CHAMPIONS OF CULTURAL SAFETY: AN EXPLORATION OF HOW CULTURAL

SAFETY CAN BE IMPLEMENTED AS A ROUTINE ASPECT OF HEALTH CARE

by

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Abstract

Background: This exploratory ethnographic qualitative study explores the perspectives of Champions of Cultural Safety (CCS) and has the potential to contribute to the knowledge development of an Aboriginal Health team's current pilot project on the Indigenous Cultural Competency transformation. This study identified Champions of Cultural Safety, who are healthcare providers (HCPs) that practice culturally safe care. It explored their experiences and how they enact cultural safety in their daily work with clients in their hospital. Given the current commitment to cultural safety and cultural humility in health services regarding Indigenous health, within the BC Tripartite Framework Agreement, this is a timely study. Conducted with the guidance of the health authority's Aboriginal Health Team, this inquiry may also assist health care providers in taking a cultural safety approach when providing healthcare in the face of ongoing judgment, racism and discrimination towards Indigenous people in healthcare and society. **Methods**: Using an exploratory, qualitative research design, recruitment began with Aboriginal Patient Navigators (APNs) who identified health care providers who represented Champions of Cultural Safety. Snowball sampling was used until 8 participants from a variety of health care disciplines were recruited. Semi structured, in depth interviews were conducted with the APNs and the health care providers. Post-colonial theoretical perspectives informed the analysis and overall inquiry. A thematic analysis was conducted using constant comparison methods. **Findings:** The key findings are: 1) The client and health care provider relationship is the cornerstone of cultural safety, 2) The organizational strategies to support cultural safety are insufficient in the current, pervasive and conventional traditional biomedical, organizational context, 3) Structural barriers to cultural safety persist in the colonial context. These findings demonstrate the complexities and intersections of the HCP and client relationship, the organizational strategies to support CS and the current systemic structure, processes which

constrained the participant's abilities to provide CS care. **Discussion:** The findings suggest three key areas for discussion: 1) The client and health care provider relationship is the cornerstone of cultural safety, for both the client and health care provider when analyzed from a cultural safety lens, 2) Many key characteristics of the hospital and wider health care context conflicts with a cultural safety approach to care, 3) Structural violence characterized by: racism and discrimination exists within the hospital environment, demonstrating a need for organizational interventions to address the continued Indigenous health inequities.

Lay Summary

This exploratory ethnographic qualitative study explores the perspectives and behaviours of Champions of Cultural Safety (CCS) to better support the cultural responsiveness of a hospital in Vancouver. This study identified CCS, healthcare providers who practice and role model culturally safe care and examined their experiences of the current hospital culture including why and how they enact cultural safety in their work. Recruitment began with Aboriginal Patient Navigators who identified CCS. Snowball sampling was used until 8 participants from a variety of health care disciplines were recruited. Semi- structured interviews were conducted with Aboriginal Patient Navigators, an Elder, and health care providers. This study is timely given the current commitment to cultural safety and cultural humility in health services within the BC Tripartite Framework Agreement. Conducted with the guidance of the health authority's Aboriginal Health Team, the study has potential to contribute to planned organizational change that could support the implementation of cultural safety approaches.

Preface

The UBC Behavioural Ethics Review Board granted ethical approval for the Champions of Cultural Safety Study - # H16-02516 and Vancouver Coastal Health Research Study approval was obtained - # V16-02516.

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Acknowledgements

1. Introduction

This study was developed through discussion and collaboration with a Lower Mainland Aboriginal Health Team (AHT), affiliated with a Health Authority, based on my interest in health inequity, patients' experience of cultural safety, and strategies for improving health care experiences for Indigenous peoples[1]. My interest in health inequity and social justice had been renewed within the discussions, readings and self-reflection as a Masters student and my hope is to contribute to the discussion about and efforts to promote cultural safety in relation to Indigenous people. My personal and professional values of respect, collaboration, and self-determination have always been integral to my broad work experience with clients, colleagues, and currently in my role as an educator with nursing students. Working with New Zealand Maori people during my previous life experience in New Zealand was extremely rewarding and enlightened my professional perspective and approach of working in partnership and collaboration with patients and their families. It was here that I became aware of power and difference and how together they affect health care and my relationship with patients. I realized what I didn't know, with my mostly singular world view, based on Eurocentric and dominant perspectives and practices. This was while working in healthcare and living in a society where the Treaty of Waitangi (New Zealand's Constitutional document), is upheld in terms of principles of cultural safety such as participation, protection and partnership (Nursing Council of New

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[1] Aboriginal people in Canada are defined as all Indigenous Peoples. The word Aboriginal and Indigenous is used interchangeably in this paper. The three main groups as identified by the Canadian Commission are First Nations (Indian), Metis and Inuit (Royal Commission of Aboriginal Peoples, 1996). The many and diverse nations and their cultures within these groups are not specified by the Commission but are acknowledged within these main groups. The Commission states the term Aboriginal people "refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so called 'racial' characteristics. The term includes the Indian, Inuit, and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982)" (p. xii).

Zealand 1996). When I returned to British Columbia and resumed working within the healthcare system in 2005, I was acutely aware of the disparities between Indigenous clients and non-Indigenous clients in terms of health care structure and services, power differential, and health care provider attitudes. Teaching clinical courses at a large urban hospital today in the fast paced, resource constrained healthcare system, these differences are still apparent. From a non-patient perspective, I have observed instances of inclusive and respectful client care when engaging in communication with some healthcare providers and practice when working with clients. Therefore, I became interested in exploring cultural safety with regards to Indigenous people and the perspectives and behaviors of those identified as "Champions of Cultural Safety" in the current health care context. Through a collaborative, participatory approach with the AHT, this small study aims to provide some ground work and knowledge development to augment the process of change in their action plan for Cultural Safety and Cultural Humility.

Following strategic directions emanating from the relatively newly formed First Nations Health Authority[2], the AHT team of Vancouver Coastal Health is currently developing a strategic plan of action for Cultural Safety and Cultural Humility implementation and sustainability as part of their Aboriginal Cultural Competency Policy (Vancouver Coastal Health Policy 2015). Their focus is on a system-wide process to create a climate for change within a specific hospital (herein referred to as 'the hospital', which is intentionally not named in this thesis in order afford confidentiality for the participants). The AHT goal is change towards cultural humility amongst health care providers where there is respectful, culturally responsive care system wide (L. Jebamani, personal communication, July 12, 2016). The purpose of this exploratory ethnographic

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[2] The First Nations Health Authority is a province wide health authority, established in 2013 which governs the programs and services of health and well-being of BC's First Nations and Aboriginal people, previously governed by Health Canada (First Nations Health Authority 2017)

qualitative study was to explore, understand and support the perspectives and behaviours of Champions of Cultural Safety (CCS) and to explore the cultural responsiveness of the hospital. In this study, CCS, is defined as a health care provider identified by experienced APNs as role models who provide respectful, cultural safe and patient centered care. Aboriginal Patient Navigators, an Elder, and the healthcare providers the APNs identified shared their self-awareness and ideas about cultural safety with other healthcare providers – which I as the lead investigator have labelled as "Champions of CS". This study involved a) interviews with Aboriginal Patient Navigators (APNs) and health care providers (HCP) within the hospital who practice culturally safe care and b) an analysis of their experiences of the current health care context including why and how they enact cultural safety in the routine aspects of their work. For the purposes of this study these HCPs were defined as Champions of Cultural Safety (see definition of the terms). This study is intended to support through knowledge development the Aboriginal Health team in their goal to implement a climate of change by building on these HCP's successes and insights and by engaging them in the implementation process of engaging other staff in providing culturally safe care. The AHT goal is for this regional hospital to be known for providing culturally safe health services.

1.1 Purpose and Research Questions

Broadly the purpose of the study was to explore, understand, and support through knowledge development, the perspectives and behaviours of Aboriginal Patient Navigators, an Elder, and health care providers who enact cultural safety in the routine aspects of their work. These categories of staff are referred to by me, as the lead investigator, as CCS. As lead investigator, I identified CCS, health care providers who practice culturally safe care, and

explored their experiences. This individual is an Aboriginal Patient Navigator (APN) and or a HCP identified as a champion by an APN or a colleague (see definition of terms for Champion of Cultural Safety). The study identified CCS, health care providers who practice culturally safe care, and explored their experiences. This study may provide some insight into cultural responsiveness within the current hospital culture which may assist the AHT in their work of implementing their cultural safety action plan, within their Aboriginal Cultural Competency policy.

The central research questions were: How do CCS, (referring to APNs, an Elder, HCPs who practice cultural safety in their health care) setting describe their experience of providing cultural safety within their organization? What are their perspectives regarding how to enact cultural safety? What are the contextual factors within health care organizations that affect the uptake of cultural safety? What are the implications for nursing practice, education, and for policy and research?

1.2 Definition of Terms

The following definitions are provided. To begin I outline the definitions provided by the FNHA. In the review of the literature section of this thesis, I will engage in an analysis of these concepts and situate them in the wider literature. The FNHA in their Creating a Climate for Change Booklet (2014) defined **Cultural Safety** (CS) as "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 while receiving health care".

Cultural Humility (CH) is defined as "a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust" (FNHA 2016).

Cultural Competency (CC) is defined as "developing cultural knowledge and skills in understanding cross-cultural interactions and an awareness and acceptance of the dynamic variety of people and populations…" (VCH Aboriginal CC Policy 2015).

Cultural Responsiveness is defined as "… involving building capacity of the system to be CC and improving professional attitudes, knowledge and behaviours, and practices, as well as strategies, plans and policies…" (VCH Aboriginal CC Policy 2015).

A **champion** (within an organizational, health care context) is defined as an individual who enthusiastically promotes innovation and change to others for the good of the organization; someone who is personally committed to high standards (Hendy & Barlow 2012). In this study, **Champions of Cultural Safety** (CCS) are identified as an individual who role models respectful, client centered CS care. This individual is an Aboriginal Patient Navigator (APN) and or a HCP identified as a champion by an APN or a colleague. These CCS share their self awareness and ideas about CS with other HCPs.

1.3 Background

The historical colonial and paternalistic relationship between the Canadian government and Indigenous people which still exists today within the Indian Act and throughout social systems has led to the many health and socioeconomic problems that affect the Indigenous people today (Adelson 2005; Pederson et al 2013). There is well documented research about the current health effects and disparities for Aboriginal people are related to historical, social, and

political inequities between Indigenous and non-Indigenous in Canada (Adelson 2005; Smylie et al 2010; Pederson et al 2013, Browne et al 2016). Browne et al (2016) specifically discuss structural violence as the ongoing, embedded and subtle systemic ways that social structures disadvantage Indigenous people. Chronic or long-term health issues such as diabetes, depression, and substance misuse may be attributed to the loss of self-direction and self-determination of Indigenous people from the effects of colonization with their loss of land and erosion of traditional culture (Adelson 2005; Browne 2009a; Browne et al 2016).

The Canadian Government have demonstrated efforts to rectify these inequities by the transfer of control and self-determination for their health and social services from the Canadian Government to the Indigenous people. One such effort is The British Columbia (B.C.) Tripartite Framework Agreement on First Nations Health Governance, which is a legal framework and agreement between the Canadian Government, the BC Government and its Health Authorities (HA) and First Nations Health Society (Tripartite Committee FN Health 2014). On October 1, 2013 Health Canada transferred its delivery and management of First Nations (FN) health program to FNHA. The goal was for BC FN to be fully involved at all levels in the health programs, service delivery, and decision making to reform healthcare for FN people (FNHA 2016). In July 2015, a Declaration of Commitment was signed by all the BC HA Chief Executives demonstrating a commitment to change and prioritizing cultural humility and cultural safety within health services as quality and safety issues (FNHA 2016). This declaration states "cultural safety must be embraced, understood and practiced at all levels of the health care system including governance, health organization, and within individual professional practice" (FNHA Relationship Agreement 2016). Eliminating disparities and changing individual, organization and system attitudes, perspectives, and environments are a commitment from all

stakeholders and a lifelong process (Like 2011; FNHA 2016). At the HCP level the San'yas Indigenous Cultural Safety Training by BC HA's, is in place to promote training in self-awareness and knowledge about cultural safety (PHSA 2015). This program is offered free of charge to HA employees and HA policy had made completion mandatory. This online program for CS examines culture awareness through a context dependent and power laden lens. The San'yas education courses were developed by Provincial Health Services Association Aboriginal Health Program Leaders for improving knowledge and self-awareness for all HA employees about Aboriginal health, inequity, and the effects of history and colonization (PHSA).

On March 1, 2017, 23 health regulatory bodies in BC signed the Declaration of Commitment to Cultural Safety and Cultural Humility (FNHA 2017). This includes large professional associations such as the College of Registered Nurses of BC and the College of Physicians and Surgeons of BC who by signing commit their members to "actions and processes which will ultimately embed CS practices within all levels of health professional regulation" (FNHA 2017, News Release page 1). In the 2014-2015 Tripartite Committee on FN Health Annual Report, some of the future priorities identified were patient centered care and multidisciplinary teams working for the improvement in patient care and health outcomes (Tripartite Annual Report 2014). One of the successes mentioned in the report in the 2 years since the FNHA governance began was "advancements in cultural safety and humility system wide" (page 37). Because the Tripartite Framework Agreement and the Declaration of Commitment by BCHA are relatively new and present a new vision for health care services and processes, there is a gap in the literature of scholarly inquiry in the phenomena of cultural safety and cultural humility within the healthcare context since the Agreement, particularly in the areas of implementation and evaluation of cultural safety and humility and patient experience and

health outcomes. By exploring the experiences of CCS, this study will provide new knowledge and insight into CS within an organization during the implementation of the HA wide CS training and awareness through engagement with the champions.

