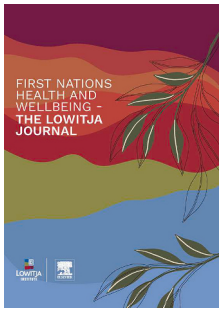

Original Research

‘I understand the importance of cultural safety but do not really know enough about how to implement it’: A qualitative exploration of health practitioners’ knowledge, attitudes and practices of providing culturally safe care for Aboriginal and Torres Strait Islander infants and families in neonatal intensive care units

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Abstract

Purpose Culturally safe care in neonatal intensive care units (NICUs) is crucial for Aboriginal and Torres Strait Islander infants and their families. Despite national efforts to improve culturally safe care, there is inconsistency in the way that health practitioners engage and translate cultural safety into their clinical practice. Currently, there is limited literature on Aboriginal and Torres Strait Islander health in NICUs to inform evidence-based practice. This study sought to explore health practitioners’ knowledge, attitudes and practices in delivering culturally safe care to Aboriginal and Torres Strait Islander infants and families in NICUs.

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Methods This paper presents the qualitative findings of an online, cross-sectional, descriptive survey conducted with health practitioners from two New South Wales NICUs. Two open-ended questions were thematically analysed. A total of 164 complete open-ended responses were provided for question one and 103 for question two. Participants were recruited via flyers located in participant workspaces over a six-month period.

Main findings Five themes were identified. Theme one: Staff are aware of the term cultural safety and their role in delivering culturally safe care. Theme two: Staff lack confidence and find it difficult to deliver culturally safe care. Theme three: Truth telling: culturally safe care is not always upheld in practice. Theme four: Education is important, but staff want experiential learning to be able to enact cultural safety in practice. Theme five: Systemic change is necessary: policies and guidelines need to be created, and Aboriginal leadership needs to be prioritised.

Principal conclusions Health practitioners in NICU settings have reported a lack of confidence and support to deliver culturally safe care to Aboriginal and Torres Strait Islander infants and their families. This study highlights the need for experiential learning, face-to-face education, and an increase in representation of Aboriginal and Torres Strait Islander leadership in health services. Further research is recommended at both a local and national level to inform policy and practice of culturally safe care in NICUs.

Keywords: Aboriginal and Torres Strait Islander health; Neonatal intensive care unit; Cultural safety

Highlights

- Cultural safety is critical to the experiences of Aboriginal and Torres Strait Islander infants and families in neonatal intensive care units.
- Health professionals report a lack of understanding of how to translate cultural safety into practice.
- Health practitioners request experiential learning to support translating cultural safety training to practice.

Introduction

Aboriginal and Torres Strait Islander infants experience higher rates of admissions to neonatal intensive care units (NICUs) than non-Indigenous infants (24.4% vs. 16.3%) (Australian Institute of Health and Welfare 2024). Large proportions of Aboriginal and Torres Strait Islander peoples are required to travel 'off Country' to access lifesaving medical care from large tertiary hospital services, which can increase their length of stay and disrupt cultural responsibilities and relationships (Bennett et al. 2025c; Kelly et al. 2014; Nolan-Isles et al. 2021). Despite high admission rates, there is limited evidence regarding the implementation of culturally safe care practices within NICU environments in Australia. Published research examining the translation of culturally safe care into clinical practice is limited across both paediatric and adult health settings. Investigations into the current practice of culturally safe care provision in child protection units and services in Australian hospitals for Aboriginal and Torres Strait Islander families have identified a gap from 'policy to

practice' in the children's sector (Flemington et al. 2021). Until recently, evidence-based approaches to culturally safe care in NICUs for Aboriginal and Torres Strait Islander infants and their families have been predominantly informed by international research conducted with Indigenous Peoples in Canada and New Zealand (Wright et al. 2020; Adcock et al. 2021; Adcock et al. 2022; Adcock et al. 2023). Addressing the need for evidence specific to the Australian context, the lead author's (JBe) broader 2025 research found that Aboriginal and Torres Strait Islander parents whose infants were admitted to a tertiary NICU in New South Wales (NSW) reported experiences of racism, poor communication, trauma, lack of empowerment and limited opportunities for parent-led care or culturally inclusive care (Bennett et al. 2025b). These experiences led to parents' mistrust of health practitioners and poor perceptions of cultural safety in the neonatal setting (Bennett et al. 2025b). Given the significant gap in the Australian neonatal literature on Aboriginal and Torres Strait Islander health, there are currently no reported perspectives on healthcare practitioners' understandings of culturally safe care practices in the NICU or the support that is required to advance health practitioners' practice of culturally safe care.

