Promising Practice

Paddling Together for Culturally Safe Emergency Care for Elders

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ABSTRACT

This paper describes a wise practice for collaborative change through the Trauma-Informed and Culturally Safe Emergency Care for Nuu-chah-nulth Elders project. For decades, Nuu-chah-nulth Elders have been avoiding emergency care due to colonial trauma and a lack of culturally safe care. To begin addressing this community priority, the First Nations Health Authority, in partnership with Island Health and university partners, organized a two-day workshop in September 2017 with Nuu-chah-nulth Elders, community members, and health partners. Key to ensuring the process was culturally sensitive was following the guidance of the West Coast General Hospital Cultural Safety Committee, a partnership between Nuu-chah-nulth people and health providers. Respect and trust were developed by centring the voices of Elders and giving them a safe space for discussion before developing recommendations with health partners. Feedback from participants was gathered from notes and audio recordings and thematically analyzed into eight major recommendations (i.e., increase engagement and relationship building; develop action plans; increase education and awareness; increase advocacy and support; incorporate First Nations medicine, healing, and foods; provide culturally safe spaces; develop policy and protocol; and link to comprehensive community support), with attention to preserving Elder voices. The recommendations were validated by returning and new participants at a gathering in June 2019. Elders noted that while experiences of unsafe care continue, noticeable improvements in cultural safety are being made and they feel heard.

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The full report can be found at <https://www.fnha.ca/what-we-do/research-knowledge-exchange-and-evaluation>.

Introduction

For many years, First Nations people have been exposed to unfair treatment due to lack of trauma-informed and culturally safe care in hospital emergency departments. As a Nuu-chah-nulth Elder said, “You observe and watch other patients get a different type of service. It is like health care staff do not believe all the terrible things—like the residential school experience—happened. But it did, and we have both intergenerational trauma and real-life experiences that are triggered by your attitudes.” The historical and ongoing trauma faced by First Nations people is a well-documented legacy of genocidal policies such as the Indian Act, which forced First Nations people onto isolated Indian Reserves, First Nations children into Indian Residential Schools, and First Nations patients into segregated Indian Hospitals, where they received substandard care, were abused in medical experiments, and were sterilized without consent (Drees, 2013; Truth and Reconciliation Commission of Canada, 2015).

Background

In Vancouver Island, collaborative efforts to strengthen partnerships and shared decision-making to create a more integrated, culturally safe, and effective health system began with the signing of the 2012 Vancouver Island Partnership Accord between Island First Nations and Island Health and its renewal in 2016 with the support of the newly established First Nations Health Authority (FNHA, 2016). Through the cultural safety and humility initiative of the FNHA, a Declaration of Commitment to advance cultural safety and humility was also signed by all regional British Columbia (BC) health authority CEOs in 2015 (FNHA & BC Health Authorities, 2015). The Accord and Declaration of Commitment opened the doors to the establishment of cultural safety committees, including one at West Coast General Hospital (WCGH). This paper outlines the trauma-informed and culturally safe emergency care project

driven by the WCGH Cultural Safety Committee (CSC) (origins detailed in the “Relationships” section) The goals of the West Coast General Hospital Safety Committee are to:

1. Promote new partnerships.
2. Manage information distribution and collection between First Nations and local health service providers.
3. Increase opportunities to improve local patient quality care.
4. Promote quality care planning that focuses on community-based and multi-stakeholder partnerships to meet the unique needs of the patients.
5. Identify opportunities to support or lead initiatives and projects that address patient quality care through the committee table, working groups, or support of other established mechanisms.

In September 2017, a two-day workshop was organized for Nuuchahnulth Elders to bravely share their experiences with trauma and emergency care. The workshop was an opportunity to engage community members on their key concerns related to experiences of colonialism, trauma, and racism, with a focus on increasing access to safe, quality health care for Elders. This workshop created the opportunity for Nuuchahnulth members and health leaders to improve trauma-informed and culturally safe care. The goals of the workshop include:

1. Engage Nuuchahnulth members to increase access to safe, quality care for Elders.
2. Develop call-to-action recommendations to improve trauma-informed and culturally safe emergency care for First Nations in the rural/remote communities of Port Alberni.
3. Increase cultural safety and humility practices and promote trauma-informed care among health care staff and physicians working in emergency care settings, and build awareness of triggers and traumas with education and leadership from Nuuchahnulth Elders.

