Metro South Refugee Health Service

Investigation of community health nurses' experience and use of an assessment framework when working with refugee families.

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Contents

Study Information

Title:	Investigation of community health nurses' experience and use of an assessment framework when working with refugee families.
Short Title:	Refugee Health Nurses experiences assessing refugee families' health needs
Study sites where project will take place:	Metro South Refugee Health Service (Logan) and Mater Integrated Refugee Health Service
Study Objectives:	The aim of this project is to explore Registered Nurses' experience and use of a family assessment framework for assessing refugee patients and their families.
Study Design:	Interpretive phenomenological analysis (IPA)
Study Population:	Registered Nurses working in refugee services in Brisbane (Refugee Nurses)
Number of participants:	N = 11
Key Ethical and Safety considerations:	Ethics was obtained across Metro South and Mater Health Services HREC/17/QPAH/599 - SSA/17/QPAH/600; AM01; and Griffith University. GU Ref No: 2017/783.

Study investigators

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Study Definitions

Term	Definition (using lay language)
Refugee Health Nurse (RHN)	An advanced practitioner within an interdisciplinary team who works in a variety of clinical environments that use a primary health care model underpinned by the philosophy of trauma informed care. RHNs acknowledge the dynamics of contemporary political environments and thus defend and advocate for the rights of the individual, family and community. RHNs deliver care to refugee populations that is culturally informed, inclusive, sensitive and safe (Refugee Nurses Australia, 2020).
Refugee	A refugee is someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group (Simeon & ProQuest, 2013)(The United Nations Refugee High Commission for Refugees 1951)
Person/ family with a refugee background	A person/family who has applied to the United Nations High Commission for Refugees and has arrived in Australia with a permanent visa, as part of Australia's Humanitarian Settlement Program. For the purpose of this report the term refugee will be used instead of person/ family with a refugee background
Family	For the current research, family is defined as a group of individuals who are bound by strong emotional ties, a sense of belonging, a commitment to being involved in one another's lives, and who call themselves 'family' (Shajani & Snell, 2019)
Assessment framework	An approach, tool or structured guide consisting of a predetermined algorithm that serves as a guide to gather information and identify the health needs of a person or population (Munroe et al., 2013)
Primary Health Care	A set of principles and an organising framework to guide health professionals in helping create socially just, equitable conditions for good health (McMurray & Clendon, 2015)
Primary care	Primary care is a component of primary health care, providing front-line personal health services to individuals. Primary care is usually provided through a general practice.
Humanitarian settlement case manager/ worker	Undertake a needs assessment, develop and implement a tailored case plan in collaboration with the new arrival. They are funded to provide up to 18-month initial support after arrival.

Family assessment framework	The Australian Family Strengths Nursing Assessment Guide (AFSNAG) is a solution focussed assessment tool designed to provide nurses with a range of questions across the qualities of Australian family strengths (Barnes & Rowe, 2013).

Introduction

Refugee health services (RHS) provide initial triage nursing assessment and coordination of care, in addition to initiating referral pathways for newly arrival refugee families across Queensland regions. The aim of this study was to explore the community health nurses' experience and the use of an assessment framework when working with refugee families, to identify potential educational support and inform future research. This study is in keeping with the strategies of the Queensland Government Refugee Health and Wellbeing: A policy and Action Plan 2017 – 2020 (State of Queensland (QHealth), 2017).

Models of care for refugee arrivals

In Australia, newly arrived people with a refugee background are settled in areas with affordable housing and where the local community welcome and support them. Each settlement area provides similar services; with the Model of Care (MOC) determined by the services of that area and the resources available.

In Queensland, Refugee Health Services (RHS) are primarily nurse-led, and work in a variety of sites including primary care, community health centre, hospital outpatient departments, specialist refugee clinics, and home visits. Refugee Health Nurses (RHN) are specialist nurses with expertise in delivering trauma inform care. They deliver care to refugee populations that is culturally informed, inclusive, sensitive and safe (Queensland Department of Health, 2017). This is supported by high level knowledge of the dynamics of contemporary political environments, hence defend and advocate for the rights of the individual, family and community.

RHN's are usually the first contact a newly-arrived family will have with the health system in Australia. Providing a referral pathway to a suitably trained primary care provider is a key function of the RHN role. While it is recognised that primary care is the best place for care, it required extra ongoing resources and support for sustainability to ensure new arrivals receive equitable care. In this context primary care provider is bilk billing, will use professional interpreted and has undertaken education and support within a refugee health care context (Refugee Health Network, 2020).

Family referrals to RHS are provided in Queensland through the Commonwealth funded Humanitarian Settlement Provider, currently Multicultural Australia (MA).