Cultural safety was conceptualised by Māori nurse Irihapeti Ramsden (Ramsden 2002). Culturally safe care can only be deemed appropriate and respectful by Aboriginal and Torres Strait Islander Peoples and/or their communities as the recipients of care (Ahpra and National Health Leadership Forum 2018; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) 2013). Ramsden's pivotal work described cultural safety as a framework that extends beyond the mere awareness of Indigenous cultures, and focuses on the power imbalances that exist in the healthcare system and the delivery of safe cultural care from health practitioners (Ahpra and National Health Leadership Forum 2018; Ramsden 2002). Since its conception, the literature on cultural safety training in health education settings often refers to related concepts such as cultural awareness, cultural competency, cultural respect and cultural sensitivity (Mohamed et al. 2024). Although these concepts appear to overlap with cultural safety, they are not interchangeable (Mohamed et al. 2024). Cultural safety moves beyond the knowledge or skills used in practice that are detailed in other cultural training models and instead centres the individual's power, assumptions and positioning as to how they behave (Mohamed et al. 2024; Ramsden 2002). In the early 2000s, cultural safety gained further momentum internationally and began to be embedded within the Australian healthcare system. These changes were driven and led by Aboriginal and Torres Strait Islander national peak bodies who advocated for the inclusion of culturally safe standards and practices in national- and state-based policy, and within professional health registration standards (National Aboriginal Community Controlled Health Organisation (NACCHO) 2009; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) 2014; Australian Indigenous Doctors Association 2013; Indigenous Allied Health Australia (IAHA) 2015; National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWA) 2013). This has also resulted in cultural awareness and cultural safety training being embedded in healthcare education as part of the Australian university curriculum accreditations with the Australian Nursing and Midwifery Accreditation Council (ANMAC) (CATSINaM 2017). In 2022, Ahpra motioned and passed a change to the Health Practitioner Regulation National Law (Ahpra 2024). The new objectives and guiding principles incorporated into the law aimed to ensure that the development of the current and

future workforce of practicing health practitioners would be culturally safe and responsive in Australia's health system (Ahpra 2024). These actions aimed to eliminate experiences of racism by Aboriginal and Torres Strait Islander Peoples in the healthcare system and to increase health practitioners' awareness of their roles and responsibilities in practicing culturally safe care (Ahpra 2024).

Calls for an increased discourse into anti-racism healthcare policies in Australian healthcare services have grown over the last decade (Paradies 2016; 2018; Australian Health Practitioner Regulation Agency 2020; Mohamed et al. 2024; Elias et al. 2021; Watego 2025). These calls for action are in response to the continued failure to 'close the gap' in health outcomes for Aboriginal and Torres Strait Islander Peoples (Parter et al. 2021). The historical effects of colonisation and its continued influence on a Eurocentric dominant healthcare system are the root cause of racism, health disparities and inequities experienced by Aboriginal and Torres Strait Islander Peoples (Watego 2021). Racism is well known as a determinant of health that negatively impacts Indigenous Peoples' health outcomes globally and it needs to be addressed (Paradies et al. 2015). To meaningfully disrupt and transform current healthcare practice, an anti-racism and Indigenous-led approach is required of health systems (Watego 2025); therefore, it is crucial to have a workforce of culturally safe practitioners who are free from racism, bias and judgement (Mohamed et al. 2024). While institutions have a responsibility to establish an antiracist environment, the responsibility to gain professional development in culturally safe care predominantly sits with health practitioners (Hardy et al. 2023; Nursing and Australia 2018a, 2018b). A recent scoping review demonstrated a gap in the literature regarding historically informed clinical practices, highlighting that current mandated cultural safety education for health practitioners cannot be evidence based (Mackay et al. 2025). Within the healthcare setting, this means that racist contamination can still exist amongst health practitioners, and systemic level barriers can continue to cause Indigenous peoples globally to feel culturally unsafe in hospital settings (Allan and Smylie 2015; Smylie et al. 2022). To date, limited research has specifically focused on the translation of culturally safe education and training into clinical practice and organisational policy (Hardy et al. 2023). In the neonatal setting, there is a lack of evidence about how health practitioners describe their culturally safe caring practices.

This paper is part of a larger study that aimed to describe healthcare practitioners' knowledge, attitudes and practices towards culturally safe care in the NICU that has been reported in a separate publication (Bennett 2025a). This paper presents findings from the qualitative analysis of responses to two open text questions from a cross-sectional survey of NICU health practitioners. Specifically, this paper aimed to explore health practitioners':

1. Perceptions of their role in providing culturally safe care in the NICU for Aboriginal and Torres Strait Islander infants and their families.
2. Reflections on culturally safe practice with Aboriginal and Torres Strait Islander infants and their families in the NICU.
3. Barriers to culturally safe care in the NICU for Aboriginal and Torres Strait Islander infants and their families.

Methods

This research paper applied both Indigenous quantitative (Walter 2013) and qualitative (Bessarab

and Ng'andu 2010) methodologies. When using Indigenous methodologies, it is:

> *not so much with the actual technique of selecting a method but much more with the context in which research problems are conceptualised and designed, and with the implications of research for its participants and their communities* (Smith 2021, p ix).

Research team

The research was led by an Aboriginal PhD candidate (JBe), who conceptualised and conducted the study as part of her doctoral research. JBe was supported by senior Aboriginal researcher MK (Wiradjuri), alongside two non-Indigenous researchers JBr and KB, who have extensive experience in Aboriginal and Torres Strait Islander health research. JBe drew on her Indigenous woman's standpoint (Moreton-Robinson 2013; Foley 2013) and social and cultural positioning as a Gamilaroi woman and her relationality as both a neonatal registered nurse and a mother with experience in infant admissions to the NICU. The research concept was driven by consultation with NSW Aboriginal communities and the stories of Aboriginal parents who had experienced an admission to a major metropolitan NICU with their infant (Bennett et al. 2025b). Aboriginal and Torres Strait Islander community researchers and health practitioners contributed to the research design, implementation and dissemination. The authors acknowledge that their world view and experiences have shaped the research study.

Ethics and governance

Ethics approval was provided by the Human Research Ethics Committee (HREC) of the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC 2020), University of Newcastle HREC (H-2023-0165) and Hunter New England Local Health District HREC (2023/ETH00910). The research upheld ethical practices and principles outlined from the National Health and Medical Research Council's Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research (National Health and Medical Research Council (NHMRC) 2018), as well as the Aboriginal Health and Medical Research Council's AH&MRC ethical guidelines: key principles V2.0 (AH&MRC 2020).