Relationships

This knowledge exchange project arose from existing and newly established partnerships. In 2015, WCGH CSC was formed, formalizing a partnership between First Nations living in Nuuchahnulth territory and health service providers working in the Alberni/Clayoquot service region. In response to Dr. Dorothy (Sam) Williams’ report to the CSC of the culturally unsafe care of First Nations Elders she witnessed at WCGH throughout her career, the WCGH CSC formed a partnership with the FNHA Research and Knowledge Exchange (RKE) team to better understand how trauma affects Nuuchahnulth Elders in accessing emergency care. Identifying the opportunity of a grant from the Michael Smith Foundation for Health Research’s Collaborating and Convening Program, the WCGH CSC and the FNHA Vancouver Island and RKE teams agreed to submit a proposal to hold a workshop to foster collaboration between Nuuchahnulth Elders and local health leaders. Island Health, University of Victoria, Royal Roads

University, and Simon Fraser University also agreed to partner on the grant, which was awarded in January 2017.

During the 2017 workshop planning, the existing relationships between FNHA community engagement coordinators (CECs), Nuuchah-nulth health directors, and Nuuchah-nulth Tribal Council enabled Elders to be invited in a culturally appropriate way.

Following Indigenous principles of relationality, respect, and reciprocity, the CEC, Janice Johnson, met Elders in person in the months leading up to the validation gathering in 2019 to prepare them by reviewing the recommendations from the 2017 workshop. Only one Elder, who was recruited at the last minute, was unable to review with a CEC before the gathering.

Methods

Guided by the 7 *Directives* (FNHA, n.d.), including the principles of OCAP,¹ this knowledge exchange project was community-driven and Nation-based, focusing on a priority of the Nuuchah-nulth community as determined by the WCGH CSC. Because this was a knowledge exchange project, institutional ethics approval was not obtained. The project team took direction from the Nuuchah-nulth CEC and WCGH CSC, consisting of health directors of Nuuchah-nulth communities, in order to ensure Nuuchah-nulth protocol was followed. Nuuchah-nulth health directors provided consent to publish this article on behalf of their Nations.

A workshop was held from September 28 to 29, 2017, for Nuuchah-nulth Elders and health partners. Over 60 people, including Elders and community members from 10 of the 15 Nuuchah-nulth communities, as well as regional and local health leaders and providers from Island Health and WCGH, participated in the Trauma-Informed and Culturally Safe Emergency Care for Nuuchah-nulth Elders Workshop at Hupačasath First Nation (near Port Alberni, BC, Canada). A report of recommendations was drafted from the knowledge shared, and this report was validated in 2019 at a follow-up gathering.

Planning and Invitation of Elders

Throughout the planning process, the WCGH CSC guided the project team with their knowledge and expertise. Having a Nuuchah-nulth staff member embedded in the community as co-lead was essential to ensuring planning was done in a culturally appropriate way. FNHA CECs engaged Elders by working with Nuuchah-nulth health directors based in each of the 15 Nuuchah-nulth Nations. Ten health directors identified and supported an Elder from their community to attend. Elders were provided an honorarium, travel, and accommodations for both events. One male Elder and one female Elder were also chosen to welcome participants to the workshop and share reflections. The Nuuchah-nulth community chose trauma and healing expert Rod Jeffries of Tyendinaga Mohawk Nation to facilitate, as he was known and respected by Nuuchah-nulth members. Rod's experience in working with Elders helped to ensure the workshop met their accessibility needs. The central community-based location of the Hupačasath

¹ Standing for ownership, control, access, and possession, OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC; <https://fnigc.ca/ocap>).

House of Gathering was chosen as the venue, and a Nuu-chah-nulth caterer was chosen to provide traditional food.

Knowledge Gathering

The workshop opened with a welcome from a representative of Hupačasath First Nation and prayer from Elder Barney Williams. After introductions, the workshop overview, and a grounding exercise, the Elders were invited to share their hopes for the workshop and how they wanted to be involved. Elders shared their wisdom, lived experiences with colonial trauma and emergency care, and hopes for improved care at WCGH. Presentations were given by Rod and FNHA senior leaders on racism, trauma, cultural safety, and trauma-informed care.

Figure 1

Trauma-Informed and Culturally Safe Emergency Care for Nuu-chah-nulth Elders Workshop, September 29, 2017

In the afternoon, participants were provided with questions to answer on flipcharts in small groups. In order to create a safe and comfortable space for discussion, two groups of Elders, two groups of Nuu-chah-nulth members and Indigenous health partners, and two groups of non-Indigenous health partners met to give Elders and Indigenous participants the opportunity to answer the questions in a safe, private environment.

On Day Two, WCGH leaders and providers shared their work to improve emergency care and cultural safety. In the afternoon, participants answered five questions in mixed breakout groups to collaboratively develop recommendations that were recorded on flipcharts. Participants were asked to sign written consent and release forms for photos and audio recordings, indicating their consent to use of their photos or statements in publications or other media activities for education and awareness purposes. Because written consent was a barrier for some Elders, the CEC, Janice Johnson reached out to Elders who did not provide written consent and went through an oral consent process with them. Quotes were only shared by participants who

provided written or oral consent, and only participants who provided consent to be credited in quotes were named.