Refugee Health Services in Queensland deliver the following:

- Triage and coordination of on-arrival health care needs – coordination with primary and tertiary care as required

- Completion of a comprehensive health assessment within 28 days after arrival, including health education

- Advocacy and case management for families with more complex health needs
- Capacity building in partnership – with all sectors of health, TAFE, settlement services, health literacy education

Metro South Refugee Health Service (MSRHS) is based at Logan Central Community Health Centre and commenced in 2006 to support newly arrived families to have a coordinated referral pathway to primary care. Families are settled in Logan, Gold Coast and West Moreton. With each location having a different MOC. In Logan, the Service provides the following additional services in its MOC:

- Integrated oral health and child health programs - conducted on same day for appointment
- Commencement catch up immunisation
- Referral to refugee friendly primary care and other routine referrals
- Health navigation support for people with a refugee background regardless of the time of arrival
- Targeted workforce support including co-location at Access Community Services, and observational placement for practice nurses working in 'refugee ready 'primary care.

A small number of families are settled on the Gold Coast. MSRHS triages clients to refugee ready primary care in this area. The MOC in West Moreton is similar, but has additional support of a RHN employed by Access Community Services. MSRHS triages referral to the RHN who then supports the refugee ready primary care in delivery of care. MSRHS provides ongoing support to the above primary care, including practice visits.

The Mater Integrated Refugee Health Service (MIRHS) MOC has a two stage delivery models. Following de-funding of the Queensland (RHQ) Hub and Spoke model in 2013, changes in affordable housing close to Mater Hospital, increase in arrivals including asylum seekers required adoption of new approaches. As housing prices near the city increased, new arrivals were increasingly being housed further and further from the city, making travel to a centralised refugee health clinic an additional burden on families.

- RHNs co-locate in refugee ready primary care. The service is supported by partnering with Brisbane South PHN to form Refugee Health Connect. A medical home is facilitated and ongoing engagement and support of the client/ family for six months after arrival. Co-location enables the nurses to provide support to clinicians and admin staff at the practice as well as the patients, by upskilling them in clinical care relating to refugee health and practical issues, such as coordination and case management support with settlement workers.
- Mater Refugee Complex Care Clinic (MRCCC) offers specialised primary health care for people of refugee background, regardless of their visa status (refugee/ asylum seeker), Medicare eligibility or length of time in Australia. The clinic is located with the Mater Hospital Brisbane and provides a trauma-informed, specialised primary care service, and also specialist

clinics – psychiatry, paediatrics, cardiovascular, child/ youth mental health and infectious diseases. RHNs work closely with doctors in the clinic to provide additional nursing support and short-term complex case management support for people with complex health needs who are unable to have their needs met by existing services including case management.

Background to refugee health

Primary health care services have been developed to meet the needs of the increasing number of refugees arriving in Australia (Kay, Nicholson, et al., 2010). RHSs provide nurse-led clinics, which use a primary health care model to triage and co-ordinate care, and ensure refugee families' receive equitable access to health care services (Joshi et al., 2013; McBride et al., 2016). Specific health services are available to support refugee groups, who have complex and diverse health care needs that are quite different from migrants who have made specific choices regarding lifestyle and employment when moving to Australia (Cheng et al., 2015). Refugees often require immediate health care, having suffered physical and emotional trauma in their country of origin and during the time they spend in temporary camps, with sub-optimal health care (Robertshaw et al., 2017).

In addition to pre-migration experiences and challenges during the resettlement period, refugees often struggle to navigate a number of barriers in Australia's complex health system (McBride et al., 2016). Social isolation, mental health concerns and assimilation into Australian culture contribute to poorer health outcomes for this group, and primary health care providers are well positioned to work with refugee families to identify and address these risk factors (Cheng et al., 2015; Day, 2016).

In Australia, the recommendation is for all newly arrived refugee families to be offered a tailored comprehensive health assessment and management plan within one month of arrival (Au et al., 2019). This assessment places nurses at the forefront of providing initial care for refugees as RHNs complete this assessment and then refer onto primary care for ongoing care. In some models of care in Australia, RHNs see the family for a single occasion of care before referring onto primary care services (Ogunsiji et al., 2018).

Nurses working in areas of high client distress often suffer emotional distress themselves (Garakasha, 2014; Turner et al., 2007). Ogunsjii et al. (2018) further describes some of the ethical, professional and personal challenges that nurse face while working in refugee health as including vicarious trauma, stigmatisation and burn-out. Important to note that in other countries, where refugee numbers are much higher, nurses play an on-going role in working with newly-arrived families and have developed specific family nursing interventions and models of care to support the transition, inclusive of, but not restricted to their health care journey (Samarasinghe et al., 2011).

Professional Interpreters are required for almost all health care services as new families will not have literacy or health literacy in the Australian context. There are numerous challenges to the role of interpreters when working with refugee families and their role is often multi-faceted. In addition to having accurate translation skills, interpreters working with refugees often come from the same background, require a deeper understanding of the clinical setting, patient advocacy and support.