This study was guided by the Winanga-li Aboriginal Governance Committee, which was formed in 2021 by lead author JBe to provide oversight and decision-making across her doctoral research as per the AH&MRC NSW Aboriginal Health Ethics Guidelines (AH&MRC 2020). Members of the committee included Aboriginal and Torres Strait Islander nurses, doctors, midwives, an Aboriginal liaison officer and researchers who reside within the local health district and who are knowledge holders in this space. The committee met at key points throughout the doctoral study and supported the research design, analysis, interpretation and dissemination of this project.

Design and setting

An online, cross-sectional descriptive survey was conducted to understand health practitioners' knowledge, attitudes and practices regarding culturally safe care when working with Aboriginal and Torres Strait Islander infants and their families in NICUs. Recruitment of participants occurred at two sites: John Hunter Children's Hospital (JHCH) in Newcastle, NSW, and Westmead Children's Hospital Grace Unit in Sydney, NSW. Both sites are large, tertiary referral paediatric centres with intensive care unit beds that provide specialised medical, surgical and trauma care for infants born prematurely and/or who are unwell at birth.

Participant eligibility

Participants were eligible to participate in the survey if they were a health practitioner registered with an

accredited healthcare body and were currently employed to care for infants in the NICU at either of the participating sites. Nurses (registered nurses, clinical nurse specialists, consultants, managers, nurse practitioners), allied health workers (speech therapists, physiotherapists, social workers, pharmacists) and doctors (junior medical officers (JMOs), registrars, fellows, consultants) were eligible to participate.

Participant recruitment

Recruitment flyers were placed in staff areas in the NICU, such as the staff break room. The principal investigator (PI) at each site also sent a series of emails to staff to inform them of the study. Emails included a recruitment flyer that contained a QR code that participants could scan to review the participant information sheet, provide informed consent and complete the survey. Additionally, as per the JHCH NICU research pathway, a series of in-services (education/information session provided to participants) on the research project were conducted. At JHCH, potential participants were able to ask questions about the research in real time with the lead author JBe, ahead of consenting and participating in the study. At the end of the in-service, participants were provided with a recruitment flyer if they wanted to participate. All participants received information about the purpose of the study, voluntary participation, the option to withdraw at any time, and confidentiality for all data. All participants involved in the study provided electronic written informed consent.

Data collection

Data collection occurred from late April 2024 to early October 2024. The survey was conducted via REDCap, an online platform designed for secure data collection (Harris et al. 2009). Participants answered two screening questions to confirm eligibility prior to commencing the survey. After completing the survey, participants were offered an AU$5 coffee voucher as reimbursement for their participation. Participants who wished to receive the voucher provided their email address via a separate survey link. This ensured that participants' data remained de-identified.

Survey development and instrument

The survey included three core concepts: knowledge, attitudes and practices. Two open ended questions were included. The first was presented at the end of the knowledge domain 'our knowing' and asked: 'in your opinion, what is your role as a healthcare practitioner in implementing and upholding culturally safe practices?' The second question was presented at the end of the survey and asked: 'Lastly, do you have any reflections on cultural safety and caring for Aboriginal and Torres Strait Islander infants and families in the NICU setting?' The final survey covered three domains and included 71 survey items (including consent and eligibility). Participants were asked to self-report their age, gender, Aboriginal and Torres Strait Islander identification, current role, length of employment, employment status, highest level of education, role in the NICU, and completion of cultural safety training or education.

The survey was refined in collaboration with Aboriginal and Torres Strait Islander practicing health practitioners, community researchers and the Winanga-li Governance Committee. This collaboration was then combined to form an expert panel of Aboriginal and Torres Strait Islander peoples for this research project. The panel used collaborative yarning to uphold Indigenous ways of generating knowledge and sharing. This process strengthened the integrity of the survey (Bessarab and Ng'andu 2010). To assess the acceptability of the survey content and the feasibility of self-completion, the survey was pilot tested with

eight members of this panel. Feedback provided by the members was incorporated before the survey was then finalised. A full description of the survey development and survey results has been reported in a separate publication (Bennett 2025a).

Data analysis

All data were analysed by the lead author to ensure that Indigenous methodologies were upheld. This was supervised by a senior Aboriginal researcher (MK). Statistical analyses for participant demographics were conducted in SAS 9.4. Descriptive statistics for the demographics of this paper were reported using frequency and proportions. Qualitative analysis was conducted using NVivo 14 software. A template analysis was conducted by the lead author (JBe) following steps highlighted for the analysis by Brooks et al. (2015). Using a template analysis allowed for both structure of the presentation of data and flexibility in responsiveness to the open-ended questions (Brooks et al. 2015). Coding was independently conducted by JBe, who had already deeply engaged with this topic through interviews conducted with Aboriginal and Torres Strait Islander parents with infants admitted to NICUs (Bennett et al. 2025b), and the quantitative findings from the cross-sectional survey (Bennett 2025a). After reading through each response, prior themes were developed by JBe using a deductive approach for both questions. After initial coding, a template was developed and further coded using an inductive approach in response to the data. Once the initial template was developed, JBe refined this through collaborative yarning with the Winanga-li Governance Committee to strengthen the integrity of the data by upholding Indigenous ways of generating knowledge and sharing (Bessarab and Ng'andu 2010). This process allowed for meaningful conversations about how the dataset was coded and highlighted the preliminary themes. The research team and governance committee were able to make changes to the analysis and strengthen its interpretation prior to finalisation (Bessarab and Ng'andu 2010). Ongoing collaborative yarning between the lead author (JBe) and the research team (KB, JB, MK) allowed for consensus of the preliminary themes and finalised the themes based off the full dataset.