This study can provide insights from HCP who are CCS. By exploring and understanding their experiences, I identify the strengths and limitations regarding provision of cultural safety within one hospital in BC, from the perspective of the staff I refer to as CCS, and the impact of the hospital context on the provision of culturally safe care. Several key questions drive this inquiry: What are the perspective and understandings and attitudes of the CCS? What is not known is the impact of cultural safety awareness on health care providers in their care delivery in the context of the mandatory Indigenous Cultural Competency training for all health care providers. What needs to be known about the impact of culturally safe care on health care interactions with clients, from the perspective of CCS? More also needs to be known about this movement towards cultural safety and cultural humility in terms of the impact on programs and services to Indigenous people. Although these impacts are being monitored and reported on by the health Authorities and the FNHA, there is no formal assessment or evaluation tool used in this hospital to monitor the current implementation of the cultural safety policy in the programs or services. The AHT may use this qualitative data to inform their action plan for their hospital wide practice support and evaluation measures for frontline staff in providing culturally safe care.

2. Literature Review

Following the theoretical perspectives, the literature review is divided into sub-sections: cultural safety and cultural competence, cultural safety as a framework, Indigenous health inequities, and champions in health care. Post-colonial theoretical (PCT) perspectives informed my research. In what follows, I provide a brief description of these theoretical perspectives. PCT is an appropriate theory with which to analyze cultural safety from the HCP perspective within the context of their current health care environment, because cultural safety challenges the dominant culture, the sociopolitical systems, the power of the dominant culture and race relations (Brascoupé & Waters 2009; Browne et al 2005, Browne et al 2009). In this study and the thesis process I have endeavored to work in partnership and collaboration with the Aboriginal Health Team where discussion and their perspectives were a starting point for me and my interest in CS and inequities for Indigenous people. This follows along with Browne et al (2005) who looked at postcolonial theoretical perspectives and Aboriginal health research and recommend partnerships and an Indigenous voice in the research process

2.1 A Post-Colonial Theoretical Perspectives

Within nursing, critical theory and post-colonial theory has been used to focus on the effects of colonization on individuals, cultures, and societies and linking the issues of power, stigma, and racism that are part of the neocolonial present within our healthcare and Canadian society (Browne, Smye &Varcoe 2005; Browne et al 2009; Browne et al 2016). This perspective is helpful for non-Aboriginal people to understand that sociopolitical structures and power imbalances between the Canadian government and Aboriginal people led to severe disadvantages in social and health care opportunities and unmet health needs (Brascoupé & Waters 2009;

Browne et al 2009; 2016). This is a key aspect of PCT because analyzing colonization history and the continuing social and structural barriers can demonstrate the racializing and dehumanizing processes that ensue when Indigenous people are regarded as a race in society (Browne et al). As Browne reported, HCPs may make negative assumptions and judgments and discriminate in their approaches to care delivery due to historical cultural myths about Aboriginal culture and people. The effects of colonialism, residential schools and economic disparities between non-Indigenous and Indigenous continue today as evidenced by disparities in health outcomes between Indigenous and non-Indigenous (Smylie at al 2012: Browne et al 2011). Pederson et al (2013) examined the social and cultural losses of the Indigenous people which have impacted their family structure with impact for Indigenous women. They link colonization and the dominance of the Canadian Government in their relationship between Indigenous people as a form of structural violence.

Cultural safety evolved as a post-colonial theoretical paradigm rooted in a critical lens and fostering reflection on power structure and reciprocity between HCP and Aboriginal, challenging healthcare, political, and social processes (Brascoupé & Waters 2009). I believe post-colonial theory perspectives are a relevant lens through which to view health care providers within their healthcare environment, especially considering the Declaration of Commitment of Cultural Safety and Cultural Humility in Health Services. I hope to assess and learn how knowledge of CCS is implemented or reflected on as they go about their client interactions which hopefully will have diminished "the socially mediated misconceptions about Aboriginal People" (Browne et al 2005 page 30; FNHA 2014).

2.2 Cultural Safety and Cultural Competence

First, I will discuss the concepts of cultural competence and cultural safety as discussed in the nursing literature. Nursing research on culture and health has mainly focused on the concept of cultural competence. Cultural competence practices for nurses examined the need for greater awareness and the application of their knowledge, skills, and attitude in meeting the needs of diverse individuals and cultures in a respectful manner (Canadian Nurses Association 2010). That is when working in collaboration with individuals across all cultures, nurses need to apply their knowledge and skills to support and meet the client's needs. Cultural competence is a concept used similarly to the concept of cultural safety (Wepa 2005; Brascoupé & Waters 2009). Though cultural competence is based on knowledge of the HCP and cultural safety is a shift in cultural approach based on power in the health relationship between HCP and the client (Browne et al 2009; Browne et al 2016).

Cultural safety was originated in New Zealand by Maori nurse leaders in 1980's who examined and brought forward the negative health outcomes of Maori people, linked to the impact of colonization (Ramsden 2002, 2005). A nursing curriculum was developed by Ramsden to integrate cultural safety knowledge and approach to health care for nurses. One of the key aspects of CS is that CS is not only about how HCP view culture and cultural practices but an individual's health and health outcomes are greatly affected by historical, political and socioeconomic forces. In Canada, there is considerable literature on CS as a concept from nursing scholars (Browne et al 2009; McCall and Pauly 2012; Varcoe and Browne 2015) in its relation to Indigenous health care. CS is regarded by Ramsden, Browne et al and Varcoe and Browne as a strategy or lens to critically reflect on and discuss how Indigenous people and their health are influenced by historical, political, and social contexts drawing from postcolonial

theory. Browne et al recommend nursing, healthcare organizations, and sociopolitical systems

increase knowledge and awareness about cultural safety which is grounded in acknowledging the

historical colonial Indigenous experience and the power relationships that exist within healthcare

and our sociopolitical systems. The Aboriginal Nurses Association of Canada (2009)

collaborated with the Canadian Association of Schools of Nursing and the Canadian Nurses

Association and developed a best practice framework for cultural competence and cultural safety

regarding Indigenous health for nursing education. This best practice framework looks at

understanding the power differentials embedded in health care and addressing them through

educational processes (ANAC 2009). By viewing health inequities through a CS lens this

framework enables nurses to: acknowledge we are all bearers of culture, analyse the political,

social and historical contexts of health care, promote discourse in concepts such as racism and

discrimination, understand CS is determined by those to whom nurses provide care (ANAC).

Cultural safety is defined by the Canadian Nurses Association (CNA) as "a process and an

outcome whose goal is to promote greater equity. It focuses on the root causes of power

imbalances and inequitable social relationships in health care" (page 1, Promoting Cultural

Competence in Nursing, Position Statement).

The broad conceptual meaning of CS (that was demonstrated above) and by using it as a

theoretical lens assists in how we view health inequities and culture. Varcoe and Browne and

Browne et al challenge HCPs to inquire, value, and acknowledge an individual's culture. Culture

is defined by Wepa (2005) broadly as "…our activities, ideas, our belongings and relationships

what we do, say, think, are. Culture is central to the way people develop and grow and how they

view themselves and others" (page 31). Wepa also views culture as not completely static, with

culture being "affected and modified by the proximity and influences of other cultures" (page

31). Varcoe (2015) also views culture as dynamic and changing and suggests nurses view the concept of culture as a relational process where it is contextually in relation to the individual, their family, and the social circumstances. CS draws attention to the uniqueness of the individual and their cultural identity. By treating everyone as equals, the HCP may unconsciously be assimilating the individual to the ways of the dominant culture. CS challenges HCP's to reflect on their own cultural beliefs, biases, and assumptions and to critically examine the dominant culture and the power relations that exist (Richardson & Williams, Browne et al). Brascoupé and Waters (2009) who looked at CS applicability in the Canadian context also call for HCP's to recognize and understand the power dynamics in the HCP and patient interaction as well as the power issues in sociopolitical systems. These CS strategies are to address the lack of trust, discrimination, and power imbalances that are experienced by Indigenous people in their health experiences and to redistribute that power to the individual (Browne 2009; Brascoupé & Waters; Gerlach 2012). In the literature, CS is generally understood as being defined and evaluated by the client who receives the health care feeling safe and respected (Wepa 2005; Brascoupé & Waters; Hole et al 2015). A CS approach or view of health care may address some of the inequities in health and access to services experienced by Indigenous people.

2.3 Cultural Safety as a Framework

Aboriginal researchers Brascoupé and Waters suggest that CS is a method and framework to develop and deliver health and social policies for Indigenous people, as this framework reveals the social determinants of health are responsible for ongoing health inequities. This is in congruence with Ramsden's views and nursing research where CS may be viewed as a process and an outcome. It can be looked upon as an interpretive, moral and educational lens (Browne et

at 2009; Ramsden 2005; Browne et al 20015) and as a sociopolitical social justice lens (Coates 2008; Adelson 2005; Browne et al 2016) to raise our awareness and question the sociopolitical structures that have and continued to privilege the dominant culture and sideline Indigenous people. A CS approach to health is in alignment with the FNHA and their mandate in the Declaration Commitment for a change within healthcare organizations to engaging in cultural safety and cultural humility.

Truong et al (2014) and Pearson et al (2007) conducted systematic reviews of CC and CS frameworks as interventions, looking at studies to improve care, patient outcomes, and reduce health disparities for minorities. These researchers' recommendations included definitions of the concepts of cultural competence and cultural safety as these concepts were used interchangeably within many disciplines. Secondly, they recommended assessing CS implementation and application at all levels; that is the individual, the organization, and system levels. They also called for further quantitative research and more qualitative research about evaluation of outcomes with evidence of rigour and credible designs. Pearson et al (2007) and Brascoupé and Waters (2009) found data in support of CC training and knowledge through formal training by HCP. They reported an increase in the knowledge, skills, and attitudes of the HCP and increased patient satisfaction with care. More research is needed about the patient experience particularly considering the increased awareness and knowledge of HCP's about trust, respect and a relational lens to the patient and provider relationship.

As an example of a CS framework, the EQUIP intervention framework is an evidenced-based guide for organizations to engage in delivering equity-oriented health services for Indigenous and non-Indigenous people (Browne et al 2016). CS is one of the four key dimensions in the framework along with trauma and violence informed care, contextually

tailored care and harm reduction. The framework has been used in the public health contexts for enhancing care and evaluating processes and policies for marginalized populations. The research will soon be undertaken in applying the EQUIP framework in the care of Indigenous people in the Emergency Departments which would support the Health Authorities commitment to embedding CS into all levels of health care services to improve health outcomes for Indigenous people.

2.4 Indigenous Health Inequities

As discussed earlier in the background, in Canada, there is well documented evidence about disparities between Indigenous and non-Indigenous people in health and access to services (Smylie et al 2010; Brascoupé &Waters 2009; Browne et al 2016). These inequities are due to colonialism, sociopolitical systems, power imbalances and racism, all of which have marginalized and disadvantaged Indigenous people in their health and life opportunities for many years (FNHA 2016; Brascoupé & Waters; Smylie et al). Their needs have not been met or prioritized by Health Canada (Brascoupé & Waters; Coates 2008). The Indian Act still governs and authorizes the government of Canada to regulate "Registered Indians" [3] and reserve communities and absorb Aboriginal culture into Canadian culture (Coates 2008). As mentioned earlier, The Tripartite Agreement and the FNHA (being the first in Canada) is seen as a new path for Indigenous people to self-determine and regulate their health needs and services with a partnership commitment from Federal and BC governments. There is no research about the

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[3] Registered Indian or Status Indian is an individual recognized by the federal government as being registered under the Indian Act. These individuals are entitled to many provincial and federal programs and services which is dependent on where they live (Indigenous and Northern Affairs Canada 2016)

effects, outcomes for Indigenous clients, or monitoring or evaluation of the CS approach to healthcare within health authorities and their organizations in BC.

The Truth and Reconciliation Commission of Canada: Health Related Recommendations (2016) brief summarizes the recommendations and actions in relation to Indigenous health. The Commission suggests an action for recommendation 18 concerning Indigenous health of... "reframing the discourse of Indigenous health inequities and differences in care from patient blaming to system enabling" (page 4). Another action they recommend is "ensuring messages related to education, research and service delivery are consistent with the Commission's message that the health gaps are the result of policy choices past and present" (page 4).

2.5 The Role of Champions in Health Care

Within nursing literature there is a gap in research about champions or clinical champions or change champions in healthcare with the bulk of the research in organizational and human resource management, social science and community health. A study by Tuomi (2015) looked at nurses as organizational champions and suggested matching talents and abilities of the nurse to the specific innovation planned within the organization. This study and Shaw et al's (2012) study discuss the benefits of the champion role in organization change. They focus on informal champions, who emerge in the organization due to their passion, interest and commitment to the project and formal organization or project champions that lead change within a unit and or throughout an organization. They described the champion as a go-to person, one who can see the big picture, motivate others and who are known for their high standards and expertise and who

may have a role in disseminating[4] knowledge to others. Hendry et al's (2012) study of organizational champions in community health care found that using a champion was helpful to motivate change in the short term within a specific area, but less helpful when the champion was asked to move outside their specialty area to inform others. They caution that in the implementation of change, some champions may lack motivation to work outside their profession, particularly depending on the culture and presence of resistance within the unit. Both studies acknowledged the importance of recognizing the champions individually and publicly as they are individuals who are frequently motivated to move beyond their current roles and responsibilities.

