FINDINGS AND RECOMMENDATIONS

REPORT

BC COLLEGE OF NURSES & MIDWIVES

RECOMMENDATIONS

Looking back to look forward:

How Indigenous ways of being, knowing, and doing must inform the BCCNM feedback process and reflect principles of cultural safety, cultural humility, and anti-racism

novatone

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Table of Contents

Acknowledgments

We would like to thank the Inquiry, Discipline and Monitoring team at the BC College of Nurses and Midwives for entrusting Novatone to undertake this important work. The team was forthright, generous and committed to reconciliation and the important work that is required to achieve meaningful change.

We are indebted to the community leaders and community members for offering their time, knowledge, and insights as we seek to understand lived experiences and the responsibilities to address gaps in the current structures that do not work well for Indigenous Peoples. Supporting initiatives to transform health care feedback processes are important and will simultaneously deliver restoration and the critical information required to drive system change. We are honoured to be able to participate in this with the BCCNM – thank you.

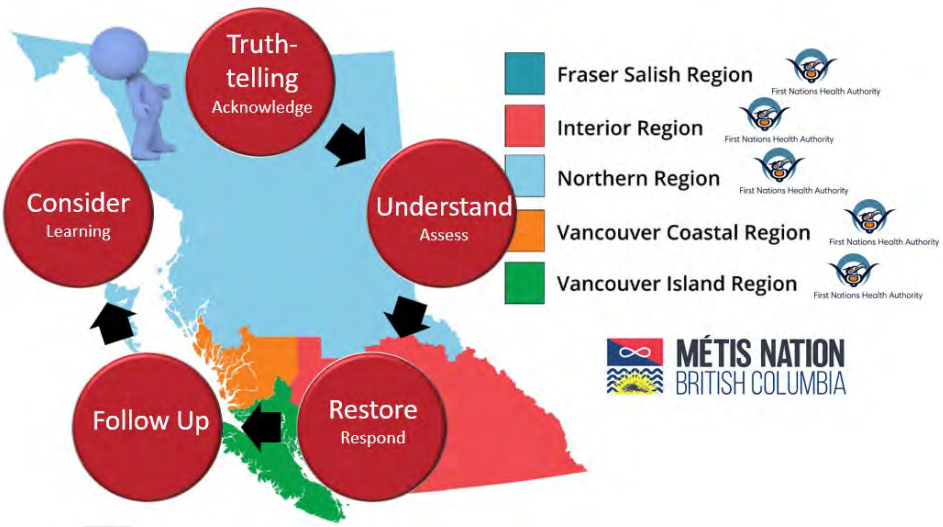
Novatone Consulting is situated on the unceded territory of the Lheidli T'enneh Nation in Prince George, BC. We express our gratitude and acknowledge the Lheidli T'enneh territory where we are fortunate to live, work, learn, and raise our families.

Executive Summary

The purpose of the project was to review the current state with a cultural safety and humility lens to make the BCCNM complaints process safer for Indigenous Peoples. The request was to offer recommendations for changes to the structures, policies, practices, norms, and values of the process.

As is often the case with systems and process review, the most pressing needs and immediate opportunities emerge through the examination of the current state. There are important dependencies that emerged through our review and are reflected in the listed recommendations but not limited to the complaints process. Remaining in scope is challenging when impacts are never siloed. Within the IDM sphere, our recommendations fall into two groups:

Recommendations for BCCNM Health Care Feedback Process	
Process Changes	Relationships
To enable a simplified, accessible health care feedback process that offers culturally appropriate pathways and begins to address the major data and information gaps related to the experiences of Indigenous peoples in health care	To offer culturally appropriate response pathways in collaboration with First Nations Health Authority Regional Offices and Métis Nation British Columbia Provide a common framework by which organization could contribute