The current research aimed to explore the experience of nurses working with refugee families within Queensland refugee health services. The inclusion of family assessment within nurse-led services can facilitate a holistic approach with a focus on both client satisfaction and cost efficiency. Particularly advanced practice nurses have the expertise to assess and delegate care to other health professionals as needed (Carryer et al., 2018). In the setting of refugee health, research highlights the need for health professionals to be able to debrief due to the distressful nature of work with refugee families (Robertshaw et al., 2017).

This collaborative research project reflects Action 6.1 of the above Queensland Health report through an evaluation of the nurses' perspective of the model of care for this vulnerable population (State of Queensland (QHealth), 2017).

Background to education Continuous professional development framework

The Registered Standards of Practice in Australia state that nurses must engage in continual professional development and maintenance of contemporary knowledge and capability for practice through a lifelong learning approach (Australian Health Practitioner Regulation Agency, 2019). The Queensland Health Framework for Lifelong Learning for Nurses and Midwives provides a structured approach to ongoing professional development of the nursing workforce (Fox et al., 2018). The ability to provide nurses with a suitable structured education pathway is dependent upon an ability to define both the expected role of the nurses and a career framework to progress. Learning linked to a career pathway can assist with transition to a role, consolidate knowledge and build capacity and sustain quality health care outcomes.

Ambiguity of role and confidence in competency appear to be major barriers for nurses when considering expansion of practice in Community and Primary Health Care (C&PHC). These may be attributed to a current lack of organised career progression frameworks resulting in confusion regarding structured education pathways. In order to establish frameworks, the roles of nurses must be first fully understood and enabled. There are many areas of C&PHC nursing practice that have little evidence to contribute to the understanding of the role's that nurses are taking on. Formal evaluation and reporting of PHC roles in all area's nurses are delivering is required to give a 'whole

picture' approach. The practice of nurses working with Refugee families provides a valuable opportunity to contribute to this evidence.

This research project seeks to inform and clarify the model of care and the clinician knowledge and skills that are required to meet the health needs of refugee families within the context in which it is delivered.

Study design

A qualitative descriptive approach was used to explore community health nurses' experience and use of an assessment framework when working with refugee families (Kim et al., 2017). This design allowed for an understanding of the experience and the content analysis to focus on the structured questions and professional development opportunities.

Study setting

This study was conducted at Metro South Refugee Health Services (MSRHS) and Mater Integrated Refugee Health Service (MIRHS). Eleven nurses who identified as Refugee Health Nurses (Refugee Health Network, 2020) participated from a potential pool of 15 nurses.

Study procedure

Personal interviews of approximately 30 minutes were conducted using a semi-structured interview format to elicit responses about the participant's experience of providing care for refugee families and use of a family assessment framework or other framework. Interviews conducted at a time and place convenient for the nurses were audio-recorded and transcribed verbatim by a professional data transcribing service. A total of eleven nurses consented to participate, completing interviews with the co-ordinating researcher [HR] and research assistant [EG].

Ethical considerations

Ethics has been obtained across Metro South Health Services, Mater Health Services and Griffith University. HREC/17/QPAH/599 - SSA/17/QPAH/600; AM01; GU Ref No: 2017/783. This study was conducted in full accordance with principles of the "Declaration of Helsinki", Good Clinical Practice (GCP), and the NHMRC *"National Statement on Ethical Conduct in Human Research"* (2007). The Clinical Nurse Consultant (CNC) of MSRHS and Nurse Unit Manager of the MIRHS were the nominated site contacts.

Safety considerations

An information sheet was provided, and written informed consent completed prior to each interview. Participation was voluntary and there were no consequences of not being involved in the study. Although the risk was considered very low, participants were given information for counselling and encouraged to engage with counselling should any distress arise from the research survey process.

Due to the low numbers of staff involved and the nature of the questions asked, the following methods reduced the risk of identification.

- No identifying information was included in interviews or transcripts
- Only Griffith University researchers conducted interviews [HR and EG] and raw data analysis was only completed by GU staff [HR, EC, EG]

Participant were numbered [N1 to N11] in all written documents to ensure anonymity within the sample and protect participant identity within a health service where overall staff number are quite small. All identifying information about the health service will be removed from publications as determined by the Health Service.

Recruitment of participants

Registered nurses who worked in Metro South Refugee Health Service (MSRHS), Mater Integrated Refugee Health Service (MIRHS) and Townsville and Toowoomba were invited to participate in the study via an emailed letter. The co-ordinating researcher [HR] then made an initial visit to each site to discuss the project with all staff and an information sheet was made available for the nurses. Participation in the study was voluntary, with no consequences for staff choosing not to be involved. A purposive sample of registered nurses working in Refugee Health Services completed personal interviews. An interview guide enabled the exploration of the experience, professional role and personal reflection of nurses working with refugee families. See Table 1 for interview questions.