In summary, there is a gap in the literature about the implementation, evaluation and progress of the CS and CH movement within HA organizations following the Declaration of Commitment by BC HA's in 2015. There is also a gap in evaluating the client experience of CS and CH within this health organization and in the literature. While there is literature about the use of organization champions to implement change within a variety of organizations, there is a gap in knowledge about the use of organizational champions to bring about change in CS and CH within health care. There is also a gap in understanding the experiences of Aboriginal Patient Navigators and HCPs in their perspectives of providing CS care. This small study can provide insights from HCP who are practicing culturally safe care. By exploring and understanding their experiences, I hope to provide some insight in the strengths and limitations of the current state of CS within the hospital and the cultural responsiveness of the hospital.

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[4] Champion refers to an individual who enthusiastically promotes innovation and change to others; someone who is personally committed to high standards. A Champion of Cultural Safety is an individual who is a role model of respectful, client centered care. An APN and or a HCP identified as a champion by an APN or colleague (see definition of terms)

3. Methods

In the methods chapter I discuss the design of the study. The post-colonial theory that underpinned the study was discussed in the previous chapter. I briefly review the aim of the study and context of the AHT and the hospital in relation to cultural safety. The recruitment, sample and data collection methods are described. The analysis and rigour of the data is discussed followed by the ethical considerations.

3.1 Design

An ethnographic exploratory qualitative study was conducted to gain an understanding and awareness about CS and its application in practice from the experiences of key health care providers who are identified as role models of CS within a major hospital in Vancouver. This hospital provides a full range of health services including acute care to community based services. Ethnography was used to seek an understanding and description of the broad concept of cultural safety from health care providers and Aboriginal Patient Navigators, who role model and engage in a cultural safety approach to their client care and who work within this hospital. Ethnography originates from the social sciences and is characterized by the researcher learning about the culture (including organizational culture and the specific context) of a group (Hole 2005; Polit & Beck 2012). This approach is grounded in examining social and cultural factors from the perspectives of the individuals within an organization; asking questions about the social and cultural practices (Hole; Polit & Beck).

The aim of the study was to understand the experiences of the CS champions through thick, rich description and thus to gain insight into the potential for cultural responsiveness to be developed within the hospital. This research will shed light on how CS is understood, enacting

and taken up in practice from the perspective of HCPs who are familiar with the theoretical and practical aspects of CS. Implications that take into consideration the current sociopolitical context of this hospital will be discussed. As stated previously the Aboriginal Health Team are focusing on organizational change aimed at more culturally safe practice within the Health Authority and amending their Aboriginal Cultural Competency policy. I built a working relationship with the team by contact by email and face to face meetings with my lead contact in the AHT and the APNs. This relationship enabled me to understand the context and their goals for the CS pilot project for this organization and helped with clarification about findings from the interviews.

3.2 Context

The participants were all open about their work and roles within their respective teams in the hospital. They talked freely about their past work experiences and their current work situations. This was helpful to understand the context in which they work in the current health care environment which aided my understanding about their perspectives and experiences about their client care and cultural safety. All the participants felt supported by their direct managers and amongst their team, in their ability to carry out their roles and responsibilities. The AHT was developing an Indigenous CS framework for the organization, the Health Authority overall, with the plan to trial the framework in this hospital. Their plan is to address the system wide transformation at all levels from the Board to the individual frontline staff. By planning initiatives to address policy change with an Organizational CS policy to engaging all stakeholders and then implementing change at all levels of the organization. This Indigenous CS Framework is in draft at the time of this study. The Aboriginal Patient Navigator role was being

revised and in transition during the study and the APNs were completing client cases that were in progress at that time. Therefore, I was unable to observe or shadow the APN's in their client consultations (as I had hoped and despite many attempts) to gain further understanding about their role and interactions with an Aboriginal client in the health care organization. Access to the organization setting in the context of observing the APN's in their day to day work would have been helpful to gain insight into the relationships between the APN's and other health care providers. To immerse myself as a researcher in the field, that is the organizational culture. Therefore, my immersion was in spending time at the AHT office with the APN's when it was possible. As all the interviewed APN's mentioned, the long-term goal of the AHT is to "Indigenize health care".

3.3 Recruitment

Participants were recruited by convenience sampling from the AHT. I started with an APN (who had been the Lead for the APN team at the beginning of this study) who helped identify APN's that consulted and worked with clients admitted to the hospital. These APNs enact CS in their practice and client relations and work to advocate for Indigenous clients and their families. APN are knowledgeable in the Aboriginal ways of health and wellness, assist, and support Aboriginal clients in their health care experience (Vancouver Coastal Health 2014). The APNs also engage with, consult, and act as a resource in Indigenous cultural practices for health care providers. The APNs identified staff from the hospital who they felt provided CS care. The HCP participants are staff who used the APN resources and who enact respectful and responsive client centered care. An Elder was also interviewed who is a consultant, advocate, and support

for the APNs and clients in a variety of health service settings. Please refer to appendix 1 for the consent form and appendix 2 for the participant demographics.

A snowball sample was recruited until 8 participants in total were interviewed, that is 5 APNs and 3 health care providers. The 3-4-month recruitment period produced 8 participants, with a goal for 10 participants. It was disappointing that I did not obtain 10 participants but due to the time limits of this thesis, I could not pursue further possible participants. The HCPs were from disciplines such as nursing and social work. In the contact, I had with potential participants (who had been suggested by an APN) there seemed to be a reluctance to talk about CS and they stated they were too busy in their work. Two potential participants didn't feel they had much to say about CS, though they thought it was important for Indigenous clients.

Inclusion criteria were HCPs who were employed by the Health Authority, who had worked with clients at the hospital and who were identified as Champions of Cultural Safety as defined by myself the lead researcher. That is HCPs who engage in respectful, patient centered care and who engage in CS dialogue with their colleagues.

3.4 Description of the Participants

There were eight participants in the study. Four were Aboriginal Patient Navigators, one was an Elder and three were HCPs who were identified as CCS by an APN and from the definition of CCS. The fourth HCP was recruited (by the snowball effect) by one of the other HCPs who met the study definition of CCS. The HCPs are individuals who role model respectful, client centered, and culturally safe care as identified by an APN. The ages of the participants ranged from 30-55 years. The three HCPs identified as Caucasian. The Elder identified as First Nations. The APNs identified as Aboriginal with one listing Aboriginal

together with other ethnicities. Two of the HCPs were RNs who worked in the Outpatient

Psychiatry Team, the other was a HCP in the acute medicine interdisciplinary care team. All but

one participant (one of the HCPs) had completed the San'yas Indigenous Cultural Competency

course. The participants were designated by letter A-H for the purpose of conducting the analysis

of their interviews.

3.5 Data Collection

Interviews- Interview data was collected by semi structured in-depth interviews between

30-115 minutes of the participants by myself. Please refer to appendix 3 for the interview guide.

The interviews were audiotaped and later transcribed verbatim with written transcripts. I also

kept notes at the interview of my thoughts and observations and points for follow-up discussion

with the participant. For examples of the open-ended interview probes see appendix 1, the

research guide. The interviews took place between December 2016 to March 2017. The

interviews were held at the participants choosing at their place of work; in a quiet and private

room. One participant chose my office at the School of Nursing. Participants received a $25.00

gift card honorarium in appreciation for their time and sharing their knowledge about CS.

The interview guide was very useful for me as a novice researcher. In all the interviews, I

chatted to the participants first about myself, my background and interest in CS prior to starting

the recorded interview. I started each interview asking the participant to discuss their background

and what brought them to their current role in the organization. This was to help establish rapport

and trust, so they felt open to discuss their perspectives and truth, as they see it. On the

suggestion of Dr Varcoe, I tried to set the interview more as a conversation about cultural safety,

trying to avoid a formal list of specific direct questions. Unplanned questions and probes

developed such as "Cultural safety has been described to me as a matter of life and death for Aboriginal people on the receiving end of healthcare. Tell me what you think about that? Talk to me about what that perspective means to you?" I considered framing the discussion and interview questions based on my current knowledge about CS but also being cognizant of not predetermining everything (as the interview guide probes/questions were formulated in advance) discussed by keeping to the interview guide questions (Thorne 2008). I clarified questions and any unclear meanings with the participant before terminating the interview, to validate what they had said to ensure greater credibility and accuracy of the data.

Policy documents- Health Authority policy documents, protocols and processes were reviewed to gain an understanding of the current organizational resources, commitments and strategies to embed CS within health services and the organization. These were obtained from the AHT lead and from the Intranet within the Health Authority.

Participant Observation-. As stated earlier I was unable to participate in spending time observing and working alongside an APN. Working alongside the APN's would have allowed access to the variety of contexts (units) within the hospital to observe the interactions between HCP and patients and observation of the patient healthcare experience.

3.6 Analysis and Rigour

The audiotaped data was transcribed verbatim by a professional transcriber, experienced in nursing and health research. The transcriptions were verified by myself for any inconsistencies or misinterpretation of the participants' words. Analysis was undertaken using reflective and analytic memos to find embedded categories and themes within the data. Using inductive thematic analysis, I found the theme statements from the transcripts of the participants' words

reading the transcripts line by line. A thematic analysis (Thorne 2008) generates conclusions from searching for consistencies and contradictions within and amongst the themes. The initial coding of themes and analysis is an iterative process which began during the data collection, whereby I confirmed and or explored any themes I became aware of from the first interviews with the participants (Thorne). Open coding of the interviews was completed by analyzing data line by line. Codes and or themes was applied to the content of the text. Codes or themes was applied to the observational data and reflections. These themes or codes were derived from the data themes and the words and direct quotes of the participants. A constant comparison method (Thorne 2008) was also used comparing all data with other data to derive patterns or categories. Coding and the analysis was discussed with my supervisor Dr. Varcoe, a highly experienced qualitative researcher, to enhance rigour of the method and to synthesize the results. I sought out Dr Varcoe with my thoughts, the emerging themes and for her feedback throughout the process to increase the dependability and trustworthiness of the data (Etherington 2007). Rigour was also enhanced by my awareness of reflexivity by self-reflective memo notes about assumptions and beliefs which could affect any stage of the research process (Etherington; Cope 2014). I checked in with Dr Varcoe at times with my thoughts and perspectives. Consulting and checking with the AHT and the participants throughout the research process, particularly during data collection and analysis about emerging preliminary findings of their experiences and perspectives, added further credibility and rigour and identified any gaps in the analysis (Sandelowski & Burroso 2003). I have included direct quotes from the participants which demonstrates the trustworthiness of the data and are not the reflections of my perspective or viewpoint (Cope 2014).

3.7 Ethical Considerations

The UBC Behavioural Ethics Review Board granted ethical approval - # H16-02516 and Vancouver Coastal Health Research Study approval- # V16-02516.

A participant information form detailing the purpose of the study and linkage to the Aboriginal Health Team cultural safety and cultural humility project, along with a consent form was provided prior to the interview meeting. The participants were informed they could withdraw from the study at any time. Confidentiality and privacy of participants was maintained using pseudonyms by assigning number codes to each participant that corresponded to the interview transcript. The transcription data was stored in password protected computer files. The audio recording device and hard copies from the study are stored in a locked cupboard in Dr Varcoe's office at the UBC School of Nursing.

The open collaborative working relationship with the AHT, enabled the study to be one of a participatory approach when the needs of the all stakeholders, researcher and health care organization staff were balanced, shared and respected (Polit & Beck 2012). Confidentiality and anonymity of the healthcare organization was maintained throughout the research process as it was referred to only as the organization.

The collaborative nature and spirit of the interdisciplinary engagement with the AHT and myself is in alignment with the FNHA Creating a Climate for Change, as I am a health care provider, a nurse educator (RN), and a student who is committed to furthering my own knowledge and self-awareness about CS. As a health care, professional I am also committed to making the health care system more culturally safe for Indigenous people. I hope this study

supports the AHT in their work and their long-term goal for cultural safety and cultural humility in the organization.

The research methodology presented the study design, recruitment and participants and data collection process. A discussion of the analysis and rigour of the data collection followed. The ethical considerations were included, along with the inclusive and collaborative nature of working with the AHT. The findings of the study will be presented in the next chapter.

4. Findings

The findings are based on analysis of interviews with the Aboriginal Patient Navigators, an Elder, and the health care providers who adopted a cultural safety focus when engaging with clients in their work.

As outlined in Chapter 1, the research questions this study endeavored to answer were: How do APNs and health care providers who practice cultural safety in their health care setting describe their experience of delivering cultural safe care within their hospital? What are their perspectives about cultural safety and some contextual factors that affect its uptake?