Making Meaning

After the workshop, FNHA qualitative analyst Leena Hasan and Janice gathered the feedback from the typed notes and flipcharts. The audio recording of the workshop was used to check the accuracy of the flipchart notes. Eight recommendation themes were identified based on types of actions recommended (e.g. engagement, education, policy, etc.). To preserve meaning, language was kept similar to the flipchart notes and recordings as much as possible. Quotations, mostly from Elders, were included throughout to make Elders' intentions and goals clear in relation to the recommendations. The report then went through multiple reviews by project team members from 2018 to 2019. The two Elders who provided final reflections at the workshop were mailed and emailed the report to give them the opportunity to provide feedback on it. In the report, health leaders also included information on initial actions taken in response to the recommendations.

Being Accountable to Community

Once the report was prepared, the Continuing Our Journey Toward Culturally Safe Emergency Care for Nuuchahnulth Elders Gathering was held for community validation and report back. Island Health agreed to fund and support the event, fulfilling the recommendation made at the 2017 workshop for a follow-up gathering.

Figure 2

Elders and Health Partners Discuss Recommendations at the Continuing Our Journey Gathering, June 2019.

To engage Elders in a respectful and culturally appropriate way, Janice Johnson met with Nuuchahnulth Elders in person to invite them to the gathering and to review the draft recommendation report with them prior to the gathering. Dakota and Ojibway cultural safety facilitator Harley Eagle and Nuuchahnulth graphic facilitator Kelly Foxcroft-Poirier were

chosen with the guidance of the Nuuchah-nulth Tribal Council Director of Health to lead the gathering.

On June 14, 2019, the one-day gathering was held at Tseshah First Nation with over 50 new and returning participants, including Elders from 10 of the Nuuchah-nulth Nations that were present at the 2017 workshop, as well as a health director who represented Nuchatlaht First Nation, attending for the first time. Before the event started, FNHA staff conducted an oral consent process guided by an oral consent script, explaining the purpose of the event and what consent was being requested for, and letting participants know they had the right to withdraw consent without consequence at any time. Participants were given the opportunity to ask any questions before indicating their consent or refusal to participate, have their quotes shared, and have their photos shared. Consent was recorded on spreadsheets and saved to a secure, password-protected FNHA server. Harley Eagle facilitated the gathering, and Island Health leaders provided updates. FNHA then presented the recommendations to participants. Graphic facilitator Kelly Foxcroft-Poirier captured main points visually in a graphic recording of the day.

Figure 3

Elder Helen Dick Shares Final Words at the Continuing Our Journey Gathering

Feedback from notes was organized under each recommendation and incorporated into the report. To make the report more accessible and engaging, images from the graphic recording were added.

Results

After hearing from the Elders and presenters on racism, trauma, cultural safety, and trauma-informed care, participants identified three major areas for improvement, detailed in Table 1.

Table 1*Key Areas for Improvement Identified by Elders*

1. Systemic racism and discrimination	<ul style="list-style-type: none"> • Due to past traumas and negative experiences with health care staff, Elders fear and distrust the health care system. • Elders need to be respected and believed; many providers are dismissive when they are in pain. • Elders are stoic/do not complain, so if they are saying they are suffering [in pain], it is likely to be an understatement. • Providers need to create treatment plans in partnership with patients and family. • Elders need better access to providers.
2. The need for advocacy and support	<ul style="list-style-type: none"> • Elders need 24-hour access to advocates who can accompany them, speak up for them, and meet their needs. • Elders often find it difficult to understand language used by health care providers, especially when English is a second language or not spoken at all. • Elders and community members who have difficulty reading need alternatives to written medical instructions or information.
3. Inflexible hospital and emergency practices, protocols, and policies	<ul style="list-style-type: none"> • Elders need emergency protocols and policies to be flexible. • Elders should not be discharged without a plan and nowhere to go. • Elders need excessively long emergency wait times to be improved for patients and family members. • Elders find it very difficult to cope with extreme delays and the lack of trauma-informed care. • Elders' privacy should be respected; they should not be asked personal questions in public spaces. This can trigger feelings of shame and make it difficult for Elders to access emergency services. • Elders need adequate supports before and after surgery; this has not been the case to date.

Participants also identified gaps in hospitals' understanding of First Nations people and trauma, as outlined in Table 2.

