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Building Cultural Safety and Capabilities in the Burn Services of The Children's Hospital at Westmead: A Pilot Study

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Abstract

Health systems built on Western philosophies of health are not culturally safe for First Nations people. Cultural competency courses developed for Australian health services tend to be a single event and fail to achieve real reflexivity and shift to culturally safe service provision. This study aimed to implement and evaluate a pilot training program on Cultural Safety and Capabilities, delivered to health professionals in the burn services at a tertiary paediatric hospital. An interactive program using Indigenous learning processes was developed by Aboriginal and Torres Strait Islander researchers in partnership with line-managers from the burns services. Evaluation included a validated questionnaire to measure health professional's attitude change and open-ended questions. Participants expressed high satisfaction with the immersive content and gain of skills to improve practice. Despite high motivation, time constraints and competing priorities were highlighted as obstacles for program completion. Immersive and interactive training programs like this one have the potential to achieve deeper learning, genuine reflexivity and changes in practice. Support from higher levels of executive management and flexible program delivery are needed to ensure ongoing access to training. Further research with stronger sample sizes and follow-up response rate is needed to objectively assess transformative learning and changes in attitudes.

Keywords

Aboriginal, cultural safety, health care training, healthcare delivery, Torres Strait Islander

Background

Racism in hospital systems is well documented and has been a topic of study for many First Nations academics globally (Elias & Paradies, 2021). For First Nations people in Canada, Aotearoa (New Zealand), the U.S.A and Australia, racism constitutes a major barrier to access equitable healthcare services (Espiner et al., 2021; Hamed et al., 2022; Pilarinos et al., 2023). Although overt racism has become less common with the advance of anti-racism discourses and racial discrimination legislation, covert racism has largely remained unresolved (A. Abu-Bakr, 2021; Elias & Paradies, 2021).

In Australia, Aboriginal and Torres Strait Islander people continue to report feeling discriminated against in the Australian healthcare system (Seet & Paradies, 2018). Research studies demonstrate Aboriginal and Torres Strait Islander people are less likely to receive the services they need. For example, Aboriginal and Torres Strait Islander people are less likely to receive cancer treatment including curative surgery (Moore et al., 2014) when presenting with acute coronary syndrome, are less likely to undergo angiography (Tavella et al., 2016), and have to wait longer time for surgical procedures compared to other Australians (Australian Institute of Health and Welfare, 2017).

Healthcare services that are based in dominant Western biomedical models of health have been proved ineffective in achieving the goals set in 2008 to close the health gap for Aboriginal and Torres Strait Islander peoples. In addition, health systems based only on Western biomedical models largely ignore different health and wellbeing paradigms, reinforcing unconscious biases that are expressed through covert racism. Academics have recognised the importance of providing healthcare services that recognise First Nations people's health paradigms and meet their cultural health needs (Laverty et al., 2017; Ramsden, 1992). To achieve this, healthcare practitioners must be trained to acquire a range of knowledge and skills that allow them to provide culturally appropriate services to First Nations people. Multiple key concepts have evolved and are sometimes wrongly used interchangeably; these include cultural awareness, cultural sensitivity, cultural competence,

cultural security, cultural respect and cultural safety. These concepts are complex and continually evolving with a wide range of definitions, interpretations and applications described in the literature depending on settings, policies, frameworks and priorities (Curtis et al., 2019a).

Cultural awareness and cultural sensitivity reflect a basic understanding of differences among cultural groups, but do not necessarily involve reflection on cultural power imbalances, inequities or changes in behaviour (Australian Health Minister's Advisory Council's National Aboriginal and Torres Strait Islander Health Standing committee, 2016; Taylor & Guerin, 2019). The concept of cultural competence, broadly, entails the healthcare providers' ability to work effectively with patients from different cultural backgrounds (Taylor & Guerin, 2019). This concept has been criticised as often focusing on simply acquiring knowledge about a cultural group without reflecting on cultural privileges, power imbalances and unconscious biases (Curtis et al., 2019a). This could promote the idea that people from a different cultural group are homogenous rather than diverse, leading to stereotyping and assumptions, and reinforcing differences (Betancourt, 2006; Curtis et al., 2019b; Paul et al., 2012a).

