



*Kelly Foxcroft-Prisler*  
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# REPORT ON RECOMMENDATIONS FOR TRAUMA-INFORMED AND CULTURALLY SAFE EMERGENCY CARE 2020



First Nations Health Authority  
Health through wellness

# DEDICATIONS

OUR DREAM IS THAT THIS MOVEMENT CARRIES ON, AND THAT THIS WORK AND THESE LEARNINGS ARE NOT RELEGATED TO THE PAST – WE DON'T WANT TO HAVE HAD A LOT OF GOOD TALK AND THEN ALL OF A SUDDEN IT DOESN'T GO ANYWHERE.

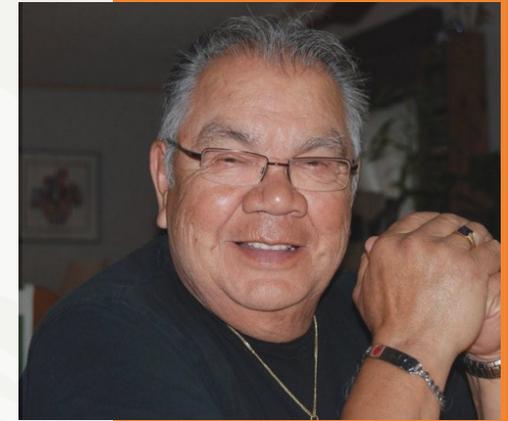
Our dream is that you will be cognizant and honour the traditional ways with an open heart, not just offer lip service to it. Don't be afraid to say that you don't know that much about traditional culture. We had a long time to learn your ways of life, your worldview. Now you need to be aware of our worldview. It's much different from your worldview.

Coming together like this creates an opportunity for all of us, not just Elders and other First Nations people, but yourselves, to begin to really genuinely work together to aspire to meet the things we've spoken of over the last two days.

We dialogued together for two days and came to a consensus about believing one another. You believe that these are issues that are problems for us and you've opened your heart and said, "We can do this." And we know it's a lot of information. We're very cognizant that we need to look at what are going to be the first things that we do. We're not asking that you do this whole thing at once. We understand that this is a lot of information, but we also understand that for over 100 years now we've talked to empty ears and empty hearts and we hope and know that there's some changes. We're not going to convince everybody. We know that from the Truth and Reconciliation Commission. So we're going to be faced with that, as well as with what we've done here, both on our side and yours. We're going to have skeptics on our side as well. We need to be really clear about that. So we all have a lot of work to do, us and you. To meet and to implement some of the things that we spoke of so that my grandchildren and I can walk into a hospital anywhere and be treated like a human being versus feeling less than. So that we can have that time together in those places with joy in our hearts instead of being hesitant to go because we don't know what attitude is going to be brought toward us.

So my dream and hope is that what we've done here, I feel we should continue and have more sessions and invite leaders and other people that can be part of this movement. To create a space for everyone to have their voices heard. It's a start. We all came here and we stayed together for two whole days. We laughed, we ate together, we got to meet different people that we don't know, but we also saw friends that we know from the past. So kleco kleco. Huy ch q'u.

*~ Klith-wii-taa, Elder Barney Williams Jr, FNHA Cultural Advisor*



### EMOTIONAL TRIGGER WARNING

This report discusses culturally unsafe experiences in health care, traumatic experiences and health and wellness topics that may trigger memories of personal experiences or the experiences of friends and family. While the report's intent is to share knowledge to begin addressing these negative experiences, the content may trigger difficult feelings or thoughts.

First Nations and other Indigenous people who require emotional support can contact the 24-hour [KUU-US Crisis Line at 1-800-588-8717](tel:1-800-588-8717).

Non-Indigenous people who require emotional support can contact the toll-free 24-hour [Crisis Services Canada Line at 1-833-456-4566](tel:1-833-456-4566).

# ACKNOWLEDGEMENTS

WE ACKNOWLEDGE THAT THIS REPORT WAS DEVELOPED AND PUBLISHED ON UNCEDED COAST SALISH TERRITORIES – x<sup>w</sup>məθk<sup>w</sup>əyəm (MUSQUEAM) Skwxwú7mesh (SQUAMISH) səliłwətaʔt (TSLEIL-WAUTUTH)- AND NUU-CHAH-NULTH TERRITORIES – Hupačasath (HUPAČASATH) AND čišaaʔath (TSESHAHT).

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This work was led by community champions, including the members of West Coast General Hospital (WCGH) Cultural Safety Committee, who played a vital community advocacy and guidance role:

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# ACKNOWLEDGEMENTS

WE WOULD LIKE TO EXTEND OUR DEEPEST GRATITUDE TO:

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for opening their hearts to share their stories and wisdom with us and for the time and energy they took to review the recommendations.

## NUU-CHAH-NULTH HEALTH DIRECTORS

for identifying, inviting and supporting the Elders in attending.

## HUPAČASATH AND TSESHAHT NATIONS

for hosting the gatherings.

## FACILITATORS

Thanks to facilitators Rod Jeffries and Harley Eagle for their key roles facilitating the workshop and gathering and for leading the two events' engagement processes.

## SPONSORS

Thanks to the Michael Smith Foundation for Health Research for awarding us the Convening and Collaborating Grant that funded the 2017 workshop. Thanks to the Island Health Research Capacity Department for sponsoring the validation gathering, and to the FNHA Vancouver Island team for providing additional funding for the workshop and 2019 gathering.



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## WEST COAST GENERAL HOSPITAL AND ISLAND HEALTH

Thanks to the WCGH Emergency Department and site leadership for their unwavering commitment to engage in this work to bring forward positive change. Thanks to the Island Health Research Capacity Department for their ongoing support, especially for the validation gathering. The dedication of senior leaders to participate also enabled the voices of Elders to be heard. Island Health's Aboriginal Health Department's committed participation and contributions are also deeply appreciated.

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The planning, organization and hosting of the workshop and gathering were led by FNHA Research and Knowledge Exchange (RKE) and Vancouver Island team members:

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## REPORT PREPARATION

The artwork used throughout the report was taken from the graphic recording and visual agenda created by Nuu-chah-nulth graphic facilitator, Kelly Foxcroft-Poirier. We are grateful for her skillful artistry and analysis in visually communicating community voices. Janice Johnson and Leena Hasan led the report writing and preparation.

Report design was started by FNHA practicum student, Claire Hiscock, and finalized by Regula Appenzeller. Copy editing was done by FNHA Health and Wellness Writer, Anita Christoff, Editor, Lynn Sully, and Alexa Norton.

# ACKNOWLEDGEMENTS

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The following project team members provided valuable input on the workshop planning and report writing process:

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# THE STORY BEHIND THE REPORT

## THE WORK LEADING UP TO THIS REPORT WAS BUILT ON WORK DONE BY NUU-CHAH-NULTH AND NON-INDIGENOUS HEALTH PROVIDERS.

Long recognizing the need for a culturally safe space at West Coast General Hospital (WCGH), Nuu-chah-nulth members working in the health field formed a volunteer Working Group led by the Aboriginal Liaison Nurse with the Nuu-chah-nulth Tribal Council. Years later, in July 2015, the First Nations Health Authority's (FNHA) advocacy for cultural safety and humility in the health system led all health authority Chief Executive Officers in British Columbia (BC) to sign a Declaration of Commitment to advance cultural safety within their health service organizations, as well as to the establishment of Cultural Safety Committees across Vancouver Island. With the support of the WCGH Cultural Safety Committee, the plan for an All Nations Room was seriously considered and ultimately given the go-ahead. Years after the idea of establishing a culturally safe space at the hospital was first proposed, the All Nations Healing Room opened in the fall of 2019.

WCGH Chief of Staff, Dr. Dorothy (Sam) Williams, also recognized the opportunity for the WCGH Cultural Safety Committee to address the culturally unsafe treatment of many Nuu-chah-nulth Elders that she had witnessed throughout her career. Dr. Williams brought forward her concerns, and the committee chair and FNHA Nuu-chah-nulth Community Engagement Coordinator, Janice Johnson, connected with Krista Stelkia, the then FNHA Research and Knowledge Exchange team Research Advisor, voicing the need to better understand how trauma affects Nuu-chah-nulth Elders in accessing emergency care. This ultimately led to the establishment of a project team that was awarded funds to hold a workshop with Nuu-chah-nulth Elders in 2017. With the support of the FNHA Vancouver Island regional team and the Research and Knowledge Exchange group, Janice acted as the liaison between the Cultural Safety Committee and the project team. At the local level, she coordinated

the planning and invitation process to ensure Elders were engaged in a culturally appropriate way. From the workshop, a report was created outlining the recommendations developed by Elders in collaboration with community members and health partners. This work would not have been possible without Janice's dedication and sacrifice to improve health services for her community.

The commitment of partners at WCGH and Island Health has also been key to the success of this work. Marie Duperreault, the Director of Port Alberni/ West Coast Communities, has been proactive in listening to the concerns of the Nuu-chah-nulth community and facilitating positive change in the region. The enthusiastic and ongoing support of Island Health Research Capacity Program's Cindy Trytten and Diane Sawchuck also made it possible to host the community follow-up gathering, which enabled the community to provide feedback on the report. Cindy has also actively spread awareness about this work and advocated for cultural safety and trauma-informed care within Island Health.

## OUR INTENTION

Our intention with this report is three-fold. First, we hope that the knowledge and recommendations shared in this report will guide health service organizations in implementing culturally safe and trauma-informed care. Secondly, the report is a way of being accountable and reporting back to everyone we engaged with during the cultural safety work done as part of this project. Finally, this report provides an example of a novel community-driven model of engagement with Indigenous communities that can improve cultural safety and humility in research and knowledge exchange. We hope this model will inspire and inform more ethical ways of engaging with Indigenous people and communities that places their priorities and needs at the centre of the work.

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# EXECUTIVE SUMMARY

THIS REPORT IS OWNED BY THE NUU-CHAH-NULTH PEOPLE. GROUNDED IN THE VOICES OF NUU-CHAH-NULTH ELDERS, IT DOCUMENTS A GROUNDBREAKING, COMMUNITY-DRIVEN PROCESS FOR COLLABORATIVE CHANGE WITH INDIGENOUS COMMUNITIES AND NON-INDIGENOUS HEALTH INSTITUTIONS.

For decades, Nuu-chah-nulth Elders have avoided emergency care due to residential school trauma and the absence of culturally safe care. To address this urgent community priority, the First Nations Health Authority (FNHA) and Island Health established Cultural Safety Committees in partnership with local First Nations and held the *Trauma-Informed and Culturally Safe Emergency Care for Nuu-chah-nulth Elders Workshop* in Port Alberni, unceded Tseshaht and Hupačasath territory, as part of their commitment to improving cultural safety and humility in the health system.

The workshop, held on September 28 and 29, 2017, brought together over 60 participants (listed in [APPENDIX A](#)), including Elders and community members from 10 of the 15 Nuu-chah-nulth communities, as well as regional and local health leaders and providers. The project was funded by a Michael Smith Foundation for Health Research grant and organized by the FNHA's Research and Knowledge Exchange and Vancouver Island teams in partnership with the West Coast General Hospital (WCGH) Cultural Safety Committee ([APPENDIX B](#)), Island Health, Simon Fraser University, the University of Victoria and Royal Roads University. The purpose of the workshop was to build a trusting environment that would enable Elders and community members to have their voices heard by health partners and to collaboratively develop call-to-action recommendations – paddling together in one canoe.

On June 14, 2019, a follow-up gathering called *Continuing Our Journey Towards Culturally Safe Emergency Care for Nuu-chah-nulth Elders* was held. Over 50 participants ([APPENDIX C](#)) attended the FNHA-organized event that was funded by Island Health; participants included Elders and

representatives from 13 Nuu-chah-nulth communities. The purpose of this gathering was for health partners to share cultural safety progress updates and for the Elders and representatives from the communities to review and validate the workshop recommendations.