The key findings are: 1) The client and health care provider relationship is the cornerstone of cultural safety. Concurrent sub-topics are: client safety flows from respectful communication, the APNs practice CS through advocacy, spirituality and communication, APNs are the primary CS strategy, HCPs CS roles are constrained, and HCP perspectives on CS. 2) The organizational strategies to support cultural safety are insufficient in the pervasive traditional biomedical, organizational context. Concurrent subtopics are the time and system pressured context, the traditional biomedical context, insufficient Indigenous resources and supports. 3) Structural barriers to CS persist in the current colonial context and these permeate health care organizations and systems. Subtopics are the structural violence towards Indigenous people and culturally unsafe care: racism and discrimination. These findings demonstrate the complexities and intersections of the HCP and client relationship, the organizational strategies to support CS and the current systemic structure, processes which constrained the participant's abilities to provide CS care.

4.1 The client and health care provider relationship is the cornerstone of cultural safety

All the participants talked of the importance of building a relationship with a client. In building a (therapeutic) relationship they spoke of needing time to speak and listen respectfully, to be genuine and gain the client's trust. The APNs talked about the key importance of the development of trust in health care interactions through listening, talking respectfully, and acknowledging the client for who they are and where they are from. Many spoke about Indigenous clients needing more time because they may not be willing to share right away about their health care and cultural needs due to previous negative experiences within health care and social systems. The APNs discussed the importance of all HCPs being aware of the client and their background. Participant A describes how to engage with a client in a CS manner:

> "*Sit and listen to their stories, who they are and where they come from. Take the time to sit and listen. This is an important way to respect and honour who they are and where they come from*".

Several of the APNs spoke of Indigenous people being part of different health and social systems for Indigenous people than non-Indigenous people. Therefore, it may take more time to develop trust between the HCP and client as the Indigenous client may anticipate discrimination based on past experiences with discrimination in the past. The APNs spoke about the importance of taking the time needed to understand Indigenous people, particularly those who have had negative health experiences who may have a heightened sensitivity when in a hospital setting when they are sick and scared and away from their family. Therefore, spending more time with the client, in a less rushed approach to care delivery and speaking in a quiet, soft tone is more respectful in establishing trust and a relationship between a HCP and client. Several of the APNs

emphasized that if an Indigenous person doesn't have a good experience (trust) with the health service and staff they won't want to come back.

> **"***Time, trust and building relationships goes against the system we are working in. People don't always feel like they matter because everyone is busy and they are rushing and not listening to those who need to be heard. So, then the client may not want to come back when they need to seek help".* (Participant C).

4.2 Safety flows from respectful communication

The participants believe a client's feelings of safety will flow on from the respectful communication and encounter which comes from a HCP who is aware of CS and seeks to understand the whole client. The main theme underlying the participant's descriptions of their perspectives of CS was respectful, client centered communication and development of a relationship between the client and the HCP. This relationship and the care delivery should be based on the values and needs of the clients. The participants discussed cultural safety in terms of the client feeling safe in the health care environment. Several participants discussed safety in terms of building relationships between Indigenous people and the health care system. If the client is feeling safe in the health care setting and respected for who they are they will likely feel comfortable to come back into that health service again, as this participant described:

> *"The end result of [CS] is where Indigenous people feel safe receiving health, receiving health care within the system. And health care staff are competent and safe in their practice working with Indigenous people. CS is the outcome of cultural competence".* (Participant B).

The participants spoke of the importance of the client feeling safe when using health care services. For the client to feel safe in the health care environment they need to feel safe to be who they are as individuals. The clients also need to experience respect and trust from their HCPs.

"Really listening to the client and who they are, understanding and acknowledging who they are is so important. Then the client will likely open up and ask questions and the conversation starts, with respectful conversations. They will start to trust you when you listen and help them with what the client needs. Safety is about being able to be who you are when you need health care and not be judged" (Participant E).

The client feeling safe in the client and HCP relationship was a very powerful emotion and concept for me particularly after one of the participants disclosed a personal situation where a child was delayed assessment and treatment. In my interview with Participant A, when I asked about their perspective on CS, said CS was "a matter between life and death for many of us on the receiving end of health care". The participant had experienced feeling very unsafe in a health care experience. The participant felt unsafe as no HCP was listening and taking the time to understand what was going on. The participant felt this was due to the participant being Indigenous. This belief about CS was timely considering the recommendations from the inquest into Brian Sinclair's death in a Winnipeg Emergency Room (ER). The 2014 inquest, revealed his preventable death was due to discrimination and stereotyping of him as a homeless Indigenous man by the ER staff (Manitoba Courts 2014). I subsequently included Participant A's statement to the interview guide to integrate as a prompt to inquire about looking at CS as a life and death situation for Indigenous people. During each subsequent interview with a participant, I inquired about how they felt and whether they agreed with Participant A's "life and death statement".

When asked about how they felt about CS being a matter of life and death, most participants said they had never really thought about CS in that way. After taking some time to consider the statement, the following responses were given by participants:

"*For sure, if an Indigenous person is not feeling safe and able to access their cultural ways when in the hospital, it could be a matter of life and death for them and their well-being".* (Participant C*).*

"*Well, oh yeah, I mean for sure it's like I said if someone is not feeling safe with their mental health state and where they're at with their health, you know for some people, yeah, it could be either life or death and how, you know, they've had bad experiences, they don't know how to seek resources and health concerns, they may overlook getting help. So, yeah, I see it as it could be life or death I've never, you know, I've never thought about that like but, yeah, I think for a lot of Aboriginal patients it could be life or death*. (Participant D).

*"Yeah, I never thought of it like that but (*Participant H describes recent case situation about an admission of an Indigenous client from a remote community*) this client had no supports, didn't know anyone here [in Vancouver] and had a long recovery and transition [back] to the community. It made such a difference when I sought out the APN and they brightened up and got people from the community to come and be with him. So, it could have been a matter of life and death for this person. The client involvement with the APN made a big difference in their well-being".* (Participant H).

The client feeling safe is the goal of a CS approach to care, where the Indigenous client accesses the health care they require and have their needs met by HCPs in a non-judgmental

way, who are respectful and informed about Indigenous history. Safety can only be determined by the client receiving the care, not by the HCP.

4.3 Aboriginal Patient Navigators practice cultural safety through advocacy, spirituality and communication

The APNs described three key ways of promoting and practicing CS were through: 1) Client and family advocacy and support within the health organization and when necessary assisting with support and navigating the client's interactions with community resources 2) Facilitating spiritual care, by providing clients access to their traditional medicines and practices. 3) Facilitating communication between the client and HCPs which helps build familiarity and trust within the health care system. Their role was implemented to improve the health of Indigenous people in the health care system; to decrease health inequities experienced by Indigenous people through assistance with accessing and navigating health services (Dancing in Both Worlds, Provincial Health Services Authority, 2014).

> *"Sometimes it is just about the client needing to see an Indigenous face. They are scared, away from home and don't know what is going on. Often, I have to explain what is going on with their care and what the doctors are saying, what they are planning to do".*
> (Participant E).

The APNs enacted CS through their presence alone as well as through active negotiation.

> "*We are moving in the support and direction [of the traditional use of tobacco and smudging ceremonies], a direct link to clinical practice, with the clients right to their traditional medicines. We want to link this with health outcomes. We are carrying out traditional healing practices for clients more than we have previously".* (Participant B).

Other supportive and advocacy roles that the APNs navigate with client were in relation to accessing non insured health benefits[5] which can assist the client in understanding and accessing health and community services. Navigating the health system and government services can be overwhelming and unfamiliar for many clients. Another example of how APNs facilitate CS is by helping Indigenous clients navigate the health system in any way they can, from driving clients to community appointments and being present for a doctor's visit, to providing emotional and spiritual care to Indigenous client and family members in acute care, to providing informal education to staff about Indigenous culture.

All the APNs support strategies required working with staff. The APNs saw that their work with HCPs had immediate impact.

"*When I am out there I like to help, the HCP understand how to work with members of our community. Sometimes they just need to take the time to really understand where they [the client] are coming from, asking what their needs are, so then they consult us [APNs] which really helps the client*". (Participant C).

"*I worked with a HCP who had taken the online training course and had identified a client who was a residential school survivor. She identified this person was high risk person who was triggered by being in a room with a belligerent and behavioural non-Indigenous client. She acknowledged that and called us [the APNs] for assistance. We went over the trauma informed practice stuff with the HCP. The HCP said before the online course she would have just seen this as conflict between two clients but now she*

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[5] Non insured health benefits are health services not covered through private insurance and or provincial health programs. Health Canada provides benefits such as vision care, prescription drugs and other benefits to Indigenous people registered as Indian according to the Indian Act or an Inuit recognized by Inuit land claim organization (Government of Canada, Benefits Information, Non-Insured Health Benefits, 2016)

had more awareness and knowledge about how things are for Indigenous people after

working with me". (Participant B).

The APNs also spoke about being engaged by staff in ways that positioned them as a "buffer" between the staff and family members of the hospitalized client. They talked about staff not always being aware of the Indigenous families and community ways of supporting one another and the individual who is sick. The staff frequently become frustrated by the large numbers of family wanting to stay with the client. The APNs come in and listen and negotiate between the staff and family. The APNs described talking to the family about their concerns and experiences when in the health care system in the past.

> "*We get asked to come in (from hospital staff) to talk to families about big numbers of*
>
> *family members hanging out in the visitor's waiting room. We get involved at an earlier*
>
> *level now, with a family if the staff have tried to work with them. Then we try to bring*
>
> *everyone together, so the staff and family all work together*". (Participant C).

The APNs then communicate and educate the staff about the family's emotions and reactions, especially when the families are in crisis, to help the staff understand the situation with a better. The APNs facilitate communication with and between the client, their family and the HCPs is another way the APN supports CS care and promotes a safer health environment.

> "*I give them [the client] that space to speak up for what their needs are not what I think*
>
> *they are. I listen closely to the client, the family and what the staff think is going on*".
>
> (Participant A).

Creating such space supported by wider organizational strategy

> "*One nurse I had been working with before one day said to me, I didn't know [about*
>
> *Indigenous history and residential schools], I didn't know. Then she told me she had*

taken the online course. Then she talked to me in a different way, looked at me in a

different way and made me feel more welcome. We talked about the Indigenous clients

that came into the unit. This changed how she communicated in our group and client

meetings. She listened a lot more to the client and often asked the client and myself for

our suggestions for the when the client left the hospital". (Participant A).

The APNs and Elder illustrated a CS approach in their work in supporting the Indigenous client and their family. Particularly creating space for clients and family members input. The descriptions also illustrate their engagement, support and impact of their work for health care staff in their commitment to bridge the gap between Indigenous and non-Indigenous people.

4.4 APNs are the primary cultural safety strategy

The APNs and Elder described CS being a primary focus of their work and described various ways in which they saw impact in the hospital. Their role is becoming increasingly visible in the hospital through their work with clients and HCPs on site and through their provision of formal small group CS facilitation for ongoing support and education for staff. Currently they facilitate informal education of staff by raising awareness and building knowledge of historical and cultural issues during their interactions with staff. The need was to provide further knowledge and awareness of Indigenous history and how staff can apply their knowledge to enhance their client care was identified by some managers. This education builds on from the San'yas Indigenous Cultural Safety course to promote ongoing awareness and implementation of a CS approach to Indigenous care through scenario based cases. Discussion is facilitated about other ways of knowing by offering an Indigenous view to health and well-being to increase awareness towards cultural safety for staff.

"We are looking at this opportunity to plant the seeds of cultural safety. We are developing strategies of how we are going to engage and reach such a large staff base; to teach but also sustain awareness by hopefully getting more staff resources to make this happen. We hope to implement this CS initiatives at [this hospital], see how that works then implement it in the other organizations". (Participant B).

"I think it [inequity towards Indigenous people] was a lack of knowledge and understanding, lack of education as it wasn't taught in high school. A lack of understanding of our culture, our history, the medicines". (Participant E).

The AHT hopes to increase resources to enable a position for an onsite Elder. Elders are highly respected members of an Indigenous community who are teachers and role models. They provide spiritual support and well-being through their traditional practices. This plan of action for strategies by the AHT is evident in this participant's comments.

"*Education and training [for staff] to come to understand and honour us as a people is still needing in many ways. To understand our history and what we have and continue to go through. Reconciling relationships at all levels of society and with governments. Hopefully the education for health care staff will have flow-on effects to society so Indigenous people will be seen and treated better"*. (Participant D).

The Elder talked about spending time with clients and families sitting down together and hearing their stories:

"*Listening to their voices and honouring them, attending to them and to who they are and where they are from. I talk to them about what they have done, their strengths and show them respect"*.

The APN group discussed CS being a "buzz word in health care" and they spoke of seeing more awareness of Indigenous issues by people outside health care as well. They saw this awareness as positive small steps of envisioning a future accepting all diverse cultures and people, where we all work together. The APNs felt that health care staff had more awareness and were asking more questions about traditional Indigenous practices. The APNs talked about their role of advocating for clients who were referred and supporting and educating staff. Some of the participants spoke about clients and families asking for traditional Indigenous healing practices alongside the Western medical treatments. The Elders and APNs carry traditional medicines and herbs and will carry out smudging if requested by clients and families. Smudging is the burning of sage or cedar for spiritual cleansing to remove negative energy and create balance and wellness; the smoke is then used to promote healing (VCH 2014). APNs and Elders have a vital role in addressing and providing cultural and spiritual care for Indigenous clients to meet their health needs and to improve the client's hospital experience.