Sample

In total there were eleven nurses included in this study, they were from across Refugee Health Services in Queensland. Their years of experience in this role varied from a few months to over ten years. Their professional experience included emergency, paediatrics, midwifery, public health and mental health as well as formal post-graduate qualifications in Nursing.

Analysis

The personal interviews were analysed using content analysis. The steps to complete the content analysis included reading the data for understanding, highlighting data, which is linked to the research questions or aspects within the data. The early analysis was completed, [HR, EC] to determine data saturation and the need for follow up interviews. Data saturation occurred at eight interviews. Experts from the transcripts are provided in a table as an Appendix. The presentation of findings is a summary of the themes derived from a content analysis across all transcripts, with some excerpts from transcripts included in italics.

Summary of findings

There were five themes developed, which related to working within these health services to achieve the best outcomes for the families. The themes were; practice related issues; assessing families; challenges of working with interpreters and settlement case manager/ workers; understanding the family and getting the best outcomes and professional support for nurses.

Practice related issues

Nurses working in the services describe their work as both challenging and rewarding, whilst deriving a high degree of job satisfaction.

> *It's dynamic, it' challenging. Sometimes really frustrating, sometimes feels futile, but the positives do outweigh the negatives.*

> *You need patience … you do have to be very open minded and don't judge too quickly, they've come from a completely different background.*

There were frustrations noted related to referral processes and being able to access services in a timely manner for clients. This frustration differed between services but both noted that the processes for follow-up were not consistent.

> *The main difficulty I find is having refugees be referred to anywhere that's outside of a refugee friendly space it becomes a massive ordeal.*

> *I believe there is a lack of information in the public and also the GP health centres.*

There was a wide range of experience and professional skills and qualifications that nurses bring to these roles, including midwifery, paediatrics, mental health and emergency nursing. There were also a range of professional development opportunities identified that are available for staff and these are regularly attended where possible.

Quite a lot of in-services and discussions so with trauma and torture. Related directly to this role is being an IPN, which is Immunisation Practice Nurse.

A bit of interpreter training…. there's some CALD training online, a multi-cultural online module that I've done. We do a lot of going to conferences, a lot of professional development days – to continually upskill

Nurses who had worked in refugee health for many years noted the increased provision of workshops and in-services specific to working with refugees and the services they might need to access, which had not been available when they commenced.

I've been working in the refugee health centre for quite a few years and the experience, initially, was unusual. I was very raw so there was no structured learning really; I just listened to what other nurses were doing.

Assessing families

Staff described assessing families, but acknowledged that they did not complete family interviews but rather interviewed one family member at a time.

We don't do family interviews; the adults are all seen separately unless there's a mental health problem in cognition or disability or something.

Nurses describe the importance to them of assessing holistically, but time constraints were challenging especially given the importance of establishing rapport and understanding the clients' often difficult journey.

We're not just clinically led, we're looking at the whole person, we're looking at everything from their observations to their journey here to their social background to their mental health history to their family dynamics

Distressing information was often disclosed when taking a medical history and determining the family structure as many clients had lost family members whilst fleeing and this could impact on the interview. For some clients, this was the first time they had told their story and given that many have fled from conflict zones and experienced and witnessed trauma or torture, there was often resultant distress.

We need to remember that asking them about children that have died may trigger off trauma, and we don't want to necessarily trigger that response because we're wanting to get that holistic assessment.

There are also additional challenges when a client is particularly unwell as this impacts the ability to complete assessments for everyone whilst attending to emergent needs of individuals.

If they're sick you've got so many things you've got to deal with and sort out and pull apart to find out really, what is the problem that we're very time limited and the interpreters are here for a set time.

The use of a genogram to "map" the family tree was widespread, with all participants agreeing that it was useful to create a visual picture of the family and found this activity to be helpful in developing rapport with the family during this process.

I am looking at, not only the demographics of how many children, who lives where but their relationship between them -so probably the genogram is my platform for doing that.

A lot of information is gleaned from the genogram and it's very valuable to do that because as you write it down you can ask further questions.

The genogram provides a further check of health history, but often includes mention of deceased relatives so can be confronting for staff and clients.

We use a picture which gives us an outline of the family tree and within that genogram we will ask specifically, where the different family members are, which family members are actually in Australia living with them, which are overseas.

There was a standardised form used to complete the health assessment that had been customised for refugee health and this was similar in both services. There is also a specific paediatric and psycho-social assessment form available that was widely used.

We have the evaluation tool, the paeds tool where the parents will fill out a form and evaluate their own child's development and behaviour and that gives us an idea of actually what the parents – what concerns the parents have in regard to their children. We do a K10 as well, so for any psychosocial history.

Several participants were aware of other family assessment frameworks, but did not use these during assessments of refugee families. Participants were also interested in being able to underpin their assessment with a more structured framework related to family functioning and structure.