Cultural safety departs from cultural awareness, sensitivity and competence and focuses on achieving a transfer of power from the health professional to the patient. This requires the health provider's capacity to reflect on the impact of colonisation, as well as on their own culture, values, beliefs, attitudes and power to enable a change in the patient-provider interaction (McKivett et al., 2019; Nursing Council of New Zealand, 2011). Being the primary concept that acknowledges the experience of colonisation, power imbalances and reflection, it has particular importance to the delivery of healthcare to First Nations people (Brascoupé & Waters, 2009; Ramsden, 2002; Ramsden, 1992). Cultural safety has also been described as the next step after cultural competence (Brascoupé & Waters, 2009), and this highlights that cultural safety should be understood as a journey rather than a goal that can be achieved after a session of training. Because cultural safety is a long and iterative

process requiring reflexivity, healthcare institutions need to guarantee that healthcare providers have access to continuous training and support to guide their journey.

Although cultural safety training in Australia is becoming compulsory among healthcare students and providers, training is usually provided as a single event to tick a box, hindering a real reflective process that achieves a shift to culturally safe healthcare service provision (The George Institute for Global Health, 2021; Wylie et al., 2021). In addition, an analysis of a national survey on cultural safety training in health care conducted by The Australian Commission on Safety and Quality in Health Care, revealed that training resulted mostly on changes related to cultural awareness such as knowledge about culture and history rather than behavioural changes reflected in health practice (The George Institute for Global Health, 2021). Similar studies have shown that training programs have limited effect on key principles of cultural safety like self-reflexivity, recognition of racism, and power imbalances (Shepherd et al., 2019).

In Australia, the need of a culturally safe health system with health professionals that are able to critically reflect on their own cultural identity, position of privilege and the impact of colonisation is well established (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017; Australian Health Practitioner Regulation Agency, 2017). Unfortunately, Aboriginal and Torres Strait Islander people continue to experience racism and discrimination in encounters with healthcare practitioners and health services that are culturally unsafe (Kelaher et al., 2014; Quigley et al., 2021; Wotherspoon & Williams, 2019). Further, previous research has identified a disjunct between Western and Indigenous knowledges in models of burn care across Australia (Fraser et al., 2018). For these reasons, a pilot study called Building Cultural Safety and Capabilities (BCC) was developed, implemented and evaluated for health workers at The Children's Hospital at Westmead (CHW). This training program was tailored by Aboriginal and Torres Strait Islander researchers and non-Indigenous researchers in partnership with health workers from CHW and was delivered to health professionals working in the burn services at the CHW. Evidence on the design and evaluation of this pilot program aimed at enhancing workforce's

cultural safety and capabilities, can inform the development and delivery of effective programs more broadly.

Methods

The aim of this pilot study was to evaluate a training program designed to improve cultural safety capabilities among healthcare practitioners including change in health professionals' attitudes and perspectives of program content and delivery.

Study Context and Setting

BCC training program was delivered at the burn services of the CHW during 2022-2023 as part of the research project "Safe Pathways". This project aims to ensure Aboriginal and Torres Strait Islander children admitted to the burn unit experience culturally safe care and have a culturally relevant discharge planning ensuring access to optimal and ongoing care.

The Training Program

The BCC training program was co-developed by Aboriginal researchers, an Aboriginal and Torres Strait Islander Reference Group and clinical and managerial staff from CHW. Topics focused on improving understanding of Aboriginal and Torres Strait Islander health within a cultural safety framework and in the context of history, society, culture and Aboriginal and Torres Strait Islander models of health (Withall et al., 2021). The collaboration with staff in the early stages of development was paramount to the successful implementation of the BCC training program at the CHW. By engaging staff from the outset, the program was tailored to align with the demanding schedules in the burn services. This proactive approach not only ensured that the content of the training was relevant and practical, but also allowed for the sessions to accommodate the unique challenges faced by healthcare professionals in this specific context.

