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A person with narrow vision has a restricted horizon; a person with wide vision has plentiful opportunities

Cultural Safety and Duty of Care: The Role of Patient-Facing Administrative Staff in Hospital-Based Health Services

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Abstract

Introduction: This review examines how patient-facing administrative staff contribute to culturally safe environments in hospital-based health services in New Zealand and Australia and the implications for workplace health and safety and duty of care.

Methods: The review followed Arksey and O'Malley's (2005) methodological framework alongside the JBI scoping review guidelines (Hadie, 2024). Ten empirical studies examining patient-facing administrative roles based in hospital settings in relation to culturally safe practice or patient interactions relevant to cultural safety met the inclusion criteria.

Findings: Three broad themes were identified, with a strengths-based approach to improve practice: improving patient experiences and expectations; increased opportunities for cultural safety training; and supportive influence of organisational culture. Across the studies, cultural safety was inconsistently defined and operationalised. The role of patient-facing administrative staff as the initial interface between patients and hospital-based health services was often overlooked. Research and training were typically integrated with clinical staff, limiting recognition of the unique contributions of administrative staff. Role ambiguity, limited support and psychosocial workplace pressures were identified as challenges affecting culturally safe practice.

Conclusion: The findings from this review provide some important understandings of the health workplaces duty of care for both people who are accessing healthcare services and those employed to support the delivery of health care. There is a clear need for research that prioritises patient-facing administrative staff in the design, implementation and evaluation of culturally safe practices in hospital-based health services. Future studies should define culturally safe practice for non-clinical roles and develop tailored training frameworks grounded in cultural, structural and emotional competencies. Mixed-methods approaches with methodological triangulation to better capture both patient and administrative staff perspectives are recommended. Such evidence is essential for developing tailored training, support systems and workplace conditions that enable patient-facing administrative staff to contribute to culturally safe practice across the patient journey.

Keywords

Cultural safety, Workplace health and safety, Patient-facing administrative staff, Hospital-based health services, Duty of care, Professional development

1.0 Introduction

The work and roles of patient-facing administrative staff employed in hospital-based health services can be emotionally demanding, communication-intensive with low-control presenting significant health and safety risks for these workers. New Zealand's increasing diversity among patients and the health workforce has intensified the psychosocial dimensions of healthcare work to include the work environment. It is important to understand the cultural and contextual factors inherent in this work to fulfil the duty-of-care obligations for both employers and employees (WorkSafe New Zealand, 2018, 2019).

Cultural safety, a concept developed by Dr. Irihapeti Ramsden and Māori nurses in the 1990s, provides an understanding of how cultural and contextual factors can impact on healthcare

experiences. This concept shifts the focus of safety to person-defined experiences, recognising that power imbalances, systemic inequities and organisational accountability can impact on a person's experience of feeling culturally safe (Curtis et al., 2019). It extends beyond ethnicity to include factors such as migration, language, age, gender and sexuality that intersect to shape health, well-being and service expectations (Curtis et al., 2019; DeSouza, 2008; Satur & Carrington, 2022).

Reflecting its relevance to safety and quality, the Health Quality & Safety Commission (HQSC) (2021) has incorporated measures of culturally safe care into national patient experience surveys to support the monitoring and improvement of health service safety. This measure of patient experience recognises the importance of both the healthcare worker and the healthcare environment in providing culturally safe care. Under the Health and Safety at Work Act 2015 (s 45), all workers have a duty of care for both their own health and safety and for actions that may affect the health and safety of others. This extends beyond legal compliance to include both physical and mental wellbeing.

The New Zealand Government Policy Statement on Health 2024-2027 emphasises the need for a skilled, culturally competent, accessible, responsive and well-supported workforce (Ministry of Health, 2024). Patient-facing administrative staff are often the first point of contact in hospital-based health services and play a critical role in representing organisational values, guiding patients through care pathways, managing sensitive information and facilitating respectful communication (Wall et al., 2013). Their ability to establish trust at the entry point is therefore a key component in culturally safe care. Despite this, discussions including education and training for culturally safe practice largely focuses on clinical teams, overlooking the contributions of non-clinical roles (Clough et al., 2024; Satur & Carrington, 2022). The specific contributions of patient-facing administrative staff to culturally safe practice and duty of care is under-explored (Chakaipa et al., 2023).