Results

A total of 164 complete open-ended responses was provided for question one and 103 for question two; most participants identified as a woman or female (92.1% and 92.2%, respectively). Overall, less than one quarter of participants had been working in NICUs for the last five years or less, and the majority of the participants were nursing staff (75%). Participant demographics are described in the Table.

When exploring health practitioners' perceptions of their role in providing culturally safe care, and reflections and barriers to implementing culturally safe care, five key themes were identified:

- Theme one: Staff are aware of the term cultural safety and their role in delivering culturally safe care. Three subthemes were identified within this theme: Key skills and attitudes for providing culturally safe care in practice; The importance of reflective practice in delivering culturally safe care; and Cultural safety is not always seen as a shared responsibility.
- Theme two: Staff lack confidence and find it difficult to deliver culturally safe care.
- Theme three: Truth telling: culturally safe care is not always upheld in practice.
- Theme four: Education is important, but staff want experiential learning to be able to enact cultural safety in practice.

Participants' characteristics	Categories	Question one 164 responses	Question two 103 responses
Age – years	<25	13 (7.9)	8 (7.8)
	25–34	57 (34.8)	35 (34.0)
	35–44	40 (24.4)	22 (21.4)
	45–54	39 (23.8)	26 (25.2)
	55–64	15 (9.1)	12 (11.7)
Gender	Woman or female	151 (92.1)	95 (92.2)
	Man or male	13 (7.9)	8 (7.8)
	Non-binary	0 (0)	0 (0)
Indigenous status	Aboriginal	8 (4.9)	5 (4.9)
	Torres Strait Islander	0 (0)	0 (0)
	Aboriginal and Torres Strait Islander	0 (0)	0 (0)
	Neither Aboriginal nor Torres Strait Islander	156 (95.1)	98 (95.1)
Current role	Medical doctor (intern, registrar, fellow, consultant)	26 (15.9)	17 (16.5)
	Nurse (RN, EN, AIN)	123 (75.0)	77 (74.8)
	Midwife	0 (0)	0 (0)
	Dual registered nurse and midwife	2 (1.2)	0 (0.0)
	Allied health (physiotherapist, speech therapist, social worker)	13 (7.9)	9 (8.7)
Length of time working as a health professional – years	<5	35 (21.9)	24 (23.3)
	5–15	62 (38.8)	38 (36.9)
	16–30	52 (32.5)	33 (32.0)
	>30	11 (6.9)	8 (7.8)
Employment status	Full time	81 (49.4)	52 (50.5)
	Part time	78 (47.6)	46 (44.7)
	Casual	5 (3.0)	5 (4.9)
Highest level of education	Current student at university	6 (3.7)	4 (3.9)
	Undergraduate degree	57 (34.8)	37 (35.9)
	Postgraduate degree	91 (55.5)	56 (54.4)
	Doctorate	10 (6.1)	6 (5.8)

Data are shown as *n* (%). AIN, assistant in nursing; EN, enrolled nurse; RN, registered nurse.

Table: Participants' demographics

- Theme five: Systemic change is necessary: policies and guidelines need to be created, and Aboriginal leadership needs to be prioritised. This theme also included two subthemes: Strengthening policies and guidelines to drive practice change; and Prioritising Aboriginal leadership and engagement.

Key illustrative quotes are embedded into the text below. Additional quotes aligned with each theme can be found in the Supplementary Table.

Theme one: Staff are aware of the term cultural safety and their role in delivering culturally safe care

Key skills and attitudes for providing culturally safe care in practice: Participants perceived that cultural safety is necessary in their role and is non-negotiable when caring for Aboriginal and Torres Strait Islander infants and families. One participant stated:

> *It is my role to work with each family and establish their needs and beliefs, understand the dynamic of*

their community and home life to then make adjustments to the care I give to facilitate their needs culturally and practically, documenting and making it clear so that my co-workers can implement the same practices, providing continuity for the family (P89, nurse).

Multiple skills were highlighted as important contributors to culturally safe practice, including: 'actively engaging', 'communicating', 'advocating', 'listening' and 'recognising'. Many participants said it was essential to be 'approachable', 'genuine', 'respectful' and 'open minded' to establish authentic and trusting relationships with Aboriginal and Torres Strait Islander families. Being consistent and active with families was noted to be helpful in creating culturally safe environments for families, as illustrated by one participant when reflecting on their responsibility to implement culturally safe care practices: 'Actively seeking information from families and communities to ensure we are meeting their needs and providing culturally safe care' (P184, nurse).

The importance of reflective practice in delivering culturally safe care: Emphasis was placed by participants on self-reflection and the need to continuously self-reflect in practice in order to be responsive in their approach towards culturally safe care. This included recognising and respecting cultural differences between Aboriginal and Torres Strait Islander Peoples, as well as acknowledging the ongoing harm caused by colonisation and coloniality, such as mistrust in the health system and examining how White privilege, unconscious biases and/or prejudice can impact culturally safe care practices. Self-reflection was seen to help facilitate the tailoring of care interventions by changing practice based on each family's cultural needs. One participant stated: 'It is my role to ensure that there is no bias towards Aboriginal and Torres Strait Islander families and that they have the appropriate support' (P53, nurse).

