是和这个老外护士没法交流。 第二天我就问那个女的中国护士，她告诉我昨天给我输了 3 升血. 就是大牛奶桶的那么一大桶，包括血浆，血清，这才知道我输了那么多的血。 因为当时对我的病情严重到什么程度心里没数，当时我心里侥幸认为这个癌不会穿过膀胱壁。 我女儿单位，她也帮我打听， 我女婿的一个亲戚也得了这个病，也通过我 女婿去问他	**(want to know/don't know)** Don't know what happened Unable to communicate with nurse therefore didn't ask, although want to know what happened A Chinese nurse answered question next day. I have no idea how serious of the disease, was hoping the best Try to gain information from family and friends	Patient during critical illness often disoriented to time Patient want the information however lack of language proficiency means depend on health professionals who can communicate in the same language. Patient also seek information or confirmation from friends and families to fill the 'hunger of information'.
	但是和这个老外护士没法交流。 第二天我就问那个女的中国护士，她告诉我昨天给我输了 3 升血. 就是大牛奶桶的那么一大桶，包括血浆，血清，这才知道我输了那么多的血 他是会说中文的，有一个是会说，有一个是中国护士，他扶我起来走。 我们就不一样。我女儿给我写的卡片，疼不疼，喝水 等小卡片， 医生不会中文，靠翻译。还有录音。 医生讲了将近一个多小时。 非常详细。	**(how to get information)** Rely on nurse who can speak Chinese for communication, information exchange Using pre-written card by family to communicate with nurse Surgeon cannot speak Chinese, he has an interpreter and recorded Doctor explain things in details and very patient	Interpreter was utilised by doctors but rarely used by nurses
	我现在就是担心我化疗后，因为我是二型糖尿病，我就担心我的脚指凉， 因为化疗时预防性的，有的人做 8 次，最小剂量，两种治疗方法，我就担心 恢复期几乎半年时间。 而且小孩从托儿所把病毒细菌带回家	**(Concerns about recovery? Information hunger?)**	
	但是从这个第一个护士服务的很好。		