Methodology

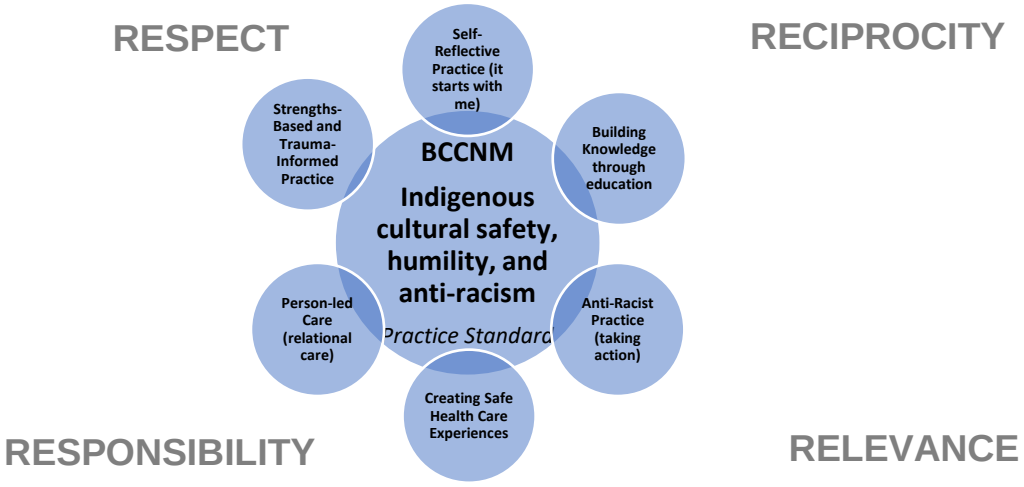
For Novatone, having a clear understanding of project methodology is a critical contribution to the success of all projects. With respect to reviewing the BCCNM complaints process with an Indigenous-related positioning, we recognize that the outcome of our work must be grounded in the BCCNM Practice Standard of Indigenous cultural safety, cultural humility, and anti-racism for all registrants. The purpose of the standard is to set clear expectations for how BCCNM registrants are to provide culturally safe and anti-racist care for Indigenous Peoples. We know that the recommended changes for a culturally safe process must:[1]

- Be grounded in Indigenous rights, cultural values, and embed traditional protocols
- Be Indigenous patient and family-centered
- Take a restorative and accountable approach
- Remove unnecessary barriers to engaging in the patient feedback process
- Be trauma-informed
- Include Indigenous peoples in leadership and positions supporting the patient feedback process
- Be responsive and provide clear, timely feedback
- Provide Indigenous patients and families with an Indigenous support person
- Provide an opportunity for Indigenous clients to identify their Indigenous/Aboriginal/Nation-based ancestry

The process must model transparency and exemplify being responsive to Indigenous knowledge, culture, values, and legal traditions. It should be specific to the region and reflect an anti-racist ethos that honours individual truths and stories. Embracing the BCCNM Practice Standard, Novatone sought consultative and collaborative relationships to exemplify engagement and develop an Indigenous patient health care feedback process that fosters trust and healing where values of the “Four Rs” — respect, relevance, reciprocity, and responsibility (Kirkness and Barnhardt, 1991) will guide the approach to an effective and restorative grievance practice.

[1] Adopted from the BC Patient Safety and Quality Council’s “Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process”

Figure 1
Six Core Concepts of the Practice Standard and the Four Rs



In addition to a careful analysis of baseline data sets and process review, there are several integral works influencing the BCCNM Indigenous patient feedback process being proposed by Novatone. This includes (and is not limited to):

- BC Declaration on the Rights of Indigenous Peoples Act (2019)
- British Columbia Cultural Safety and Humility Standard (2022)
- Final Report of the Truth and Reconciliation Commission of Canada (2015)
- Health-related provincial mandate letters
- Indigenous health-related self-identification academic literature
- In Plain Sight report (2021)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)
- Remembering Keegan – a BC First Nations Case Study Reflection (2022)
- Restorative justice/healing resources and literature
- Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process (BC Patient Safety and Quality Council, 2022)
- United Nations Declaration on the Rights of Indigenous Peoples (2006)