4.5 Health Care Providers' roles in relation to cultural safety are constrained

The HCPs CS roles are constrained but within the limits of their role they strive to provide client centered care. The HCPs all spoke of how their pressures of their caseloads challenged their time, energy, and ability to be client centered. The HCPs strive to provide care with a client centered approach in their communications and interactions with clients. CS is an approach that requires HCPs to reflect on their own cultural identity, recognizing the impact of their culture on their nursing practice (Wepa 2005). It was evident the HCPs had reflected on their own beliefs, culture and practice in their descriptions of their perspectives of CS and client centered care. The HCPs spoke about focusing on providing client centered care, understanding

where the client is at with their health and social situations. This demonstrates their approach to their client care as one that is collaborative; with the goal of a partnership, in contrast to the HCP directing the client care. One of the goals of CS care is the client leading and taking control of their own health needs through self advocacy (Wepa 2005). Participant H described their client centered approach to their interactions:

"*I listen and consider what they are telling me, trying to piece together who they are and what is going on. I consider everything, the whole client, not just their social situation, I consider their context which can change along with their health over time*".

Participants felt they provided CS care by listening, being client focused and respectful but felt due to the pressures of their case load they had to divide their time and carry out the care as best they can. This client centered approach is reflected by Participant G's description:

"*Each individual [HCP] looks at the client and their individual situation and I try to look at the context and the big picture. I look to see where they are from, if they have housing and supports and ask them what they need. I try to listen, be respectful and divide my time and care out equally the best I can. Sometimes all they want is some food. Then they usually will open up and talk*".

Participant F's description of how they interact with clients in their day to day work:

"*I try to meet with the client, give them my full attention and really listen to them and try to understand who they are and where they are at. I try to understand what they know about their health and what they think they need*".

4.6 HCP perspectives on cultural safety

The HCP participants discussed their perspectives of CS from their own personal awareness and knowledge which was consistently client and family focused and respectful with a focus on "meeting clients where they are at" regarding their health and well-being. From the HCP perspective, CS was mainly viewed within their individual level in their relationships with their clients.

> *"I try to take the time to listen to their story about who they are and where they are at in their health and life in a non-judgmental way. Get to know them and build a relationship. Then I will ask if they would like a referral [to an APN]. In my experience, it always makes a big difference once the APN sees the client. Everything starts to get better for them".* (Participant F).

All the HCP participants discussed viewing the client in a holistic way, considered the client and the client within their context. The clients were frequently away from their family and community supports and clients presented with many chronic conditions including mental health and addictions, as the HCPs worked with clients in acute care or discharging from acute care to the community health services.

The HCPs believe knowledge and training is important (in alignment with the APNs and Elder) to increase HCP awareness about the history of Indigenous people in Canada. The knowledge they gained from taking the Indigenous Cultural Safety course was very valuable in understanding the lived experiences of the Indigenous people and it helped them look at their clients in their context. They spoke about this understanding and insight was helpful in seeing the client and where they are at and why, which may be complex and challenging due to previous negative experiences and or a lack of basic needs such as housing and employment.

"*Cultural safety is about being allowed to be who you are and show your culture, not hide who you really are. If they don't feel comfortable and safe telling us about what is going on with their health then we aren't really helping them and their health will suffer*". (Participant E).

The participant's perspectives about cultural safety also centered on understanding the client and their needs, and their culture. They spoke about respectful communication, listening about who the client is and what culture means to the individual in a non-judgmental way. They felt their understandings about culture and Indigenous ways of knowing and health from their training shaped the way they thought about the client when working with Indigenous clients.

"You know, I ask them what does their cultural mean to them, are they interested in their culture, how important is that to them because, you know, I find some patients, they're not always interested in knowing their culture, they don't always participate in their culture because they've been abused, not feeling safe, so they often, you know, may have declined or ignored their culture due to negative experiences. So, you know, I feel cultural safety is all about the individual and what it means to them". (Participant D)

"Though I haven't completed the CS course yet, I did cover Indigenous knowledge and the concepts in school years ago. We covered health inequities and social justice. I practice in a client and family centered approach and focus on who they are and what they need". (Participant H).

They felt some of their colleagues were unaware of Indigenous health issues because they did not use the APN service or did not know about the APNs role in working with Indigenous clients. The following are descriptions from HCPs about the benefits of the knowledge and awareness from their Indigenous Cultural Safety training:

"I didn't train here so it [Indigenous Cultural Safety Course] helped me understand the Aboriginal history and the effects of residential schools and relations with the government. It helped me understand their holistic view about health and wellbeing". (Participant G).

"Yes, I found the on-line CS course really helpful. It was similar way of looking at care and the whole patient like we do in mental health. I thought the real-life situations and narratives of the Indigenous speakers were very powerful and made me think. It is horrifying what they [Indigenous people] have been through". (Participant F).

The HCPs sought out resources and supports such as the APN service for their clients when necessary or requested by the client and or family.

"When I first meet a client, I listen closely to what is being said but listen more closely to what is not being said… Some people have had very bad experiences for themselves and their families. They have a lot of mistrust in the system, so I take my time and just listen" (Participant A).

The APNs perspective on CS (also client centered) was a broader focus given the nature and scope of their role was to provide support by informing non-Indigenous staff about Indigenous history and colonization.

4.7 The organizational strategies to support cultural safety are insufficient in the pervasive traditional biomedical, organizational context

Values and knowledge pertaining to health, health care and health systems are founded in colonialism and this traditional biomedical view is still dominant in the organizational context.

4.7.1 A time and system pressured context

Time and system pressures dominate in the health care context making it difficult for the participants to keep CS in the foreground of their care.

"*There is not enough time for us to spend with a client and we have more time than the doctors and nurses who are always rushing around. A higher workload is a short-term cost approach which does not look at the larger picture and how it affects the client and their hospital experience".* (Participant C).

The day to day pressured contexts of the HCPs working with large caseloads of clients challenged them and was a barrier to providing care and care that is culturally safe. The HCP in acute care spoke of the constant focus on discharging clients.

"*There is always a push for discharges and beds"* (Participant H).

All participants spoke about their busy client case-loads which seemed to frequently involve working with clients and their families with complex needs, who required significant time to assess and seek out the required supports in the community. They said this was not something that could happen quickly due to the complexities of community resources being informed and organized and engaging with the family. In many situations, Indigenous family members were performing the tasks of activities of daily living, such as bathing and toileting or assisting with meal preparation.

"*The APNs are important to educate the staff on how to be with a family or how to be with a patient is very, very, vital. But their workloads are very busy now as it can take time to understand what the client and family needs. We must connect with the community members. It doesn't always happen quickly*". (Participant A)

The HCPs spoke about doing the best they can with the time, resources and caseloads they have. The APNs concurred but did not speak about their work pressures as frequently as the HCPs. I regularly observed and heard about the time pressure in the work environment from the HCP participants. They spoke of having to frequently prioritize and be flexible to accommodating new clients they had to see, while also making time to connect, build relations and seek out community resources for clients with complex chronic and social needs.

"*You can feel trapped and pushed by wanting to do the best by someone who needs a lot of time and continued follow-up in the long term and digging into the charts on a new patient in the ER who has no fixed address or family supports and needs to be on psych medications*". (Participant G).

4.7.2 Traditional biomedical context

The traditional biomedical context pervades throughout the hospital which was evident in the stories of the participants and their day to day work. For the HCP participants CS was not a focus or discussion topic in their team approach to care.

"*In our teams, we talk about individual clients and approaches and how we can all assist in our roles. But I am not aware of the topic of CS being discussed or a client's specific culture being mentioned*". (Participant G).

"*These conversations [about CS] are coming up with different team members but it is still very western medicine kind of focus to interventions and client care*". (Participant H).

In reflecting about system issues and a biomedical approach to care, the HCPs specifically noted a gap on documentation forms and admission forms about assessing for a client's culture. They all said it would assist in getting HCPs to consider inquiring about an

individual's culture. The current forms are not holistic as culture is not included, so you don't know if a HCP has inquired about culture. There is also a lack of standardized assessment tools for HCP client assessment therefore assessing a client's culture was not consistently being done by all staff. The HCPs felt this as a barrier to providing CS care in their day to day work.

> "*But we need to change our systems, so a tick box for culture on a standardized form may help staff to change their ways, help them remember to ask a client if they have any cultural considerations*". (Participant F).

The HCP participants saw documentation as one strategy but recognize CS requires an ongoing commitment from the hospital, team and individual.

> "*A template or standardized form would be helpful as asking about culture is not consistent with all disciplines. It would show our commitment and value [to CS]*". (Participant H).

> "*A prompt [to assess culture} within the interdisciplinary care plan would be helpful for everyone as it might remind HCPs to consider asking about the client's culture. It may help to implement our knowledge about CS*". (Participant G).

The traditional biomedical model for treatment and interventions does not allow for alternative ways of knowing and the integration of Indigenous holistic healing and traditional practices to the client's care plan. An Indigenous perspective of holistic health care integrates the body, mind, spirit with the land and community (First Nations Health Authority 2017). Through a partnership and CS approach to care, the integration of traditional healing and wellness to Indigenous clients care plan will enhance and improve the health of Indigenous people (FNHA).

When I probed about the organizational supports and resources for Indigenous clients and CS, the HCPs talked about not having the time to access them. They had accessed the APN service but were not aware of other resources, information or policies.

> **"***I haven't really tapped into that [Aboriginal resources] because we are so stretched. I am not sure what the organization has for CS. I know there is a special place [Sacred Space Room] for Aboriginal people but I never see anyone using it*. (Participant G).

The HCPs spoke of Indigenous clients who were admitted who did not advocate for an APN and there were HCPs who were not aware of the service or did not assess the clients need for an APN or cultural preferences. Participant G and H spoke about how the interdisciplinary teams can "forget about" referring to an APN and including them in the care plan. All the HCP participants said their teams used the APN service if they had Indigenous clients who had complex health and discharge needs. Some of the participants said the APNs were not called in enough to visit and or support Indigenous clients. Two of the participants had worked with an APN participant, when the HCP had consulted with the APN service for some of their Indigenous clients. These were clients with complex discharge needs and the HCP liaised with the APN who has knowledge of Indigenous communities and available resources. The HCP participants described the improvement in the client's outlook and spirit when the APN became involved in the case and assisted in the care plan for the Indigenous client. The following describes the impact of the APNs work:

> *"After I had worked with the APN and saw what a difference it made, I always ask my Indigenous clients if they want to be referred now. The APN is good at looking at and connecting with the client and the community. They liaise with the community and the health care team"*. (Participant H).

4.7.3 Insufficient Indigenous resources and supports

From the perspectives of the participants in this study, more resources (APNs and Elders) are needed to meet the demands of a 24-hour health care system, as they believe the current number is insufficient. Currently there are 4 APNs, 2 CS Facilitators, and 1 CS Coordinator, employed within the organization to support, engage and teach frontline staff about Indigenous ways and health (L Jebamani, personal communication, June 7, 2017). There are 20 staff in the AHT who all engage/support/ facilitate education work at some level, with all levels of staff throughout the organization. There are no Elders regularly employed by VCH; rather Elders are given an honorarium for their time and service of providing spiritual healing and traditional healing practices rather than being regular employees. There is a need for more resources to support positions for APNs and Elders within the hospital for client advocacy and support as well as to provide teaching and support to staff. The HCPs had awareness and knowledge about the APN service for their Indigenous clients but were not aware of other resources or supports for themselves or their clients. These findings also speak to the lack of awareness and or visibility of the APNs by frontline staff about accessing the AHT service for their Indigenous clients. All the participants spoke of the need for more APNs, so that an APN would be a more visible presence as part of the interdisciplinary team on a consistent basis. An APN on site (in the hospital) which would create more awareness for staff and a more visible presence for staff and clients.

> "*Ideally we would like to have more APNs and have an office at each hospital so we would have more of a presence and people would know we are there and able to be consulted. I think it would make a difference for the staff and patients*". (Participant B).

"Anyone can refer to us, a client, family member, HCP. I try to get the word out there. We have cards but usually word of mouth works best. Sometimes they [the client] just want to see another Indigenous face". (Participant E).

The HCP participants had some knowledge of the work of an Elder but were not aware of their role as knowledge keepers, teachers and role models of traditional practices within their indigenous communities. The APNs also stated there was a lack of awareness about the Elder role amongst frontline HCPs. The APNs talked about the need for more APNs and Elders to meet the needs of the ongoing education and training of the HCP, beyond the online CS training. Several spoke of HCPs wanting more face to face teachings with APNs and Elders for greater understanding in how to apply some of the knowledge from the online training to their everyday work with clients. Participant B and G mentioned their concern that HCPs may revert to their old ways (of not considering a CS approach) if there is not commitment by the organization for more Indigenous services and ongoing CS training.

"We have limited resources to meet the demand for CS training, which has now extended to small group face to face education. We have a high demand for this and want to deliver a variety of modes of knowledge delivery about Aboriginal history and the current and ongoing effects of inequities". (Participant B).

APN and HCP participants discussed that despite more awareness amongst staff about the APN role and their abilities to support an Indigenous client, it is still slow amongst frontline staff. The lack of numbers of APNs may be a contributing factor to the uptake of utilizing the APN services. The APNs spoke of consulting with HCPs in certain units within the hospital more than other units for spiritual support and traditional healing practices. The acute care and

intensive care units may consult more with the APNs for end of life support for Indigenous clients and their families.

> "*Now we are carrying our own bundles [traditional medicines, herbs] which is amazing. Sometimes we are called in last minute to provide cultural support for the client and family when the client is dying*". (Participant E).