This review examines the literature on culturally safe practices in patient interactions involving patient-facing administrative roles in hospital-based health services in New Zealand and Australia. The beginning question for the review was *"What is the role of patient-facing administrative staff in influencing culturally safe interactions in hospital-based dental services?".*

Although the beginning research question was initially intended to focus on hospital-based dental services, based on the primary author's experience working in this area, limited literature necessitated expansion to other hospital-based health service areas with comparable patient-facing administrative contexts. The review explores patient experiences and expectations, maps existing knowledge and gaps, and examines interventions designed to support administrative staff in promoting culturally safe practice and strengthening patient engagement. Findings from this review are discussed in relation to duty of care. Insights from this review may also inform understanding of other patient-facing non-clinical roles within healthcare systems.

2.0 Methods

Adhering to PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) guidelines (Hadie, 2024), this review used a framework to systematically map existing evidence in an under-explored and conceptually diverse area and to identify gaps to inform future research. The framework includes: (1) identifying the research question, (2) identifying relevant studies, (3) establishing inclusion and exclusion criteria, (4) charting the data according to key themes, and (5) collating, summarising, and reporting the results (Arksey & O'Malley, 2005). As this review formed part of an academic assessment, database searching, screening, study selection and data extraction were conducted solely by the primary author with supervisory guidance from the second author.

2.1 Search Strategy to Identify Relevant Studies

The literature search was guided by the PCC (Population/Problem, Concept, Context) framework, which is recommended for exploratory reviews addressing emerging or conceptually diverse topics (Hadie, 2024). Relevant studies were identified through electronic database searches of Scopus, ProQuest, PubMed and Ovid (including MEDLINE, Embase and Emcare). These databases were selected for their coverage of literature on health services, patient experience, trust and behavioural aspects of healthcare delivery. Search terms and Medical Subject Headings (MeSH) were developed iteratively and are presented in Table 1. To balance sensitivity and specificity, highly defined concepts were searched in titles to ensure relevance and broader concepts in titles and abstracts to capture diversity in terminology. To ensure comprehensive coverage, keywords related to cultural components were searched as text words and explored within the full-text articles to capture variations in language

and conceptual framing across studies. Additional searches were conducted using Google Scholar and Research Rabbit to support citation tracking and identify empirical studies not captured in database keyword searches.

Table 1. Keywords used for literature search

PCC Element	Keywords
Population	Receptionist, admin*, "office staff", clerical, clerk, "front desk", "front office", scheduler, non-clinical, "consumer-facing", "patient facing", "customer service" [TITLE/ABSTRACT]
	Māori, Indigenous, aboriginal, "first nation", "first people", pacific, refugee, Asian, ethnic*, refugee, migrant, LGBTQ, gender [TITLE/ ABSTRACT]
Concept	cultural*, trust, consumer*, utilisation*, divers*, "limited English", language, barrier, experience, "cultural safety", communication, perception, perspective, acculturation, "patient-relation", consumerism, satisfaction [Text Word]
Context	"oral health", dental, dentist, hospital, "secondary", "tertiary", “New Zealand”, “Australia” [TITLE]
NOT	"health promotion", "health education", hygienist, nurse, “dental student", technician, trial, fluoride [TITLE]

Retrieved articles were managed using Zotero reference management software (Ivey & Crum, 2018), which was used to identify and remove duplicates. As outlined in the PRISMA-ScR Flowchart (Figure 1), the initial search retrieved 1892 records. Following duplicate removal, titles and abstracts were screened, yielding 401 results for full-text review. Of these, ten articles met the inclusion criteria and were included in the final review.