The training program included six modules which were delivered throughout twelve months (Figure 1). Each module of the program had three components (Figure 2):

1. Participants were given learning material which included a manual with a summary of the main theoretical concepts of each topic, videos, links to webpages and readings.

2. Bi-monthly yarning sessions with an Aboriginal or Torres Strait Islander guest expert on the topic of each module. Yarning is an Indigenous conversation process of equitable sharing and exchanging of knowledge and experiences where partnership relationships are established so all participants feel safe and supported (Bessarab & Ng'andu, 2010).
3. Reflexivity and critical thinking. Reflexivity allows participants to look at their inner selves by examining personal beliefs and values, preconceived ideas, assumptions, implicit biases, whilst through critical thinking, participants challenge them (Mulnix, 2012).

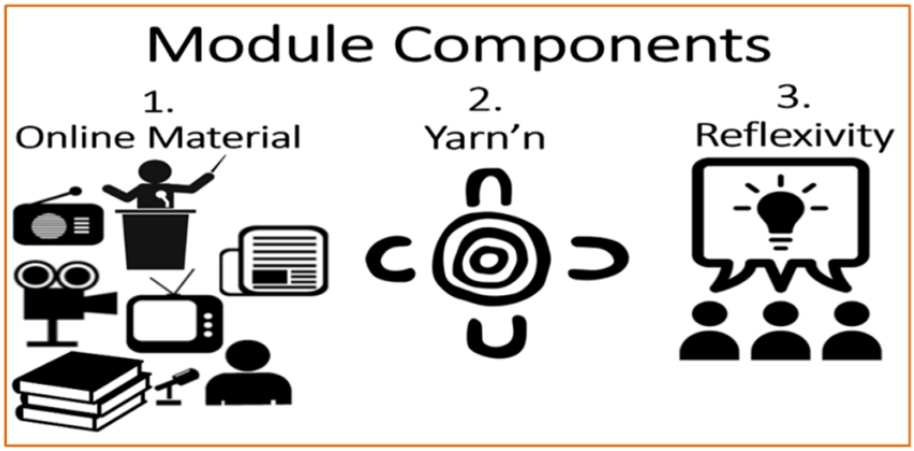
Figure 1

Program structure

Module	Name
1	1.1 Culture and Identity. 1.2 Cultural Frameworks in Health.
2	2.1 Colonialism, Trauma, and Intergenerational Effects. 2.2 Racism and Health and Well-Being.
3	Social Emotional Well-Being and Mental Health.
4	Models of Health.
5	5.1 Statistical Genocide and Data Sovereignty. 5.2 Aboriginal and Torres Strait Islander Health Research.
6	6.1 Capacity and Resilience. 6.2 Aboriginal Community Controlled Health Organisations and Work Force.

Figure 2

Module Components



Participants

All clinical staff at the burn services of the CHW were invited to participate in the training program through an email sent by the Nurse Unit Manager. Participants who were interested in undertaking the training program were given a participant information sheet and a link to the consent form and baseline questionnaire in REDCap to complete (Harris et al., 2019; Harris et al., 2009).

Evaluation

We applied a before and after study design. The BCC was evaluated using a previously validated questionnaire to measure attitude change in health professionals after completion of an Aboriginal Health and Cultural Safety programme (Ryder et al., 2019). The tool is a 15-item questionnaire using a Likert scale designed to measure cultural safety, transformative unlearning and critical thinking (Ryder et al., 2019). Participants were asked to complete the same questionnaire before commencing the training course (once informed consent had been obtained) and after they have completed all training modules. Aside from the questions included in the tool, the baseline questionnaire included an open-ended question about participant's reasons to take part in the training program. The post-training completion questionnaire included open-ended questions about the aspects of the training

that participants enjoyed the most or did not enjoy, the main learnings taken home, and comments or suggestions to improve the training content or delivery.