Grounded in the voices of Nuu-chah-nulth Elders and community members, this report outlines areas for improvement and recommendations for trauma-informed and culturally safe emergency care made at the 2017 workshop and revised at the 2019 validation gathering. (A separate document will share the specific action items proposed at the 2019 gathering.) We have grouped the recommendations into eight themes:

1. INCREASE ENGAGEMENT & RELATIONSHIP BUILDING
2. DEVELOPMENT OF ACTION PLANS
3. EDUCATION & AWARENESS
4. ADVOCACY & SUPPORT
5. FIRST NATIONS MEDICINE, HEALING & FOODS
6. CULTURALLY SAFE SPACES
7. POLICY & PROTOCOL DEVELOPMENT
8. LINKS TO COMPREHENSIVE COMMUNITY SUPPORT

The recommendations are intended to guide future action by health system institutions and service providers, especially WCGH, Island Health, the FNHA, Nuu-chah-nulth governments, the City of Port Alberni and health providers. (For definitions of concepts related to cultural safety and trauma-informed care, please see [APPENDIX D](#).)

# BACKGROUND

FIRST NATIONS COMMUNITY MEMBERS REPORT THAT THEY HAVE AVOIDED EMERGENCY CARE FOR DECADES DUE TO ONGOING RACIAL DISCRIMINATION AND COLONIAL TRAUMA, AND THEY HAVE EXPRESSED CONCERNS ABOUT THEIR ABILITY TO ACCESS QUALITY CARE.

The Truth and Reconciliation Commission clearly outlined the injustices done to First Nations people in the past, including the *Indian Act*, which forced First Nations people onto isolated Indian Reserves and First Nations children into Indian Residential Schools. The *Indian Act* also criminalized illness, forcing First Nations patients into racially segregated tuberculosis hospitals, which later became Indian Hospitals where patients received sub-standard care and were forced into abusive medical experiments and sterilization.<sup>1,2</sup>

In response, the Nuu-chah-nulth community has been calling for action to make emergency care culturally safe and trauma-informed. Growing recognition of this urgent need led the WCGH to establish a Cultural Safety Committee (members listed in [APPENDIX B](#)) in 2014 to improve communication, partnership and connection between First Nations and health service providers in the Alberni Region.

In light of the Nuu-chah-nulth community's concerns, committee members wanted to better understand how intergenerational trauma from past and ongoing colonialism and racism affects Elders in accessing emergency care. The committee reached out to the FNHA's Research and Knowledge Exchange team, who identified a grant opportunity and brought in partners from Island Health, the University of Victoria, Royal Roads University and Simon Fraser University. The partners proposed to hold a workshop to engage Nuu-chah-nulth Elders and develop call-to-action recommendations for culturally safe and trauma-informed emergency care. On January 16, 2017, the team was successfully awarded the Michael Smith Foundation for Health Research Convening and Collaborating Award and the project began.

## 1. TRUTH AND RECONCILIATION COMMISSION OF CANADA. (2015).

*Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada.*

[http://www.trc.ca/websites/trcinstitution/File/2015/Honouring\\_the\\_Truth\\_Reconciling\\_for\\_the\\_Future\\_July\\_23\\_2015.pdf](http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf)

## 2. DREES, L. M. (2013).

*Healing Histories: Stories from Canada's Indian Hospitals.*  
University of Alberta.



*Health Partners at the Trauma-informed and Culturally Safe Emergency Care for Nuu-chah-nulth Elders Workshop on Orange Shirt Day. From Left to Right: Marie Duperreault, Jennifer Murray, Janice Johnson, Cody Caruso, Elia Nicholson-Nave, Diane Sawchuck, Celeta Cook, Leena Hasan and Cindy Trytten*

# WORKSHOP OBJECTIVES & GOALS

## WORKSHOP OBJECTIVES

- **Create a trustworthy sharing environment.** Understand how to engage effectively around trauma-informed emergency care for Elders.
- **Develop awareness and understanding.** Listen to Elders' key concerns to understand what is needed to make the emergency setting safe and accessible.
- **Build upon participants' strengths, skills and experience.** Discuss current work by the WCGH Cultural Safety Committee, the WCGH and the FNHA with respect to trauma-informed and culturally safe care.

## WORKSHOP GOALS

- **To engage community members** on their key concerns related to experiences of colonization, trauma and racism with a focus on increasing access to safe, quality health care for Elders.
- **To develop call-to-action recommendations** to improve trauma-informed and culturally safe emergency care for First Nations Elders in the rural/remote communities of Port Alberni, BC.
- **To increase cultural safety and humility practices** in emergency care settings for Elders, promote trauma-informed care among health care staff and physicians, and build awareness of triggers and traumas with education and leadership from Nuu-chah-nulth Elders.



# METHODS

## PADDLING TOGETHER: WORKSHOP PLANNING & ENGAGEMENT

Throughout the workshop planning process, the WCGH Cultural Safety Committee drew on its members' knowledge and expertise to guide the project team. FNHA Nuu-chah-nulth Community Engagement Coordinators engaged Elders in a culturally appropriate way by working with Nuu-chah-nulth Health Directors based in each of the 15 Nuu-chah-nulth Nations. Ten Health Directors identified and supported an Elder from their community to attend. Two Elders, one man and one woman, were also chosen to welcome participants to the workshop and share opening and closing reflections on the gathering.

The Nuu-chah-nulth community chose trauma and healing expert Rod Jeffries of Tyendinaga Mohawk Nation to facilitate the workshop.

Nuu-chah-nulth Elders began by sharing their lived experiences with trauma and emergency care, their wisdom and their hopes for improved care at WCGH. After presentations by FNHA senior leaders and Rod, a safe space was created for discussion. Private groups of Elders, Nuu-chah-nulth members and Indigenous health partners, and non-Indigenous health partners provided answers to three questions ([APPENDIX F](#)) on flipcharts.

On the second day, WCGH shared their work to improve emergency care and cultural safety. To collaboratively develop recommendations, participants then answered five questions ([APPENDIX F](#)) on flipcharts in breakout groups.

After respectfully listening to the voices of the Elders and developing recommendations together, many participants stated that they felt better able to understand trauma, and better appreciated the needs and concerns of Elders regarding trauma-informed care in clinical settings. Key to this successful outcome was the respect and safety established by putting Elder and community member voices first, and health partners listening with open hearts and minds. As Elder Barney Williams put it, participants "came to a consensus about believing one another."



*Facilitator Rod Jeffries and Nuu-chah-nulth Community Engagement Coordinator Janice Johnson*



*Janice Johnson reports back on Elder feedback*

# METHODS

## WORKSHOP REPORT DEVELOPMENT & VALIDATION GATHERING PLANNING

Following the workshop, FNHA Qualitative Analyst Leena Hasan and Nuuchah-nulth Community Engagement Coordinator Janice Johnson analyzed the workshop feedback. The audio recording of the workshop was used to check the accuracy of the flipchart notes. Quotations from Elders were incorporated throughout the report to put their voices at the centre of the work. Eight recommendation themes were identified based on various types of actions (e.g., engagement, education, policy). To preserve meaning and intent, the language was kept similar to that found on the flipchart notes and in recordings. Project team members completed multiple reviews of the report from 2018-2019. Team members also added initial actions in response to the recommendations.

The next step was to validate report recommendations with the communities. Workshop participants recommended that a follow-up session be held, and the FNHA, with support from Island Health, organized *Continuing Our Journey Toward Culturally Safe Emergency Care for Nuuchah-nulth Elders (2019)*, a gathering to ensure the report recommendations accurately reflected the voices of participants and to provide them with progress updates.



# METHODS

## CONTINUING OUR JOURNEY: REPORT BACK & VALIDATION

To engage Elders in a respectful and culturally appropriate way Janice met with Nuuchahnulth Elders in person to invite them to the gathering and review the draft recommendation report prior to the gathering.

On June 14, 2019, a one-day gathering was held with previous and new participants (listed in [APPENDIX C](#)), including Elders and representatives from the Ahousaht, Huu-ay-aht, Ka;yu;'k't'h'/ Che:k'tles7et'h', Mowachaht/Muchalaht, Tla-o-qui-aht, Tsehaht, Uchucklesaht, Yuulu?a?ath, Hesquiaht, Ditidaht and Nuchatlaht nations to validate the recommendations at Tsehaht Nation. Cultural Safety Facilitator, Harley Eagle, facilitated the gathering and Island Health provided updates. FNHA then presented the recommendations to participants. Note-takers recorded what was shared orally and captured small-group feedback on flipcharts. Graphic Facilitator, Kelly Foxcroft-Poirier, also captured main points visually in a graphic recording of the day. Following the gathering, the FNHA Research and Knowledge Exchange team incorporated feedback from all sources into the report.



*Elder Helen Dick shares final words at Continuing Our Journey gathering*



*Elders and health partners discuss recommendations at Continuing Our Journey gathering. From Left to Right: Cary-Lee Calder, Pam Rardon, Sheila Leadbetter, Elder Marie Samuel, Elder Ray Samuel and Kateri Deustch.*

# WHAT WE HEARD

THIS SECTION SUMMARIZES GROUP FEEDBACK FROM DAY 1 OF THE *TRAUMA-INFORMED AND CULTURALLY SAFE EMERGENCY CARE FOR NUU-CHAH-NULTH ELDERS WORKSHOP*. RESPONSES WERE INFORMED BY THE WISDOM AND EMERGENCY CARE EXPERIENCES SHARED BY ELDERS IN THE MORNING SESSION ([APPENDIX E](#)).

## KEY AREAS FOR IMPROVEMENT

1. SYSTEMIC RACISM & DISCRIMINATION
2. ADVOCACY & SUPPORT
3. EMERGENCY CARE PROTOCOLS & POLICY

## WHAT HOSPITALS NEED TO KNOW ABOUT FIRST NATIONS PEOPLE & TRAUMA

1. IMPACTS OF RACIST COLONIAL SYSTEMS
2. IMPACTS OF TRAUMA
3. INDIGENOUS PERSPECTIVES & CULTURAL SAFETY
4. ADVOCACY & COMMUNICATION
5. COMPREHENSIVE SUPPORT

Workshop participants highlighted the need to create a safer health care environment for Elders, who experience a lack of cultural safety and trauma-informed emergency care. Understanding the importance of partnership, WCGH staff expressed their commitment to sharing this journey to implement culturally safe and trauma-informed care by developing action plans.



# SYSTEMIC RACISM & DISCRIMINATION

## AREA FOR IMPROVEMENT 1

### ELDERS & COMMUNITY MEMBERS

- Elders need health care providers to take steps to ensure Elders feel safe, recognized and supported. 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 or do not believe them when they are in pain, leading to misdiagnoses and avoidable suffering.
- Elders are stoic and 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 their family, instead of creating plans without asking about their needs.
- Elders need better access to providers; they need providers to spend more time with them.

### HEALTH CARE PROVIDERS

- Providers recognize that racist attitudes and behaviours, with the resulting distrust of the health care system on the part of patients, continues to be an issue.
- Providers understand that this includes misdiagnosis, less effort, conditions minimized, delay/denial of services and withholding medication as examples.
- Providers realize the importance of working together to address these issues.
- Providers need more opportunities for regularly updated cultural safety and trauma-informed training.
- Metrics need to be developed to measure cultural safety.
- Providers agree that more staff are needed so providers can spend more time with patients.

***“WE NEED TO RECOGNIZE THAT TRAUMA IS CURRENT, NOT JUST IN THE PAST; KNOWLEDGE IS POWER, AND UNDERSTANDING THE CULTURE YOU ARE SERVING IS IMPORTANT.”***

***“I WAS INVOLVED IN A MEDICAL CONFERENCE. I HEARD DOCTORS TALKING TO OTHER [NEWCOMER] DOCTORS ON HOW TO TREAT [INDIGENOUS] PEOPLE. THE WHITE MAN WAS TELLING THE INDIAN DOCTOR HOW TO TREAT THEM. THEY’RE BEING TAUGHT TO BE RACIST IN THIS COUNTRY. WHERE DOES THIS COME FROM?”***

# ADVOCACY & SUPPORT

## AREA FOR IMPROVEMENT 2

### ELDERS & COMMUNITY MEMBERS

- Elders need 24-hour access to advocates who can accompany them, speak up for them and meet their needs, as Elders tend to be stoic and avoid complaining.
- 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.

### HEALTH CARE PROVIDERS

- Providers understand the need for self-determination.
- Providers recognize that nurses should be regularly checking on patients.
- Providers agree that there is a need to address language barriers and to communicate in a way that patients can understand.
- Providers acknowledge that it is difficult for community members to stay in hospitals outside of their community due to separation anxiety and family commitments.