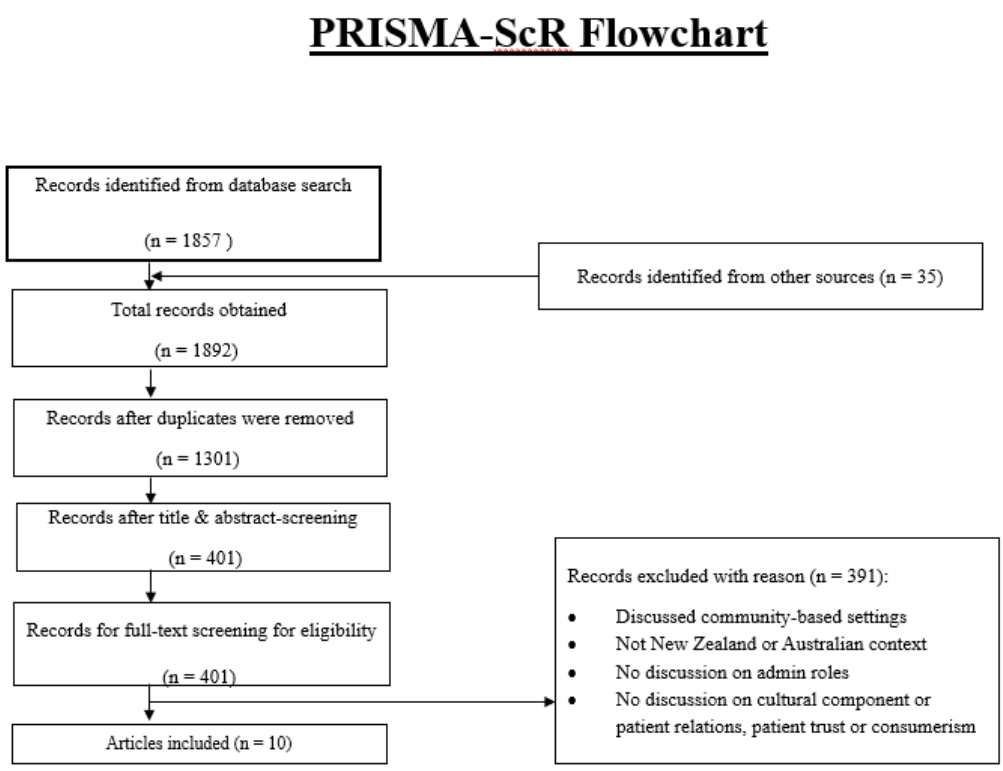

Figure 1. PRISMA-ScR Flowchart of database search

2.2 Inclusion and Exclusion Criteria

Empirical studies published in English were included, with no date restrictions, to understand how the concept of cultural safety has evolved over time, and to assess whether patient-facing administrative roles have historically been acknowledged. While the primary focus was initially on hospital-based dental services, studies involving administrative staff from other hospital-based health services with similar patient-facing contexts, such as outpatient services, emergency departments and general reception areas, were also included due to limited availability of relevant literature. Given the paucity of New Zealand-based research, Australian studies were included because both countries share similar public hospital structures, administrative pathways and equity priorities, shaped by Indigenous health contexts and the impact of colonisation. Studies that discussed Indigenous, Pacific, migrant, refugee and LGBTQ (Lesbian, gay, bisexual, transgender, queer) populations were included to ensure the unique cultural needs among these groups were covered, as these groups more likely to experience discrimination and inequitable treatment (Satur & Carrington, 2022; Tharp et al., 2022).

Studies were excluded if they focused on non-healthcare settings or exclusively examined primary care services, community-based health promotion or education programmes, or examined clinical staff only without reference to patient-facing administrative roles. Administrative roles without patient interaction, such as finance, payroll and business support positions, were also excluded, as were studies lacking discussion on patient relationships, trust or cultural safety. Articles without full-text access were also excluded. Eligible articles were appraised using the Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong et al., 2018). Common limitations included inconsistent conceptualisation of cultural safety, reliance on self-reported data and limited administrative staff-specific research across studies.

2.3 Data Extraction

Ten articles met the inclusion criteria. New Zealand-based papers, (Ashill & Rod, 2011; Rod & Ashill, 2015) were derived from the same dataset but addressed distinct aspects of non-clinical roles—one focusing on burnout processes and the other on customer orientation in hospital-based health services; these will be discussed as separate studies. Although no date limits were applied, included studies were published between 2011 and 2024, indicating that research on cultural safety in patient-facing administrative roles remains an emerging area. No eligible studies specifically focused on LGBTQ populations. Studies were evenly distributed between Australia and New Zealand (n=5 each). Only one study (Riggs et al., 2016) was conducted in a dental-service context. The remaining studies were drawn from broader hospital-based health settings and were included due to their transferable relevance to patient-facing administrative interactions relevant in hospital-based dental services. Only one study (Slater, 2011) exclusively included administrative staff, while the remaining studies either combined administrative and clinical roles or examined cultural safety at an organisational level.