Cultural safety is not always seen as a shared responsibility: While most participants viewed cultural safety as everyone's responsibility, some participants believed that all patients should be treated equally, rather than tailoring care to meet the individual cultural needs of Aboriginal and Torres Strait Islander families. Some participants felt that the presence of cultural services such as Aboriginal liaison officers (ALOs) was providing culturally safe care. Participants also stated that providing care to Aboriginal and Torres Strait Islander peoples can be challenging due to cultural differences across Aboriginal and Torres Strait Islander nations in the health district. As a result, some participants felt that the infant's medical care should be the priority in the NICU, not the family's or their cultural values. This was illustrated by one participant when reflecting on how they perform culturally safe care: 'I treat all families with respect no matter their cultural background. I engage with ALOs often but definitely leave it to the ALO to offer cultural care as such' (P119, nurse).

Theme two: Staff lack confidence and find it difficult to deliver culturally safe care

Participants described motivation and openness towards practicing culturally safe care; however, many stated that they did not know how to start their learnings or how to use the learnt skills in practice, including how to initiate the process or who to engage. One participant said: 'I understand the importance of cultural safety but do not really know enough about how to implement same' (P25, nurse). Several participants also expressed that accessing resources was difficult, and that they needed to become more aware of what was available. However, some staff reported that they felt it was not just an individual

responsibility but the organisation's to help promote the resources and policies. Participants expressed the need for support to translate their current knowledge on cultural safety into practice. As one participant reflected: 'To continue communication around the importance of implementing and upholding safe practices' (P95, nurse).

Participants expressed concerns about uncertainty when determining how to appropriately communicate with Aboriginal and Torres Strait Islander families. One participant reported: 'Sometimes I feel that we are scared to engage as we view things through a privileged White lens – we know we can do better but don't know how to ask for fear of adding to perceptions of ignorance' (P116, nurse). Participants did not want to appear 'insensitive'. Interactions between themselves and the families sometimes felt 'daunting' and 'scary' due to fears of causing offence or being culturally inappropriate. One participant wrote: 'My biggest barrier is being worried about not getting it right in being open with discussions regarding culturally appropriate supports, etc, not feeling confident to discuss freely as I have knowledge gaps' (P61, allied health). Some participants felt it was hard to determine the most appropriate approach to care due to their lack of knowledge and cultural awareness, for example, one participant said: 'I want to work with them as a team but sometimes feel rejected by them [Aboriginal families] and that is respected by me they do not want to engage' (P49, nurse). Asking about identification of Aboriginality also caused concern, with participants fearing it might cause offence or be perceived to be making an assumption on the parents' appearance. Additionally, engaging with parents who had experienced racism in other episodes of healthcare was seen as a barrier to building trust and effective communication. One participant reflected on the overwhelming and scary nature of the NICU for families, saying: 'We can improve on being more aware of our families' cultures and what would help make their experience less overwhelming and more supportive' (P155, nurse).

Theme three: Truth telling: culturally safe care is not always upheld in practice

Cultural safety in the NICU was reported to be lacking or nearly absent, and was not prioritised or was poorly implemented. One participant said: 'We do not do cultural[ly] safe care well here in the NICU' (P1, nurse). Some participants acknowledged a sense of complacency in their approach and a hesitancy to actively engage in culturally safe practices, due to a lack of discussion around culturally safe care in their workplace. Several participants reported that culturally safe practice requires attention and prioritisation in the NICU due to the large representation of Aboriginal and Torres Strait Islander infants and families that access the service. One participant stated:

> *I believe that it could definitely be completed better and more appropriately... I believe for [the] information and resources we are given we complete it well; however, there is a lot of room for improvement given our large number we care for* (P42, nurse).

Due to workload and high acuity, it was reported that culturally safe care gets pushed aside in the NICU. This was reflected by a participant saying: 'It is not always a priority to identify what culture a patient is from when they are acutely unwell. Once care has stabilised and so has the patient, there is more time to better communicate' (P187, nurse). Some participants stated that cultural safety was rarely discussed amongst staff; this was felt to negatively affect care of Aboriginal and Torres Strait Islander infants and their families. Additionally, participants also reported that this was unintentional and participating in the

research survey served as a reminder for staff to increase their awareness of culturally safe care practices.

Culturally unsafe care was witnessed by participants, including poor communication and interaction, as well as a lack of advocacy for families. Some participants felt that they and their colleagues were unable to speak up during these interactions due to their personal lack of cultural awareness, insufficient education and lack of support systems to do so. A lack of knowledge was seen as a contributing factor to culturally unsafe practices. One participant suggested for action to be taken:

> *Over years I have heard a lot of what should happen as opposed to what actually occurs... I have seen inappropriate care and non-culturally safe practices in place and people are sometimes intimidated to call it out. It's time we made a real difference* (P28, medical doctor).

Common misconceptions about Aboriginal and Torres Strait Islander Peoples and their cultures were seen as contributing to culturally unsafe care. One participant described an episode of misinformation in a staff meeting: 'The last minutes of the team meeting have an interesting comment. It stated that some Indigenous feedback was that Indigenous families did not want to talk' (P15, nurse). Participants also described resistance to deliver culturally safe practice, due to the fear of doing it incorrectly. For example, one participant said: 'I feel that when NICU gets busy, I forget to think specifically about the cultural background of the family. I worry that I don't ask enough specific questions about what else we can do to make them feel safe in the NICU. I want to do better' (P171, medical doctor).