Table 2*What Hospitals Need to Know About First Nations People and Trauma*

1. Impacts of racist colonial systems	<ul style="list-style-type: none"> • Elders know that racism is still happening in hospitals. It is necessary to understand and move away from racist, colonial attitudes and behaviours toward positive, respectful ones. • Elders know that colonialism, with its inherent abuses of authority, including in Indian Residential Schools and Indian Hospitals, has severely affected the health of First Nations people.
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Table 2 con't

2. Impacts of trauma	<ul style="list-style-type: none"> Elders need health care providers to recognize signs of trauma and understand triggers and impacts of trauma. Elders want providers to know that their lack of trust in authority is a result of dehumanizing and traumatic experiences. Elders believe that understanding the impacts of trauma on health can build empathy and help health care providers provide the most appropriate treatment. Elders want providers to realize that sickness and imbalance are connected to multiple layers of unresolved trauma. Elders need care that is tolerant, non-judgmental, and compassionate toward sick people.
3. Indigenous perspectives	<ul style="list-style-type: none"> Understanding of First Nations culture will allow health professionals to serve their patients in a more culturally safe way. Space for family is important. When patients are dying, relatives are left to stand in the hallway due to lack of space for family. Respecting traditional ways of knowing and understanding, especially ceremony, is important. Culturally safe spaces are needed in order to practise traditional ceremonies, access cultural support, and accommodate large families. Access to traditional foods is important as a source of comfort and form of medicine. Long waits in emergency can be difficult for Elders without comfortable seating or warm blankets to rest in.
4. Advocacy and communication	<ul style="list-style-type: none"> Elders need access to advocates and support people 24 hours a day, seven days a week. Elders are not getting proper treatment due to (a) avoidance of health care facilities, (b) misdiagnosis due to racism, (c) use of overly complex language, and (d) feeling unsafe sharing symptoms. Elders say delays in treatment happen because many Elders do not ask for second opinions. Elders need regular updates on wait times. Elders stress that communication between hospital and community is needed.
5. Comprehensive support	<ul style="list-style-type: none"> Elders need to have traditional healers for end-of-life support because it is important that their familiar, comforting traditions are present and that they are not alone. Elders need service providers to recognize the important roles of family, traditional practices, and healers. Elders need improved communication between First Nations communities and hospitals; this would increase access to additional support and resources both during their hospital stay and after discharge.

To address the three areas for improvement and the five gaps in understanding about First Nations people and trauma, eight major recommendations were developed from the workshop. Nuuchahnulth Elders expressed the importance of the following recommendations (full recommendations in Appendix).

1. Increase Engagement and Relationship Building

Participants highlighted the importance of holding follow-up events to continue the conversations started at the workshop and to share knowledge with community members and health providers. They also called for dialogue between health staff and community members. In the hospital, participants recommended the promotion of relationship building between hospital staff, community service providers, and caregivers.

2. Develop Action Plans

Participants called for the development of action plans with realistic short-term and long-term goals and deadlines. It was recommended that updates to communities be tied to action plans to keep health partners accountable.

3. Increase Education and Awareness

Education and awareness was a major recommendation area with three sub-themes. The first sub-theme was training in cultural safety and trauma-informed care. Participants recommended that this training be mandatory, yearly, taught in person, and co-delivered with Nuuchahnulth members. Recommended content included education about trauma, especially ongoing experiences and impacts of trauma from colonialism; de-escalation training; self-reflection on cultural humility; and Indigenous perspectives, practices, teachings, and storytelling.

For the second sub-theme, participants provided recommendations to support health care providers in improving their communication. Participants recommended that providers be conscious to ensure that their words, tone, and body language are always respectful and do not trigger patients. It is also important to ensure patients understand their care plan, and to use alternative forms of communication for patients who cannot read. Experiences of trauma should be noted in patient charts. When in WCGH, providers should update Elders' families and/or close friends daily and make the time to tell families about the passing of loved ones.

For the last sub-theme, participants recommended increasing awareness and knowledge sharing with communities and health providers by holding hospital orientation tours and workshops about available resources and services for Elders; starting a newsletter for communities and health providers; hosting cultural awareness exchanges, workshops, and training for health providers; developing print and online resources in partnership with Nuuchahnulth Tribal Council, especially a patient care plan booklet integrating culture, traditional healing, and family and friends in the patient's care circle.

4. Increase Advocacy and Support

Many participants called for daily 24-hour access to advocates and counsellors to support Elders in accessing resources, dealing with trauma triggers, overcoming language barriers, and having their concerns taken seriously. As Elder Barney Williams shared, “A lot of our people will not jump up and make noise because they are filled with respect and humility.” Staff need to be aware that Elders in pain are often stoic, so it is important that they are always given the option of advocate support.

