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Community development

Improving patient safety by enhancing the use of health services

Background

Community development plays an important role in increasing the access of disadvantaged groups to resources and services. We examined how community development in primary healthcare services may improve patient safety by involving people in activities that lead to their enhanced use of services.

Methods

Audits of service activity and 68 in-depth interviews at six primary healthcare services in South Australia and the Northern Territory. Managers, practitioners and administration staff, plus regional health service executives and departmental funders participated in the interviews.

Results

Each of the services undertook some community development. Reported benefits included engaging people in health promoting activity, providing people with social contacts and, crucially, encouraging people to use health services.

Discussion

Community development is a means of engaging people who, for a range of reasons, are reluctant to use services and therefore can increase patient safety.

Keywords

patient centred care; public health; Aborigine (health); community health services; health services, research; community development; community outreach

Patient safety is the prevention of errors and adverse effects to patients associated with their healthcare,¹ including in primary healthcare (PHC).² Traditionally, patient safety was a technical issue concerned with errors in diagnostics and treatment. The definition was broadened by Kuzel et al³ who saw that breakdowns in access and relationships are important aspects of patient safety, and by Lee,⁴ who added underuse as a threat to safety. There has been little research about how hard-to-reach services may undermine patient safety in this context. This article examines how community development may improve patient safety by involving people in activities that lead to their enhanced use of health services.

In Australia, parallel systems of primary healthcare have developed. These are largely fee-for-service general practice, state government funded and managed services consisting of a range of allied health professionals (occasionally including general practitioners), and Aboriginal controlled health services that employ a range of health professionals. The World Health Organization has advocated comprehensive PHC since the 1970s⁵ and recently reaffirmed its commitment to this style of service.⁶ There has been little research examining what exactly is distinctive about comprehensive PHC services, and existing research generally focuses on one particular program rather than the service as a whole.⁷ The research reported in this article was designed to take a whole-of-service view of the role of community development activities.

Community development has been used as a strategy in PHC for many years,^{8,9} including in the Australian community health sector.¹⁰

Community development is a process of working with community members and groups on health issues of concern to them in a way that increases empowerment^{10,11} and is widely recognised as a strategy that can improve the health and wellbeing of individuals and communities.^{12–14} Examples include citizen groups campaigning against unhealthy urban developments, community capacity building after a natural disaster and peer support around specific health issues. Here we examine how community development can be used by PHC services to encourage disadvantaged people to use health services and therefore improve patient safety.

Methods

Data were collected as part of a 5 year study evaluating the effectiveness of comprehensive PHC. The study is based on research partnerships with six services (*Table 1*): an Aboriginal community controlled health organisation (Congress); a nongovernment organisation sexual health service (SHineSA); and four services (North, South, West and the Aboriginal health team) funded and managed by the South Australian government. These services were chosen because they provide a range of service models and because good working relationships were already established with the research teams. These relationships facilitated the in-depth study of the service provider's activities.

Audit of PHC sites

An audit of the sites was conducted for the periods June to December 2009 and January to June 2010, including the data relating to community development activities reported here.

Interviews

At each site, 7–15 semistructured interviews were conducted with managers, team leaders,

practitioners and administrative staff. Interviews were conducted by different members of the research team. In addition, six regional health executive staff and two representatives from the central office of the state health department were interviewed (total N=68). Interview schedules were developed by the research team and piloted with three practitioners and one manager. Interviews were transcribed by an external service then checked by a member of the research team. This article draws on data relating to community development.

Data analysis

Preliminary analysis of the data revealed both emerging common themes as well as some divergent views, constituting a meaningful range.¹⁵ Codes were developed, discussed and revised during regular team meetings, ensuring

rigour through constant monitoring of analysis and interpretation.¹⁶ Analysis of patterns and relationships progressed from description, to explanation or interpretation of the patterns and their broader meanings and implications.¹⁷ Following data collection, emerging findings were presented to participants at staff meetings and to investigators and stakeholders at project meetings, and interpretations discussed.

Ethics approval was received by the Flinders University Social and Behavioural Ethics Committee and Aboriginal Health Research Ethics Committee.

Results

All the services did some community development work (*Table 2*). The two nongovernment services – ShineSA and Congress – undertook the widest range of community development. Reported activities included lunches and camps at which

health issues such as violence, kidney health and diabetes care were discussed; drop-in centres; community gardens; cultural awareness raising; youth actions teams and peer support to encourage healthy eating and breastfeeding.