的医生说化疗以后糖尿病的药要坚持吃，化疗药会引起血糖升高。 告诉我每天两片。 化疗期间说正常人也会有血糖升高。 我不需要放疗，因为化疗时预防性的，有的人做 8 次 · 最小剂量，两种治疗方法，我就担心 恢复期几乎半年时间。--脑子总是想这些问题，以前可以抱孩子，现在都不可以，化疗后一两个月才可以，因为化疗的毒素排完才可以，而且小孩从托儿所把病毒细菌带回家，怕感染我 · 我的房间不敢让小孩进，每天搞卫生，我的碗筷都时单独的，衣服都时手洗，不敢用洗衣机洗。 都得注意。我女儿犹豫加入澳洲公民的问题。家里的房子给她了，但是她加入澳洲国籍就要把这个房子卖掉。 我们在排队办移民。比以前难。 把家里最好的房子给她了，因为就一个女儿。 她也比较担心这些澳洲入籍的问题。I: 您住院的过程中有没有担心术后化疗的问题，就像您现在想的这些问题？ 没有，我当时心态比较好，当时心里强大，走完一个过程再走下一个过程。因为当时对我的病情严重到什么程度心里没数，当时我心里侥幸认为这个癌不会穿过膀胱壁。 我家亲属有膀胱癌，没有穿过膀胱壁就不需要化疗，就没有考虑这么多，因为没有得过病。 就这一个病才进医院，要不是 27 号的血尿，我还准备 3 月 27 号回国，票都买好了，因为这个事情就不能回去了。 因为我知道血尿的严重性。所以连续做膀胱镜检查，手术，前后 40 天。第一就是先做手术，膀胱转移的机会比较小.. 医生不会中文，靠翻译。还有录音。 我现在的记忆力还可以。 他说完以后我就没有考虑下一步。 I: 当时您对治疗的了解是全靠医生吗？有没有问问别人，想没想见一见有同种病情的人？ 有 · 我女儿单位，她也帮我打听， 我女婿的一个亲戚也得了这个病，也通过我 女婿去问他，因为当时有一些术语我们不太懂，我女婿（就问他）给我们解释。但是他们都说有可能化疗，但是都没有说是确定，医生也是只说有可能，要做完手术再说。 做完手术以后他就说要化疗。手术恢复期过了以后再化疗。医生把手术中的的情况和以前没有说的就和我们说了一下。 就说这个有一个点已经穿透膀胱壁，这个就有可能转移。讲了将近一个多小时。 非常详细。 他说他不是肿瘤医生，我需要去见一个会说中文的肿瘤医生。他说肿瘤在澳洲任何地方的治疗方法都是一样的。是公式性的。 又讲了很多危害， 两点好处，其他都是坏处。 提高生存率，其他的都是坏的。我的脑子里没有这个印象，只是想把手术恢复完，复查的时候才考虑化疗问题。 说化疗不能晚于三个月，晚于三个月效果就不会那么好。 I: 那您在重症监护的时候，你觉得好或者不好的有没有提供一些反馈意见啊？ 没有提任何意见喝反馈，过完今天想明天，人家叫我做什么就做什么 · 而且我脑子里觉得医生护士很负责任的 · 一来 7.8 个人，三级医生都在你周围，尽到他们的责任了，比中国好多了，所以没有什么意见 I: 还有一个问题要问的是我们中国人在国内得病不是病人做决定，是家属决定治疗，在这里您自己做决定，您感觉怎么样？ 这里是比较好的，自己决定， 病人对医疗知识不懂，在国内不会给你讲的很清楚，家属就会有病乱投医，在思维过程中会混乱，没有合理的判断事情。在澳洲给你讲的很清楚，每一个细节都降到，给你病人解释的很清楚，这么做的好处是什么，不好的是什么，在中国人家不可能给你一个病人讲半个小时一个小时的。澳洲医生就可以这么做，就提高了病人对事物的判断能力。 你愿意做就签字或者不愿做不签字，当面说清楚，利弊分析到。你就可以做决定。中国就不行。 工作方法和人们习惯是不一样的，中国压力大，病人多，没有时间沟通。他还觉得病人知道病情以后对心里承受不了，对病人的康复没有好处。也怕承担责任。 中国医生和病人之间，患者是弱势。医生的责任心问题，和病人沟通也是问题。 都是为了挣钱。医疗技术有差距，责任心有问题。 中国用中药，中国也保守，医护人员的认识度不一样。 澳洲医生进医院就很认真。中国护士在中国就态度生硬，但是你们在澳洲就很认真，态度也很好，就时说大的环境很重要。 给我化疗的护士叫我进去以后又给我解释一遍，在国内就很粗糙， 到国外就不一样了。	我没有焦虑。 但是嘴干，喝其他水没办法，只有要冰块。后来我带了保温杯，在医院打热水喝. 适合人家这个。对于我们这些外国人语言不通时正常现象，需要自己应该克服。人家尽心尽力给你服务已经尽到了他们的责任，语言问题是我们的缺陷，尽到他们的责任了，比中国好多了，所以没有什么意见 没有提任何意见反馈，过完今天想明天，人家叫我做什么就做什么， 病人对医疗知识不懂，在国内不会给你讲的很清楚，家属就会有病乱投医，在思维过程中会混乱，没有合理的判断事情。在澳洲给你讲的很清楚，每一个细节都降到，给你病人解释的很清楚。 澳洲医生就可以这么做，就提高了病人对事物的判断能力 中国压力大，病人多，没有时间沟通。 医生的责任心问题，和病人沟通也是问题。 都是为了挣钱。医疗技术有差距，责任心有问题。 中国用中药，中国也保守，医护人员的认识度不一样。 中国护士在中国就态度生硬，但是你们在澳洲就很认真，态度也很好	**I was not worried** **Mouth was dry, only can ask for ice chips** Health service is better than China, therefore happy with the service (Happy migrant effect—Garret et al.) Following doctor orders,do what was told (trust? Or powerless?) Powerless—Garret et al. compare Australia to China (comparison?)	Nursing service was highly praised especially one to one nursing care. Compare to previous experience/or home health system, therefore happy with the service (Happy Migrant Effect) Completely trust doctors in Australia

Appendix D Ethics approval letter



Office for Research
Flinders Medical Centre
Ward 6C, Room 6A219
Flinders Drive, Bedford Park SA 5042
Tel: (08) 8204 6453
E: Health.SALHNOfficeforResearch@sa.gov.au

Government of South Australia
SA Health
Southern Adelaide Local Health Network

Final Approval for Ethics Application

5 August 2018

A/Professor Lilly Xiao
College of Nursing and Health Sciences
Flinders University
Sturt Road
Bedford Park
SA 5042
Lily.xiao@flinders.edu.au
Cc ying.yu@flinders.edu.au

Dear A/Professor Xiao,

OFR Number:	78.18
Project title:	The experience of critically ill people and their carers from culturally and linguistically diverse background in Australian Intensive Care Unit (ICU)
Chief Investigator:	A/Professor Lilly Xiao

Ethics Approval Period: 30 July 2018 – 30 July 2021

The Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC EC00188) have reviewed and provided approval for this application which meets the requirements of the *National Statement on Ethical Conduct in Human Research (2007).*

You are reminded that this letter constitutes **Ethics** approval only. **Ethics approval is one aspect of the research governance process**.