Language barriers were another major concern. Elder Geraldine Edgar, a senior cultural wellness worker, noted, “The doctors and nurses, they give up when they can’t [understand our language].” Participants called for all health providers to take a more proactive role in supporting and speaking up for Elders. Elder Helen Dick, a compassionate service volunteer and retired nurse, also illustrated the significance of language services for Elders: “I speak the language, I understand the Nuu-chah-nulth dialects, and that’s important for our Elders.”

5. Incorporate First Nations Medicine, Healing, and Foods

Nuu-chah-nulth participants highlighted the need for access to traditional foods, healers, and medicines in health care facilities. Specifically, Elders and traditional/spiritual healers need to be made available and be financially compensated for their services. Traditional medicine needs to be incorporated in treatment plans. Elder Marie Samuel shared the importance of traditional ways for her healing journey: “The best medicine I could have ever taken was our cultural and traditional ways in finding myself again.”

6. Provide Culturally Safe Spaces

Participants recommended providing a culturally safe space for families to gather and perform traditional practices and ceremonies, and a comfortable and accessible waiting room for Elders.

7. Develop Policy and Protocol

Participants called for a culture shift within WCGH and for more flexible policies and protocols, especially in the areas of triage, complaints, and discharge planning, that incorporate Indigenous worldviews to make emergency care culturally safe and welcoming. One Elder illustrated the difference between current practices and the Indigenous approach to care: “When somebody calls you and asks you to help, you go and you go help them. ... We don’t say ‘I can’t. It’s not in our policy.’ Indigenize our programs.”

Human resource policy was another major area for improvement. Participants recommended a requirement for cultural humility in job descriptions, creating tools to assess cultural humility and trauma-informed care for staff, staff wellness opportunities, opportunities for exchanges between WCGH and community providers, hiring more providers, and encouraging providers to spend more time with patients. Other recommended changes include continuously monitoring and reporting on wait times, using respectful rather than threatening signage, and posting a Patient Bill of Rights in the hospital.

8. Link to Comprehensive Community Support

Participants called for improved links to community supports and services in the areas of hospital discharge planning, helping to keep patients connected to their families, primary care access, and detox services. As Elder Helen Dick said, “The best medicine for you is to have your family, especially when you’re in the last stages of your life.” Elders noted that collaboration between the hospital and Nuuchahnulth community supports is vital to ensure community members do not fall through the cracks.

Limitations

This project presented particular limitations, including restrictions to engage with more Nuuchahnulth members. It is possible that some issues may have been missed, as there was only enough funding available to engage with one Elder per Nation, and not all Nations were able to send an Elder. However, having seven new Elders participate in the 2019 gathering helped to provide more perspectives and confirm concerns common to Nuuchahnulth communities. The newly joined Elders agreed with all of the recommendations, and their feedback mainly helped to refine and add to the recommendations, making them more detailed and clear.

Another challenge the team faced was in balancing the urgency to complete the report with the time needed by Nuuchahnulth communities to carry out the project in a culturally appropriate way. Following the guidance of the Nuuchahnulth CEC was key to ensuring the team provided the time flexibility needed to appropriately engage with Nuuchahnulth partners and Elders throughout the project while remaining accountable in moving the work forward within a reasonable time frame.

Discussion

Widespread anti-Indigenous racism in the Canadian health system has been well-documented (Barrera, 2020, Brian Sinclair Working Group, 2017, Zimonjic & Stefanovich, 2020). In Browne and colleagues’ (2011) study of Indigenous experiences at an urban Canadian emergency department, concern about being stereotyped by health providers for appearing to be Indigenous and/or living in poverty was a major theme, consistent with what Elders expressed in the workshop.

Elder Ruth Charleson also found the knowledge exchange approach used for the workshop and gathering preferable to the way research has been done in the community: “It seems to work better for us to gather like this and share something ... it’s better to do this than come into our community and into our homes.” Key to this successful outcome was the respect and safety established by privileging the voices of Elders and community members. This approach helped to even the power dynamic between health institutions and communities by acknowledging and centring Nuuchahnulth wisdom and knowledge. Many participants stated that they felt better able to understand trauma, as well as the needs and concerns of Elders regarding trauma-informed care.

At the 2019 gathering, Elders and health partners noted a number of significant impacts that the workshop had on cultural safety planning by Island Health and WCGH. As Elder Geraldine Edgar said, “You listened to what the Elders said. You have just about acted on half of it.” Island Health has been integrating key recommendations into the 2019/2020 Island Health Priorities Plan, and WCGH is acting on these priorities. Some of WCGH’s actions include setting the expectation that all new staff participate in cultural safety training, starting exchange programs for health care staff, and increasing access to Aboriginal Liaison Nurse and Nurse Navigator support to seven days a week in partnership with Nuu-chah-nulth Tribal Council. Building on the efforts of a working group of Nuu-chah-nulth health providers, WCGH opened the All Nations Room in 2019 with the support of the WCGH CSC. Elder Geraldine Edgar illustrated the importance of this space: “Grateful for the All Nations Room. It makes [patients] feel that there is care and support there for them.” Island Health is also piloting an Elder-in-Residence program in North Island hospitals that it plans to expand to other hospitals, integrating traditional healers into primary care networks, and establishing an anti-racism strategy. The June 2019 gathering itself was organized in fulfillment of three of the recommendations: (a) contributing to relationship building; (b) being accountable by reporting progress back to Nuu-chah-nulth participants; and (c) providing the opportunity to validate the recommendations.