*“A LOT OF THE ELDERS DO NOT HAVE A VOICE. I AM ADVOCATING FOR THOSE PEOPLE WHO DON'T WANT TO GO TO THE HOSPITALS, AND I AM REALLY GRATEFUL FOR ISLAND HEALTH PEOPLE HERE TODAY WANTING TO MAKE POSITIVE CHANGES.”*

# EMERGENCY CARE PROTOCOLS & POLICY

## AREA FOR IMPROVEMENT 3

### ELDERS & COMMUNITY MEMBERS

- Elders need emergency protocols and policies to be flexible; they are currently too inflexible.
- Elders should not be discharged without a plan and nowhere to go, as has been done in the past.
- Elders need excessively long emergency wait times to be reduced for patients and family members waiting to hear about loved ones.
- Elders find it very difficult to cope with extreme delays and the lack of trauma-informed care; this needs to be changed.
- 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.

### HEALTH CARE PROVIDERS

- Providers see the need to improve policies and protocols in the areas of discharge planning, triage practices and the complaints process.
- Providers believe that stronger communication networks between community and health care providers will help address issues in emergency intake and discharge planning.
- Providers see the need to address structural, logistical and socioeconomic barriers to accessing emergency care.
- Providers believe that ongoing dialogue will be important to address these issues and that working together to provide culturally safe and trauma-informed care will create a positive impact.
- Providers agree that more support is needed for community members to access services, especially those travelling from remote communities.

*“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.”*

*“CREATE [POLICIES] BASED ON WHAT ELDERS SAID IN THE WORKSHOP— COULD BE COMPOSITE.”*

# WHAT HOSPITALS NEED TO KNOW ABOUT FIRST NATIONS PEOPLE & TRAUMA

THIS SECTION IDENTIFIES WHAT HOSPITALS NEED TO UNDERSTAND ABOUT FIRST NATIONS PEOPLE AND TRAUMA.

## RACISM & IMPACTS OF TRAUMA:

Elders shared how their personal and community experiences with Indian Residential Schools, Indian Hospitals, racial discrimination and the resulting trauma negatively affect them and their community when accessing health care.

## CULTURAL SAFETY, ADVOCACY & COMPREHENSIVE SUPPORT:

Elders also emphasized the need for culturally safe spaces, traditional (comfort) foods, and culturally safe advocacy support in hospitals. They recommended developing a network so patients could have better access to community supports.

After listening to the Elders, health care providers said they recognized the need for staff and institutions to understand the trauma and intergenerational trauma resulting from past and ongoing colonialism and racism, the importance of incorporating Indigenous perspectives on health and wellness, and the need for relationship-building between providers and patients, as well as within the community.

***“WE WERE GIVEN UNREASONABLE MEDICAL AND DENTAL CARE WHILE WE WERE [AT INDIAN RESIDENTIAL SCHOOL]. I REMEMBER BEING OFFERED TO HAVE MY TEETH PULLED OUT, MY FRONT TEETH, BECAUSE MY DENTIST SAID I WOULD BE CUTER WITHOUT MY FRONT TEETH AND MY TEETH WERE PERFECT. I DON’T HAVE MY OWN TEETH NOW. I HAD THEM REMOVED BECAUSE I WAS SEXUALLY ABUSED IN THAT MANNER AND I COULDN’T STAND MY OWN MOUTH AND THAT’S ONE OF THE THINGS THAT HAPPENS WITH YOUR BODY. MANY THINGS HAPPEN WHEN YOU’VE BEEN ABUSED LIKE THAT AND I THINK THESE ARE THINGS THAT PEOPLE WHO WORK IN THE MEDICAL PROFESSION SHOULD KNOW ABOUT.”***



## CRISIS LINE SUPPORT

First Nations and other Indigenous people who require emotional support can contact the 24-hour [KUU-US Crisis Line at 1-800-588-8717](https://www.kuu.us/crisis-line).

Non-Indigenous people who require emotional support can contact the toll-free 24-hour [Crisis Services Canada Line at 1-833-456-4566](https://www.crisisservices.ca).

# IMPACTS OF RACIST COLONIAL SYSTEMS

## WHAT HOSPITALS NEED TO KNOW 1

### ELDERS & COMMUNITY MEMBERS

- Elders know from painful experiences that racism is still happening in hospitals. It is necessary to understand and move away from racist, colonial attitudes and behaviours and toward positive, respectful attitudes and behaviours.
- Elders know that colonialization, with its inherent abuses of authority, including in Indian Residential Schools and Indian Hospitals, has severely affected the health of First Nations people.

### HEALTH CARE PROVIDERS

- Elders may react when they enter clinical and institutional spaces and feel different or intimidated, especially if they are the only Indigenous person there.
- Institutions and their policies evolved from colonialism. Health transformation is coming from First Nations voices through collaboration.
- The power and influence health care providers have to interrupt racism and role model cultural safety is important to consider.

***“IF A PERSON HAS AN ADDICTION OR IS AN ALCOHOLIC, THEY ARE STILL A HUMAN BEING AND SHOULD NOT BE TREATED AS A DOG. WE ARE HUMAN BEINGS. A LOT OF OUR PEOPLE WILL NOT JUMP UP AND MAKE NOISE BECAUSE THEY ARE FILLED WITH RESPECT AND HUMILITY.”***

# IMPACTS OF TRAUMA

## WHAT HOSPITALS NEED TO KNOW 2

### ELDERS & COMMUNITY MEMBERS

- Elders need health care providers to recognize signs of trauma and understand triggers and the 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.

### HEALTH CARE PROVIDERS

- Trauma and racism is not only in the past. Trauma is intergenerational and everyone's trauma is different.
- Learning the history of colonization, including Indian Residential Schools and Indian Hospitals, will increase the ability of providers to recognize signs of trauma and be better able to support those affected.
- There are different types and signs of trauma. Trauma can present differently and everyone has different coping mechanisms.
- The impacts of lateral violence need to be addressed at all levels of service delivery.

*“YOU OBSERVE AND WATCH WHAT HOSPITALS NEED TO KNOW 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.”*

# INDIGENOUS PERSPECTIVES & CULTURAL SAFETY

## WHAT HOSPITALS NEED TO KNOW 3

### ELDERS & COMMUNITY MEMBERS

- An 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 all family members.
- It is important to respect traditional ways of knowing and understanding, especially ceremony.
- Culturally safe spaces are needed to practice traditional ceremonies, along with access to cultural support and the ability to 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.

### HEALTH CARE PROVIDERS

- Elders' knowledge, wisdom and teachings are essential to culturally safe and trauma-informed care.
- Learning different cultural perceptions through consistent dialogue and strong partnerships will enhance the delivery of culturally safe and trauma-informed care.
- An Indigenous lens will be essential to guide the future development of hospital protocols and policies.
- Health care providers need to recognize different perspectives on health and wellness.
- White privilege can get in the way of providing culturally safe services.



Go to [APPENDIX D](#) for the definition of Cultural Safety

# ADVOCACY & COMMUNICATION

## WHAT HOSPITALS NEED TO KNOW 4

### ELDERS & COMMUNITY MEMBERS

- Elders need access to advocates and support people 24 hours a day, seven days a week.
- Elders are not getting proper treatment due to 1) avoidance of health care facilities and 2) feeling unsafe sharing symptoms, as well as 3) misdiagnosis due to racism and 4) health care providers' use of overly complex language.
- Elders say delays in treatment happen because many Elders do not ask for second opinions.
- Elders need regular updates on wait times.

### HEALTH CARE PROVIDERS

- Time and safe spaces are needed to recognize and address harmful behaviours by health providers (e.g., one-on-one discussions, huddles with staff).
- Providers recognize they need to spend more time communicating with patients. They may misinterpret interactions with patients experiencing anxiety or anger as a result of triggered trauma.
- Time, effort, commitment and courage are needed to recognize, interrupt and address Indigenous specific racism. This may be uncomfortable but is necessary to create accountability and responsibility to embedding cultural safety in the health care environment.

*"WE NEED SOMEONE TO GUIDE US THROUGH THE SYSTEM. IT IS FOREIGN TO US, AND IT IS VERY HARD FOR ME TO ASK QUESTIONS OR MAKE DECISIONS BECAUSE OF MY EXPERIENCE AT RESIDENTIAL SCHOOL, WHERE WE WERE NOT ALLOWED TO ASK QUESTIONS, WE WERE NOT ALLOWED TO HAVE AN OPINION, AND WE HAD TO ACCEPT WHAT THEY TOLD US OR THE PUNISHMENT WAS REALLY SEVERE."*

*~ ELDER GINA LAING*

# COMPREHENSIVE SUPPORT

## WHAT HOSPITALS NEED TO KNOW 5

### ELDERS & COMMUNITY MEMBERS

- 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.

### HEALTH CARE PROVIDERS

- Providers need an increased awareness of community resources to help them better integrate their services and support their patients.
- Health care providers also need to be open to creating environments and providing services where traditional practices are welcomed and supported.
- Health care providers need to examine critically what beliefs and practices might be getting in the way of safe services for Indigenous people.



# RECOMMENDED ACTIONS FOR CULTURALLY SAFE AND TRAUMA-INFORMED CARE

THIS SECTION SUMMARIZES THE MAJOR RECOMMENDATIONS MADE COLLABORATIVELY BY ELDERS, COMMUNITY MEMBERS AND HEALTH PARTNERS, AS WELL AS THE CORRESPONDING INITIAL ACTIONS/RESPONSES COMMITTED TO BY WEST COAST GENERAL HOSPITAL, ISLAND HEALTH, THE FIRST NATIONS HEALTH AUTHORITY AND NUU-CHAH-NULTH TRIBAL COUNCIL AS OF JANUARY 2019.

CLICK ON THE TILES TO GO THAT SECTION

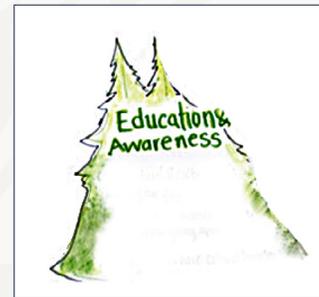
## 1 INCREASED ENGAGEMENT & RELATIONSHIP BUILDING



## 2 DEVELOP ACTION PLANS



## 3 EDUCATION & AWARENESS



## 4 ADVOCACY & SUPPORT



## 5 FIRST NATIONS MEDICINE, HEALING & FOODS



## 6 CULTURALLY SAFE SPACES



## 7 POLICY & PROTOCOL DEVELOPMENT



## 8 LINKS TO COMPREHENSIVE COMMUNITY SUPPORT



# INCREASE ENGAGEMENT & RELATIONSHIP BUILDING

## RECOMMENDATION 1



CLICK ON THESE TILES TO GO BACK TO THE FIRST PAGE OF THE SECTION

*"IT SEEMS TO WORK BETTER FOR US TO GATHER LIKE THIS AND SHARE SOMETHING...IT'S BETTER TO DO THIS THAN [RESEARCHERS] COME INTO OUR COMMUNITY AND INTO OUR HOMES."*

- ELDER RUTH CHARLESON,  
HESQUIAHT FIRST NATION

RECOMMENDATIONS	RESPONSES & ACTIONS
<p>1.1 Host a follow-up gathering with Elders, community service staff, health care staff and community members.</p>	<p><b>Response to 1.1</b> The First Nations Health Authority and Island Health hosted a community follow-up gathering with Elders, community members and health partners at Tseshaht Nation on June 14, 2019.</p>
<p>1.2 Facilitate ongoing dialogue between community and health care providers* 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 at Cultural Safety Committee meetings).</p>	<p><b>Response to 1.2</b> The Vancouver Island Regional Centre—a partnership between Island Health and the University of Victoria, and part of the BC SUPPORT Unit promoting community-oriented research—has created a new role for an Indigenous Research Coordinator. This role will work in collaboration with the FNHA and will focus on building relationships with Nuu-Chah-nulth and other Indigenous community members to support Indigenous-led knowledge generation that will foster learning and understanding.</p>
<p>1.3 Promote relationship building between hospital providers, community service providers (e.g., nurses and pharmacists), family and caregivers for comprehensive care.</p>	<p><b>Response to 1.3</b> West Coast General Hospital will bring concerns to Cultural Safety Committee Indigenous Patient Partners and will ensure alignment of this work with the development of integration teams.</p>
<p>1.4 Health leaders can learn by going into community which will help to make better decisions.</p>	

\*Health care providers are defined here as workers who directly provide health care services to patients, such as medical doctors, nurses, pharmacists, community health workers, counsellors, social workers, dentists, optometrists, dieticians, physiotherapists and occupational therapists.