I would like to focus more on that (family assessment) framework because everywhere in the clinics, everybody has different ways of doing things, but if we could have a common strong one, a strong framework to work with.

Without knowingly going in with that intent, structure is there. We do look at the structure of the family and the function of people within the family and their roles and we break it down

<u>Challenges of working with interpreters and settlement case managers/workers</u>

Participants described this aspect of the role as challenging, but most had become accustomed to working with interpreters. They described a range of strategies they had developed for enhancing the flow and interaction of the interview.

> *Challenging at times, but it also is about the relationship we would have with our interpreters that we regularly use.*

> *Prefer to have onsite interpreters to see body language, and over the phone can be really hard, but sometimes we do get phone interpreters*

All participants identified that they had well developed relationships with some of the interpreters, which made the tasks much easier. There were also challenges related to ensuring the "right" interpreter was booked given the range of dialects within some languages, but nurses always chose not to rely on a family member to translate.

> *Critical thing is that we're getting, not only the right language but the right ethnicity*

Given how few people speak some of the dialects, there is also the concern of confidentiality with small close-knit communities where the interpreter may already know the family or their friends, and at times staff needed to provide a reminder about privacy.

> *When ensuring client confidentiality, communities are small and we know that breaches occur… because the interpreter belongs to the same community, they know family dynamics or other personal information.*

The issue of generational or gender appropriate interpreters was raised as in some cultures this is a significant concern, especially when discussing personal health concerns.

> *Generational interpreting becomes really challenging, especially when we're talking about reproductive health, men's health. It's not appropriate for younger people to have that conversation, so there are things that we do to normalize that*

Some of the nurses had not worked with interpreters before and acknowledged that they would have benefited from some early training specific to these interactions.

There were also mixed responses about the services provided by settlement case managers/ workers, who seemed to have a range of qualifications to support this role. Some had formal social work qualifications, but many were employed through links to the local community or with minimal qualifications or experience in navigating our complex health systems.

> *There's been a change, recently in the qualifications or contract of who's rolling out the settlement - which has changed the criteria for case worker in terms of their qualifications...They've got basically a social work background now.*

At times the existing connections with communities created privacy concerns, but also assisted nurses in understanding specific issues the families might be dealing with.

If a certain case worker is worried about a family, they'll actually provide that information to us and flag their concerns so that we can then, work through any of those issues with individuals during that assessment.

Participants referred to a lack of communication at times about referrals and linkages to services - sometimes the settlement case managers/ workers inexperience was potentially disadvantaging families trying to access specific services.

As soon as you're outside of a specifically trained culturally sensitive area, it's really difficult. Our patients find it frustrating that they get – not necessarily turned away – but they don't understand the care because they didn't use the interpreter.

Sometimes it's not us linking them to the services, it's the case manager linking them to the services, so they may have that in place but we don't necessarily know about it.

Understanding the family and getting the best outcomes

Most participants described the frustration of limited time to assess the family, much less observe the family interaction or gain a sense of family dynamics.

We're looking for the dynamics within that family group

We look at those dynamics …with a husband and wife… and see whether we can actually get a sense of that relationship effectively working

The nurses described trying to observe the family during their interactions to determine the family "leader" or decision maker. The participants noted that it was important culturally to acknowledge this position, as that person was more likely to offer information or encourage the other family members to participate.

Depending on the dynamics of the family, so if the male is the speaker and the decision maker, then we'll actually talk with him about who gets interviewed first.

Sometimes families demonstrated strong connections with each other or in relation to their spirituality and the nurses commented on the inner strength some families' exhibit, despite the difficulties they have encountered.

It's interesting and challenging, but also you see how families are so strong - some are really supportive of each other, and some have a lot of issues.

Their faith sometimes becomes more important than anything else that we can do. So, we may ask if - socially if they've been linked with a church or a mosque

For the nurses, it was also important to have an understanding of cultural norms in relation to roles within families for the different ethnic groups that present at the service.

Different families have got different roles, and the role that a father does in one community might be different from their family and they know what tribe they are from… so it does influence the way they ask questions according to what suits their community

For some of the participants, it was noted that families only present once and this created frustration for both staff and clients, who often have different expectations of what the clinic offers.

We see them only once - their first contact with the health system. Usually we are the first port of call for newly arrived people, it's critical that we build some rapport, build some trust so that they're more likely to engage with the primary care provider and stay linked.

Sometimes I wonder how worthwhile it is in what we do here because sometimes the people come in and they have higher expectations. They probably think we're going to do blood tests; they think we're going to do a pregnancy test. Sometimes you get the feeling that they feel like it's been a waste of time.

The nurses also described hearing that for most of the refugee families, there was confusion about this type of service compared to what they had been used to in their country of origin. This often led to inappropriate presentations when accessing other health care services, for example at large Emergency Departments for minor concerns or being unsure when they should go to a GP.