The findings from this project build on the emerging research in cultural safety in primary care. The workshop recommendations are consistent with the interview findings from Abraham and colleagues (2018) about Maori patients’ experiences with emergency care. The Maori patients identified the need for family-friendly cultural spaces; more offering of spiritual assistance, language support, and advocacy support from a cultural support worker; shorter wait times, especially for Elders; more privacy; the use of the Maori language; and cultural training for health professionals. The recommendations also support and build on Browne and colleagues’ (2012) four key dimensions of equity-oriented primary health care (i.e., inequity-responsive care; trauma- and violence-informed care; contextually tailored care; and culturally competent care) and ten strategies to guide organizations in enhancing capacity for equity-oriented services. These were developed from interview findings from 114 participants (77% Indigenous), 900 hours of participant observation, and analysis of key organizational documents at two primary health care centres mandated to serve marginalized populations.

However, it is important to recognize that some recommendations may be challenging to implement. Accounts of positive experiences highlight the impact of brief, supportive interactions with providers (Browne et al., 2011). However, cost constraints and staff shortages that create pressure for efficiency in emergency care make it challenging for providers to speak with patients and respond to their needs in a culturally safe and trauma-informed way (Browne et al., 2011, Hall et al., 2016). Thus, advocacy is needed to ensure change happens in parallel at the organizational, clinical programming, and patient-provider levels (Browne et al., 2012).

Conclusion

Through the workshop and validation gathering, Nuu-chah-nulth and health partner participants have done groundbreaking work in coming together to make recommendations for

culturally safe and trauma-informed emergency care. As Elder Ina Seitcher put it, “We’re all in one canoe.” We hope this work will guide and inspire others to work alongside Indigenous communities toward a future where Indigenous people feel safe and welcome in accessing all health care. We end with the final reflections of Elder Helen Dick at the 2019 gathering:

Honour, respect and dignity. That’s all First Nations people want. It gives them hope they will survive whatever medical problem they have. Hope that they can change their lives. Remember how you want to be treated and pass that on to others.

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Appendix

Recommendations for Culturally Safe and Trauma-informed Emergency Care

RECOMMENDATION 1: Increase engagement and relationship building
1.1 Host a follow-up gathering with more Elders, community services and health care staff and community members.
1.2 Facilitate ongoing dialogue between community and health care providers ¹ to improve attitudes on both sides, build relationships and move forward in a good way (e.g., have doctors share meals and learn from Elders and community members).
1.3 Promote relationship building between hospital providers, service providers (e.g., nurses and pharmacists), family and caregivers for comprehensive care.
1.4 Health leaders can learn by going into community which will help to make better decisions.
RECOMMENDATION 2: Develop action plans
2.1 Develop action plans with concrete deadlines, prioritize short-term and long-term goals and clarify roles in partnership with Nuu-chah-nulth members.
2.2 Be accountable by updating community on plans in a timely manner by tying communication directly to action plans.
RECOMMENDATION 3: Increase education and awareness
3.1 Cultural safety and trauma-informed care training <ul style="list-style-type: none"> 3.1.1 Ensure staff meet a minimum level of cultural safety and humility. Deliver mandatory in-person cultural safety and trauma-informed care training yearly for all hospital and health care staff (health care providers, lab technicians, security guards, housekeepers), co-delivered by Nuu-chah-nulth members, that evens the power dynamic between provider and patient and promotes respect for spirituality. Trainees, especially on short-term locum, need to learn about the community they are serving. 3.1.2 Educate about ongoing experiences and impacts of historical trauma from colonialism, particularly the intergenerational effects of abuse from the Indian Residential Schools, Indian Hospitals and 60s scoop on Nuu-chah-nulth Peoples. 3.1.3 Support staff in being self-reflective about their level of cultural humility, which will further enable cultural safety. 3.1.4 Incorporate Nuu-chah-nulth and other First Nations storytelling, traditional teachings, history of practices and perspectives on wellness into education. Emphasize the importance of respect for family members of patients. Learn how to say the name of the Nations and regions where you are working. 3.1.5 Educate on trauma triggers, individual traumas, reactions, and how they relate to being in a vulnerable position in hospital. Provide de-escalation training and promote understanding of each individual's specific situation. 3.1.6 Ensure collaboration between Island Health and Port Alberni City Council to address systemic racism, as frontline staff are community members.
3.2 Health Care Provider Communication

¹ Health care providers are defined here as workers who directly provide in-person health care services to patients, such as medical doctors, nurses, physician assistants, pharmacists, community health workers, mental health workers, psychologists, counsellors, social workers, dentists, optometrists, dieticians, physiotherapists and occupational therapists.