Perceptions of community development activities in each service

Community development was viewed differently in each service, presumably affected by the history of the service, the focus of its service delivery and the attitudes and experience of the staff. The most positive views of community development were evident in the accounts of staff at both of the Aboriginal health services and SHineSA. Workers at each of the three other services reported that the services did less community development than previously. Some workers regretted this, describing

Table 1. Characteristics of the six case study sites in 2010

Site	Budget (per annum)	Main source of funding and management	Location	Approximate number staff (full-time equivalent)	Disciplines employed
South	\$1.7 m	SA Health funded and managed	Inner metropolitan	36 (22)	Nurse, dietician, speech pathologist, psychologist, occupational therapist, cultural worker, social worker
North	\$1.2 m	SA Health funded and managed	Outer metropolitan	16 (13.5)	Social worker, nurse, speech pathologist, occupational therapist, dietician, cultural worker, lifestyle advisor
SHineSA	\$6.1 m	SA Health + Commonwealth Department of Health & Ageing (DoHA) Nongovernment organisation with board of management	Metropolitan, but also providing services in rural and remote areas	108 (58)	Medical officer, nurse, counsellor, workforce educator, community health worker, disability worker, Aboriginal educator, multicultural worker
West	\$1.1 m	SA Health funded and managed	Inner metropolitan	26 (20)	Medical officer, lifestyle advisor, primary healthcare worker, podiatrist, nurse, speech pathologist
Aboriginal health team	\$0.5 m	SA Health	Outer metropolitan	12 (10.8)	Aboriginal health worker, primary healthcare worker
Congress	\$20 m	DoHA Community controlled board of management	Regional city	320 (188)	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist

Table 2. Community development activities at each of the six participating sites in 2010

Site	Community development activities
North	<ul style="list-style-type: none"> • Community foodies, community kitchens (nutrition, increase food security) • Health promotion talks, eg. keeping well in difficult times • Community development work with newly arrived migrant populations (particularly on nutrition, food security) • Visits, support for childcare centres, Learning Together at Home program, Aboriginal children’s playgroup • Contribution to local networks
South	<ul style="list-style-type: none"> • Community foodies • Community garden for people with mental illness • Healthy eating for children • Supporting schools to have healthy canteens • Healthy weight peer leadership • Contribution to local networks • Playgroups, including for newly arrived migrants from Africa
West	<ul style="list-style-type: none"> • Community foodies • Outreach to children’s centres • Aboriginal breastfeeding program, including peer support workers for younger Aboriginal women as lactation consultants • Early intervention with Aboriginal children, including health promotion days • Contribution to local networks
Aboriginal health team	<ul style="list-style-type: none"> • Nunga lunches: regular drop-in lunches for the community • Camps • Playgroup • Support of National Reconciliation Week events, lead reconciliation events in region • Lead NAIDOC events in the region • Cultural awareness raising in other health services
Congress	<ul style="list-style-type: none"> • Male health: health education, drop-in centre, shower facilities, men’s shed, cultural program • Women’s health – cultural program, community health education for young women, including train-the-trainer • Education and training for health professionals, building capacity of local workforce • Community development activities to promote social and emotional wellbeing • Contribution to leadership in local networks
SHineSA	<ul style="list-style-type: none"> • Health promotion programs, broad range of clinical services, relationships counselling, provision of information and resources • Developing capacity of workforce to respond to sexual health: training doctors, nurses, Aboriginal health workers, youth workers, disability workers, cultural and linguistically diverse workers, teachers, ‘pregnancy choices’ training • Respectful relationships and sexual health education in schools • Aboriginal sexual health education and promotion • Youth action teams

their services as consequently less welcoming to community members, especially those from disadvantaged backgrounds. All services felt pressure to prioritise the direct delivery of services. Even in the Aboriginal health team, where there was strong endorsement of community development, the time allocated to the activity had been reduced:

‘The worst thing I can see is our men’s group was on a weekly basis, now it’s been moved to a fortnightly basis so that’s going to hit hard in a way ... I think we’re going to lose clients and ... you know you miss one men’s group, we won’t see that bloke for a month then, a lot of things happen. [Practitioner, Aboriginal health team]

This concern expresses the importance of informal contacts in encouraging people to become familiar with, trust and then use services.

Patient safety benefits of community development

Distinct benefits of community development activity were articulated for individuals and the community. Examples from each service illustrate how these benefits were seen to accrue.