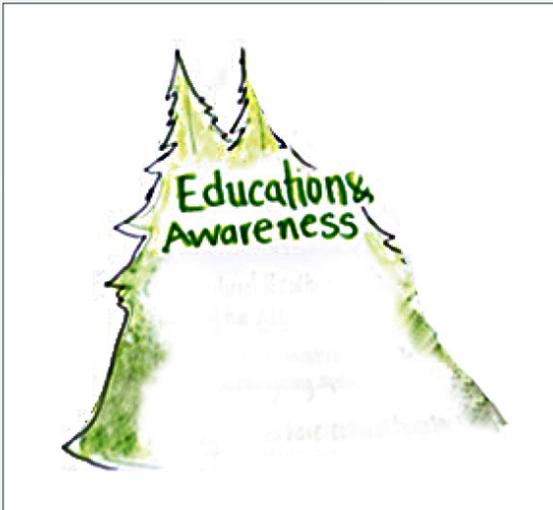
# DEVELOP ACTION PLANS

## RECOMMENDATION 2



RECOMMENDATIONS	RESPONSES & ACTIONS
<p>2.1 <b>Develop</b> action plans with concrete deadlines, prioritize short-term and long-term goals, and clarify roles in partnership with Nuu-chah-nulth members.</p>	<p><b>Response to 2.1</b> Island Health <i>commits to creating a Nuu-Chah-Nulth Patient Advisory Council to provide a venue for continued learning, Indigenization and updating protocols, framework development, implementation planning and evaluation processes for cultural safety and trauma- and violence-informed care. This committee will provide a consistent and ongoing connection and accountability with an established group of engaged community members with strengthened relationships, and a deep understanding of what is needed for ongoing change and improvement.</i></p>
<p>2.2 <b>Be accountable</b> by updating community on plans in a timely manner by tying communication directly to action plans.</p>	<p><b>Response to 2.2</b> On June 14, 2019, Island Health and the FNHA <i>shared planned actions at the community follow-up gathering.</i></p>

## RECOMMENDATION 3



### RECOMMENDATIONS

3.1 CULTURAL SAFETY & TRAUMA-INFORMED CARE TRAINING

3.2 HEALTH CARE PROVIDER COMMUNICATION

3.3 AWARENESS & KNOWLEDGE SHARING

# CULTURAL SAFETY & TRAUMA-INFORMED CARE TRAINING

## RECOMMENDATION 3.1



RECOMMENDATIONS	RESPONSES & ACTIONS
<p><b>3.1.1 Ensure</b> staff meet a minimum level of cultural safety and humility.</p> <p><b>Deliver</b> 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.</p>	<p><b>Response to 3.1.1.</b> Island Health <i>commits to creating a Nuu-Chah-Nulth Patient Advisory Council to provide a venue for continued learning, Indigenization and updating protocols, framework development, implementation planning and evaluation processes for cultural safety and trauma- and violence-informed care. This committee will provide a consistent and ongoing connection and accountability with an established group of engaged community members with strengthened relationships, and a deep understanding of what is needed for ongoing change and improvement.</i></p>
<p><b>3.1.2 Educate</b> about ongoing experiences and impacts of historical trauma from colonialism, particularly the intergenerational effects of abuse from Indian Residential Schools, Indian Hospitals and the 1960s scoop on Nuu-chah-nulth Peoples.</p>	
<p><b>3.1.3 Support staff</b> in being self-reflective about their level of cultural humility, which will further enable cultural safety.</p>	

# CULTURAL SAFETY & TRAUMA-INFORMED CARE TRAINING

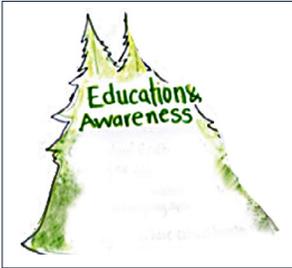
## RECOMMENDATION 3.1



RECOMMENDATIONS	RESPONSES & ACTIONS
<p><b>3.1.4 Incorporate</b> 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.</p>	
<p><b>3.1.5 Educate</b> 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.</p>	
<p><b>3.1.6 Ensure collaboration</b> between Island Health and Port Alberni City Council to address systemic racism, as frontline staff are also community members.</p>	

# HEALTH CARE PROVIDER COMMUNICATION

## RECOMMENDATION 3.2



***"I SPEAK THE LANGUAGE, I UNDERSTAND THE NUU-CHAH-NULTH DIALECTS, AND THAT'S IMPORTANT FOR OUR ELDERS."***

*– ELDER HELEN DICK,  
COMPASSIONATE SERVICE VOLUNTEER,  
RETIRED NURSE,  
TSESHAHT FIRST NATION*

### RECOMMENDATIONS

**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.

### RESPONSES & ACTIONS

**Response to 3.2.1** Island Health will support leadership and staff to advance their cultural safety learning journey and support the creation of processes that create accountability around racism, including the participation in Communities of Practice and other advanced cultural safety learning opportunities.

Health Care providers are committed to continuing to improve understanding of the health impacts of trauma to improve communication while providing trauma-informed care.

Providers will reduce the use of jargon and stigmatizing language, use active listening and compassionate confirmatory questions to ensure comprehension.

# HEALTH CARE PROVIDER COMMUNICATION

## RECOMMENDATION 3.2



RECOMMENDATIONS	RESPONSES & ACTIONS
<p>3.2.2 <b>Ask</b> (in a polite tone) questions such as, “Do you understand?” or “Can you repeat what I said?”</p>	
<p>3.2.3 <b>Provide</b> alternatives to written forms of communication for those who cannot read (e.g., advocacy support, visuals).</p>	<p><b>Response to 3.2.3</b> Family members <i>will be asked to help foster communication when and as needed between providers and Elders. The Aboriginal Liaison Nurse will also provide this support.</i></p> <p>The work of the Island Health Nuu-chah-nulth Patient Advisory Council <i>will include exploring better ways to communicate with Elders, including visual aids.</i></p>
<p>3.2.4 <b>Recognize</b> 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 <b>Ask</b> 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 <b>Establish</b> 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 <b>Record</b> personal stories of patients in the patient chart, including experiences of trauma.</p>	<p><b>Response to 3.2.7</b> Providers <i>will seek to understand Elders’ personal stories and past trauma and will explore how to better document personal stories in medical charts to ensure all care team members are aware.</i></p>

# AWARENESS & KNOWLEDGE SHARING

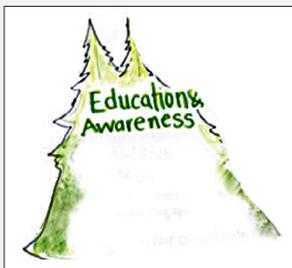
## RECOMMENDATION 3.3



RECOMMENDATIONS	RESPONSES & ACTIONS
<p>3.3.1 <b>Hold</b> hospital orientation tours and open houses to make Elders aware of hospital resources and allow them to meet doctors and other health care providers before they come as patients.</p>	<p><b>Response to 3.3.1</b> Nuu-chah-nulth Tribal Council <i>will continue to host events to promote accessibility and safety in hospitals.</i></p>
<p>3.3.2 <b>Establish</b> a health newsletter on all events happening in the medical and Nuu-chah-nulth communities for community and health care providers. Use existing FNHA and Nuu-chah-nulth websites to raise awareness and provide consistent information. Provide more regular updates about health care programs and services providers, working closely with the Nuu-chah-nulth Tribal Council.</p>	
<p>3.3.3 <b>Host</b> cultural awareness activities for health staff (e.g., cultural exchange programs, cultural workshops and training).</p>	<p><b>Response to 3.3.3</b> Island Health and the Nuu-chah-nulth communities <i>will continue an exchange program for health care staff. Some nurses have already participated.</i></p> <p><i>A recognition that these efforts to build awareness will also be accompanied by sustained efforts to address racism and ongoing colonial dynamics to address the roots of harm.</i></p>

# AWARENESS & KNOWLEDGE SHARING

## RECOMMENDATION 3.3



RECOMMENDATIONS	RESPONSES & ACTIONS
<p>3.3.4 <b>Develop</b> print and online resources for communities in partnership with the Nuu-chah-nulth Tribal Council (especially resources like the Patient Care Plan booklets, such as the Aboriginal Pregnancy Passport) that integrate the cultural and traditional healing patients are seeking 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 a booklet that lists financial and mobility resources for Elders. Make resources available in communities and in the waiting room.</p>	
<p>3.3.5 <b>Develop</b> training booklets for health care providers and booklets on each Nuu-chah-nulth community.</p>	
<p>3.3.6 FNHA should <b>hold</b> more educational events (e.g., workshops on Pharmacare, prescriptions and harm reduction).</p>	<p><b>Response to 3.3.6</b> The creation of the Health Benefits Community Relations team <i>has led to more engagement and awareness raising since 2018. The FNHA Health Protection team leads <a href="#">harm reduction workshops</a>.</i></p>
<p>3.3.7 <b>Ensure</b> pharmacists are aware of changes to medical coverage. <b>Ensure</b> 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>	<p><b>Response to 3.3.7</b> FNHA Health Benefits <i>is continuing to build relationships with providers across BC. The Health Benefits Community Relations team has been supporting this effort and work to actively reach out to individual pharmacists. We also hold relationships with the BC Pharmacy Association and through that relationship have delivered information workshops for pharmacists about plan changes.</i></p>

# ADVOCACY & SUPPORT

## RECOMMENDATION 4



RECOMMENDATIONS	RESPONSES & ACTIONS
<p>4.1 Provide 24/7 access to Elder advocates and counsellors to help those with language barriers and trauma triggers.</p>	<p><i>Response to 4.1 and 4.4 WCGH and Nuu-chah-nulth Tribal Council in partnership are providing seven-day-a-week Aboriginal Liaison Nurse and Nurse Navigator support.</i></p>
<p>4.2 Health providers and advocates should <b>be</b> proactive, knowledgeable, 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 to determine and address the barriers to culturally safe services and increase their own capacity to provide culturally safe services.</p>	
<p>4.3 Increase visibility of Aboriginal Liaison Nurses/Patient Navigators. <b>Ensure</b> they are clearly positioned near the entry to emergency and that Elders to not have to ask for them. Elders should never have to be in the emergency room alone.</p>	<p><i>Response to 4.3 WCGH has brought forward posters in the Emergency Department to create awareness of the Aboriginal Liaison Nurse and Nurse Navigator.</i></p>
<p>4.4 <b>Include</b> family members as part of the care team. Proactive efforts must be made, as it's not something that people are familiar with yet.</p>	
<p>4.5 <b>Build capacity</b> in communities to hire employees and recruit volunteers who can support Elders in raising concerns, accessing resources and explaining trauma-informed care.</p>	
<p>4.6 <b>Make</b> First Nations Health Benefits support line available 24/7 and <b>expand</b> benefit coverage for Patient Travel.</p>	<p><i>Response to 4.6 The next benefit area FNHA Health Benefits will be reviewing for transformation is Medical Transportation.</i></p>

# FIRST NATIONS MEDICINE, HEALING & FOODS

## RECOMMENDATION 5



*"THE BEST MEDICINE I COULD HAVE EVER TAKEN WAS OUR CULTURAL AND TRADITIONAL WAYS, IN FINDING MYSELF AGAIN."*

— ELDER MARIE SAMUEL,  
AHOUSAHT FIRST NATION

RECOMMENDATIONS	RESPONSES & ACTIONS
<p>5.1 <b>Increase</b> access to traditional foods and medicines. Include traditional food options in hospital and incorporate traditional medicines into treatment plans.</p>	
<p>5.2 <b>Embed</b> 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.</p>	
<p>5.3 <b>Create</b> an Elder-in-Residence position.</p>	<p><b>Response to 5.3</b> Island Health Island is piloting an Elder-in-Residence program in North Island hospitals with the intent of expanding this program across the island following a meeting of Coast Salish and Nuuchahnulth Health Directors (the Health Director Table is to identify Elders and ensure respect of protocols and traditional values for recruitment process). In the meantime, steps and actions need to be taken to ensure that health care environments are safe for Elders and other Indigenous people to work and to access services.</p>
<p>5.4 <b>Promote collaboration</b> 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.</p>	
<p>5.5 <b>Integrate</b> 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.)</p>	

# CULTURALLY SAFE SPACES

## RECOMMENDATION 6



**“GRATEFUL FOR THE ALL NATIONS ROOM. IT MAKES [PATIENTS] FEEL THAT THERE IS CARE AND SUPPORT THERE FOR THEM.”**

— ELDER GERALDINE EDGAR,  
SENIOR QUU'ASA CULTURAL WELLNESS WORKER,  
HESQUIAHT NATION

### RECOMMENDATIONS

**6.1 Provide** culturally safe spaces for families to support one another and to practise traditional ceremonies, including brushing, smudging and other forms of traditional medicine.