Key study characteristics and themes were recorded using a structured data extraction table (Hadie, 2024). Data extraction focused on study characteristics, administrative role descriptions and findings related to cultural safety, patient experience and trust (Table 2). Extracted data were analysed using a narrative synthesis approach to identify recurring concepts and themes.

Table 2. Data Extraction Table

Author/ Year	Country/ Setting	Method	Population	Key Findings
Ashill & Rod (2011)	New Zealand, public hospital	Quantitative (cross-sectional survey)	152 non-clinical staff (receptionists, ward assistants and administrative nurses)	Job demand stressors (e.g. role overload, conflict, ambiguity) were strongly linked to burnout, which reduced job satisfaction, organisational commitment and service recovery performance. Highlights the need for role clarity and organisational support for administrative staff

Author/ Year	Country/ Setting	Method	Population	Key Findings
Bourke et al. (2019)	Australia, Australian hospital and health service (HHS)	Qualitative case-study (action research)	Aboriginal and non-Aboriginal hospital staff and leadership examined at institutional/organisational level (No individual participants)	Institutional racism embedded in hospital policies, procedures and culture; leadership-driven, whole-of-organisation approach; inclusion of Indigenous voices; cultural-capability, training and accountability. Highlights the role of staff (clinical and non-clinical) in maintaining or challenging racist systems.
Chapman et al. (2014)	Australia, hospital emergency department	Quantitative (quasi-experiment)	Emergency department staff (n=44; 77% nurses, limited inclusion of administrative staff)	Cultural awareness training improved staff perceptions of Aboriginal and Torres Strait Islander people but did not significantly change underlying attitudes; training well-received, long-term effectiveness uncertain. Highlights limited focus on patient-facing administrative roles.
Hamilton et al. (2023)	New Zealand, Dunedin Hospital outpatient services	Qualitative (semi-structured interviews)	13 hospital staff and 9 patients: mostly NZ European; included patient-facing administrative staff	Appointment notifications rely on posted letters with late-stage text reminders; delays and miscommunication contributed to missed appointments, patient distress, and treatment delays; patients suggested self-booking and email notifications. Highlights critical role of administrative communication in patient engagement and culturally appropriate processes.
Lee et al. (2012)	Australia – Five hospitals	Quantitative (quasi-experiment)	>3000 healthcare staff, including clinical and non-clinical (patient-facing administrative staff included)	Hospital-wide 'Communication and Patient Safety' training improved staff understanding of communication and its link to patient safety, attitudes, self-reported behaviours, and teamwork. Positive engagement across staff groups; direct patient outcomes not assessed due to study complexity. Highlights need for sustained cultural change through leadership support, refresher training and staff role-modelling in communication practices.
Pennell et al. (2024)	New Zealand – Public Hospital Paediatric Ward	Mixed-Methods Quality Improvement (QI) project (pre-post surveys + qualitative analysis)	Clinical staff (49 pre-intervention; 36 post-intervention). Administrative processes indirectly involved via ethnicity documentation systems.	A visual sticker prompt improved recognition of Māori tamariki. Barriers to culturally responsive care included time pressures, limited staff knowledge and systemic constraints. Highlights how administrative prompts can support culturally responsive practice.