As noted by the BC government, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) foundational for the BC Declaration on the Rights of Indigenous Peoples Act and the Final Report of the Truth and Reconciliation Commission of Canada (TRC) focus on improving the rights and well-being of Indigenous peoples. This includes child welfare, education, language and culture, health, social and economic outcomes and justice (Province of BC, 2020). TRC Calls to Action 27, 28, and 50 provide guidance for considering Indigenous legal traditions within the redesign of the BCCNM Indigenous patient

feedback process. Likewise, the In Plain Sight (IPS) report demands attention to Indigenous-specific racism and discrimination, issues of equity and marginalization in health services, and an overall need for health delivery reform. Including the good work of the aforementioned documents and resources instills an urgency to enact and embrace ways to redefine and rethink how Indigenous and other restorative measures can be integrated into the BCCNM health care feedback process.

In addition, the methodological principles of the Four Rs in the creation of an Indigenous health care feedback process inclusive of the Practice Standards of the BCCNM reflect:

> **Respect**. All 6 BCCNM Practice Standards reflect the necessity to intentionally include the knowledge of Indigenous Peoples in BC in the BCCNM health care feedback process redesign. Honouring and maintaining respect is important.
>
> **Relevance**. Introducing Indigeneity in the feedback process must be community-driven and Nation-based. This includes honouring traditional protocols, Indigenous systems of knowing and legal traditions, as well the authentic experiences of Indigenous peoples and their communities. Relevance must be rooted in an overall approach to achieving an effective feedback process.
>
> **Reciprocity**. Reciprocity, a traditional concept for Aboriginal people (Archibald, 2008; Atleo, 2004; Atleo, 2010), reflects that the "giving and taking" between Indigenous and non-Indigenous systems must be meaningful. Being without prejudice to Indigenous interests and increasing Indigenous decision-making and control exemplifies authentic reciprocal relationships. Such relations have the potential to be enduring and irreplaceable.
>
> **Responsibility**. The last of the "Four Rs" is responsibility. Responsibility is a value that is inherent in Indigenous knowledges and within oral traditions (Archibald, 2008). Embracing the importance of being responsible to the health and well-being of First Nations, Inuit and Métis can enrich and sustain relations for optimal outcomes as related to the BCCNM feedback process.

A revised health care feedback process can be transformational and become a symbolic example of trust and healing for all Peoples in Canada. On May 11, 2021, BC's four largest health regulatory colleges in British Columbia issued an apology to Indigenous Peoples and communities for the racism prevalent in our health care system. The colleges recognize that upholding Indigenous rights, eliminating racism within the health care system, and earning the trust of Indigenous Peoples requires consistent and persistent concrete actions. Having a holistic and integrative approach to honour the diverse cultures and Indigenous experiences in British Columbia will lend to the success of this initiative. By doing this work collaboratively and through respectful and responsible engagement, a safer, and more culturally appropriate feedback process for the BC College of Nurses and Midwives will be realized.

Current State

Novatone captured the current state process by reviewing background documents that were shared with us at the beginning of the project combined with key rights and stakeholder interviews, an analysis of the Inquiry Discipline and Monitoring (IDM) case summary spreadsheet and a workshop review. The list of reviewed documents and consultations is listed in Appendix A.

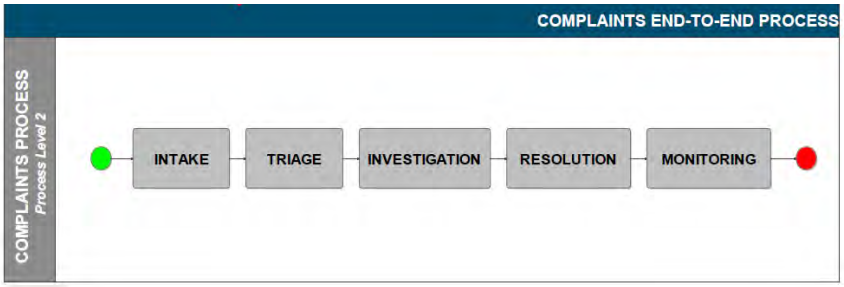
The IDM team provided important context and collaborated readily. This was a critical factor that contributed to the successful completion of the review and the timely delivery of the recommendations. The team's experience and skill are notable, and the consultant is confident in asserting that the good intentions exhibited through the review will lend themselves to action. Ongoing cultural safety and humility training for the IDM team will be important to facilitate the change management required for the future state. Constant personal reflection and humility is essential in the journey of reconciliation.