### RESPONSES & ACTIONS

**Response to 6.1** In the fall of 2019, WCGH opened the All Nations Healing Room – a culturally safe and peaceful space within the Patient Care Centre for families to gather and practise traditional ceremonies, such as smudging, cleansing and singing that is welcoming and open. The project is moving forward with the support of the WCGH Cultural Safety Committee. The room is located in an easy area to find, accessed from the atrium close to the washrooms and adjacent to the West Coast Café. The space has a kitchenette and space for food preparation as well as adjustable lighting to support a variety of needs.

**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.

**Response to 6.2** Island Health commits to ongoing efforts to build awareness about the importance of this initiative and to address any questions or misunderstandings that may come to the surface around why this space is needed. Island Health commits to supporting staff to be able to respond to any racism that comes up around this or other initiatives to create safety.

**6.3 Improve** the physical accessibility of the emergency department (e.g., locate Emergency Admissions closer to the parking lot).

# POLICY & PROTOCOL DEVELOPMENT

## RECOMMENDATION 7



### RECOMMENDATIONS

7.1 INDIGENIZE & UPDATE PROTOCOLS

7.2 CONTINUOUSLY MONITOR & REPORT ON LONG WAIT TIMES IN EMERGENCY

7.3 REPLACE THREATENING SIGNAGE WITH RESPECTFUL SIGNAGE & POST A PATIENT BILL OF RIGHTS THROUGHOUT HEALTH FACILITIES TO RAISE AWARENESS AMONG STAFF & COMMUNITY MEMBERS

7.4 HUMAN RESOURCES

# INDIGENIZE & UPDATE PROTOCOLS

## 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.*

RECOMMENDATIONS	RESPONSES & ACTIONS
<p>7.1 Implement a cultural safety policy within WCGH to receive complaints and address issues in a culturally safe way (e.g., develop a case quality review committee, offer navigator support for the Patient Quality Complaints process and install complaints boxes in main service areas).</p>	<p><b>Response to 7.1</b> Island Health <i>has made increasing cultural safety and humility practices a major priority in its Annual Priorities Plan for 2018-2019. The work of spreading cultural safety and humility will continue to 2019/20 and subsequent years.</i></p> <p><i>The KUU-US Crisis Line is available for Indigenous patients in emergency departments who need follow-up with mental health issues.</i></p> <p><i>Island Health will explore the option of including the Nuuchahnulth First Nations Patient Quality Table.</i></p> <p><i>Island Health is in the process of exploring the use of its Patient Safety and Learning System to provide a method for community members to input their complaints around a lack of cultural safety. This would ensure that complaints are documented and compiled for further management.</i></p>
<p>7.1.2 Ensure Indigenous perspectives and beliefs are reflected in policies (e.g., protocol to ask and respect families' beliefs around death).</p>	
<p>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.</p>	

# POLICY & PROTOCOL DEVELOPMENT

## RECOMMENDATION 7.1, 7.2 & 7.3



*“POLICIES AREN’T JUST IN THE HOSPITALS, IT’S ALL MEDICAL CARE – BECAUSE WE’RE RED TAPE, INDIGENOUS PEOPLE ARE RED TAPE. HAD THAT EXPERIENCE WHERE DOCTORS WON’T DO REFERRALS OR FOLLOW-UPS BECAUSE OF THE RED TAPE – “TOO MUCH WORK.”*

*– ELDER GAIL GUS,  
TSESHAHT FIRST NATION*

RECOMMENDATIONS	RESPONSES & ACTIONS
<p>7.1.4 <b>Include</b> coverage of BC Paramedic services as part of Medicare for consistent quality of care regardless of First Nations status.</p>	
<p>7.1.5 <b>Reduce</b> 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/reimbursement for medical equipment and services.</p>	<p><b>Response to 7.1.5</b> The recent FNHA Health Benefits <i>transition of dental, vision care, medical supplies and equipment (MS&amp;E), and some pharmacy benefits to Pacific Blue Cross</i> means that the process for accessing benefits should be simpler, faster and more streamlined.</p>
<p>7.2 <b>Continuously</b> monitor and report on long wait times in emergency.</p>	<p><b>Response to 7.2</b> WCGH will continue to <b>monitor</b> and assess wait times for emergency care (Monthly Emergency Department Activity Report).</p> <p>Island Health is increasing trauma-and violence-informed care in all Emergency Rooms, and will invite Nuu-chah-nulth Elders to contribute to this project.</p> <p>Island Health is in the process of developing a Harm Reduction policy, to which Nuu-chah-nulth Elders and community could contribute.</p>
<p>7.3 <b>Replace</b> 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><b>Response to 7.3</b> Island Health will bring the Patient Bill of Rights to communities for input and development.</p>

# HUMAN RESOURCES

## RECOMMENDATION 7.4



*“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.”*

*– ANONYMOUS ELDER*

RECOMMENDATIONS	RESPONSES & ACTIONS
<p>7.4.1 <b>Include</b> cultural humility in job descriptions as a requirement.</p>	<p><b>Response to 7.4</b> Island Health Senior Executives <i>attended the follow-up gathering in June 2019 to learn about the report findings and participate in the engagement process.</i></p>
<p>7.4.2 <b>Develop</b> 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 (which could include a conversation with an Elder).</p>	
<p>7.4.3 <b>Provide</b> health care providers with opportunities to maintain a healthy mind, body and spirit and prevent burnout.</p>	
<p>7.4.4 <b>Encourage</b> providers to seek opportunities to work in communities and create opportunities for community nurses to work in hospitals.</p>	
<p>7.4.5 <b>Improve</b> 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>	

## RECOMMENDATION 8



### RECOMMENDATIONS

8.1 DISCHARGE PLANNING

8.2 FAMILY CONNECTION SUPPORT

8.3 PRIMARY CARE ACCESS

8.4 CULTURALLY APPROPRIATE DETOX SERVICES

# DISCHARGE PLANNING & FAMILY CONNECTION SUPPORT

## RECOMMENDATION 8.1 & 8.2



RECOMMENDATIONS	RESPONSES & ACTIONS
<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"><li>• <b>Ensure</b> health providers make family members and advocates aware of the discharge plan for Elders.</li><li>• <b>Be flexible</b> 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.</li><li>• <b>Actively use</b> the referral pathway to the KUU-US Crisis Line Society when discharging suicidal patients.</li><li>• <b>Ensure</b> medical equipment is provided when patients are discharged.</li></ul>	
<p>8.2 Support Elders to stay connected to family and community:</p> <ul style="list-style-type: none"><li>• <b>Be creative</b> with remote health services.</li><li>• <b>Network</b> the networks.</li><li>• <b>Provide</b> access to telehealth or Skype to talk to family.</li><li>• <b>Increase</b> hospital visiting hours.</li></ul>	<p><i>Response to 8.2 Island Health has made the Internet available in all hospitals and will continue to work with the FNHA to strive to increase access to telehealth.</i></p>

# PRIMARY CARE ACCESS & CULTURALLY APPROPRIATE DETOX SERVICES

## RECOMMENDATION 8.3 & 8.4



RECOMMENDATIONS	RESPONSES & ACTIONS
<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 <b>sending</b> mobile primary care teams and specialists to remote communities, <b>opening</b> more walk-in and urgent care clinics in communities and <b>keeping</b> these clinics open after office hours.</p>	
<p>8.4 Increase access to culturally appropriate detox services.</p>	<p><b>Response to 8.4</b> The WCGH Cultural Safety Committee <i>will seek opportunities to develop culturally appropriate detox services.</i></p>

# HOW WE WILL KNOW WHEN TRAUMA-INFORMED CARE IS SUCCESSFUL

ELDERS AND COMMUNITY MEMBERS SAID THEY WILL KNOW TRAUMA-INFORMED CARE IS SUCCESSFUL WHEN THEY CAN FEEL SAFE, RESPECTED AND ACKNOWLEDGED – RATHER THAN FEEL FEAR AND APPREHENSION, AND AS THOUGH THEY HAVE TO FIGHT FOR SERVICES WHEN THEY COME TO THE HOSPITAL – AND WHEN HEALTH PARTNERS AND COMMUNITY ARE WORKING TOGETHER EFFECTIVELY.

Indicators of how Elders and community members will know trauma-informed care is successful are listed on the right. To determine whether cultural safety and trauma-informed care are both adequately implemented, participants recommended developing an evaluation process that looks at the experiences of every Elder and community member accessing care. Participants also recommended incentivizing the delivery of culturally safe care, bringing case studies and experiences to the Cultural Safety Committee, getting feedback from an Elder committee in a neutral environment, and receiving coordination support from the FNHA.



Graphic facilitator Kelly Foxcroft-Poirier begins the graphic recording of the Continuing Our Journey gathering, June 2019

## INDICATORS

### TRAUMA-INFORMED CARE & CULTURAL SAFETY

- Improved provider and patient satisfaction with treatment and communication (i.e., satisfactory answers to questions);
- increased reports of positive experiences;
- reductions in harmful incidents;
- a change to more positive, accepting attitudes free of discrimination from service providers and hospital staff;
- positive pre-discharge evaluations with Elder advocates;
- inclusion of traditional medicines in care;
- the presence of family rooms in the emergency department;
- completion of cultural safety and humility training by 100% of staff;
- feedback from Nuuchahnulth Patient Advisor Table;
- cultural safety starts to appear in new and updated job descriptions;
- cultural safety and humility interview questions and response matrices developed; and
- new tools evolve to measure and support development staff cultural safety and humility.

### ACCESSIBILITY & SAFETY OF PRIMARY CARE CLINIC

- reductions in emergency visits due to increased availability of physician care in communities; and
- reductions in preventable illness and deaths (linked to increased use of health services, especially before patients get seriously ill).

# THE BEST WAY TO IMPLEMENT TRAUMA-INFORMED CARE

WORKSHOP PARTICIPANTS MADE BOTH OVERARCHING AND SPECIFIC RECOMMENDATIONS ON HOW TO BEST IMPLEMENT TRAUMA-INFORMED CARE IN THEIR COMMUNITIES AND HEALTH CARE SYSTEM. BASED ON FLIPCHART NOTES FROM BREAKOUT GROUPS, THE RECOMMENDATIONS THAT GENERATED THE MOST CONSENSUS ARE:

1. Improve communication between health staff and families.
2. Make cultural safety and trauma-informed care training mandatory for all staff.
3. Create safe spaces for Elders and family to be together.
4. Plan follow-up and next steps to maintain the momentum for taking action.
5. Develop a framework, implementation plan and evaluation process for cultural safety and trauma-informed care with a trauma-informed care team made up of Elders, community representatives, hospital staff, doctors and research and quality improvement representatives.