The participants identified a need for more Indigenous staff and APNs to facilitate CS education and awareness. There was also a need for more APNs to sustain the knowledge, awareness and commitment to a CS focus amongst frontline staff. The Elder role was not well understood by the HCP participants. Lack of awareness by staff about the APN service was mentioned which may be due to the small number of APNs and some staff not considering or referring their client. A concern I have as a researcher which was not discussed by the participants, is a lack of awareness amongst Indigenous clients and their families about the APN service and their right to access this service and resource.

The Sacred Space room is a relatively new area for all Indigenous people and individuals of any faith who wish to pray, meditate or seek spiritual guidance and support during their hospitalization. The APNs were not sure how frequently it was used by clients and their family's other than when they have used it to provide traditional healing practices. Generally, the Sacred Space room seems to be an underutilized resource which may be due to the small number of APNs, the clients and staff being unaware and not utilizing the APN services. The AHT is attempting to further align the organization with CS facilities and structures, to accommodate Indigenous traditional practices and to provide an environment that is welcoming to Indigenous clients.

4.8 Structural barriers to cultural safety persist in the continuing colonial context

Many contextual factors affect the participant's abilities to provide CS care within the hospital due to the existing traditional colonial health care system structures and processes. The health care context within which the participants work was oriented to an individualist, biomedical, Western health care structure with very early efforts of integrating CS into health practices. The participants said challenges such as the pressured biomedical health system, discrimination and stereotyping towards Indigenous clients and devaluing of the relational aspect to HCP and client care are examples of the colonial values that predominate in the health care system. These challenges were barriers to provide CS care and an Indigenous holistic focus to health and wellbeing within the traditional current health systems. Structural constraints such as the time pressured system and the pervasive biomedical model inhibited their ability to provide CS care at their individual level and at the broader hospital level. These constraints demonstrate colonialism and its embedded presence in the health care context. Systems rooted in colonial practice influence Indigenous peoples' health and perpetuate health inequity.

> "*I agree, we have a social responsibility to the populations that we serve to be safe….so there is clinical safety, spiritual safety and cultural safety. We need to change health systems and structures to allow for all clients to feel safe to access any type of health care service".* (Participant B).

4.8.1 Structural violence towards Indigenous people

> "*Some staff still look at our people and judge them and blame them for the lives they lead. Indigenous people aren't given a chance. Society is not an even playing field, so there is no wonder our people are suffering".* (Participant A).

Structural violence exists when marginalized groups including Indigenous people may have limited access to basic services and opportunities due to political, social and health structures that are not inclusive to their needs (Kurtz, Nyberg, Van Den Tillert, Mills, 2008). These existing systems may be viewed as structural violence towards Indigenous people. Structural violence stems from colonial beliefs and practices (Kurtz et al). Colonialism is perceived as a barrier for Indigenous people to maintain their own health due to the government policies and lack services and restrictions to traditional practices. All the participants spoke of the societal and health system issues that Indigenous people face, where some Indigenous peoples' basic needs are not met (such as housing and income). The APNs being Indigenous themselves had a direct awareness and sensitivity towards the understanding that these systemic issues are the result of government policies.

> "*I think another part of Indigenous CS in health care is acknowledging publicly the vested interest that the current power holders have in the system [the governments] and the systems remaining more the same than different. And the power in health care is still with the clinical team and not with the client".* (Participant E).

Two of the HCPs talked about challenges with the government funding for Indigenous clients regarding covering their medications in the community. They said they weren't covered for the same medications that were prescribed in the acute care setting only the second-generation medications. Some of the participant's conversations about clients who were poor, had chronic diseases and trust issues with health services due to previous negative experiences, also relates to the social realities, and systemic marginalization of Indigenous people.

"Many of my Aboriginal clients with substance and mental health issues can be homeless at one time or another. There is not sufficient housing for them. That makes it hard to track them down to follow-up with them about their mental health". (Participant G).

As was previously stated in the APNs section about their experiences of providing CS care, hospital visiting hours were discussed as a policy that did not integrate the Indigenous families' way of being and supporting the family member who was hospitalized. This was felt to be a system issue by some of the participants where the biomedical system approach to health did not accommodate the Indigenous view of health and wellbeing. The client feeling safe and HCPS providing a relational approach to health care supports the need to integrate the Indigenous ways of knowing, health and well-being alongside the traditional biomedical model and systems. Acknowledging other ways of knowing and a holistic approach to client care and policies are required to change existing structures to allow for a more inclusive provision of care, improving health care for Indigenous people.

4.8.2 Culturally unsafe care; racism and discrimination

I directly inquired to the participants if they had encountered racism, discrimination or stereotyping in their work places, teams or client care situations. This probe was useful to gain more description and understanding about their experiences and gave me some insight into the CS environment in the hospital. After asking this question, I consistently observed and felt a pause in the interview, when (what may be considered) an uncomfortable question was asked. Initially during the interviews, all participant's experiences about providing culturally safe care were mostly positive experiences when they reflected on experiences with clients in the health care system and staff interactions between HCPs and clients. However, as a researcher I wanted

to understand their lived day to day experience of CS and their reflections on these experiences. The following is a situation with an Indigenous client and family who experienced discrimination and stereotyping in their care. The APN was consulted who then facilitated another HCP who engaged in a more CS approach to care:

> **"***It is fortunate we were called in because in many cases we are not called in. The family had come in to be with the client, and they were from out of town. The family had come in to meet the case manager and she said you people are so complex, in a sharp unfriendly tone. The family said they would not work with that case manager as she didn't listen to their situation and needs. Another case manager was assigned who wants to be an ally and work closely with me and the family, who listens to what they want*". (Participant E).

Other examples describe the participant's experiences and the challenges they observed when engaging with clients and staff in the hospital in relation to the provision of care. The following description from an APN highlights a culturally unsafe experience:

> **"***I was visiting this elder who was hospitalized with a respiratory issue. I had been working with her for the last eighteen months and she knew because of her diabetes and cardiovascular issues things were not looking good for her. We were having a conversation about how it really hit home with her that day as she was very tired and scared. She was telling me she was DNR, I want to be DNR. A doctor knocked and asked can I come in? But before the client could say anything he was in the room. The doctor just asked something about her aspirin… The client felt violated and uncomfortable and it kind of broke our conversation about her feelings of being scared. The conversation went in another direction*". (Participant C).

Lastly, in the findings about the participant's negative experiences regarding unsafe care, examples of racism and stereotyping towards Indigenous people in health care had been observed by the participants.

> **"***I could go on all afternoon and into tomorrow about different examples [of discrimination and racism]. A client was discharged with seizures… the doctor said all he needs is a couple of drinks and he will be ok. He didn't drink"*. (Participant E)*.

This sense (of racism and stereotyping) appeared heightened within the APNs and Elder participants as all of them had directly experienced racism. Participant F and G had not experienced racism towards Indigenous people working in their current mental health team but when working in other teams such as in the judicial system.

> **"***Sometimes our people don't want to speak up, they are sick and in hospital; often staff don't listen to them and their needs are not being met. Sometimes they still feel it is because of their brown skin, they are being ignored. It's based on the system running in the system and on the reservation or Indian Affairs. It is important to understand that as an Aboriginal person you are affected by, we are affected by the constructs of society"*.* (Participant C).

> *"You know, you need space and time and the right setting to be able to provide culturally safe care as well for the patient needing to feel safe and secure where they are and being able to speak with you so I feel that's important, the environment. Our health systems are very pressured and so I feel, you know, I know friends that work in acute care they can't always, you know, deliver the kind of care they want to because of the challenging nature of the healthcare system"*. (Participant D).

From the descriptions by the participants there are many examples of racism and discrimination towards Indigenous people in the hospital and within Canadian society. At an individual level from a HCP this was evident in the examples of stereotyping and discrimination, to an interdisciplinary team forgetting to refer a client to the APN. The health care system and organizational structure was also a barrier in engaging in a CS approach to care due to the ongoing effects of colonialism and our one world system view.

4.9 Conclusion

The APNs, and the Elder, and the HCPs who participated in the study shared their stories, perspectives and experiences in relation to culturally safe care in the health care setting of the organization in which they work. Their insights demonstrate the complexities and intersections influencing many Indigenous peoples' health care experiences, the inequities they experience, the colonial and organizational policies shaping health and access to care, the nature of individualistic biomedical model health systems and its impact on Indigenous peoples' health and well-being, and the ongoing systemic violence and racism and stereotyping of Indigenous people. They described the importance of a cultural safety approach and framework to view health care. Cultural safety could also be viewed as a process and outcome for all levels of government to address Indigenous health and social inequities.

5. Discussion

5.1 Introduction

The research questions this study endeavored to answer were: How do CCS, (referring to APNs, an Elder, and HCPs) who practice cultural safety in their health care setting describe their experience of providing cultural safe care within their organization? What are their perspectives about cultural safety and the contextual factors that affect the uptake of cultural safety? The analysis of the interviews identified themes that were interrelated to these questions. The participant's perspectives and insights demonstrate the complexities and intersections among the social determinants of health and Indigenous inequities, colonial and organizational policies, traditional biomedical model health systems and Indigenous view of health and well-being, systemic violence and racism and stereotyping of Indigenous people. The findings suggest three key areas for discussion: 1) The client and health care provider relationship must be valued and analyzed though a cultural safety lens, 2) Many key characteristics of the hospital and wider health care context conflict with a CS approach to care 3) Structural violence: racism and discrimination exist within the hospital, demonstrating a need for organizational interventions to address the continued Indigenous health inequities.The discussion, guided by postcolonial and CS lenses, analysed the key concepts used in the study and how the findings related to the research questions and the literature.

5.2 The client and health care provider relationship

The main finding and theme from the participants of their perspectives on CS was their descriptions of the HCP and client relationship. The interpersonal relationship they described of

respectful communication, listening, and exploring who the individual is, what their needs are and what culture means to them is in alignment with Hole et al (2015) and Browne et al (2011) who discuss the importance of positive interactions such as feeling valued and respected between the HCP and the client. Positive CS health care experiences by Indigenous people were reported when they felt respected and valued for who they were and what they had to say (Hole et al: Kurtz et al 2008). When their voices are not silenced by HCPs who are supportive and engaged in respectful communication and relationships, Indigenous women were found to have positive health care experiences (Kurtz et al). From the Indigenous client perspective (in the literature), respect, listening and not being judged was valued by the client, making them feel worthy and human (Hole et al). The participants all valued a relational approach to their client interactions which was important to them in best understanding clients and their needs within the health care system; "meeting them where they are at" (Participant D). The participants did not specifically mention the power imbalance present in the HCP and client relationship, which is a key component of the broader concept of CS in the literature (Smye et al 2006; Browne et al 2009; Varcoe 2015) but referred to it in their descriptions about client situations and interactions in the health care system. They spoke of the power still being centered in the HCP within the HCP and client relationship. With a CS approach to health care the relationship is a collaborative partnership and one that shifts power to the client who is no longer a passive recipient of care (Ramsden 2005; Brascoupé & Waters 2009). Over time with HCPs who are knowledgeable about cultural competency and the practices, this builds greater trust between the HCP and client, developing a CS relationship and health environment (Yeung 2016). This leads to a transfer of power to the client over time. As stated earlier the CS approach to health care is in its infancy in the study organization and with these participants there is evidence of culturally appropriate

interventions and practices. Ramsden and Yeung posit that given time the application of culturally competent practices by the HCPs will integrate into the culture of the organization, leading to an environment of CS and cultural humility. Therefore, the client and HCP relationship is a key component of CS which may affect all levels of the health care system and perpetuate the health inequities for Indigenous people if health care is not valued or analyzed from a CS lens.

As evidenced by their descriptions of CS, the participants did not appear to make assumptions about Indigenous people and Indigenous culture; they all spoke of checking in with the client and what culture meant to the individual. This approach is supported by Bourque-Bearskin (2011), who discusses that Indigenous people and groups should define how they wish to be identified. She reminds us that cultural practices are not assumed to be transferred from one Indigenous client to the other as each may hold different beliefs while both identifying as Indigenous. The participants' view of the concept of culture seemed to be broad as I heard in their stories while working with clients and their frustrations with the socio-political and economic factors that impacted their client's health (mental and physical). The stories from the participants were of a conversational and relational approach to their client interactions. Through their active listening and by connecting with the client and where they were at with their needs the participants demonstrated a nonjudgmental inclusive approach to their clients and culture. This broad view of culture is supported by Browne and Varcoe (2006) and Wepa (2005) who advise HCPs to take a critical view of culture and its broader contextual factors to avoid stereotyping client behaviours as their 'culture' because clients may have different behaviours and views than the HCPs.

Several of the participants spoke about CS being defined by the client as feeling safe in their health care encounter. In my experience as a HCP, feeling safe is not something we ask the client, nor do we formally evaluate feelings of safety. However, this is discussed in the literature as being a key indicator of a CS health care encounter or health service (Hole et al 2015; Bras coupé & Waters 2009; Ramsden 2005; FNHA 2017). Strategies for monitoring and evaluating CS health services and practices of staff is discussed in the proposed AHT's CS framework. Currently there is no formal reporting or evaluative process for CS interventions.