They tend to go to emergency department but the majority of presentations will get a knock back and they won't understand. They don't have health literacy so it just sets them up to fail

<u>Professional support for nurses</u>

All participants identified their risk of vicarious trauma in this role and had attended some related professional development workshops.

For us there is the risk of the vicarious trauma and that's something that I own very openly.

There is the need to debrief because it is high trauma that you've been given but, there is that jaded aspect where you're hearing the same stories again and again.

The services offered informal de-briefing sessions, though staff with closer working proximity such as the clinics felt that this was more consistent and participants felt they were more likely to de-brief with colleagues. For those working in mostly autonomous roles within the co-located GP clinics, this

was less opportunistic but support from peers was readily offered. Despite this, all participants felt that there was appropriate and sufficient support within their teams and that they regularly checked in on each other.

[Debriefs] Informal absolutely, yeah, there's no formal debrief sessions.

The strategies that we have in place, we do an, 'are you okay' check morning and afternoon.

We've had training around and I find that team of peers a valuable resource, not only to talk about things that are challenging but to talk about the successes

We all know that these things happen, but more of a structured one [debrief], but I suppose they're opportunistic, it's when something happens that you – and often you're in that moment hearing those things.

Staff were also aware of other counselling services that they could access if they needed to and some participants described using self-care techniques such as meditation, mindfulness and walking as stress relievers.

I'm going to go for a walk, I'm going to do whatever it is that makes things better. It may be that you would consider calling for some counselling.

Meditation and things like that have helped with different things, because you do get –tired of hearing so many stories and feeling at times like useless, like you can't do anything more.

I listen to a mindfulness tape - I think I can separate, what has been traumatic for someone, and I can leave it at work.

Participants described being encouraged to develop and maintain a mental health self-care plan to support their own wellness in this environment.

We have a mental health self-care plan for each person - it's about normalising emotional wellbeing, taking stigma away from it and part of the language that we use as a normal every day

All participants described a positive supportive culture within their teams.

In my team we're very strong colleagues that I have around me, very supportive - though I don't deny we need further development.

We do have the team debriefing, and there's the employment assistance scheme where you can ring up and talk to somebody if you need

Discussion

This study explored the community health nurses' experience of working with refugee families, providing insight into the experience, family assessment processes and support services provided for nurses. The analysis of the transcripts highlighted the focus for the nurses and the challenges they worked through to achieve best outcomes for the families.

Practice related issues

Refugee Health Services are nurse-led services with a key role to coordinate, triage and deliver initial nursing care for newly arrived refugee families. The models of care in this study have a wellness focus to guide clinical practice and deliver culturally safe care. The nursing team complete comprehensive nursing health assessments, review immunisation history, commence immunisation catch up, and arrange referrals to relevant specialist health services. The participants talked about challenges of the work, which related to the diversity of migration history, confronting situations and limited health literacy of their clients (Mengesha et al., 2017). This process could feel frustrating at times, but also very rewarding when the nurse was able to work though the situation to provide the correct services and health care links for the family. Similar to previous research, the participants did not discuss the difficulty of navigating the cultural aspect of working with refugees and spoke of cultural awareness training being available (Ogunsiji et al., 2018).

Assessing families

The use of a genogram as a family assessment tool during the initial assessment process has been reported to help the nurses identify and differentiate immediate family members and family relationships (Glasper & Richardson, 2010). The participants described the benefits of holistic assessment to enable tailored support. Holistic assessment including the family allows for support to be tailored to the family as a unit of care and leads to better health outcomes (Shajani & Snell, 2019). The participants were all interested in further expansion of a family assessment tool and exploring the use of other family assessment frameworks and interviewing families to give them greater insight into family functioning. The participants revealed the skills they had developed with experience, particularly when working through clients' history and the triggers related to recalling traumatic events. It was during the disclosure of distressing information that the participants themselves highlighted that this could be overwhelming. Previous research has identified the risk of vicarious trauma for nurses working with refugees and the need for support and structure within their work environment (Garakasha, 2014).

To enable holistic assessment of families, professional development to enable an expansion of family assessment practice including simulation and role modelling would prepare the nurses for complex situations during the assessment (Coyne, Frommolt, et al., 2018). Mentoring and

education in the advanced use of a genogram and ecomap would provide additional visual information about the family structure.

Challenges of working with interpreters and case workers

The participants described challenges of working with interpreters. This related to accuracy of interpretation, professionalism and using the right interpreter for the family dialect. Mayo et al. (2016) stress the importance of using professional interpreters with the participants identifying their own concerns about the quality and appropriateness of interpreters at times (Department of Communities Child Safety and Disability Services). Eklöf et al. (2017) outline the multiple factors that influence using an interpreter and found that whilst their role is pivotal to communication between nurse and client, problems often arise. These challenges include increasing workloads, create relationship issues between nurse and client and can create ethical concerns (Eklöf et al., 2017). Hiring of bi-lingual interpreters does not always ensure care that is culturally sensitive (Bischoff & Hudelson, 2010; Würth et al., 2018).