## CONCLUDING THOUGHTS

ABOVE ALL, NUU-CHAH-NULTH FIRST NATIONS ELDERS AND COMMUNITY MEMBERS EXPRESSED THE NEED FOR AN ENVIRONMENT OF TRUST. Encouraged by the success of the workshop, they hope to create a health care environment that respects and welcomes family, respects and welcomes diversity and differences, and most importantly, is prepared to compassionately care for all First Nations Elders and community members presenting to the Emergency Department. Elders and community members highly recommended that First Nations communities continue to work together with hospitals to create safer health care environments, and to recognize that healing from trauma is a long-term journey that will require consistent and respectful engagement with health care providers. In response to Nuu-chah-nulth Elders' and community members' recommendations, participating health partners agreed to paddle together on this journey to create a safer health care environment. Two years later, Elders at the 2019 Continuing Our Journey gathering shared that they have started to see hopeful signs of improvement:

***"I'VE BEEN SEEING THE DIFFERENCE, I'VE BEEN PAYING ATTENTION. TO FEEL THE CHANGES THROUGH MY DAUGHTER WAS AWESOME – MY LAST EXPERIENCE AT THE HOSPITAL WAS A REALLY GOOD ONE...I WAS NOT TREATED LIKE I WAS INSIGNIFICANT."***

*- ELDER GAIL GUS*

However, there is still much work to be done, as Nuu-chah-nulth patients and caregivers continue to have culturally unsafe experiences. We call on Island Health, West Coast General Hospital and other responsible actors in the health system to continue moving forward with their commitment to improving cultural safety and implementing trauma-informed care by following the recommendations outlined in this report and listening to First Nations voices with open hearts, so that every patient is treated with honour, respect and dignity.



# APPENDIX A: TRAUMA-INFORMED & CULTURALLY SAFE CARE WORKSHOP PARTICIPANTS

## NUU-CHAH-NULTH ELDERS

- Ina Seitcher,  
Former Manager of Nursing at West Coast General Hospital,  
Tla-o-qui-aht First Nation and Ahousaht First Nation
- Barney Williams,  
FNHA Cultural Advisor, Tla-o-qui-aht First Nation
- Ruth Charleson,  
Hesquiaht First Nation
- Benedict Jack Sr,  
Mowachaht/Muchalaht First Nation
- Harley Wylie,  
Tseshah First Nation
- Christina Christianson (Cox),  
K:yu:'k't'h'/Che:k'tles7et'h' (Kyuquot/Cheklesah) First Nation
- Christine Edgar,  
Ditidaht First Nation
- Levi Martin,  
Tla-o-qui-aht First Nation
- Hilda Nookemis,  
Huu-ay-aht First Nation
- Daisy Georgina Laing,  
Uchucklesah First Nation
- Ray Samuel,  
Ahousaht First Nation
- Marie Samuel,  
Ahousaht First Nation

## COMMUNITY REPRESENTATIVES

- Edward Johnson,  
Huu-ay-aht First Nation
- Hambone August,  
Ahousaht First Nation
- Bea Sam,  
Ahousaht First Nation

- Michelle Sam,  
Ahousaht First Nation
- Joe McKinnon,  
Alberta
- Gail Baker-Gus,  
Tseshah First Nation
- John Watts,  
Tseshah First Nation
- Agnes Jack,  
Mowachaht First Nation
- Laverne Cook,  
Huu-ay-aht First Nation
- Samantha Christianson,  
Ka:'yu:'k't'h'/Che:k'tles7et'h' First Nation
- Matilda Atleo,  
Tseshah First Nation
- Jennifer Gallic,  
Tseshah First Nation

## PRESENTERS

- Rod Jeffries,  
Facilitator, Ancestral Visions, Tyendinaga Mohawk Territory
- Janice Johnson,  
FNHA NuU-chah-nulth Community Engagement  
Coordinator & WCGH Cultural Safety Committee Chair
- Dr. Amanda Ward,  
Director, Research and Knowledge Exchange, FNHA
- Dr. Shannon McDonald,  
Deputy Chief Medical Officer, FNHA
- Marie Duperreault,  
Director Alberni Clayoquot Region
- Pam Rardon,  
Site Director for WCGH

# APPENDIX A: TRAUMA-INFORMED & CULTURALLY SAFE CARE WORKSHOP PARTICIPANTS

- Kelly McColm,  
Clinical Coordinator WCGH Emergency/Intensive Care
- Harley Eagle,  
Cultural Safety Facilitator, Island Health
- Linda Fynes,  
Social Worker, WCGH
- Michelle DeGroot,  
Executive Director, Programs and Community Wellness Services, FNHA

## COMMUNITY AND HEALTH PARTNERS

- Melony Edgar,  
Ditidaht Health Director
- Darlene Leonew,  
Port Alberni Friendship Centre
- Elia Nicholson-Nave,  
Executive Director, KUU-US Crisis Line Society
- Rose Vandusen,  
KUU-US Crisis Line Society
- Kateri Deustch,  
KUU-US Crisis Line Society
- Ian Caplette,  
Quu'asa Program
- Maureen Knighton,  
Quu'asa Program
- Cindy Trytten,  
Director, Research Capacity Program, Island Health
- Dr. Diane Sawchuck,  
Research Liaison Officer, Island Health
- Vanessa Gallic,  
Aboriginal Nurse Liaison,  
Nuu-chah-nulth Tribal Council, West Coast General Hospital
- Megan Muller,  
Nuu-chah-nulth Tribal Council
- Jackelyn Seitcher,  
Home and Community Care LPN, Nuu-chah-nulth Tribal Council
- Eunice Joe,  
Vancouver Island Regional Manager, FNHA
- Sandra Tate,  
Nuu-chah-nulth Community Engagement Coordinator,  
Vancouver Island, FNHA
- Cody Caruso,  
Vancouver Island Regional Health Liaison, FNHA
- Namaste Marsden,  
Acting Director, Research and Knowledge Exchange, FNHA
- Leena Hasan,  
Qualitative Analyst, Research and Knowledge Exchange, FNHA
- Jennifer Murray,  
Acting Manager, Research and Knowledge Exchange, FNHA
- Joy Phillips,  
Nurse Navigator, Vancouver Island, FNHA
- Celeta Cook,  
Regional Planner, Vancouver Island, FNHA
- Candy-Lea Chickite,  
Community Relations Representative, Health Benefits Services, FNHA
- Larisa MacGregor,  
Nurse Navigator, Vancouver Island, FNHA
- Jesse McConnell,  
West Coast Mental Health & Addictions Services, Island Health
- Mary Knox,  
Aboriginal Health Program Manager, Central Island Team, Island Health
- Marnie Bennie,  
Island Health
- Dr. Elizabeth Hartney,  
Director, Centre for Health Leadership and Research, Royal Roads University
- Gail K. Gus,  
Tseshaht Crisis and Wellness Coordinator

# APPENDIX B: WEST COAST GENERAL HOSPITAL CULTURAL SAFETY COMMITTEE

## NUU-CHAH-NULTH COMMUNITY REPRESENTATIVES

- Bella Fred,  
Tseshah Health Director
- Charlotte Rampanen,  
Uchucklesah Health Director
- Colleen Vissia,  
Hupačasath First Nation Representative
- Coral Johnson,  
Huu-ay-aht Health Director
- Gail K Gus, Tseshah,  
Crisis Care & Wellness Coordinator
- Melony Edgar,  
Ditidaht Health Director
- Vanessa Charlong,  
Hupačasath Health Director

## NUU-CHAH-NULTH TRIBAL COUNCIL

- Deb Melvin,  
Home & Community Care Nursing
- Vanessa Gallic,  
First Nations Advocate Nurse  
(Aboriginal Liaison Nurse)
- Benedict Leonard,  
Nurse Navigator

## PORT ALBERNI FRIENDSHIP CENTRE

- Jackie Wells,  
Family & Health Services Team Leader

## KUU-US CRISIS LINE SOCIETY

- Elia Nicholson-Nave,  
Executive Director

## FIRST NATIONS HEALTH AUTHORITY

- Janice Johnson,  
Nuu-chah-nulth Community Engagement Coordinator & Chair, FNHA

## ISLAND HEALTH

- Harley Eagle,  
Cultural Safety Facilitator
- Kelly McColm,  
(Former Clinical Coordinator WCGH Emergency/Intensive Care)  
Current Manager ICU Nanaimo General Hospital
- Marie Duperreault,  
Director, Port Alberni/West Coast Communities
- Jesse McConnell,  
Manager West Coast Mental Health & Substance Use
- Pam Rardon,  
Site Director for West Coast General Hospital
- Mary Knox,  
Aboriginal Health Program Manager (Central Island Team)

# APPENDIX C: CONTINUING OUR JOURNEY VALIDATION GATHERING PARTICIPANTS

## NUU-CHAH-NULTH ELDERS

- Barbara Johnson,  
Huu-ay-aht First Nation
- Ben Jack Sr,  
Mowachaht/Muchalaht First Nation
- Cheryl Thomas (Johnson),  
Huu-ay-aht First Nation
- Christina Christianson (Cox),  
Ka:yu:'k't'h'/Che:k'tles7et'h' Nation
- Daisy Georgina Laing,  
Uchucklesaht First Nation
- Dorothy Shepherd,  
Ditidaht First Nation
- Gail Gus,  
Tseshah First Nation
- Geraldine Edgar,  
Senior Cultural Wellness Worker, Quu'asa Program  
Hesquiaht First Nation
- Helen Dick,  
Tseshah First Nation
- Levi Martin,  
Tla-o-qui-aht First Nation
- Margaret Touchie,  
Yuulu?ath First Nation
- Marie Samuel,  
Ahousaht First Nation
- Marvin Samuel,  
Ahousaht First Nation
- Ray Samuel,  
Ahousaht First Nation
- Ruth Charleson,  
Hesquiaht First Nation

## NUU-CHAH-NULTH COMMUNITY REPRESENTATIVES

- Alice Sam,  
Ahousaht First Nation
- Audrey Smith,  
Nuchatlaht Health Director
- Edward Ross,  
Tseshah First Nation
- Regina Frank,  
Uchucklesaht First Nation
- Roberta Johnson,  
Huu-ay-aht First Nation
- Samantha Christianson,  
Chief, Ka:yu:'k't'h'/Che:k'tles7et'h' First Nation
- Victoria Dick,  
Tseshah First Nation
- April Martin,  
Uchucklesaht First Nation

## FACILITATORS AND PRESENTERS

- Elin Bjarnason,  
Vice President Clinical Services Delivery, Island Health
- Harley Eagle,  
Cultural Safety Facilitator, Island Health
- Janice Johnson,  
Nuu-chah-nulth Community Engagement Coordinator,  
FNHA
- Kelly Poirier,  
Graphic Facilitator, White Raven Consulting
- Namaste Marsden,  
Manager, Research and Knowledge Exchange, FNHA
- Pam Rardon,  
Site Director, West Coast General Hospital

# APPENDIX C: CONTINUING OUR JOURNEY VALIDATION GATHERING PARTICIPANTS

## HEALTH AND COMMUNITY PARTNERS

- Alexa Norton  
Research Advisor, Research and Knowledge Exchange, FNHA
- Amanda Ward  
Director, Research and Knowledge Exchange, FNHA
- Benedict Leonard,  
Nurse Navigator
- Carol Fuller,  
Director of Human Resources, Island Health
- Cary-Lee Calder,  
Kwakaka'waka Community Engagement Coordinator, FNHA
- Chrystine Green,  
Patient Care Quality Office, Island Health
- Cody Caruso,  
Vancouver Island Regional Health Liaison, FNHA
- Courtney Defriend,  
Regional Manager Mental Health and Wellness, FNHA
- Dr. Diane Sawchuck,  
Research Liaison Officer, Island Health
- Elia Nicholson-Nave,  
Executive Director, KUU-US Crisis Line Society
- Eunice Joe,  
Vancouver Island Regional Manager, FNHA
- Jackie Wells,  
Port Alberni Friendship Centre
- Jeanette Watts,  
Manager of Nursing Services, NTC
- Jennifer Cartwright,  
BC SUPPORT Unit
- Jennifer Murray,  
Research Analyst, Research and Knowledge Exchange, FNHA
- Joanna Salken,  
Community Health Services Manager, Island Health
- Jon Rabeneck,  
Coast Salish Community Engagement Coordinator
- Kateri Deustch,  
KUU-US Crisis Line Society
- Kathleen Harris,  
Regional Nurse Manager, FNHA
- Kelly Suhan,  
Patient Care Quality Office, Island Health
- Leena Hasan,  
Qualitative Analyst, Research and Knowledge Exchange, FNHA
- Lynette Lucas,  
Director of Health, NTC
- Marie Duperreault,  
Director, Alberni-Clayoquot Region
- Mary Knox,  
Aboriginal Health Program Manager, Central Island Team, Island Health
- Michelle Hanna,  
Rural Site Director for Tofino Hospital
- Dr. Nel Wieman,  
Senior Medical Officer, Mental Health and Wellness, FNHA
- Oonagh O'Connor,  
Cultural Safety Facilitator, Island Health
- Robert Busch,  
Intern, Community Relations Team, FNHA
- Rose Vandusen,  
Crisis Response Supervisor, KUU-US Crisis Line Society
- Shannon McDonald,  
Deputy Chief Medical Officer, FNHA
- Sheila Leadbetter,  
Executive Director, Clinical Services Delivery Geo 2
- Uta Sbotto-Frankenstein,  
BC SUPPORT Unit Research Navigator, Mid-Island and North Island
- Yvette Ringhamcowan,  
Cultural Safety Facilitator, Island Health