Analysis

Analysis was conducted by comparing results from the baseline and post-training 15-item questionnaires. We used descriptive analyses to present the quantitative data. Both quantitative results and qualitative themes were synthesised to provide a comprehensive understanding of health professionals' attitudes and perceptions of the program and the potential impact of the BCC program on care delivery.

Ethics Approval and Consent to Participate

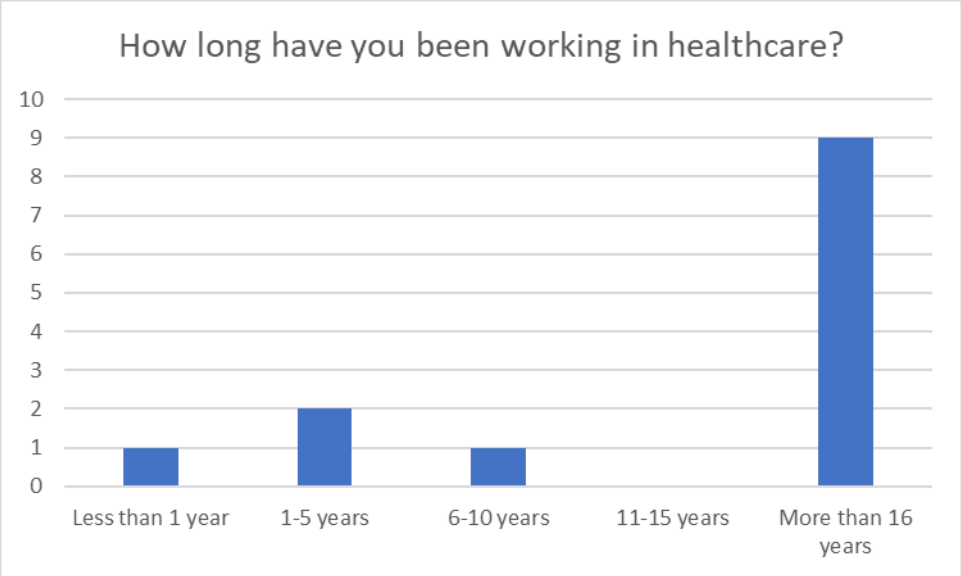
The project Safe Pathways including the implementation of the BCC has received ethics approval from the Australian Health and Medical Research Council (AH&MRC) (1690/20) and the Sydney Children's Hospitals Network (SCHN) (2020/ETH02103). Signed informed consent to participate was obtained from all participants before commencement of the training program and application of baseline questionnaire.

Results

There were 13 members from the multidisciplinary team that were recruited to the pilot study. Of those, four participants were Registered Nurses, two Social Workers, one Physiotherapist, one was the Nurse Unit Manager, one Nurse Practitioner, one Medical Consultant, one Clinical Nurse Specialist, one Clinical Nurse Consultant and one Aboriginal Health Worker. Most participants (N=9) had been working in healthcare for over 16 years, one for 6-10 years and the rest (N=3) had been working in healthcare for less than 5 years (Table 1).

Table 1

Participant's Years of Healthcare Experience



1. Baseline Data

1.1. Motivations for Participation

When asked about motivation to participate in the training program, participants highlighted a commitment to enhancing health outcomes and reducing health inequities for Aboriginal and Torres Strait Islander people. In addition, they expressed a desire to learn about Indigenous health, culture, values, identity, beliefs and the diversity of Aboriginal and Torres Strait Islander communities. Some participants aimed to reflect on their practice, values, and beliefs and expressed a desire to understand and learn how to respect Aboriginal culture so they could connect authentically with patients and set an example and improve understanding for their peers. One participant stated that they were encouraged by their manager to participate in the training.