Theme four: Education is important, but staff want experiential learning to be able to enact cultural safety in practice

Participants described a lack of access to available and frequent educational resources in their current employment, including a lack of opportunity to pursue professional development, often due to a lack of staffing and availability of cultural safety training. A participant described: 'I am eager to continue to learn; however, there seems to be a lack of services and support available' (P34, nurse). Participants acknowledged that cultural safety education is part of a continuum and culturally safe care can only be provided when participated in all areas of education in that continuum. However, due to a limitation in the availability of resources in the health service, it was felt that they were not supported to actively become culturally safe in their practice. Reviewing the principles of practicing cultural safety more frequently as part of their role was described as positively influencing how participants practice cultural safety and would keep them accountable in reporting culturally unsafe care. One participant explained the importance of education in improving their responsibility to the parents: 'Includes calling out culturally unsafe practices and language used by colleagues' (P215, nurse). Participants recognised individual responsibility for ongoing education, along with a commitment to fostering accountability and normalising cultural safety education in practice and amongst colleagues, such as: 'Understand what it [cultural safety] means and what I can do to ensure it is consistently practiced. Also to educate others and hold people accountable' (P28, medical doctor). Several participants also reported that accessing education and training would improve their opportunity to teach and guide other colleagues in being culturally safe practitioners.

Responses from participants indicated that the cultural safety education they currently accessed was perceived to lack depth to effectively guide its application to practice when working with Aboriginal and Torres Strait Islander families. Participants asked for hands-on and face-to-face education in spaces that staff can learn and ask questions, including direct learnings from Aboriginal and Torres Strait Islander peoples, such as ex-NICU families or community members. This was seen by participants as a way to further help support families. For example, one participant wished for: 'A safe space for staff conversations/learnings so they are well equipped to support our Indigenous families that pass through the NICU' (P95, nurse). Participants felt that confidence would be higher amongst their peers if culturally safe care was championed and role modelled in clinical practice. Mandatory education was described as 'never available' and 'needs to be delivered more'. Examples of additional education suggested by participants included regular hospital in-services, seminars and simulation workshops specific to clinical staff. Some participants also suggested on-Country experiences, as they felt that talking about culture and a person's lived experiences in person is more applicable than learning virtually.

Theme five: Systemic change is necessary: policies, guidelines and resources need to be created, and Aboriginal leadership needs to be prioritised

Strengthening policies and guidelines to drive practice change: Most participants described a gap in the availability of cultural safety policies and guidelines in their health organisation, as well as access to practical and ongoing education relevant to culturally safe practice. One participant said: 'We have a lot of "words" to describe culturally safe care, but few clear guides on how to do this best, and very few evidence-based facts to guide us' (P98, medical doctor). Participants reported being unaware of resources that were accessible or available in their health district that supported their practice as culturally safe practitioners. The implementation of culturally safe resources into practice, such as parent education materials, was seen as a way to support the care they were providing. Personal feelings of inadequacy towards practicing culturally safe care were noted to be a common feeling among colleagues. Participants believed that their confidence would grow if there were concise, structured guidelines and policies to follow. One participant said: 'I have struggled with the lack of "evidence" or literature available to guide the delivery of culturally safe care specifically in NICU. I feel a strong desire to practice cultural sensitivity but simultaneously so concerned that I will inadvertently misstep that I do avoid interactions around culture at times' (P101, nurse). A lack of confidence was common in sensitive episodes of care, such as when families experienced Sorry Business, when families travelled back to Country (parents who live out of area) or when parents needed to include family kinship. Participants said this was because they were lacking knowledge on how to navigate those cultural needs in care. A call for amendments to current care guidelines and policies was made by participants, due to the lack of cultural considerations and restrictions to how they can perform cultural safety in practice: 'Sometimes the NICU environment, its policies and rules make it feel impossible for us to be able to provide cultural safety' (P99, allied health). Participants also suggested the need for audits and evaluations to be conducted in their organisation, to determine if policies and guidelines are being implemented in practice.

Prioritising Aboriginal leadership and engagement: Participants recommended an increase in the representation of Aboriginal and

Torres Strait Islander staff, particularly leadership roles within their service to increase cultural safety education, support and care coordination in the NICU. It was stated clearly by one participant: 'We need to have Aboriginal and Torres Strait Islander people involved in hospital leadership positions' (P139, medical doctor). The employment of an Aboriginal liaison officer or Aboriginal health worker directly in neonatal services was thought to be beneficial. Participants felt that referring parents to the ALO was one act of providing culturally safe care as the health practitioner. However, there were some participants who stated that they did not understand the ALO's role and had not interacted with an ALO during their employment. One participant reflected:

> *I feel underprepared and unsure as to whether I am always providing the most appropriate care. I take the time to check in with the parents, being responsive to their feedback and including this in my care plan, however I have never engaged or spoken with an ALO during my time at my workplace* (P51, nurse).

Participants identified that there was currently a lack of engagement with Aboriginal and Torres Strait Islander families to provide feedback on culturally safe practices in the NICU. One participant stated:

> [*The*] *key to achieving all of this [is] listening and learning from families as well as others (including clinicians from the same cultural background)… they are the experts in their lived experience and if you listen close enough and truly partner with them in their healthcare journey, catering to their specific healthcare needs is 100 times easier and 1000 times more effective at achieving the shared end goal of best possible care for their baby and family* (P160, nurse).