You must not commence this research project at any SA Health sites listed in the application until a Site Specific Assessment (SSA), or Access Request for data or tissue form, has been approved by the Chief Executive or delegate of each site.

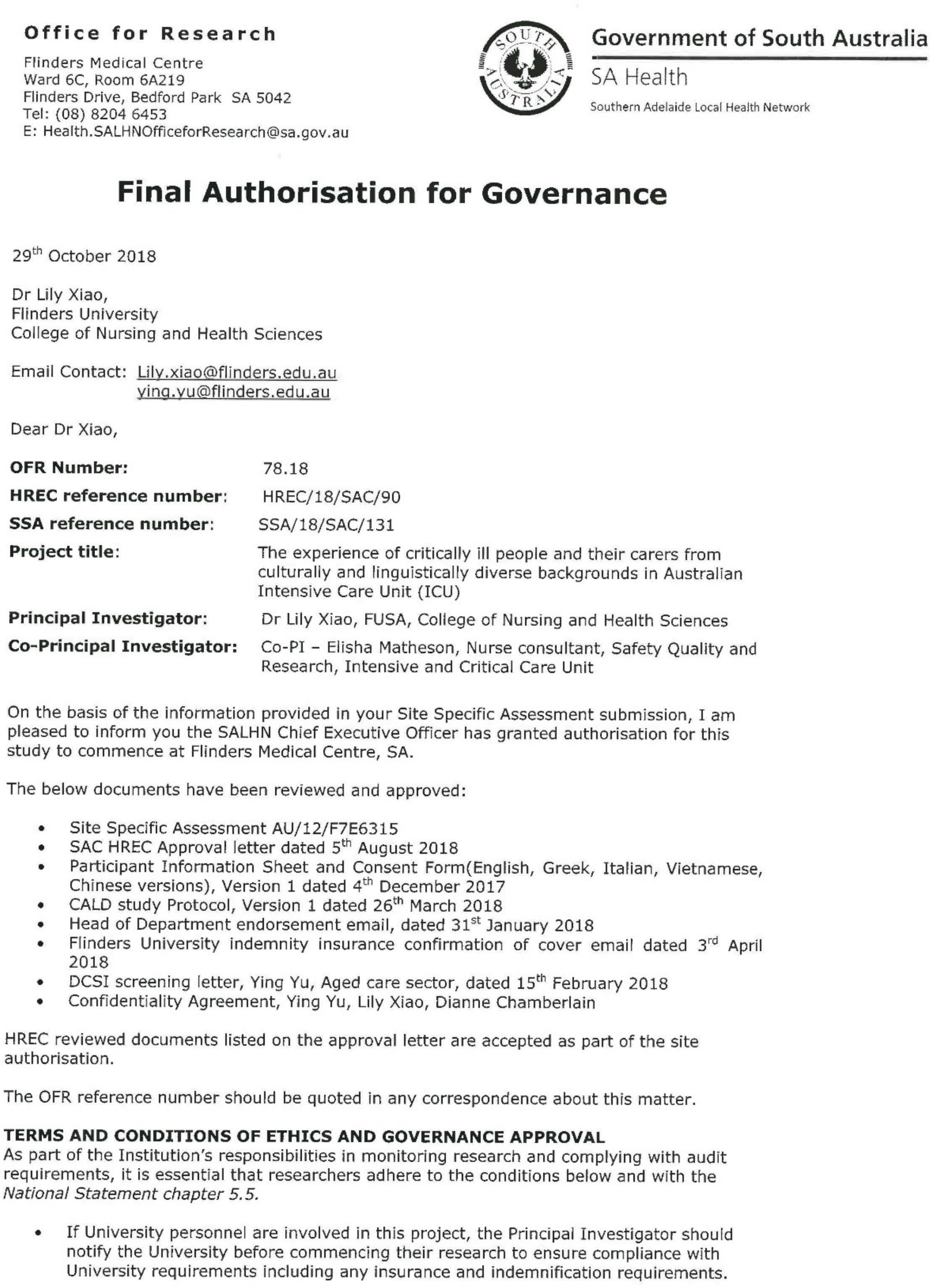
Public health sites approved under this application:
- Flinders Medical Centre, SA
- Lyell McEwin Hospital, SA

The below documents have been reviewed and approved:

- HREA 21/05/2018
- Amendment and clarification for SAC HREC 08/06/2018
- Participant information sheet and consent form v4 08/06/2018
- CALD research protocol v3 08/06/2018
- Follow up letter v1 07/06/2018
- Reviewed at 30th April meeting
- Cover letter v1 17/02/2018
- Head of Department Letter of Support FMC 20/02/2018

Page **1** of **2**

Appendix E Authorisation for governance letter



Office for Research
Flinders Medical Centre
Ward 6C, Room 6A219
Flinders Drive, Bedford Park SA 5042
Tel: (08) 8204 6453
E: Health.SALHNOfficeforResearch@sa.gov.au

Government of South Australia
SA Health
Southern Adelaide Local Health Network

Final Authorisation for Governance

29th October 2018

Dr Lily Xiao,
Flinders University
College of Nursing and Health Sciences

Email Contact: Lily.xiao@flinders.edu.au
ying.yu@flinders.edu.au

Dear Dr Xiao,

OFR Number:	78.18
HREC reference number:	HREC/18/SAC/90
SSA reference number:	SSA/18/SAC/131
Project title:	The experience of critically ill people and their carers from culturally and linguistically diverse backgrounds in Australian Intensive Care Unit (ICU)
Principal Investigator:	Dr Lily Xiao, FUSA, College of Nursing and Health Sciences
Co-Principal Investigator:	Co-PI – Elisha Matheson, Nurse consultant, Safety Quality and Research, Intensive and Critical Care Unit

On the basis of the information provided in your Site Specific Assessment submission, I am pleased to inform you the SALHN Chief Executive Officer has granted authorisation for this study to commence at Flinders Medical Centre, SA.

The below documents have been reviewed and approved:

- Site Specific Assessment AU/12/F7E6315
- SAC HREC Approval letter dated 5th August 2018
- Participant Information Sheet and Consent Form(English, Greek, Italian, Vietnamese, Chinese versions), Version 1 dated 4th December 2017
- CALD study Protocol, Version 1 dated 26th March 2018
- Head of Department endorsement email, dated 31st January 2018
- Flinders University indemnity insurance confirmation of cover email dated 3rd April 2018
- DCSI screening letter, Ying Yu, Aged care sector, dated 15th February 2018
- Confidentiality Agreement, Ying Yu, Lily Xiao, Dianne Chamberlain

HREC reviewed documents listed on the approval letter are accepted as part of the site authorisation.

The OFR reference number should be quoted in any correspondence about this matter.

TERMS AND CONDITIONS OF ETHICS AND GOVERNANCE APPROVAL
As part of the Institution's responsibilities in monitoring research and complying with audit requirements, it is essential that researchers adhere to the conditions below and with the *National Statement chapter 5.5.*

- If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.

- Compliance with the National Statement on Ethical Conduct in Human Research (2007) & the Australian Code for the Responsible Conduct of Research (2007).
- To immediately report to the Office for Research anything that may change the ethics or scientific integrity of the project.
- Report Significant Adverse events (SAEs) as per SAE requirements available on the Office for Research website.
- Submit an annual report on each anniversary of the date of final approval and in the correct template from the Office for Research website.
- Confidentiality of research participants MUST be maintained at all times.
- A copy of the signed consent form must be given to the participant.
- Any reports or publications derived from the research should be submitted to the Committee at the completion of the project.
- All requests for access to medical records at any SALHN site must be accompanied by this approval letter.
- Once your research project has concluded, any new product/procedure/intervention cannot be conducted in the SALHN as standard practice without the approval of the SALHN New Medical Products and Standardisation Committee or the SALHN New Health Technology and Clinical Practice Innovation Committee (as applicable). Please refer to the relevant committee link on the SALHN intranet for further information.
- Researchers are reminded that all advertisements/flyers need to be approved by the committee, and that no promotion of a study can commence until final ethics and executive approval has been obtained. In addition, all media contact should be coordinated through the FMC media unit.
- It is the responsibility of the Principal Investigator to ensure any non-SA Health personnel who conducts or monitors research meets SA Health screening requirements as per the SA Health Criminal & Relevant History Screening Policy Directive before they access any SA Health site. The cost of any such screening is the responsibility of the individual accessing the site or their employer.
- A SALHN confidentiality agreement will need to be signed by all non-SA Health staff who will require access to SA Health data.

Should you have any queries about the consideration of your Site Specific Assessment form, please contact the Office for Research on 8204 6453 via email: Health.SALHNOfficeforResearch@sa.gov.au.

Yours sincerely

Paula Davies
Acting Director,
Research Operations,
Office for Research