> I decided to participate in the 'Building Cultural Capabilities' training program because...
>
> I am a visitor on aboriginal [sic] land and I am benefiting by living here and working here. I want to be able to give back to the people of the land and help them as much

> as I can in the healthcare sector. I want to decolonise my world view and can only learn that from the first nations [sic] of Australia as long as I am living on this land and country. (Participant 1)
>
> I would like to further develop cultural safety skills that I can implement into my clinical practice when providing care for children from Aboriginal and Torres Strait Islander backgrounds and model these skills for the wider hospitals' burns team. (Participant 5)
>
> Because there is so much diversity in First Nations Communities and there is so much to learn. (Participant 3)
>
> Important part of improving health outcomes, furthering education and reducing health inequities. (Participant 4)
>
> It is important for me to ensure I am providing culturally safe and appropriate practices in my interventions with children and families. (Participant 9)
>
> I wanted to understand what represents respectful engagement with Aboriginal people in order to ensure that all my engagements with Aboriginal people are respectful and empower them to advocate for what they need as much as is possible, to be mindful and avoid any communication or actions that serve to disempower a proud culture. I also needed to remain mindful of my own values and how these may at times conflict with the values of Aboriginal people. (Participant 13)

1.2 Baseline Likert Scale Questionnaire

All 13 participants completed the initial questionnaire (Table 2). Most participants (N=11) were familiar with the importance of recognising cultural values to provide healthcare services and agreed that quality of care could be compromised if a health professional is oblivious to the family's cultural attributes and values. Many participants (N=8) agreed that their beliefs and attitudes are influenced by their culture, however, only six (N=6) thought that their own cultural beliefs have influence on their healthcare decisions. Almost all

participants thought that all Australians need to understand Aboriginal history and culture (N=12) and almost all agreed that time allocated during work hours devoted to self-reflection and self-awareness is time well spent (N=11).

Most participants recognised the importance of communication skills agreeing that a health professional's ability to communicate with patients is as important as their ability to solve clinical problems (N=12) and the majority (N=11) stated that they would feel comfortable asking the patient or family members more information about a person's culture. Many of the participants (N=10) agreed that when considering Aboriginal health issues, it is necessary to think beyond the individual. Despite this, almost half of them (N=6) disagreed with the statement that more than two family members in a patient's hospital room is disruptive and should be prohibited, while almost the rest of them remained neutral (N=6).

Interestingly, the majority (N=10) of participants disagreed with the statement that the Western medical model is sufficient in meeting the health needs of all people including Aboriginal peoples and almost all of them agreed that Aboriginal people should not have to change their culture just to fit in (N=11). Only three participants agreed that Aboriginal people, due to their own cultural beliefs and values, have the poorest health status in Australia and almost all participants felt that they have a social responsibility to work for changes in Aboriginal health (N=12). However, more than half of them (N=7) remained neutral with the statement that Aboriginal people should take more responsibility for improving their own health.

Finally, half (N= 6) of the participants agreed with the statement that equity in the provision of healthcare means treating Aboriginal people the same as other clients, while three remained neutral.

Table 2

Baseline Questionnaire Results

Question	Strongly disagree/ disagree	Neutral	Strongly Agree/ Agree
I think my beliefs and attitudes are influenced by my culture.	2	3	8
Health professionals' own cultural beliefs influence their health care decisions.	4	3	6
Time allocated during work hours devoted to self-reflection and self-awareness is time well spent	0	2	11
A health professional's ability to communicate with patients is as important as his/her ability to solve clinical problems	0	1	12
The presence of more than two family members in a patient's hospital room is disruptive to staff and roommates and should be prohibited.	6	6	1
The quality of patient/client care could possibly be compromised if a health professional is oblivious to the family's cultural attributes and values.	2	0	11
As a health professional if I needed more information about a person's culture to provide a service, I would feel comfortable asking the person or one of their family members.	1	1	11
Aboriginal people, due to their own cultural beliefs and values, have the poorest health status in Australia.	6	4	3
Aboriginal people should take more individual responsibility for improving their own health	3	7	3
The Western medical model is sufficient in meeting the health needs of all people including Aboriginal peoples.	10	2	1
All Australians need to understand Aboriginal history and culture.	0	1	12
Aboriginal people should not have to change their culture just to fit in.	0	2	11
We practice equity in the provision of healthcare by treating Aboriginal people the same as all other clients.	4	3	6
I need to think beyond the individual when considering Aboriginal health issues.	1	2	10
I have a social responsibility to work for changes in Aboriginal health.	0	1	12