The more experienced participants reported that they had developed a range of strategies to manage their interactions with clients and the interpreters. For experienced staff, they had learned “on the job”, but as the services expand and refugee numbers increase, it is important for new staff to be offered additional training to support this important aspect of the role.

The participants talked about the relationship between the family and settlement case manager /worker as highly important, including the importance of the settlement case manager /worker ability to communicate effectively between the family, nurse and interpreter. Mengesha et al. (2017) further highlight that the practical demands of resettlement are often given priority over health care, with case workers focussed on immediate needs related to housing, employment and income.

Understanding the family and getting the best outcomes

Participants identified the importance of understanding family dynamics, particularly in relation to identification of decision makers. The influence of relationships within families is important to acknowledge and identify as these are both barriers and enablers which can impact on health outcomes for family members (Brandenberger et al., 2019). Other family assessment frameworks could be introduced to support nurses to explore family strengths and resources within the family unit (Shajani & Snell, 2019). Other skills could include interviewing family groups, as this is an important aspect of developing care plans for refugee families. Good communication is an effective means of promoting resilience in adverse situations, specifically related to ongoing war trauma or prolonged refugee situations (Walsh, 2016). The resiliency framework could provide a framework for nurses to understand the influences of multiple factors on these vulnerable families.

Best practice models – transition to practice

The Framework for Lifelong learning for Nurses and Midwives in Queensland identifies transition as the period of learning and adjustment a nurse new to the area requires to successfully adjust to their role (Fox et al., 2018). To function effectively, nurses require an understanding of the knowledge, skills and attributes required for to fulfill role responsibilities. Clearly defined expectations of the role and scope of practice enable the development and provision of education pathways for successful practice.

Exploration of roles and mapping of practice enables description and tangible representation of the nursing practice required for optimal patient outcomes. This examination of the community health nurses' experience and the use of an assessment framework when working with refugee families, identifies and contributes to defining the practice utilised in the refugee nurse role. Clarity in role definition will inform the learning required and education mapping for nurses transitioning to the refugee health setting and ensure successful expansion of practice in Community and Primary Health Care (C&PHC) settings.

An example of a model of care to improve links to services and navigate the acute hospital journey is the Refugee Health Nurse Liaison role in Victoria. This role demonstrated improved care co-ordination to enhance the patient experience in addition to providing educational support to health professionals to increase their capacity to respond appropriately to the needs of refugee families (McBride et al., 2016).

Professional support for nurses

Whilst all staff identified informal de-briefing processes and for some, mental health self-care plans had been developed. However, there was not a consistent approach. Given the risk of vicarious trauma for staff, additional professional development and support would be beneficial. Most participants felt they had access to informal de-briefing within their workplace and were aware of but had not accessed any professional counselling services. Nurses experience stress related to the traumatic stories shared with them in addition to the perceived lack of knowledge for some participants about cultural perceptions or norms (Samarasinghe et al., 2010).

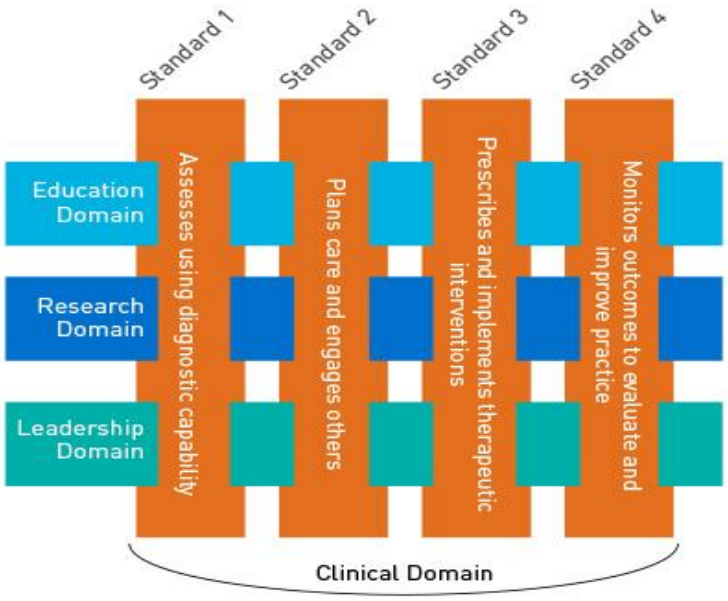
Staff would also benefit from revisiting the positives of reflective practice and structured de-briefing, like clinical supervision. An Australian study also identified the need to ensure resources are readily available to support refugee health nurses who are at higher risk than usual of being affected by vicarious trauma given their frequent interactions with families that have experienced confronting experiences as they have fled conflict and persecution in their home countries (Ogunsiji et al., 2018).