Participants felt that involvement with local communities would help them navigate and strengthen culturally safe care in the NICU. One participant illustrated the importance of this relationship to culturally safe care in the NICU: 'A stronger presence of connection between Aboriginal community and our team I believe would heighten our awareness and ability to provide the right support' (P34, nurse).

Discussion

All practicing health practitioners have a responsibility, as per their code of conduct (Ahpra 2024; Ahpra 2020), to be culturally safe and responsive in their practice when working with Aboriginal and Torres Strait Islander Peoples. This study provides a unique exploration of health practitioners' perceptions of their role in providing culturally safe care, their reflections on culturally safe practice and barriers to culturally safe care, while caring for Aboriginal and Torres Strait Islander infants and their families in NICUs. This study found that health practitioners are aware of their role in practicing culturally safe care. Health practitioners understand that, in order to improve health outcomes for Aboriginal and Torres Strait Islander infants and their families, it is essential to further their education and training to implement cultural safety into practice. However, health practitioners reported a lack of preparedness, empowerment and confidence in providing culturally safe care in practice, due to systemic failures and lack of continuous training opportunities.

The principles of cultural safety include reflective practice, minimising power differentials, engagement and discourse, regardful care and understanding historical context of colonisation (Australian Institute of Health and Welfare 2023; Australian Health Ministers' Advisory Council's National Aboriginal and

Torres Strait Islander Health Standing Committee 2016; Best 2017). The health practitioners in this study were aware of the principles of cultural safety and that cultural safety focuses on the patient's experience, based on their ability to apply those principles into practice. These findings are consistent with previous research that has measured staff knowledge of cultural safety following engagement with cultural education and training (Chapman et al. 2014; Mooney et al. 2005; Kerrigan et al. 2020; Withall et al. 2021). Multiple research studies have consistently demonstrated positive perceptions and motivation from health practitioners towards providing care of Aboriginal and Torres Strait Islander patients, after receiving theoretical knowledge on cultural safety (Chapman et al. 2014; Mooney et al. 2005; Kerrigan et al. 2020; Withall et al. 2021). That said, minimal research has explored changes to practice after cultural safety training, as the studies were unable to follow the participants' implementation of cultural safety into practice (Chapman et al. 2014; Mooney et al. 2005; Kerrigan et al. 2020; Withall et al. 2021). Participants in this study expressed a lack of confidence and a fear of making mistakes when practicing culturally safe care in the NICU. This self-reflection could also be a barrier to their practice and the implementation of their knowledge into skills. The term *Pākehā paralysis* has been coined in New Zealand, where non-Indigenous health practitioners working with Indigenous peoples are immobilised in their efforts to practice equitable healthcare due to personal feelings of guilt and fear while working within a colonised system that still creates unequal power dynamics and experiences of racism (Crawford and Langridge 2022; Kidd et al. 2020). While the individual is responsible to be proactive in their learning and practice cultural responsiveness, health organisations also need to provide education, training and policy directives, and not leave sole responsibility to the health practitioner (Crawford and Langridge 2022; Kidd et al. 2020). A lack of organisational policies and guidelines that support the delivery of culturally safe practice in the neonatal setting was also highlighted in this study. For health practitioners to break free of the paralysis and meaningfully engage with education and training, continuous monitoring and accountability is required to improve the practice of culturally safe care (Crawford and Langridge 2022; Kidd et al. 2020). Therefore, cultural competency, the knowledge about a culture and the skills taught and required to deliver healthcare, should be re-imagined in health organisations, with the focus on upskilling health practitioners and monitoring their progress to create culturally safe environments (Curtis et al. 2025). The current findings indicate that current limitations to culturally safe care are influenced by a lack of NICU-specific guidelines and policies, including a gap in the implementation of cultural safety education and training and auditing of its inclusion in practice.

The reporting of a lack of ability to be culturally safe in practice in this study has highlighted systemic issues in the theoretical implementation of cultural safety education and training into practical application. ANMAC has mandated university curricula to include cultural safety education with clearly defined guidelines and outcomes to move students from novice to graduate-ready practitioners (ANMAC 2019). ANMAC has also highlighted the responsibility of healthcare organisations, such as public hospitals, to ensure that their services are culturally safe (ANMAC 2019); this includes taking ownership of supporting health practitioners to be culturally capable and aligning current education standards with professional development, employment practices and clinical practice standards (Australian Institute of Health and Welfare 2023). While it is evident that health services

such as NSW Health have applied cultural safety measures such as 'Respecting the Difference' training (NSW Health Workforce Planning and Talent Development 2022), health practitioners in this study felt that online training does not support the application of culturally safe knowledge into culturally safe practice. Additional training and education were called for by the participants, with a large emphasis placed on the need for experiential learning to help translate cultural safety into practice. Experiential learning is 'the process whereby knowledge is created through the transformation of experiences' (Kolb 2014, p 51). Health practitioners participate in experiential learning during their health undergraduate degrees. This style of learning exposes the learner to practical techniques, which are learning through experience and the opportunities to reflect in a judgement-free environment (Grace et al. 2017; Cashman and Seifer 2008; Marriott et al. 2015). This type of learning has real practical application for health professionals due to the hands-on nature of their profession. A recent pilot evaluation in WA reported that the mandated online cultural training had little relevance to practice (Lin et al. 2023). Participants of a clinical yarning education program positively reflected on the practical focus and skills-based approach to the real-world setting and recommended the program be extended to address the gap that exists in current cultural safety education for health professionals (Lin et al. 2023). The implementation of experiential learning in neonatal and paediatric settings globally has seen success in programs such as the Schwartz rounds (Spierson et al. 2023). It is recommended that the uptake of an Indigenised delivery of cultural safety education and training be implemented in the NICU through the introduction of face-to-face education, regular in-services and hands-on training that collaborate with the local community and Aboriginal and Torres Strait Islander families; this would apply local Aboriginal and Torres Strait Islander knowledge and diversity and make it relatable to the NICU setting.