2. Post- BCC Training Data

Initially, a committed cohort of thirteen health workers actively engaged in the initial eight months of the training program, attending to four out of the six series of yarning sessions programmed. However, as the subsequent four months unfolded, there was a gradual tapering of participation. When the series concluded, only four health workers persevered for the final yarning session. Multiple factors contributed to decreased participation. Staff from CHW stated that this could be due to participants' transition to different healthcare facilities due to rotations in nursing training, changes in schedules, or relocation to other wards within the hospital. The exact number affected by these shifts remains unknown. Additionally, some participants cited time constraints as an obstacle, expressing challenges in dedicating time to engage with the readings provided in the resources, leading to their discontinuation from the yarning session and training. Despite the declining attendance, those who remained showcased unwavering dedication to the yarning sessions, underscoring the importance they attributed to these interactive and collaborative learning experiences.

2.1 Post-training Likert Scale Questionnaire

In the program's concluding phase, only six participants out of the original thirteen completed the final questionnaire and provided feedback of the training program. Due to the low number of participants completing the post-training questionnaire, we lacked statistical power to conduct pre/post-analyses comparison.

2.2 Comments and Feedback About the Training

The six participants who completed the post-training evaluation tool answered that they had acquired new knowledge and skills through the BCC training program which they are now applying in their practice. This included increased knowledge and understanding of Aboriginal and Torres Strait Islander culture and raised awareness about the impact of colonisation and intergenerational trauma that Aboriginal people experience. This was helpful in reducing stereotypes and assumption making. In addition, participants said they had improved their communication skills through learning what is yarning and how to yarn.

I have learned…

The importance of engaging with families and facilitate families to be “educators” on Aboriginal culture to avoid making any assumptions. (Participant 10)

Patients & family's cultural safety, impact of colonisation, intergenerational trauma, racism on health care. (Participant 4)

So much about parenting styles, how rich the culture is, how damaging,

the events of the past have been, and how traumatising it is across the generations. (Participant 12)

I have enhanced my knowledge and understanding of Aboriginal culture and my role in supporting children and families. (Participant 2)

Describe the way you have applied what you have learnt in this training course to your way of working.

Taking more time to introduce myself and discuss general issues first. (Participant 2)

The way I yarn with people, the way I approach. (Participant 10)

More management with families and awareness of potential cultural factors. (Participant 12)

Yarning points, families, greater knowledge of colonisation intergeneration trauma and racism. (Participant 4)

When asked about the aspects of the BCC program that they enjoyed the most, participants highlighted the bimonthly yarning sessions around the topic of each module. The yarning sessions were enjoyed because they gave participants the opportunity to actively engage in yarning with the guest speakers, who were Aboriginal and Torres Strait Islander people with extensive knowledge and experience on Aboriginal and Torres Strait Islander health and lived experiences. Aspects not enjoyed by the participants focused on the length

of some reading material and the difficulty of finding time to engage with the training materials and activities within a busy workload.