	<p>3.2.1 Use simple, accessible and respectful language at a level the patient can completely understand, rather than medical or stigmatizing language to prevent patients from being triggered. Listen with your heart, not just your ears. Compassionate and thoughtful communication, including tone and body language, are very important, especially when a family member passes. Always respect Elders.</p> <p>3.2.2 Ask (in a polite tone) questions such as, “Do you understand?” or “Can you repeat what I said?”</p> <p>3.2.3 Provide alternatives to written forms of communication for those who cannot read (e.g., advocacy support, visuals).</p> <p>3.2.4 Recognize that part of the role of provider is to take the time to communicate about the passing of loved ones.</p> <p>3.2.5 Ask families/close friends if there is a designated spokesperson to communicate bad news to the rest of the family. Family/close friends should consider designating a spokesperson to connect with providers if this has not been done.</p> <p>3.2.6 Establish frequent family case conferences with family, liaisons and circle of care. The head nurse-in-charge should provide daily consultation updates with Elders’ families.</p> <p>3.2.7 Record personal stories of patients in patient chart, including experiences of trauma.</p>
	<p>3.3 Awareness and Knowledge Sharing</p> <p>3.3.1 Hold hospital orientation tours and open house opportunities to make Elders aware of resources available in the hospital and allow them to meet doctors before they come as patients.</p> <p>3.3.2 Establish a health newsletter on all events happening in medical and Nuu-chah-nulth communities for community and health care providers. Use existing First Nations Health Authority (FNHA), Nuu-chah-nulth websites to raise awareness and provide consistent information. Provide more regular updates about health care programs and service providers, working closely with Nuu-chah-nulth Tribal Council.</p> <p>3.3.3 Host cultural awareness activities for health staff (e.g., cultural exchange programs, cultural workshops and training).</p> <p>3.3.4 Develop print and online resources for communities in partnership with the Nuu-chah-nulth Tribal Council (especially patient care plan booklets like the Aboriginal Pregnancy Passport) that integrate culture and traditional healing patients want in their care, including care circles (e.g. family members), to increase providers’ cultural awareness. Develop care plans before patients get sick. Co-develop a patient complaints booklet and booklet that lists financial and mobility resources for Elders. Make resources available in community and in the waiting room.</p> <p>3.3.5 Develop training booklets for health care providers and booklets on each Nuu-chah-nulth community.</p> <p>3.3.6 FNHA should hold more educational events (e.g., workshops on Pharmacare, prescriptions and harm reduction).</p> <p>3.3.7 Ensure pharmacists are aware of changes to medical coverage. Ensure pharmacists are participating in cultural safety learning journeys so that the stereotypes Indigenous people face when accessing Pharmacare are addressed and stopped. Create a safe feedback process so community members have the opportunity to share whether these services are actually becoming safer.</p>
RECOMMENDATION 4: Increase advocacy and support	
	<p>4.1 Provide 24/7 access to Elder advocates and counsellors to help those with language barriers and trauma triggers.</p>
	<p>4.2 Health providers and advocates should be proactive, knowledgeable, and helpful and have a strong voice to make changes. Providing culturally safe services is the responsibility of all providers and they must be open to working with the Aboriginal Nurse Liaisons and/or Navigator</p>