The APNs felt there was increased knowledge and awareness by the frontline HCP about CS (therefore the history of Canada, the history of Indigenous people and government policy); this may be partly due to the recent CS training within the hospital. There also has been an increase in client referrals along with more frequent questions asked by HCPs of the APN team regarding Indigenous cultural situations or practices. Some of the APNs spoke of the priority need for resources to apply and sustain the CS training beyond the online San'yas Indigenous Cultural Safety education. Providing cultural safety training for all health care professionals is recommendation 23 of the Health-Related Recommendations of the Truth and Reconciliation Commission of Canada (HealthCareCan 2016). The HCP participants also spoke about increasing awareness for the APNs service. They talked about implementing and sustaining CS in the form of using documentation and assessment tools to improve communication amongst team members and demonstrate accountability of care.

There is evidence of critical self-reflective practice by the participants in this study as demonstrated by their responses to the question about their perspective on CS. I heard from their descriptions there was an intentional strategy to listen to their clients and inquire about their needs and culture. It is evident in their knowledge, understandings, and perspectives comes from

a client centered, holistic view about the health and well-being of Indigenous clients in the health care system.

5.3 Many key characteristics of the hospital context conflicts with a cultural safety approach to care

Many key characteristics of the hospital and wider health care context conflict with a CS approach to care and this affects the uptake of CS in the hospital, both at the individual and systems level. Through the participant's descriptions I saw how the systemic and organizational processes effect the HCPs and the Indigenous clients, factors which are in conflict to a CS approach to health care. Examples of some of these descriptions were a lack of APNs and elders to support and advocate for Indigenous clients in the health care system, the underutilization of the Indigenous cultural supports and resources and the Westernized visiting policy which does not meet the needs of the Indigenous family based culture. From the literature review and in the findings CS is shaped by the knowledge and values of HCP and the context where it takes place.

A CS approach to client care was challenging to uphold due to the existing structures within the hospital which constrained the participant's abilities and intentionality such as client caseloads, time pressures and discharges. This systemic and organizational process of valuing the individual (client focus) is in opposition to a community, holistic approach to care which is in alignment with CS (Oelke et al 2016). Other contextual factors of a poor understanding of the role APN/Elders and Indigenous healing practices and a lack of resources and supports (a need for more APNs and Elders) may be viewed as understandable given the early stages of the Health Authority and AHT's development of a system wide CS transformation. This analysis is relevant

information for the AHT given that these findings come from HCPs who use the APN service and who have an understanding and intention to CS care.

Though not mentioned by any of the participants, I question the Indigenous client's opportunities to access the APN service; their opportunities for self-advocacy. Self advocacy may empower clients to manage their health needs by providing them resources about the APN service and their rights to access traditional healing practices and spaces within the hospital. These areas are being addressed in the AHT's Indigenous CS Framework plan, starting with implementing it in this hospital, then enacting it throughout the HA. Visible public posters about CS for clients and staff, public antidiscrimination posters and increased number of APNs and Elders as part of the interdisciplinary team could enhance respect, awareness and access to Indigenous information and resources. Aboriginal self-identification at point of care is being undertaken at Interior Health to offer APN services and information if a client identifies as Indigenous. The information is voluntary and provides awareness to staff of the individual's ethnicity and culture (Interior Health 2017). Self-identification has a benefit in that it provides awareness and access to Indigenous resources and services if desired by the individual. Varcoe et al (2009) advise to use caution with self-identification as there are challenges and potential harms to individuals due to the lack of transparency for clients with data collection of ethnicity in health care and what it may be used for. Their study also found that stereotyping and discrimination may be exacerbated by HCPs with the use of self-identification. Other contextual factors that are contrary to CS are within the current health systems include the biomedical model which values quick fix disease interventions over time available to the HCP to build trust and a relationship with a client and does not consider the Indigenous knowledge of healing and wellness (Howell et al 2016). The Aboriginal health model holistically covers dimensions of

health such as physical, mental, emotional and spiritual. All participants spoke of HCPs needing "time to really get to know the whole patient, in every way". The pressured high workloads of the participants along with no consistent holistic assessment tool for HCPs, indicates that culture and psychosocial needs of the client are not being valued in the current system. In this context, there is a power imbalance between the HCP and client, which does not empower the client by rushed, quick and pressure interactions with their HCP. For a CS, relational approach to health care the HCP forms a relationship with the client that the client judges as safe and appropriate (Browne et al 2009; Ramsden 2006). Implementing CS care requires the client to be a partner in the health care experience and the client to determine if the care received is culturally safe (FNHA 2014; Browne et al). Actions by the HCP that are seen to diminish or disrespect the knowledge and identity of an Indigenous client are seen as culturally unsafe practices (Howell). It is well documented in the literature the client will not return to the health care service if they feel unsafe, fearful and not respected by the HCPs. (Browne et al; Yeung 2016).

Positive strategic measures to support and work towards a CS environment by the hospital and the Executive include to providing teaching and education to staff about historical consequences that impact Indigenous health through small group sessions for HCPs by the APNs. The APN participants spoke of the staff using the APN and Elder services more frequently currently to support their work with meeting their client's needs and to refer clients to the team. The HCP participants spoke of the value to the client and their health, what a difference they made, when the APN and or Elder visited the client and became part of the health care team. Other hospital supports are the integration of traditional practices for health and wellbeing which are now being implemented by the APNs and Elders when required by a client. Other supports such as the Sacred Space room for Indigenous clients and families and policy measures such as

the Indigenous Cultural Safety Framework and Policy is being developed to guide and inform staff at all levels in the organization. Increased staff awareness about CS, the AHT and APN/Elder service, availability, and integration of traditional Indigenous practices may be viewed as implementation measures from the Declaration and Tripartite Agreement between BC Health Authorities, and FNHA to commit to creating a climate for change. By committing to and focusing with an Indigenous lens and a cultural safety approach to health care, the HA and the organization is working towards the goal of a climate of cultural humility in health service delivery at all levels. While it appears that progress is being made in "small steps" as echoed by many of the APNs and Elder, this climate of change is in the early stages of development, implementation, and sustainability at all levels within the HA and therefore this hospital. As stated earlier the commitment and embedding of the Indigenous lens and a CS approach to health care has been undertaken in the past year and a half in the HA.

5.4 Structural violence: racism and discrimination and organizational inventions to address Indigenous health inequities

Structural violence was evident in the participant's descriptions of racism and stereotyping, the health system processes and inequitable social practices. Analyzing the unsafe cultural experiences of the participants highlights the complexities and intersection of attempting to implement a CS approach in an organizational context that conflicts a CS approach to health care. The colonial socio-political and health structures, the biomedical health model are all structures and views of health of the dominant Caucasian culture which may be viewed as structural violence in marginalizing Indigenous people (Kurtz et al 2008; Oelke 2016). Structural violence is an outcome of colonialism where Indigenous people have been oppressed and assimilated into the dominant culture through residential schools, the Indian Act and reserves (Kurtz et al; Oelke). The historic, and systemic factors, and policies which are ongoing today in this organization, continue to impact and disadvantage the health, wellbeing and lives of Indigenous people in comparison to non-Indigenous people (Oelke). The needs of the Indigenous people have been ignored at all socio-political levels, provincially and federally. The Tripartite Agreement in BC and the new FNHA have emerged to work towards Indigenous self-determination and governance in meeting their health needs by the instigation of new commitments to policy change, addressing Indigenous health needs. The organization will need to continue an ongoing commitment, intentionality, and sustainability to the AHT's Indigenous CS policy and system wide transformation, evaluating the CS framework, interventions and the Indigenous client's perspectives and health outcomes.

The APNs and Elder (who all identified as Indigenous people) have direct experience in living within the ongoing effects of the socio-political and health inequities of the health of

Indigenous people on a day to day basis. At the organization level, the framework for enhancing health care equity proposed by (Browne et al 2016) may be a possible strategy to address health inequities for Indigenous people within the organization. The key areas supporting health and well-being are inequity-responsive care, CS care, trauma and violence informed care and contextually tailored care. This framework could be useful at an organizational level as it addresses the health indicators affecting marginalized populations such as Indigenous people which could be implemented into the AHT CS framework to be used in acute care settings. This framework is also based on evidenced informed practice that can potentially challenge the current standard of practice, thereby altering the health context (system) which is not meeting the needs of many Indigenous people (Browne et al; Yeung 2016). Farmer (2016) discusses social determinants such as education, housing and access to health care as structural social limitations of marginalized populations. Historical and structural racism are also factors that impact health to marginalized population such as the Indigenous people and a social determinants approach to health is needed, which is beyond the ability or desire of the individual to achieve health (Farmer). The findings of this study certainly echo the need for organizational-level interventions such as those proposed by Browne et al, 2016, which may address the health and social structural violence that cause the continued health inequities for Indigenous people.

In relation to other examples of change and a commitment to CS care in the health sector context, in March 2017, 23 health profession regulatory bodies in BC signed and pledged their commitment to promote the value of CS training for the professional that they regulate. These regulatory bodies include the College of Physicians and Surgeons of BC and the College of Registered Nurses of BC. They acknowledge the problem of racism and stereotyping in health care for Indigenous people and plan to lead with a vision of expecting CS care delivery by

implementing education sessions for certification for their professionals (College of Registered Nurses of British Columbia, March 2017).

5.5 Limitations

The study had some limitations in relation to the small sample size and the time frame of completing a Master's thesis as I would like to have had more participants providing the HCP perspective on CS. The observational component of ethnographic methods in shadowing alongside an APN in their role and interactions with clients and staff would have deepened the understanding of how CS is being enacted and would have strengthened the study.

The participants are all from one health organization in BC, which may be observed as a limitation but was intentional to gain insight into some of the perspectives of CCS within the culture of a specific hospital. The CS approach to healthcare within this hospital is in the early stages of development and implementation by the AHT. Finally, the study is limited by my novice abilities as an interviewer and researcher, though supervision was provided by an experienced researcher in Indigenous health and inequities, Dr. Colleen Varcoe. Despite these limitations, this study has developed understanding and new knowledge about CS within a hospital. The insights and ideas may be considered and transferable to other health care contexts.

5.6 Conclusion

A small sample of HCP participants identified as CCS were interviewed to gain their perspectives on CS, their lived experiences in providing CS care, and their thoughts about the contextual factors that affect the uptake of CS in the hospital. The study highlighted the CCS

participants were reflective HCPs who provide respectful, non-judgmental client centered care. It also highlighted their positive and negative experiences in providing CS care and the intersecting contextual factors which effect the uptake of CS in their work and in the hospital. A CS approach to health care and creating a climate for change is still a relatively new initiative and commitment at all levels of government, within the Health Authorities, within this hospital, and amongst HCP within their day to day interactions with clients. From the detailed descriptions of the participants, there is evidence of movement toward culturally safe care within the hospital. Examples of this was at the individual level by APNs and HCPs in their day to day interactions with clients. As described by the participants and the AHT there is also some evidence of concrete action at all levels of the sociopolitical and health system that demonstrate societal change, albeit at a very slow pace to eliminating the persistent inequities in care experienced by Indigenous and non- Indigenous people.

6. Implications

This last chapter will conclude with my recommendations and implications for practice, nursing education, future research, and health policy. My self reflection on the research experience, my personal and professional growth follows the implications section concluding the thesis.

6.1 Practice Implications

In clinical practice a CS assessment framework was discussed in the literature review as a method and framework to develop and deliver health and social policies for Indigenous people. Findings from the study and the literature demonstrate the great benefits to a client's health and well-being when HCP and health services provide a CS approach to health care for Indigenous people. A CS framework is being developed by the AHT to direct the focus, care delivery, and policy for addressing Indigenous health inequities for this organization. A CS framework is an approach for HCPs to provide client centred care, to meet their professional obligations in providing safe and ethical care (Bearskin 2011; CRNBC 2016). The HCP and client interaction and relationship in any health care service is foundational to reducing point of care inequities. In using a CS framework at the organizational, hospital and unit level this may decrease structural inequities and violence for Indigenous people (Josewski 2012). As stated in the discussion 5.4, The EQUIP intervention framework is an evidenced-based guide to engage in delivering equity-oriented health services for Indigenous people which could be adapted at the hospital level to support reducing health inequities. This framework also recognizes the social and cultural basis of health which is not evident in the biomedical model and current health systems, thus it would

support the uptake of CS at an individual and hospital level. This framework would inform and challenge the current health structures and attitudes to Indigenous health that have been negatively shaped by colonialism. Beavis et al (2015) posit that current Western, biomedical practices may perpetuate colonialism through its practices which cannot be "separated from their broader sociocultural contexts" (Beavis et al page 2).

The findings also suggest that a CS assessment tool for HCPs would assist HCPs in implementing a holistic, culturally safe approach to their client care. The tool would ensure a standardised method of assessing the client's cultural needs and preferences (Truong et al 2014). This tool would assist with the continuity of information amongst HCPs and promote the beginning of relational HCP and client interaction. However, standardized tools must be used with caution. In using standardized tools, there is a risk of applying a 'pan-Indigenous' understanding to individuals, and of HCPs imposing assumptions about the importance and features of culture. Opportunities need to be preserved for clients to define how and whether they wish to be identified regarding their culture; cultural information is not transferable from one client to the next. Bearskin (2011) an Indigenous nurse scholar recommends for nurses and health care organizations to be culturally safe, we need to move our practices and policies beyond those driven by technology and cost savings and move towards relational engagement.