# APPENDIX D: GLOSSARY

## RACISM

1. a belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race
2. a) a doctrine or political program based on the assumption of racism and designed to execute its principles  
b) a political or social system founded on racism
3. racial prejudice or discrimination<sup>1</sup>

**INTERPERSONAL RACISM:** Interpersonal or relational racism occurs when a person experiences discriminatory behaviour from people they encounter in their daily life (e.g., being followed by sales people in stores; being denied promotion by an employer when others are receiving one for doing less well; and having others avoid close personal contact, particularly in isolated locations or at night). Relational racism also manifests as more overtly damaging behaviour, including name-calling, as well as physical and sexual assault, and sometimes murder. Much of this behaviour is based on hostile attitudes informed by negative stereotypes. Relational racism is the most obvious form of racism. Therefore, we often perceive racism as being associated with this type of irrational bigotry that is demonstrated in personal interactions and includes demeaning language, discriminatory behavior, and/or assault. Yet, by confining racism to the realm of the interpersonal, we neglect the more insidious and perhaps destructive impacts of systemic racism (Klitgaard, 1972).<sup>2</sup>

**SYSTEMIC RACISM:** Also known as structural or institutional racism, systemic racism is enacted through societal systems, structures and institutions in the form of “requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups” (Paradies et al., 2008). Systemic racism is not in the failure by those in power (e.g., policymakers, funders) to redress such inequalities (Reading, 2013). It is commonly manifested in social exclusion and isolation that limits or

prevents political and economic participation, or access to and participation in other social systems such as education and health (Reading, 2013).<sup>3</sup>

## COLONIZATION

Colonization is a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolution level than the colonized.<sup>4</sup>

**CULTURAL SAFETY:** Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.<sup>3</sup>

**CULTURAL HUMILITY:** Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience.<sup>3</sup>

**TRAUMA:** Trauma is a normal response to a set of extremely abnormal circumstances. Trauma can be the result of early life experiences, such as child abuse, neglect, witnessing violence and disrupted attachment, as well as traumatic life events and experiences that are out of one’s control, such as violence, accidents, natural disaster, war and sudden unexpected loss. Colonization violently imposed European ideologies, ways of life and government policies on Indigenous Peoples that resulted in collective trauma reactions. Prolonged and continued exposure to these kinds of circumstances can result in trauma, including intergenerational and historical trauma.<sup>5</sup>

**INTERGENERATIONAL TRAUMA:** Intergenerational trauma is the physical, psychological, emotional and spiritual effects that can be experienced by people who live with, are related to, or are close to trauma survivors. The Aboriginal Healing Foundation describes intergenerational

## APPENDIX D: GLOSSARY

trauma as “unresolved grief that is the product of historic and traumatic experiences and that is continuously acted out and recreated in contemporary Indigenous cultures.”<sup>6</sup> There is evidence that trauma endured can be passed on to children and can lead to biological effects, including genetic modifications.<sup>7,8</sup>

**HISTORICAL TRAUMA:** Historical trauma is the cumulative emotional, psychological and spiritual wounding that carries throughout the lifespan, across generations, and emanates from a massive group trauma. From a Native American perspective, this has been referred to as a “soul wound”: trauma that occurs in the soul or spirit and disrupts critical life forces, resulting in unhealthy outcomes that are passed on and manifested in future generations.<sup>9</sup> Examples of historical trauma include genocide, colonization (e.g., Indian hospitals and residential schools), slavery and war. Intergenerational trauma is one aspect of historical trauma.

**TRAUMA-INFORMED CARE:** Trauma-informed care can be defined using several terms including trauma-informed services, trauma-informed practice, and trauma- and violence-informed care; there is no single agreed-upon definition. The FNHA’s Research and Knowledge Exchange team’s working definition of trauma-informed care for Indigenous Peoples is “health care that acknowledges that historical and intergenerational trauma at an individual and population level is a common lived experience that many Indigenous people share.”<sup>10</sup> The concept is rooted in the understanding that health care settings have directly or indirectly contributed to the “re-traumatization” of Indigenous Peoples, leading to inadequate, inappropriate, and, in some cases, deeply harmful “care.” Care that is not trauma-informed can negatively affect the physical, mental, emotional and spiritual health of an individual. Although there are many populations for which trauma-informed care is needed, trauma-informed care for Indigenous Peoples seeks to inform health care providers about past trauma and unresolved grief in order to provide health care that is free of discrimination, racism, stigmatization or re-traumatization.

Below we outline some of the definitions that have guided the FNHA’s approach to the concept.

**TRAUMA-INFORMED PRACTICE:** Trauma-informed practice, according to Dr. Evan Adams, FNHA Chief Medical Officer, is a holistic approach that begins from a place of understanding that First Nations people are overrepresented among those who have experienced psychological trauma, and this is considered in all aspects of policy, planning and service delivery.

**TRAUMA- AND VIOLENCE-INFORMED CARE:** The term trauma- and violence-informed care has been adopted by Annette Brown and colleagues, who have called for the use of a decolonizing lens when discussing the traumas experienced by Indigenous Peoples. They define trauma- and violence-informed care as “care that is respectful and affirming, requiring all staff in an organization to:

- recognize the health effects of violence from structures of society and from individuals,
- understand people’s health and social issues within the local context, and work to reduce re-traumatization.”<sup>11</sup>

**EQUITY-ORIENTED HEALTH CARE (EOHC):** Equity-oriented health care is an approach that directs resources to those with the greatest needs rather than treating everyone the same because everyone has different needs.<sup>12</sup> Specifically, EOHC reduces the effects of structural inequities, the impact of racism, discrimination and stigma and mismatches between dominant approaches to care and the needs of those most affected by health and social inequities.<sup>13</sup>

**WHITE PRIVILEGE:** White privilege is what white people experience (often unconsciously) because they are not subjected to racism. It is the unquestioned and/or unearned benefits, advantages, access and/or opportunities that exist for white members of society, or in a given context.<sup>14,15</sup>

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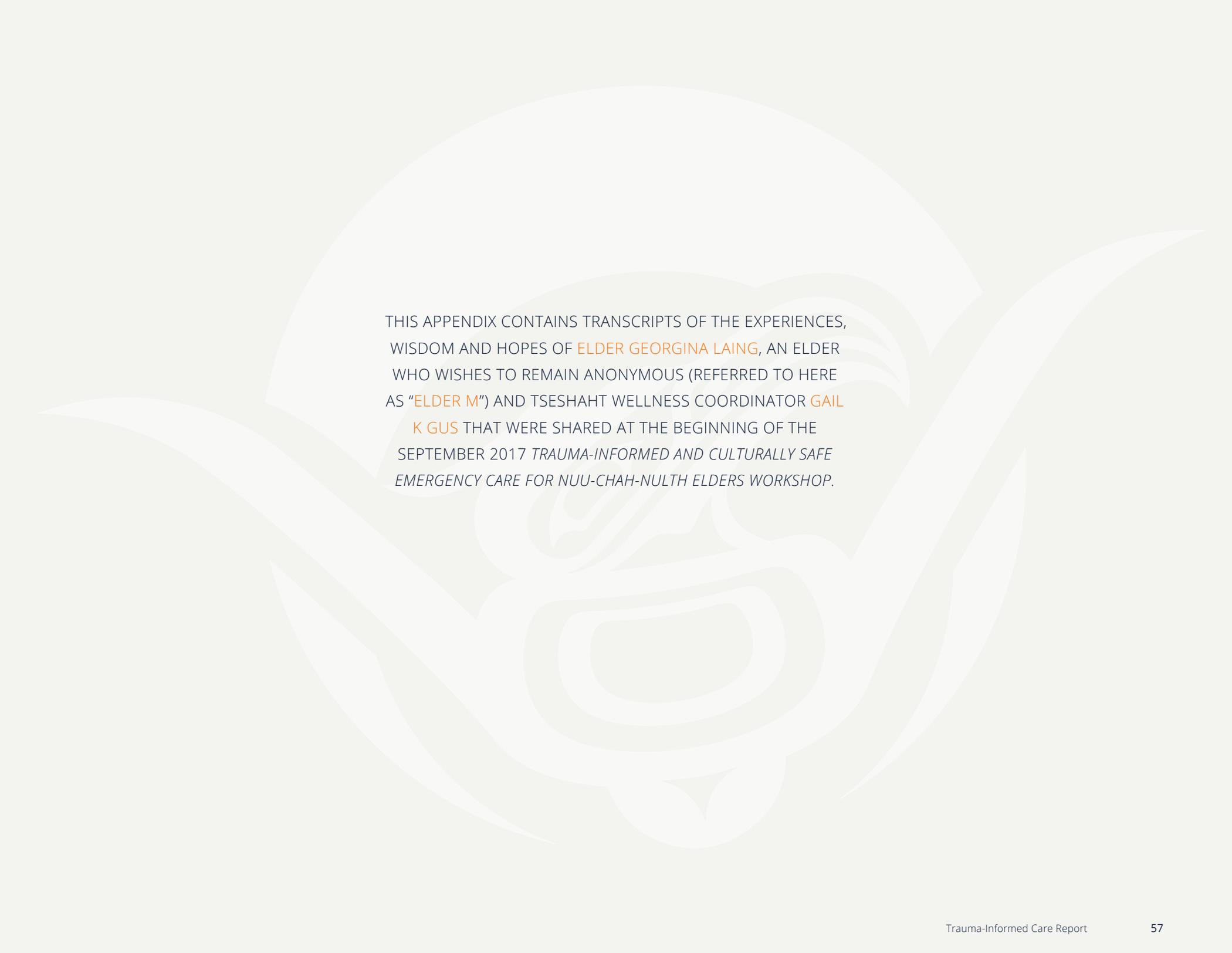
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THIS APPENDIX CONTAINS TRANSCRIPTS OF THE EXPERIENCES, WISDOM AND HOPES OF ELDER GEORGINA LAING, AN ELDER WHO WISHES TO REMAIN ANONYMOUS (REFERRED TO HERE AS "ELDER M") AND TSESHAHT WELLNESS COORDINATOR GAIL K GUS THAT WERE SHARED AT THE BEGINNING OF THE SEPTEMBER 2017 *TRAUMA-INFORMED AND CULTURALLY SAFE EMERGENCY CARE FOR NUU-CHAH-NULTH ELDERS WORKSHOP*.

# APPENDIX E: KNOWLEDGE & VOICES OF ELDERS & COMMUNITY

## ELDER DAISY GEORGINA LAING

**TREAT US WITH DECENCY AND RESPECT:** I am a residential school survivor and the impact of residential schools has made a huge difference in how I relate to the medical profession, at the hospital. I remember walking in one day into emergency and there was a child curled up on the floor and she was Native and I asked her, I said to the receptionist, nurse “What’s going on? Why is she on the floor?” And obviously she had fallen out of her wheelchair and I took another look at her and she wasn’t a child. She was an adult and I asked her “What’s wrong” and she said to me she had been having seizures and I asked her “Well hasn’t anybody looked at you?” And she said no, so I went to the nurse and I said to her she’s been laying on the floor and she’s been having seizures. She’s supposed to be in the wheelchair and I think she needs some help.” So they came out and dragged her into the emergency room and dealt with it, but I wonder if I hadn’t said anything how long she would have been laying there and it really hurt to see her in this condition. I know that she’s an addict and I don’t feel that because a person is an addict or a drunk that they need to be treated like they’re a dog. I know my words are harsh, but that’s how I feel and maybe I don’t really understand what happens and the protocol of the hospital, but I know that I’m a human being and so is she and there’s a certain amount of decency and respect. This is emotional for me.