Congress

Congress runs a men’s health program called ‘Ingkintja’ which operates as a drop-in centre where men are able to shower and wash their clothes and ‘hang out’ in a safe place. The trust that has been developed in the service was summed up by the comment: ‘A lot of men actually like to come in here because they said there’s no humbug here.’ [Manager, Congress] The men’s program was felt to have reduced the stigma associated with seeing a psychologist: ‘We got one psychologist but then we didn’t have any customers for weeks and weeks and weeks and weeks, then the word got around and it’s been swamped ever since. I think we’ve broken down a few barriers in regards to mental health.’ [Manager, Congress]

Through their community development and outreach services, Congress engages people who may otherwise be excluded from these services. This community development capacity is also used to follow up people who need a particular service:

‘Plus we can ask other guys if we know we’re looking for this guy ... if he needs to go

to hospital or something like that we spread the word around – ‘do you know where this guy is?’ [Manager, Congress]

SHineSA

SHineSA uses a range of community engagement methods to increase accessibility, acceptability and knowledge of their services. Their youth action teams encourage the involvement of young people in the planning and design of services to help ensure they are acceptable to young people. As one of the management said:

‘It’s actually about saying how do we get that message across so that there isn’t the inequality in a person’s right to have the information in a way where they are motivated.’ [Manager, SHineSA]

North

North is situated in an area of very high socioeconomic disadvantage. Workers described how they engaged low income women, including recently arrived migrants and refugees, through a community kitchen, parenting groups and an Aboriginal art group. How these activities can lead to health services engagement is shown in the following statement:

‘In the Aboriginal women’s art group when the nurse came in as a guest speaker they were able to arrange for a group of the women to go and have mammograms with BreastScreen SA and for some of those women they’d never ever had it before.’ [Manager, North]

West

This service had many ways of engaging with local Aboriginal and migrant populations, including speaking at external community groups:

‘I think it’s quite effective for people who can’t necessarily access telephone systems or service providers and it’s often people with English as the second, third, fourth language.’ [Practitioner, West]

A worker from this service noted that they were less able to do community development than in the past and regretted this change because of the benefits she had seen from the community work:

‘When I started we ran a lot of things that were more like social health programs. So things

that addressed social isolation, things like art and craft groups and stuff for young women that had an arts and health focus. So that they would come and do art and craft, but at the same time we were able to link them in to our doctors and podiatry and all that sort of thing. Which worked really well, and were good ways of getting people through the door.’ [Practitioner, West]

South

South provided a community garden for residents of boarding houses with a mental illness. The garden provided direct benefits in terms of socialisation and learning about growing and then cooking healthy food. It was also perceived to be a means by which those coming to the garden became more comfortable with using health services:

‘There are all sorts of different people in this region ... some have very low access to healthcare. But a garden is, we have seen this here at South, it is such a great way to get people involved in something and essentially they are contributing to something that they see changes over time – growing plants and vegetables. But they are also socialising, they are also interacting with health professionals, like myself, who can really, if they want and are open to it, can gain support from us or assistance or advice if needed.’ [Practitioner, South]

Aboriginal health team

The Aboriginal health team saw their lunches and camps as an important way of reducing social isolation and providing opportunities for attendees to feel comfortable with a range of services relevant to their health:

‘With the Nunga lunches that is the most important gathering for the community people ... it’s an opportunity for us to promote our health professionals in this area as well and so that the community can put faces to names.’ [Manager, Aboriginal health team]

The camps are designed to include fun and healthy activities such as fishing, walking and the sharing of meals. They also provide an informal way of talking with people about their health and encouraging them to use services:

‘You know someone might back up and walk beside me while the other guys are all walking ahead and start talking, and I say, “well come

see me man and we’ll talk about it then,” or we talk about it then and it’s just, “well you need to talk to someone soon or you need to act on this or don’t do that, see this person because he deals with that”.’ [Practitioner, Aboriginal health team]

Another worker described the benefits of having women’s groups and lunches in terms of Aboriginal people getting to know the social worker and podiatrist and noted that it is ‘just that trust in getting to know someone.’ [Practitioner, Aboriginal health team]

The informal meeting spaces created by the community development activity was a means of following up with clients. The team leader noted that at another health service in the north of Adelaide where the lunches were cut, the case load of workers had fallen, in effect, reducing access to the services.

Discussion

Our study indicates that community development can be one way that PHC services assist patient safety by engaging the patients who find access to health services difficult. The PHC services in our study engaged Aboriginal people, those with a mental illness, women on a low income, recently arrived migrants and refugees and young people, all patient groups who experience a range of barriers to accessing services that may compromise their health.

Staff, particularly in the state managed PHC services, reported reduced community development activities with the pressures of direct service provision. Without community engagement, PHC services may not attract those at highest risk. We recommend that community development be routinely used by PHC services. In the current context, Medicare Locals should consider these processes as a means of engaging patients who find PHC services hard to reach. Further research on the role of community development in patient safety is required to document the exact nature of effective practice and the precise processes by which individuals are engaged and encouraged to use PHC services.

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