to determine and address the barriers to culturally safe services and increase their own capacity to provide culturally safe services.
4.3 Increase visibility of Aboriginal Liaison Nurses/Patient Navigators. Ensure they are clearly positioned near the entry to emergency and that Elders do not have to ask for them. Elders should never have to be in the emergency room alone.
4.4 Include family members as part of the care team. Proactive efforts must be made to implement this recommendation as it's not something that people are familiar with yet.
4.5 Build capacity in communities to hire employees and recruit volunteers who can support Elders in raising concerns, accessing resources and explaining trauma-informed care.
4.6 Make the First Nations Health Benefits support line 24/7 and expand benefits coverage needs to for patient travel.
RECOMMENDATION 5: Incorporate First Nations medicine, healing and foods
5.1 Increase access to traditional foods and medicines. Include traditional food options in hospital and incorporate traditional medicine into treatment plans.
5.2 Embed traditional healers into the health system. Facilitate the intake of qualified Indigenous traditional practitioners and spiritual healers to work in the hospital, especially for end-of-life support, and compensate them for their services and travel to create access to traditional knowledge and practices.
5.3 Create an Elder-in-Residence position.
5.4 Promote collaboration between medical and traditional healers. Physicians need to be educated about the role of traditional healers and become better able to meet the Elders in a cultural context.
5.5 Integrate First Nations culture not just into the hospital, but into the care itself (e.g., care plan). Provide the option to pick the healer or physician. Ensure staff understand why these initiatives are important and that any racist beliefs around these efforts are addressed (e.g., special treatment, "what about other cultures?", etc.).
RECOMMENDATION 6: Provide culturally safe spaces
6.1 Provide culturally safe spaces for families to support one another and to practice traditional ceremonies, including brushing, smudging and other forms of traditional medicine.
6.2 Create a comfortable Elder-designated waiting room for Elders to wait and rest. The room should provide water, warm blankets and comfortable seating.
6.3 Improve the physical accessibility of the emergency department (e.g., locate admitting closer to the parking lot).
RECOMMENDATION 7: Develop policy and protocol
RECOMMENDATION 7.1 A culture shift is required for the entire hospital. The system is oppressive and no amount of training can help this. Indigenize and update hospital protocols and policies with the involvement of First Nations to make them more culturally safe and flexible, particularly in the areas of triage, discharge planning and complaints. 7.1.1 Implement a cultural safety policy within West Coast General Hospital to receive complaints and address issues in a culturally safe way (e.g., develop a case quality review committee, navigator support for Patient Quality Complaints process, install complaints boxes in main service areas). 7.1.2 Ensure Indigenous perspectives and beliefs are reflected in policies (e.g. protocol to ask and respect families' beliefs around death). 7.1.3 Implement a culturally safe triage protocol in which patients are greeted warmly, the first point of contact is culturally aware/safe, patient privacy is protected, intake is simplified, staff fill out intake forms for those in need of support, staff check in with and update those in the waiting area, necessary lab work is done at triage, concerns are taken seriously so patients don't have to return multiple times, and Elders are prioritized. 7.1.4 Include coverage of BC Paramedic services as part of Medicare for consistent quality of care regardless of status.

<p>7.1.5 Reduce red tape (e.g. paperwork requirements) that acts as a barrier to accessing health benefits by discouraging providers from accepting FNHA clients and delays the provision of and reimbursement for medical equipment and services.</p>
<p>7.2 Continuously monitor and report on long wait times in emergency.</p>
<p>7.3 Replace threatening signage with respectful signage and post a Patient Bill of Rights throughout health facilities to raise awareness among staff and community members.</p>
<p>7.4 Human Resources</p> <p>7.4.1 Include cultural humility in job descriptions as a requirement.</p> <p>7.4.2 Develop measurement tools to assess cultural humility among staff and to promote accountability (e.g. evaluate if care plans were respected). If tools show a lack of improvement in cultural safety for a staff member, have a conversation to develop a learning plan (could include a conversation with an Elder).</p> <p>7.4.3 Provide health care providers with opportunities to maintain a healthy mind, body and spirit and prevent burnout.</p> <p>7.4.4 Encourage providers to seek opportunities to work in communities and create opportunities for community nurses to work in hospitals.</p> <p>7.4.5 Improve the quality and quantity of services. Hire more doctors and increase the amount of time they spend with patients and family (e.g. incentives to spend adequate time with patients) in order to reduce wait times and prevent patients from being “put away and forgotten.” Bring more nurse practitioners into communities.</p>
<p>RECOMMENDATION 8: Link to Comprehensive Community Supports</p>
<p>8.1 In discharge planning, improve links to community services and be more helpful in referring patients to comprehensive community supports:</p> <ul style="list-style-type: none"> • Ensure health providers make family members and advocates aware of the discharge plan for Elders. • Be flexible in discharge planning to allow for more support to be set up at home. Contact Nations to get approval for accommodation to prevent Elders from being left on the streets. • Actively utilize referral pathway to KUU-US Crisis Line Society when discharging suicidal patients. • Ensure all Elders get Lifeline (automatic fall detection device) in case of falls. • Ensure medical equipment is provided when patients are discharged.
<p>8.2 Support Elders to stay connected to family and community:</p> <ul style="list-style-type: none"> • Be creative with remote health services • Network the networks • Provide access to telehealth or Skype to talk to family • Increase hospital visiting hours
<p>8.3 Increase local access to primary care and specialist services and reduce the need for Elders and community members to go to emergency by sending mobile primary care teams and specialists to remote communities, opening more walk-in and urgent care clinics in communities and keeping these clinics open after office hours.</p>