Conclusion

Refugee health services are underpinned by Primary Health Care principles and have been identified as a suitable model of service delivery to meet the diverse need of newly arrived families (Joshi et al., 2013; Kay, Jackson, et al., 2010). This study has identified that within the area of refugee health, little is known about the nurses' experiences, their roles and the extent to which they use a framework such as a Family Nursing assessment tool for gathering information and tailoring care for their clients. Providing care for clients using a holistic framework helps provides a focused approach, which can systematically improve quality and safety in caring for clients and their families. A more focused, systematic approach increases the ability of the nurse to find solutions and understand the client strengths (Bell, 2013; Robertshaw et al., 2017). A family focused framework can increase the nurses' sense of benefit with the client interaction, which can in turn, reduce the nurses' personal distress (Jovanovic et al., 2004; Wright, 2015).

Recommendations

The recommendations have been developed in relation to the standards for advanced practice (*Australian Health Practitioner Regulation Agency* 2018). These recommendations highlight the needs for transition to advanced practice working in refugee health services in line with the pathway for continuous professional development



("Australian Health Practitioner Regulation Agency ", 2018

Based on the findings of this research project, the following recommendations are presented:

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1. Transition to practice modules which incorporate model of care, assessment, working with case workers and interpreters and reflective debriefing. Nurses completing tailored education packages.

2. Clinical mentoring and supervision. This enables the transition from clinical nurse to advanced practice nurse working with refugee families highlighting the need for mentoring of the assessment process and also the need for reflective debrief.

3. Development of simulation videos to be used within transition to practice enabling professional development in the area of advanced family assessment, reflective debriefing and working with case workers and interpreters. The development of simulation videos ensure ongoing education which is timely and able to be watched repeatedly. The use of simulation videos provides a safe learning area, repeated watching and debrief questions to engage the learner in deeper engagement with the resources (Coyne, Rands, et al., 2018).

4. Pathways of learning for the settlement case manager /worker, the provision of health literacy assessment and then tailored professional development for them. This would be in modules to enable repeated engagement and the use of simulation videos to provide learning scenarios.

5. Provision of interpreter service on location and the development of flow charts of service provision and ability to escalate concerns. Education for interpreters in relation to health literacy and understanding of health service provision.

6. Continuation of current debriefing practice and reflection. Consider support for supervisors. Acknowledge importance of timeliness for debriefing.

7. Twelve-month review of uptake of education and professional development for nurses, case-workers and interpreters. The training and evaluation of training for case works and interpreters.

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Table 1: Interview Guide

You and Your Practice	How would you describe your experience of working with refugee families?
	Describe your training or qualifications that relate directly to this role? [post graduate study, in-service sessions, on-line training or workshops
Use of structured framework for family assessment	Describe how you clarify with the patient who they include as their family support persons and other social supports?
	Describe how you include the family members in the discussion and assessment, what frameworks do you use?
	Describe how you would assess the family functioning, their strengths and resources?
Communication	What types of interpreter services do you use?
	How does the use of interpreters influence your ability to communicate and build rapport with your patients?
	Can you describe some of the strategies you use to manage working with interpreters?
	How does working with interpreters impact on your ability to complete an assessment of the family?
	Settlement agency caseworkers support co-ordination of this healthcare access. Describe how you work with the settlement agency caseworker and how their role influences your ability complete the assessment?
Professional support	Describe how you manage your own response to some of the information shared with you?
	Discuss what opportunities you have for debrief, support and mentoring when working with refugee families? When do you use these resources?

Table 2: Timeline

	2018			2019			2020
Activity 2018 / 2020	**June/ Sept**	**Oct/ Nov**	**Dec/ Jan**	**Feb/ April**	**May/ June**	**July/ Dec**	
Extension of ethics from Griffith University	X						
Extension of Ethics to Mater site			X	X			
Recruitment of participants		Metro South		Mater			
Conduct interviews	X	X		X			
Preparation of report					X	Submit Initial report	Finalise report
Transcription/ analysis of qualitative data					X	X	
Write up for journal						Draft paper	Submit paper after report approved
Submit ethics grant reports						Interim	Final report

Budget report

Activity	**Cost**
Research assistant: 60 hours @$47.30/hr + 30% oncosts	$3,690.50
Rands: buy out of marking: 37 hours at 44.93/hr + 30% oncosts	$2161.41
Coyne: buy out of marking: 22 hours at 44.93/hr + 30% oncosts	$1283.46
Transcriptions of interviews: 12 interviews x 35 min x 2.6/min	$1092
Research equipment digital recorder	$160.00
Parking at Mater site	$44
Actual spend	**$8,431.37**
Total grant	**$8,439.00**

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