Author/ Year	Country/ Setting	Method	Population	Key Findings
Riggs et al. (2014)	Australia, Monash Health (public maternity hospitals & public dental services)	Qualitative (focus groups)	Dental service staff (clinical and administrative staff - likely patient-facing) and refugee-background pregnant women	Refugee-background women reported significant barriers (oral health literacy, inconsistent advice, unclear referral pathways, socioeconomic, geographic and administrative barriers) to accessing dental care. Highlights the need for supporting staff to provide consistent messaging, streamlined referral and collaborative training to improve access.
Rod & Ashill (2015)	New Zealand, public hospital	Quantitative (cross-sectional survey)	152 non-clinical staff (receptionists, ward assistants and administrative nurses)	Strong customer orientation can enhance patient satisfaction but when poorly supported, increases burnout and depersonalisation; staff perceived inconsistent internal communication of service values. Highlights the importance of organisational support and role clarity to strongly influence wellbeing and service performance
Sheridan et al. (2011)	New Zealand, National health system (DHBs & PHOs)	Quantitative (cross sectional survey)	Representatives (administrative and organisational leadership roles) from 15 of 21 DHBs, 21 of 84 PHOs and 31 expert informants	Equity monitoring and targeting were inconsistently implemented across the health sector. Health Equity Assessment Tool (HEAT) was used mainly for strategic planning rather than guiding implementation or monitoring. Equity work was strongest for Māori but less developed for other groups. Cultural and diversity training was often not mandatory. Frontline and administrative staff were noted as having significant influence in the success or failure of equity-related initiatives. Highlights systemic gaps in organisational culture and training.
Slater (2011)	Australia, Queensland Children's Cancer Centre, paediatric oncology service	Mixed-Methods longitudinal service evaluation (team interviews, staff consultations, staff-surveys, review of sick-leave data as service performance indicators)	16 administrative staff supporting the service (likely including patient-facing roles)	Initial challenges: low morale, poor communication, unclear processes. Interventions: team interviews, business and performance plans, workload/process review, quality-improvement initiatives. Outcomes: improved morale, teamwork, communication, role clarity, motivation to serve patients, reduced sick leave. Highlights the role of structured organisational interventions and recognition of administrative staff contributions in strengthening staff wellbeing, team functioning and the quality of patient experience.

3.0 Findings

This review identifies a growing, yet still underdeveloped body of literature addressing cultural safety within hospital-based health services across New Zealand and Australia. The included studies demonstrated methodological diversity, incorporating qualitative, quantitative and mixed methods designs that capture perspectives from patients, frontline staff and organisational leaders. However, cross-sectional surveys limited causal inference while qualitative studies, though rich in narrative, lacked generalisability. Most studies relied on self-reported data, introducing response bias, often compounded by low response rates, small sample sizes, inadequate representation of administrative staff and a lack of disaggregated analysis for this group, further restricting external validity.

The findings are discussed based on the revised research question: *"What is the role of patient-facing administrative staff in influencing culturally safe interactions in hospital-based health services?"*

Three broad themes were identified taking a strengths-based approach to contributions for improving practice: improving patient experiences and expectations; increased opportunities for cultural safety training; and supportive influence of organisational culture. These themes are discussed below.

3.1 Improving patient experiences and expectations

Two studies (Hamilton et al., 2023; Riggs et al., 2016) provide insights into how administrative challenges contribute to culturally unsafe patient experiences. In both cases, patients reported poor health literacy, difficulties with appointment systems, lack of culturally safe communication and fragmented care pathways. While both studies incorporated perspectives from patients and hospital-based administrative staff using qualitative methods, the administrative role was not their primary focus. Hamilton et al. (2023) explored the experiences of nine patients who had recently missed their appointments; while the small sample lacks generalisability, the findings provide valuable insights into the processes of sending appointment notifications and reminders and offers practical recommendations for improvement. Riggs et al. (2016), focusing on the oral health experiences of refugee women, offered guidance on joint training, interprofessional collaboration and co-design of health care services as methods to improve patient experiences and expectations. This research provides valuable insight into the importance of culturally safe initiatives for improving patient experience despite the research being primarily provider-focused and including only two ethnic groups.

3.2 Increased opportunities for cultural safety training and interventions

Three studies evaluated cultural training initiatives for healthcare staff (Chapman et al., 2014; Lee et al., 2012; Pennell et al., 2024). Chapman et al. (2014) and Pennell et al. (2024) demonstrated that targeted initiatives, including administrative prompts, increased staff awareness and improved consistency in ethnicity-related practices. However, the long-term impact of these initiatives on changing staff attitudes remains unclear, given the reliance on short-term follow-up, self-reported data and limited representation of patient-facing administrative roles. Additionally, Chapman et al. (2014) acknowledged that their evaluation tool may have lacked sensitivity to effectively measure the impact.