> The best part of the training program was...
>
> Yarning sessions and guest speakers. (Participant 2)
>
> Listening to Aboriginal people and the ways to approach and communicate, their history and culture relating to health care. (Participant 10)
>
> Talking to the curators about the stimulus material & hearing their stories. (Participant 12)
>
> Learning firsthand from TGI [The George Institute] team good yarning. (Participant 4)
>
> I didn't enjoy...
>
> some of the dry reading. (Participant 2)
>
> I wish I didn't miss sessions; I would have, liked to be able to do more. (Participant 12)
>
> Sometimes difficult to [find] time at UNI, a busy workload. Seem to be the same core group, of staff to attending cultural sensitivity approach. (Participant 4)

Only three of the six participants that completed the post-training evaluation questionnaire offered recommendations to improve the training program. Suggestions centred on strategies to increase training flexibility and adaptability to better fit busy schedules and high workload.

> What changes would you suggest making to this training course, so it is more acceptable to health workers?
>
> Record yarning sessions to review later. (Participant 2)

Maybe smaller chunks delivered more regularly and to try and get it in. (Participant 12)

"A self-directed course would be great, could do it in time. (Participant 4)

Discussion

The Australian health system, rooted in Western philosophies, presents inherent challenges to providing culturally safe care for Aboriginal and Torres Strait Islander people. Traditional cultural awareness programs often fall short, lacking depth, being treated as single events that hinder a genuine reflexive process and perpetuating stereotypical attitudes (Betancourt et al., 2003; Curtis et al., 2019a; Paul et al., 2012b). In response to this gap, the BCC training program emerged, offering an immersive and interactive experience.

The BCC was designed with emphasis in the critical importance of ongoing training to instigate real behavioural change and foster a shift toward culturally safe healthcare service provision. The program attempted to achieve this through the yarning sessions that enabled reflexivity by inviting participants to listen to and share ideas and experiences in a safe space.

Answers from the participants regarding their motivation to participate in the training program evidenced health professionals' interest in acquiring knowledge and skills to enhancing healthcare quality for Aboriginal and Torres Strait Islander people. This included interest in better understanding Aboriginal and Torres Strait Islander cultures and worldviews and strategies to build rapport and engagement efficiently with patients. In addition, results from the baseline questionnaire showed that healthcare providers recognise limitations of the Western biomedical model to meet the health needs of culturally diverse people and feel responsible for actively contributing to reducing health inequities. Other studies evaluating cultural safety training programs have also found that health professionals are interested in and enjoy taking part on this type of training as they think they are beneficial and relevant to their practice (Downing et al., 2011; Durey et al., 2017; Hinton & Nagel, 2012; Kerrigan et al., 2020; Sinnott & Wittmann, 2001; Vass, 2015).

Results from the baseline questionnaire evidence health provider's awareness about the importance of recognising cultural values and strong communications skills to providing quality healthcare. Despite this, many were unaware that cultural beliefs shape unconscious biases that can influence practitioner's healthcare decision making (Abiola Abu-Bakr, 2021; Quigley et al., 2021). Further, although participants acknowledged the importance of recognising cultural values among culturally diverse patients, they displayed confusion between practicing equity and equality within healthcare provision. This confusion among healthcare practitioners has been reported elsewhere (Rissel et al., 2022). This suggests that cultural safety and capabilities training programs should emphasise concepts of unconscious biases and difference between equity and equality.

Line managerial involvement and championship are key to enabling staff's access to training and thus fostering change (Bartlett, 2001). The training was developed in partnership with staff members in managerial positions at the burn services of the CHW and with the collaboration of the Clinical Nurse Educator. All of them strived to accommodate the training to the demanding schedules of health practitioners and a space for the yarning sessions was open within the time slot that is usually reserved for practitioners' professional development during working hours. Despite this, the declining number of participants towards the end of the program suggest a shift in involvement, potentially influenced by changing priorities, scheduling conflicts, or other professional commitments. Participants' feedback also highlighted challenges in finding time to engage with the modules' learning materials. This underscores the dynamic challenges confronted by healthcare professionals, highlighting the necessity of commitment from higher leverage points in the hospital system to ensure that health practitioners can access ongoing training. Academic experts have highlighted in multiple occasions that engagement and accountability from senior organisational leadership is a must (Browne et al., 2016; Durey, 2010; Wylie et al., 2021). Their role is to ensure capacity to factor in staff time for ongoing access to training and organisations' policies and procedures that support cultural safety enactment and lasting

system change (Browne et al., 2016; Durey, 2010; Westwood & Westwood, 2010; Wylie et al., 2021).