### **WHAT I WANT US TO ACHIEVE AT THIS WORKSHOP**

I would like for the people who are present to make sure it doesn’t go away once we have said what we have to say here. I would like to see something moved on. I’d like to see someone in the hospital for people who come in and the Elders. They have no voice because they’ve lost it at the residential school.

**EXPERIENCES OF TRAUMA AND ABUSE AT INDIAN RESIDENTIAL SCHOOL:** I have a list here. I started this list when I first started dealing with what happened to me at residential school and that’s about 12 years ago now. And I remember the fear in my parents, in their voice. I remembered

in their actions and I remember them saying that if they don’t let me go to residential school that they’d be thrown into jail and I realized my parents were powerless to do anything and their situation was perilous. I feel like we were kidnapped. In some cases, many of us were taken completely out of our parents’ arms and forced to go to residential schools. When we were brought to residential school, we were confined and everything that we knew as our culture, our religion, our language was stripped from us forcibly. We were separated, isolated from our family and community. Our teachings. We were surveilled. Every moment of our time was watched. We were deprived of everything that was normal to us. Our food, our teachings, our grandparents and on and on. And we indoctrinated into a completely new, absolutely brand new religion, which when you compare it to ours is almost similar. Names are different. That’s about it. Many of us were tortured. There were broken limbs. There were bruises, cuts and they were inflicted by the people that took care of us. We were abused in every manner you could think of, physically, mentally, emotionally, culturally and spiritually. The sexual abuse was rampant. Most of the people that looked after us were pedophiles. They did nutritional experiments on us and I think I was there for the end of that and if I wasn’t there for the end of it, I feel sorry for the people and feel a lot of remorse for them because they went through way more than I did.

**IMPACTS OF TRAUMA:** I was hungry all the time and all these things have an impact on how we grew up and how we relate to things and we were given unreasonable, I think, medical and dental care while we were there. I remember being offered to have my teeth pulled out, my front teeth, because my dentist said I would be cuter without my front teeth and my teeth were perfect. I don’t have my own teeth now. I had them removed because I was sexually abused in that manner and I couldn’t stand my own mouth and that’s one of the things that happens with your body. Many things happen when you’ve been abused like that and I think these are things that people who work in the medical profession should know about.

**RE-TRAUMATIZATION IN THE HOSPITAL:** When I talked about myself being held down over top of a table, I thought I was going to be raped again. I was held down by the nurse, the doctor, the assistant nurse because I fought. I didn't want this to happen again and they took eight needles and scratched my back and I *still* have those scratches on my back to this day. There's four on each side of my spine and I don't know what to think of them because no one will tell me what it was and to me it means that I had introduced into my body eight different diseases. I take eight different pills for different things to stay alive now. And that's what I come to the conclusion of, I don't know if it's true, but no one will tell me and I don't have access to my medical files from the residential school. And we were rewarded for our culture and traditional ways with violence and all these things that I'm talking about today, they affect how we relate to you at the hospital. And a lot of the injuries we suffer today, I think, come from what happened to us back then at the residential school and it's ongoing. I know I had many mental problems growing up and I was very withdrawn. I wasn't even allowed to grieve for my grandmother when she died because she was the most important person in my life.

**DAMAGING PHYSICIAN MISDIAGNOSIS:** I got sick and I remember learning in Grade 1 how Dick and Jane used to bath and comb their hair and get all ready to go and see the doctor because he was like a god. Well, the first time I saw a doctor he came to see me because I wasn't eating and I wasn't sleeping and I was losing weight and the doctor came in, looked in my eyes, ears, nose, mouth, tapped my knees and my elbows and said I was retarded, so from that day forth I thought I was retarded and therefore my growth and education stopped and I just realized maybe 10 years ago I am not a stupid person. I am fairly intelligent and well capable of doing a lot of things and a lot of years were wasted because of the influence of the residential school. And I really feel that the hospital and the stuff, like has been said here a few times already, need to understand the impact of the trauma from residential school and how it affects our health and how we deal with walking into a hospital. And our reaction to the treatment. We need more tolerance, understanding and spiritual help while we're there. We need someone to guide us through

the system because I feel that I had no right to understand any of it because when we were taught something, we were not allowed to ask questions. We were not allowed to have an opinion and we had to accept what they told us or the punishment was really severe. And I think there should be more tolerance and respect, especially for Elders because they've lived this long and gone through this trauma and I just wanted to relate this too.

**RACIST TREATMENT IN EMERGENCY CARE:** I raised my granddaughter. She got hurt and our skipper for our boat was incapacitated so I couldn't ask her to help so we had to get the boat from Bamfield. Well, it took five hours; so five hours of suffering coming into town, getting an ambulance, going into hospital. And I told the doctor, it's been a really long day. My social worker wants a note from me saying that I'm here and I need a place to stay for the night and I need food. He told me "I don't write notes" and I said "Well, I need one for my worker, otherwise I'm gonna be on the street with my granddaughter." And he said to me "I don't write notes and I know you people from Bamfield, you come in here and you want a note from the doctor so you can go down to the bar and spend a weekend down there." Now that's the opinion of his and that's not the right way to treat people, especially when they've been through trauma. It was horrible and it was evil actually. I ended up leaving there with my bracelet and my social worker was actually very generous and took that as evidence that I had actually been there.

**NEED FOR UNDERSTANDING OF INTERGENERATIONAL TRAUMA AND SPIRITUAL KNOWLEDGE:** I have never drank in my life and I've never done drugs. And I don't smoke. And I tell this, it seems to make a difference. And I'm really sad to say it makes a difference because people who smoke and drink and do drugs are that way because of what happened to their parents, their parents before them and themselves and I think that's something that every professional needs to know and my way of trying to be involved is by being here and telling you all of this. And I think the spiritual aspect of our culture is thoroughly healing and I think that the hospital needs to know more about it and allow our people to come in there and not make fun of them.

# APPENDIX E: KNOWLEDGE & VOICES OF ELDERS & COMMUNITY

## ELDER M

**INDIGENIZE PROGRAMS:** Today is a good day. I feel excited. I feel excited when we can work together and talk about issues that we've been experiencing over the years. One of the things I feel is important for our people [is] I think we need to Indigenize our programs, Indigenize our council. We live by the policies of Indigenous and Northern Affairs Canada (INAC). When our people go to our council, go to the workers, the workers and the council say, "I can't help you. These are the policies of INAC. I can't help you." Almost 15 years ago I paid off my mortgage for my house and I signed a paper saying that I now own this house. And now the council says "I can't help you because it's your own house. We only help those houses that are still in the same agency program." So anything that I need for the house, I've got to pay for it myself. It's almost like being excluded instead of rewarded for something that was an accomplishment, paying off a mortgage. Things like that.

### NUU-CHAH-NULTH TEACHINGS

**SPEND TIME WITH ELDERS:** Our Elders said "How you treat your Elders is how you are going to be treated when you become an Elder." I worked for NTC for a period of five years and I went to every community and every community that I went to, I took time to sit with the Elders. In one of the communities, I knocked on the door and the lady of the house answered and I wanted to talk to [Vernon]. I wanted to go and sit with him. And she said "He's sick right now." I said "Okay." She said "You can go see him. He's in his bedroom. He's been there for four days." So I went and I sat with him. I sat with him for two hours and we just spoke our language. We talked about things like birds and animals, the things our people did, our ancestors did. Speaking in our own language for two hours and when I got up and was ready to leave he said "You have brought me back to life. Gave my life back to me. I feel good. I want to get up." So I feel like that is

one of the important things that our people did. My late wife Millie, she took in Elders into our home without asking any money or support from anybody, just brought them in. Over a period of a year or so...[An] Elder was staying in our home. None of the family members of that Elder came to visit. None of them, but when she passed away, they talked about her like she was the greatest person on the earth, but they didn't take time to come and visit. So when my late wife became ill and she had a stroke and a heart attack sometime later, she said "This Golden Age is not what it's supposed to be." She spoke about the same thing again. People don't come visit. They don't. Simple things, simple things like that.

**WHEN SOMEBODY ASKS YOU TO HELP, YOU HELP:** And I'll just share with you one of our other teachings. They say to us, when somebody calls you and asks you to help, you go and you go help them. You go to them. You help them. We don't say "I can't. It's not in our policy." Indigenize our programs.

**PASSING ON KNOWLEDGE TO YOUNGER GENERATIONS:** And right now I got an apprentice, a couple of my grandchildren. I finished one. I spent 900 hours with her, just teaching and sharing our language, our culture, going to the forest, spending time on the beach and connecting, connecting to the ocean, connecting to the animals, connecting to the forest and that is the greatest teacher that we have. Our people would have a bench where they would sit down and just listen and observe and connect to nature. I can tell you things that I've learned and experienced by being here for a few days, so I thank you. I thank you for this time. I thank you for your ears. Chu.

# APPENDIX E: KNOWLEDGE & VOICES OF ELDERS & COMMUNITY

## GAIL K GUS, TSESHAHT CRISIS AND WELLNESS COORDINATOR

### WHAT WE WANT TO ACHIEVE

**RACISM AND CULTURAL SAFETY TRAINING:** For 19 years of going to WCGH, I've really, I've beat my head against the wall in a number of situations over the years in caring for our Elders. My late mother, my late grandparents, my late mother-in-law, and today it just dawned on me we can't fix what we don't acknowledge and we're acknowledging that there's something that's off and not right in this room. In 1992, I went to South Africa. I rode on the floor of a car because of the colour of my skin in 1992. You were either black, white or coloured. There was nothing else. Black, white, coloured. Those were the neighbourhoods I could go to and if I was the wrong colour then you had to be in the floor of a car. I met lots of doctors, lots of doctors who didn't even want to talk to me, who were Dutch Afrikaans doctors. We're covered in Port Alberni. Almost every doctor in Port Alberni is South African, and I've had some racial issues over the years that kind of have been addressed and what's come out is, "Well your mother-in-law could be apologized to, but is it really going to be a real apology?" and no it's not, but I can still advocate and say no this isn't acceptable treatment. And when Harley was talking about how we need to have continuous cultural training so people understand. I think that right now the people that take the cultural training are people that don't even need it. The ones that don't want to take it are the ones that really need to have it and it needs to be a mandatory thing for any kind of change to happen.

### HOW I WANT TO BE INVOLVED

I want to be involved in all of it happening. I want to be a part of change, and even I can't count how many times I've said the same thing because over the years, in the middle of the night when I take people to the hospital, and they have an answer and go "Why are you here? What are you here for?" and then I come around the corner and they shrink, but you know what? How many times is there somebody not advocating for them? And they're so sick and they're so weak that they don't have the support or they have a shy grandchild whose bringing them in or they don't have somebody who's really outspoken. I want to make sure that we have somebody available for advocacy 24/7, at 3:00 am, not just 8:00 to 4:30. I think we need to have something on other hours as well.

# APPENDIX F: 2017 WORKSHOP QUESTIONS

PARTICIPANTS OF THE 2017 *TRAUMA-INFORMED AND CULTURALLY SAFE EMERGENCY CARE FOR NUU-CHAH-NULTH ELDER'S WORKSHOP* JOINED TOGETHER IN SMALL GROUPS TO ANSWER THE QUESTIONS BELOW. The Day 1 questions were discussed by two groups of Nuu-chah-nulth Elders, two groups of Nuu-chah-nulth community members and Indigenous health partners, and two groups of non-Indigenous health partners. The Day 2 questions were discussed in six mixed breakout groups made up of Elders, community members and health partners.

## DAY 1: HEARING OUR VOICES DISCUSSION QUESTIONS

1. What are six concerns in accessing emergency care for Elders?
2. What do hospitals need to understand about First Nations people and trauma?
3. What needs to change to make emergency care culturally safe?

## DAY 2: RECOMMENDATIONS FOR ACTION QUESTIONS

1. What are the three of the most important aspects of trauma-informed care that you want to see implemented?
2. How can we best address barriers?
3. What is the best way to implement trauma-informed care?
4. How do you know trauma-informed care is successful?
5. What do you see as next steps?



# "ENSURING OUR ELDERS ARE WELL LOOKED AFTER..."



CONTINUING OUR JOURNEY TOWARDS CULTURALLY SAFE EMERGENCY CARE FOR NUU-CHAH-NULTH ELDERS  
 MAHT MAHS GYM, UNCEDED TSESHAHT TERRITORIES | JUNE 14, 2019



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