Assessing the CS of the health services settings/units within the organization from staff and client perspectives would be a beneficial measurement in the initial roll out phase of the ICS framework and policy (Oelke 2016). The assessment could also be completed by a cultural safety 'walk though' from the Emergency department to the acute care unit from an Indigenous client perspective.

In my discussions with the AHT regarding their strategies for enhancing awareness and supporting advocacy, there was a plan for public posters throughout the hospital presenting organizational leaders talking about CS and the hospital. I would also recommend at the same time implementing posters about the APN and Elder services in each unit to inform the public and indigenous clients what is available to support them in their health care experience. Printed cards or handouts about the APN/Elder services could be made available to the in-patient units, social workers and the outpatient services. These strategies would promote staff and client awareness and support self advocacy for Indigenous client's health needs (O'Brien et al 2009). O'Brien et al also suggests including more Indigenous staff as HCPs and APNs in the involvement and implementation of CS strategies such as the small group education sessions. Another recommendation from the findings for further HCP support in training and knowledge application of CS and cultural competency, is for the AHT and other health care teams to host lunchtime case scenario debriefing about Indigenous client stories; Indigenous health rounds. The case study could highlight a CS lens to the health care experience and how the client's experience was enhanced by the support of an APN/Elder. This type of lunch and learn meeting could take place in the Sacred Space room to promote awareness, recognition and respect to Indigenous people and their views of health and well being by Indigenous staff. Therefore, more resources for supporting APNs and Elders in their role as client advocates and staff education and training are required to implement and sustain a CS approach in the hospital.

6.2 Nursing Education Implications

The implications of a CS focus and lens to approach nursing education is also highlighted by the study findings. As recommended by the Truth and Reconciliation Report all health care

professionals must have training and education in CS and Indigenous history in Canada (Truth and Reconciliation Commission of Canada: Health Related Recommendations Brief 2016). The College of Registered Nurses of BC has committed its nursing professionals to learning about CS and to work towards cultural humility; lifelong learners in coming to understand an individual's experience. Therefore, there is an urgent need for nursing undergraduate schools to incorporate CS, Indigenous history, colonialism and the ongoing systemic and health effects along with a more fluid view of culture (Browne et al 2009; Beavis et al 2015). Nursing students and all health care students need education and awareness about historical Indigenous events such as Residential schools impacting an individual's present-day health status and health care experience (Beavis et al). Post colonial analysis and health related content should be taught in all health care provider education institutions to inform students about health inequity with a goal to improving direct care delivery for Indigenous people as they are impacted by colonialism.

The Truth and Reconciliation Commission and report recommends collaborating and working with Indigenous experts and Elders. By focusing on real world situations that Indigenous people face and hearing their stories, in a co-teaching model the students could discuss their feelings, beliefs and the application of their CS approach to nursing care in these situations. This call for increased knowledge and awareness about Indigenous people in Canada, will require schools and regulatory bodies having partnerships with Indigenous communities and practice (Browne et al 2009). It will require education institutions and schools to embed and commit to a CS approach to education, teaching and service delivery.

6.3 Directions for Future Research

In looking at the implications for future research there are many areas to explore and evaluate practice in relation to the current health and organization context of the commitment to CS health services for Indigenous people. As has been previously mentioned, there is a BC Health Authority wide commitment for a CS approach to health care which is in the early stages of development and implementation in this hospital and other Health Authorities. This study may inform the AHT in their work of CS transformation in the hospital in this study. Due to the limitations of this Masters study, further research could be conducted using qualitative methods involving a larger cross section of HCPs who could share their perspectives on CS from this hospital to further understand, evaluate, and provide insight into the hospital environment. Future research will also be required to inquire into the implementation and evaluation of health care organizations' CS strategies and interventions. One key question to explore is: What are the health outcomes of Indigenous people after the implementation and transformation of a CS approach to health care in BC? Regional and provincial specific health outcomes will need to be studied.

There is also a priority need to inquire and evaluate the Indigenous client's perspective on receiving culturally safe care; do they feel safe in this hospital? Would they likely return for future health services? Exploring Indigenous peoples' perspectives was beyond the scope of this study, nor have Indigenous clients' experiences been studied or evaluated within the particular hospital that served as the setting for this thesis. Indigenous peoples' abilities to access CS health services and integrate traditional practices (within this hospital context) is also not known. In terms of health outcomes for Indigenous clients there is a need for monitoring and evaluating the effects on the client's health status that is less chronic illness and health inequities. This is in the

current context of the HA intention to effect change within the health system for Indigenous people using a CS framework and to work towards a climate of cultural humility in health care. There is a gap in the literature on the APN/Elder service and support in relation to client health outcomes. There is a gap in the APN/Elder perspectives on their roles within the health care team and their perspectives on their ability to provide CS care for Indigenous clients. There is a gap in the literature about the perspectives and outcomes of HCPs and their ability to provide CS care in the current health care context.

6.4 Policy Implications

In the discussion, I spoke of evaluating and monitoring CS strategies and outcomes at the hospital and unit levels. In their study of CS policy in an urban BC hospital Gurm and Cheema (2013) found that incorporating policy in practice may differ from the written organizational policy. They suggest monitoring and evaluating the application of a CS policy with benchmarking indicators. This CCS study has implications for the AHT and this o in the knowledge that these processes (for evaluation) should be developed in the early phase of the CS framework along with education and training to ensure the application and sustainability of the CS strategies and Organizational CS policy. As was mentioned in the recommendations for practice, there are policy implications for CS in regard to assessing the health systems for power relations and health inequities for Indigenous people. As CS can be viewed as an outcome of the power relationship between HCP and the client, the AHT and Indigenous groups need to continue the dialogue to help create policies that work with the HA and governments (Browne et al 2009; Josewski 2012). This may lead to a shift in power in policy over time when Indigenous leaders engage in policy discussion with other health leaders and government. This shift in power

and policy may decrease some of the systemic violence in the health care system, addressing social justice issues for Indigenous people. With a CS policy, organizations and HCPs may be able to determine the cause of the clients' health issues, thereby delivering more effective interventions and care. This is the goal for the new FNHA structure and their health plan for Indigenous people.

Caseload and time pressures were identified by the participants as barriers to their client centered care. Thus, policy in relation to HCP case and workloads must be considered to provide an environment to support culturally safe practice. This may have further implications to policy and practice areas now that professional regulatory bodies have pledged their member support to adhering to a CS approach to their practice.

The province of BC is in the early stages of the Tripartite Agreement and the FNHA health plan on improving health services for Indigenous people. In the areas of practice, education, and research and policy there is a lot of work to be done in our understanding, application and evaluation of culturally safe care in the goal to progress towards cultural humility at the HCP level and at the organizational, and sociopolitical contexts.

6.5 Self Reflection

Undertaking and completing this research process was a new and valuable learning experience as I came to understand through direct experience the nature of the research process, its complexities and the vast time, energy and persistence required. This study has helped me examine and gain further knowledge and awareness about Aboriginal health and inequities that persist in health care and throughout Canadian society. As a nurse educator, it has allowed me to take time to reflect on my professional practice and values and to consider exploring and

becoming involved in how we deliver CS and Indigenous health within the undergraduate

nursing program. The research process has encouraged me to deepen my own view of CS and

social justice within the wider health and sociopolitical systems. I am grateful for the open,

collaborative, and supportive relationship that I gained working with the AHT on the study.

I am committed and I plan to contribute individually and collectively as a nurse and

concerned citizen, to work toward change and reconciliation, which we owe to Indigenous

people to have CS systems and health care. I care about reconciliation. It requires us all to

remember, "it starts with me" (FNHA 2016 Policy Statement on Cultural Safety and Cultural

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Appendix One: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

T201-2211 Wesbrook

Mall

Consent Form: Champions of Cultural Safety

For the Research Project: Champions of Cultural Safety

Study Team

Principal Investigator: Dr. Colleen Varcoe, RN, PhD
                         Professor, UBC School of Nursing

Co-Investigator: Paula Foster, RN, BScN, Critical Care Certification
                         UBC, Masters of Science of Nursing Student

Funding

Purpose

Thank you very much for your interest in this study. This study explores, the attitudes and behaviours of healthcare providers, identified Champions of Cultural Safety, healthcare providers who role model and practice culturally safe care. You have been invited to participate in this study because you have been identified as a Champion of Cultural Safety.

Understanding Champions of Cultural Safety's experiences will provide insight into why and how they enact cultural safety and explore the cultural responsiveness of the organization. What we learn may help the Aboriginal Health Team to implement change towards their action plan of

a climate of cultural safety and cultural humility. It may also assist health care providers in taking a cultural safety approach when providing healthcare in the face of ongoing judgement, racism and discrimination towards Aboriginal people in healthcare and society.

Study Procedure

Data collection for this study will occur through semi-structured interviews conducted by a Master of Science in Nursing graduate student who is conducting this research as part of a master's thesis (coinvestigator Paula Foster).

The health care providers who choose to participate in the study will be asked questions designed to explore their understanding of what it means to provide culturally safe care in the context of their healthcare environment/unit. Interviews, which will occur at a mutually convenient location and time, will take approximately 30-60 minutes and will be audiotaped throughout. A small honorarium of a $10 coffee card will be offered to all participants to acknowledge their participation in the study. In addition to an interview if you agree, I would like to observe you in your work and interactions with a patient. A session with a patient that you judge to be appropriate and reasonable. The patient who may be observed in the interaction will be given an introduction letter about the purpose and the study.

The audio recordings of the interviews will be transcribed into computer text files and anonymized. All electronic files and devices containing identifying information will be encrypted and stored on password-protected USB keys; when not in use, all information will be stored in a locked file cabinet. All tapes and audio files will be kept for 5 years and then destroyed.

Potential Risks

A potential risk associated with participation in the study is that interviewees may experience negative emotions or responses in relation to discussing their patient care and work experiences. Some of the questions may be sensitive and you do not have to answer them if you don't wish to. Your participation in this study is entirely voluntary, and you may refuse to participate or may withdraw from the study at any time with no implications or repercussions.

Benefits

Knowledge gained from your perspective and participation may assist health care providers in taking a cultural safety approach when providing healthcare considering the ongoing judgement, racism and discrimination towards Aboriginal people in healthcare and society. The goal is improved patient health care experiences.

Confidentiality

We respect your right to privacy and confidentiality. While the information received in the interviews may eventually be published, all identifying names and places will be removed from the information prior to analysis and reporting of the findings and conclusions. Your personal information, such as data provided on the consent form and the audiotapes, will be kept in a secured, locked location and only members of the research team (the researcher and committee members) will have access to the information. All the interview and demographic information

will be coded with specific identifiers to ensure participant anonymity and confidentiality. Participant's roles (e.g. Aboriginal Patient Navigator, social worker) will only be used in ways that individuals cannot be identified.

Consent

Your participation in this Champions of Cultural Safety study is completely voluntary. Your decision to participate will in no way influence your employment.

If you decide to participate in the study and then change your mind, you are free to withdraw from the project at any time with no consequence. If you decide to withdraw, your data will be removed deleted. You may also ask to have certain comments deleted if you wish.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

For questions or comments about this study contact Dr. Colleen Varcoe (principal investigator) at the UBC School of Nursing.

By signing this consent form, you agree to participate in the study described in the for mentioned information (see above). You have received a copy of this consent form for your records

Do you give permission for the researcher to record the individual interview? Yes __ No__

_____   _____

Signature of Participant   Date

_____   _____

Print Name   Contact information email/phone

I would like to receive a final report of this study?   Yes___ No___

Appendix Two: Participant Demographics

T H E   U N I V E R S I T Y   O F   B R I T I S H   C O L U M B I A

School of Nursing

T201-2211 Wesbrook

Mall

Participant Demographics

1. Position/role within VCH-

2. Number of years in current position- Years_____

Months_____

3. Employment Status- Fulltime_____

Part time_____

Casual _____

4. Age- 20-25 years_____

25-30 years_____

30-35 years_____

35-40 years_____

40-45 years_____

45-50 years_____

0ver 50 years_____

 5. Gender Identity- Male_____

                        Female_____

                        Other_____

6. Identified Ethnicity-

7. Highest Education Level-

8. Cultural Safety Courses Completed-

Appendix Three: Interview Guide

Interview Guide:

As you know I am interested in understanding about cultural safety from the healthcare provider's perspective and what that looks like within this organization. Could you please start by telling me about your current role and how you got into your role?

Follow-up Probes:

1. What does CS mean to you?

 2. How are you supported in your role to provide culturally safe, ethical care (APN). What resources or supports do you need to in your role to provide culturally safe care? (Other HCP)

3. What policies are in place to support hcp provide culturally safe care?

4. What policies or resources are needed?

5. What barriers reduce the ability of health care services to be culturally respectful?

6. How are services integrated and linked?

7. The San'yas Indigenous Cultural Safety Training course discusses antiracism training. Tell me what you do differently in your practice. Please provide an example.

8. How has the course impacted your practice and provide an example.

9. Describe for me how you approach your patient care in a holistic, culturally responsive manner.

10. Describe an example of when you have provided ethical culturally safe care to a patient. Tell me about the client and family's response to the care.

11. Describe a health encounter with an Aboriginal client compared to an encounter with a non-Aboriginal patient.

12. Tell me about when you have observed how a patient's socio-cultural background influences health care decisions.

13. How would you describe the current cultural or ethical climate that you work in?

14. How could we do better to serve our patients? Provide an example.

15. Is there any individual in the organization who should be included in these interviews?

16. Is there anything else I should know?