The intervention in Pennell et al.'s (2024) study, used a visual sticker system to support identification of Māori tamariki/children, improved staff recognition and enabled culturally safe interactions. However, implementing similar tools in hospital-based health services settings would likely involve front-desk staff, raising concerns about increased workload and the sensitivity of collecting ethnicity data at reception.

In contrast to Chapman et al. (2014) and Pennell et al. (2024), Lee et al. (2012) implemented a training programme with ongoing follow-up, selecting topics through consultation with healthcare staff to support reflection on cultural perspectives and practical communication skills. Despite relying on self-reported data, the study provided a structured and sustained training approach with potential for long-term impact on cultural awareness and communication practices.

3.3 Supportive influence of organisational culture

Five studies (Ashill & Rod, 2011; Bourke et al., 2019; Rod & Ashill, 2015; Sheridan et al., 2011; Slater, 2011) explored broader systemic factors that negatively impact cultural safety. Bourke et al. (2019) conducted a policy-audit and document review to examine how institutional racism was embedded within Australian public hospitals, analysing organisational policies and publicly available institutional data rather than staff perspectives. Sheridan et al. (2011) identified inconsistency in the

implementation of equity frameworks in New Zealand. For example, the Health Equity Assessment Tool (HEAT) is applied in strategic planning but not routinely in implementation or monitoring. Despite potential reporting bias in Bourke et al. (2019) due to reliance on institutionally published data, and response bias in Sheridan et al. (2011) arising from self-reported organisational practices, both studies offer valuable insights into the structural and behavioural challenges to culturally safe care and highlight the need for a leadership-driven, whole-of-organisation approach.

Ashill and Rod (2011) explored the compounding effects of unclear expectations and lack of organisational recognition of emotionally demanding administrative roles on burnout and depersonalisation. In a follow-up, they discussed how these effects can offset organisational commitment to customer orientation (Rod & Ashill, 2015). Although only half of the participants were receptionists, and appointment scheduling roles or cultural safety were not explicitly discussed, the study highlighted the importance of role clarity and organisational support for enabling front-office staff to engage meaningfully in service delivery. The study also revealed gaps in internal integration and communication of service values within hospital-based health services.

4.0 Discussion

The findings from this review provide some important understandings of the health workplaces duty of care for both people who are accessing healthcare services and those employed to support the delivery of health care. The role and contribution of patient-facing administrators in contributing to a culturally safe workplace is not well understood. The duty of care for employers in supporting these workers in the contribution to the delivery of health care is also underdeveloped.

4.1 Valuing the patient-facing administrator role in contributing to a culturally safe healthcare environment

Administrative staff typically take on key boundary-spanning roles, yet their influence on cultural safety and the impact on duty of care is frequently implied rather than directly examined. Most studies concentrated on clinical staff, with administrative staff often grouped with the clinical team, limiting clarity around their specific responsibilities and training needs. Even when cultural safety training was provided, it was rarely mandatory or demonstrated support through ongoing monitoring, raising concerns about its potential to drive sustainable change.

While power dynamics in patient-provider relationships are well-defined, those involving patient-facing administrative staff remain conceptually unclear. Administrative staff are often perceived by patients as gatekeepers, despite having limited decision-making authority, particularly when managing patient frustration while navigating expectations from management and systemic constraints (Rod & Ashill, 2015). In the absence of organisational structures that clarify roles, support decision-making and recognise relational labour, this positioning can create a *pseudo-power dynamic* that has received little explicit attention in cultural safety research and practice. These challenges may be further intensified in telephone-based interactions with patients, especially for culturally and linguistically diverse administrative staff, where language fluency, accents and differing communication norms increase the risk of misunderstanding or discriminatory responses.

Both the employer and the employee have a shared responsibility for addressing these organisational issues as part of their duty of care. Studies addressing broader systemic issues, such as institutional racism, burnout and equity planning were particularly valuable in positioning administrative roles within broader organisational structures (Ashill & Rod, 2011; Bourke et al., 2019; Rod & Ashill, 2015; Sheridan et al., 2011; Slater, 2011). Research such as that of Slater (2011) although not explicitly framed around cultural safety, demonstrates how valuing administrative staff contributions enhances morale, teamwork and patient experience.