Strengths and Limitations

Participants' feedback at the end of the training program suggest it was successful at increasing participant's understanding about Aboriginal and Torres Strait Islander cultures and values, and the ongoing impact of colonisation and stereotyping on health inequities. Moreover, feedback suggests that the training was relevant and applicable within participant's practice. In particular, the bimonthly yarning sessions with Aboriginal academics and experts were highly enjoyed by participants. The yarning sessions offered a safe and interactive space to learn and ask questions. At the same time, through modelling and active involvement, participants expressed enhancement of their engagement, communication and interactions with patients by learning to yarn with them. However, we recognise the need for further research into more effective strategies that foster true cultural safety and capabilities. This includes exploring innovative methods of training that prioritise reflective practice and continuous education, rather than relying solely on one-time programs. By addressing these limitations and advancing our assessment tools, we can contribute to the development of training programs that lead to more profound, lasting changes in attitudes and behaviours among healthcare professionals.

A major limitation of this study was the small number of participants engaged in the training program exacerbated by the decline in participation and very low completion of the post-training evaluation tool. This hindered objective measurement of changes in participants' attitudes, transformative learning, cultural safety and critical thinking (Ryder et al., 2019). A similar study applying the same evaluation tool also encountered declining response rates and completion at follow-up, but found statistically significant improvements in attitudes toward Aboriginal and Torres Strait Islander culture (Rissel et al., 2022).

Besides support from higher leverage points in the hospital to ensure practitioners' ongoing access to the training, this could be enhanced through some of the participant's

suggestions such as delivering the program's content in shorter and more regular segments and increasing online delivery.

Conclusion

There is a pressing need to develop health practitioners' capabilities to deliver culturally safe health services. Many cultural awareness and cultural sensitivity programs in Australia are delivered as a single event, lacking depth and failing to achieve behavioural changes in healthcare practice. Immersive and interactive training programs have the potential to achieve deeper learning, genuine reflexivity and real changes in healthcare practice. This pilot study evidenced health practitioners and onsite line-managers' genuine interest and commitment to enhancing cultural safety skills and providing considered, person-centred and culturally safe care. However, support and engagement from higher levels of executive management in the hospital system and more flexible program delivery designs are needed to facilitate ongoing access to training. Further research with stronger sample sizes and follow-up response rate is needed to assess practitioner's learning outcomes and skills and to tailor and enhance training programs' content and delivery. After reflection and discussion with co-designers, we are continuing to extend this work. This next stage of development of the cultural safety education curriculum includes professionals moving beyond the initial training program to ensure engagement in ongoing reflective practice. This aligns with the growing recognition that cultural safety is not a static achievement but a dynamic process that requires regular revisitation and reinforcement. Ensuring that an ongoing cultural safety program is recognised through the allocation of continuing professional development points for all participating health personnel could be a potential avenue for advancing cultural safety training within healthcare institutions.

List of abbreviations

BCC: Building Cultural Safety and Capabilities

CHW: Children's Hospital at Westmead

Declarations

Consent for Publication

The manuscript does not contain any individual person's data in any form.

Availability of Data and Materials

The datasets and materials are available from the corresponding author upon reasonable request.

Competing Interests

The authors declare that they have no competing interests.

Funding

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Authors' Contributions

JC, KH, and KBB conceptualised the study. CR developed the training modules and content. CK drafted the manual provided to participants as part of the learning material. JC, CR, KH, KBB, KB, KB, AJAH and MJ edited and approved the final manual. JC, CK, and KH analysed the data. CK and JC drafted the manuscript and KH, CR, MJ, KBB, AJAH, BB, KB, SMF AND KB reviewed, edited and approved the final paper.

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