Research has demonstrated the valuable role that the Aboriginal and Torres Strait Islander health workforce plays in improving health equity and health outcomes for Aboriginal and Torres Strait Islander Peoples, due to the unique cultural lens and insight they bring to the workforce (Australian Institute of Health and Welfare 2023; Bailey et al. 2020; Conway et al. 2017). This study identified the need for an increase in representation of Aboriginal and Torres Strait Islander health practitioners in the NICU, particularly in leadership positions to create structural change. However, Ramsden acknowledged at the conception of culturally safe care that there are not enough Indigenous peoples to 'provide a critical mass in the health workforce' (Ramsden 2000, p 9). Therefore, while increasing the number of practicing Aboriginal and Torres Strait Islander health practitioners in public hospitals is crucial, it is imperative that non-Indigenous employees are not washed of their responsibility of being culturally safe practitioners (Nursing and Midwifery Board of Australia, 2018a, 2018b; CATSINaM 2017; Mohamed et al. 2024). Health services can achieve better health outcomes when everyone (including the non-Indigenous workforce) is empowered and proactive in creating culturally safe spaces (Mercer et al. 2014). This includes fostering opportunities and partnership between Aboriginal and Torres Strait Islander staff and non-Indigenous staff (Mercer et al. 2014) and integrating more Indigenous knowledges into a Westernised system (Wilson et al. 2020; Mohamed et al. 2024). By integrating Aboriginal and Torres Strait Islander health practitioners into all levels of the health system, more meaningful and genuine relationships can support structural transformation (Lloyd et al. 2008). Aboriginal and Torres Strait Islander families in the NICU have called

for the opportunity to receive care and support from Aboriginal and Torres Strait Islander staff (Bennett et al. 2025b). Parents felt that an increase in Aboriginal and Torres Strait Islander leadership and workforce would increase the cultural safe practice of non-Indigenous staff, as well as boost the coordination of culturally safe care and support for infants and families (Bennett et al. 2025b). Families of Aboriginal children in the paediatric setting have also reported positive impacts to their health experience, including trust and information translation, when Aboriginal staff, communities or other Aboriginal families were involved in hospital settings (Tanner et al. 2005; Chamberlain et al. 2016; McAuliffe et al. 2016). This study recommends having identified Aboriginal and Torres Strait Islander leadership roles embedded into NICU, to consult, lead, design, implement and translate culturally safe practice into care.

Limitations and strengths

The study findings should be interpreted with reference to the following limitations. Firstly, this study was conducted in two major children's hospitals in NSW and does not collectively represent the knowledge and experiences of NICU health practitioners across Australia. Secondly, the study may have been completed by health practitioners who are more likely to understand or want to implement culturally safe care in their role, which should be considered when applying these findings to practice. Thirdly, health practitioners' participation in the study may have been affected by their access to technology to complete the online survey and/or their availability to complete the survey due to high patient acuity. While this study was based in the NICU, the findings of this study could be more broadly applied to healthcare settings to uphold Aboriginal and Torres Strait Islander Peoples' rights to culturally safe care.

Conclusion

Despite understanding the principles and importance of culturally safe care in practice, health practitioners have reported a lack of support and confidence in practicing culturally safe care with Aboriginal and Torres Strait Islander infants and their families in NICUs. This study has identified key recommendations to help improve health practitioners' knowledge of culturally safe care and its implementation to practice. Urgent investment in cultural safety resources, education and training for neonatal health practitioners (such as hands-on and face-to-face, as well as clear organisational policies and guidelines) is necessary for staff to become more confident and capable in their delivery of care with Aboriginal and Torres Strait Islander infants and their families. While these actions are necessary to increase the current workforce's capability, it is vital that NICUs increase Aboriginal and Torres Strait leadership in their service and guide, develop, lead and implement cultural safety education and support for the benefit of Aboriginal and Torres Strait Islander infants and their families. It is crucial that further research is conducted on both local and national levels to build evidence-based practice on culturally safe care in NICUs. Future research should be led and governed by Aboriginal and Torres Strait Islander peoples and communities. Research in the neonatal space that is conducted through an Aboriginal lens will better inform policy and practice for Aboriginal and Torres Strait Islander families and infants accessing the NICU.

Author contributions

All authors contributed to the study design, including identifying the research questions, participant recruitment and planning data collection. **J. Bennett:** Conceptualisation, methodology, investigation software, validation, formal analysis, writing – original

draft, writing – review and editing, visualisation, fund acquisition and project administration; **K. Booth:** Investigation software, formal analysis, writing – review and editing, visualisation, supervision; **J. Bryant:** Methodology, formal analysis, writing – review and editing, visualisation, supervision; **M. Kennedy:** Methodology, formal analysis, writing – review and editing, fund acquisitions, visualisation, supervision.

Data sharing

In line with Indigenous Data Sovereignty and Aboriginal and Torres Strait Islander Ethical Research Principles, no data sharing is available from this study. The full survey tool is available on request from the author.

Declaration of interests

Associate Professor Michelle Kennedy is an Associate Editor of First Nations Health and Wellbeing – The Lowitja Journal. The other authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary material

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