4.2 Understanding cultural safety as part of duty of care

This review identified widespread limitations and gaps in how cultural safety is conceptualised, operationalised and evaluated in hospital-based health service environments. Acknowledging factors beyond ethnic identity, including accountability, understanding power dynamics, ongoing self-reflection and structural transformation are recognised as the core principles of cultural safety (Curtis et al., 2019; Satur & Carrington, 2022). Yet, these elements were inconsistently addressed across the reviewed studies. In relation to ethnic identity, there was a stronger emphasis on cultural competence, particularly in Indigenous health and other vulnerable ethnic groups, rather than cultural safety, with limited consideration of intersecting factors such as gender or sexuality. Several studies relied on

related concepts such as cultural competence, inclusiveness, patient-centred care, communication or patient satisfaction, reflecting conceptual ambiguity that complicates implementation and evaluation of culturally safe practice (Ashill & Rod, 2011; Hamilton et al., 2023; Lee et al., 2012; Riggs et al., 2016; Rod & Ashill, 2015; Slater, 2011).

Policy and standards frameworks across New Zealand and Australia emphasise the need to understand and enact culturally safe practice within health care systems (Hunter et al. 2021; Ministry of Health 2024). In line with this, patient-facing administrative staff and their employers also have a key role in creating and maintaining culturally safe environments as part of their duty of care. Despite this, there was a limited clarity regarding how ongoing personal and structural transformation, as aspects of duty of care, are operationalised. No studies explicitly discussed tools of accountability or mechanisms to support such transformation, limiting understanding of how culturally safe practice and duty of care are integrated within hospital-based health services. This gap is significant given the emotionally demanding nature of patient-facing non-clinical roles. Expectations of patient-centred care without role clarity and insufficient organisational recognition contribute to stress, depersonalisation and reduced capacity for service recovery, with implications for staff wellbeing and patient safety (Ashill & Rod, 2011; Rod & Ashill, 2015).

5.0 Future directions

There is a clear need for research that prioritises patient-facing administrative staff in the design, implementation and evaluation of culturally safe practices in hospital-based health services. Future studies should define culturally safe practice in terms relevant to non-clinical roles and develop tailored training frameworks grounded in cultural, structural and emotional competencies. Notably, the HQSC (2021) acknowledges that its quantitative surveys cannot capture deeply personal experiences of patient and whānau and recommends further qualitative research, highlighting the need for more robust and integrated methodological approaches. Therefore, future research should adopt mixed-methods approaches with methodological triangulation to better capture both patient expectations and the challenges administrative staff face in enacting culturally safe practice, while reducing reliance on self-reported data.

Moving forward, fostering culturally safe hospital-based health services through a duty of care approach requires systemic commitment to supporting patient-facing administrative staff through staff wellbeing initiatives, clear role expectations, effective communication and institutional accountability.

6.0 Conclusion

Cultural safety refers to the creation of a safe space in which no action undermines, devalues or disempowers a person's cultural identity and wellbeing and applies across the entire patient pathway. This review highlights the critical yet often overlooked role of patient-facing administrative staff in culturally safe interactions that build trust and improve patient participation. While culturally safe practice is increasingly recognised as essential for health equity, its application in hospital-based services remains inconsistently defined and largely focused on clinical staff. Patient-facing administrative staff, through culturally safe communications, have unique opportunities to positively influence patient experiences. However, the experiences and contributions of people working in these roles remain under-researched and under-supported, signalling potential gaps in role recognition and workforce preparedness. Future research with robust mixed-methods approaches is needed to inform training, support and organisational commitment that enable administrative staff to contribute meaningfully to culturally safe care. This review provides evidence to complement national efforts to strengthen culturally safe practice, staff wellbeing and engagement within increasingly diverse work environments.

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Declaration of AI use: Artificial Intelligence tools (ChatGPT, OpenAI and Microsoft Copilot) were used to assist with language refinement of the manuscript. The authors retain full responsibility for the content of the final submission.

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