The current state process reflects the duty of the college "to serve and protect the public, to exercise its powers and discharge its responsibilities under all enactments in the public interest." [section 16 of Health Professions Act]

The most significant observation of the current state is how infrequently Indigenous Peoples engage with the current complaints process to provide information about their health care. This is not unique to BCCNM. IPS explains that Indigenous Peoples find the health care feedback process inaccessible, which is reflected in the low number of health care complaints filed. As noted in the IPS report:

> Between 2017 and 2019, 355 complaints involving Indigenous people were identifiable when searching complaints data from health authority PCQOs, FNHA Quality Care and Safety office, and the regulatory colleges for dentists, nurses and midwives, physicians and surgeons, and psychologists in BC… This three-year total amounts to an annual average of roughly 118 complaints. (p. 87)

The following illustration of the current state process reflects its historical duty and structure as an adjudicative and disciplinary body. The process is linear, transactional, and perpetuates colonial principles and practices. The model can be found in Appendix B.

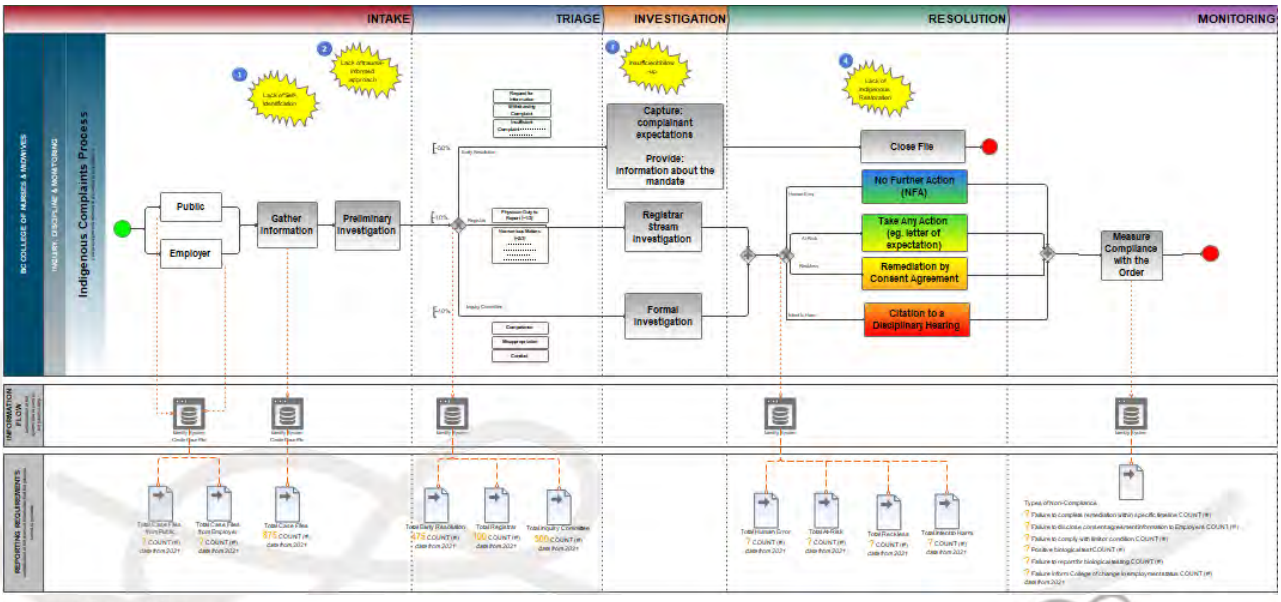


On October 5th, 2022, Novatone delivered and in-person workshop with the IDM team and presented our current state understanding. The presentation can be found in Appendix C. The current state reflected:

- 875 Active Cases, of which
  - ~ 50% went to investigation (registrar or inquiry committee)
  - ~ 50% went to early resolution

- The most complete source data for IDM is the case summary excel spreadsheet that captures closed cases. The information is captured manually in an excel document

- The current reporting priorities include (but not limited to):
  - New cases
  - Registrar stream investigations
  - Inquiry Committee investigations
  - Citations to hearing
  - Hearing in progress
  - Appeal to the BC Supreme Court
  - Open Health Professions Review Board (HPRB) reviews
  - Monitoring
    - Failure to complete remediation within specific timeline
    - Failure to disclose consent agreement information to employers
    - Failure to comply with limit or condition
    - Positive biological test
    - Failure to report for biological testing
    - Failure to inform College of change in employment status



In pursuit of meeting its mandate and protecting the public, the process has an opportunity to expand beyond its traditional role and be used as a tool to drive necessary transformation required for the college to meaningfully contributed to dismantling systemic racism and barriers within the health care system.

In short, **for Indigenous Peoples**, the current state can be summed up in three words: complicated, confusing, and inaccessible. The complexity of the process itself is a barrier. The current state misses the chance to learn from the multitude of encounters with the health care system and advocate for systematic change.

Baseline data

To capture baseline process performance, Novatone requested Indigenous health care feedback data from the IDM team.

Total # of Cases (2015 - 2022)
2112
Total # Cases (Jan 2020 – Jul 2022)
887
% of Cases by Issues Category
Conduct 76% Competence 15% Health 15% Blanks 3%
Of the 887, 18 were possibly related to Indigenous-specific racism. These were reported by:
Public 14/18 Employer 3/18 Colleague 1/18

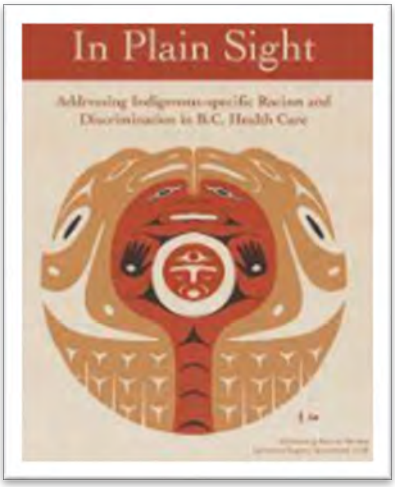
2% of cases were potentially attributable to Indigenous reporters

During the current state evaluation, the team did share that 46 or 47 health care complaints had been submitted to the IPS investigation.

These cases were not shared with us during our assessment.

To support our analysis, significant reference is made to the IPS report where there is an extraordinary representation of gaps identified in the current state.

According to IPS, the top five barriers to making a healthcare complaint are the following:



- Expect poor treatment throughout the complaint process
- Would take too much effort or energy
- Would not be taken seriously
- Would receive worse treatment from health staff in the future
- Submitted a complaint in the past and it did not make a difference

The multiple processes identified in the current state are a testimony to the range of organization-specific initiatives and affirm IPS's statement that "Current improvement efforts are uncoordinated and lack a systemic focus".[2]

[2] In Plain Sight (full report): Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care p. 116

What the literature tells us

Emerging and innovative systems of health care and wellness practice are an important and integral contribution to Indigenous self-determining efforts for healing and community well-being. In addition, the landscape of Indigenous-informed innovative solutions and ideas continue to push the boundaries of western-based systems of health and health practice. Lavoie et. al (2016) write:

> *Over the past decades, Indigenous communities around the world have become more vocal and mobilized to address the health inequities they experience. Many Indigenous communities… have developed their own culturally-informed services, focusing on the needs of their own community members. p. 1*

While the paper written by Lavoie et. al (2016) brings forward an international Indigenous representation for health system innovations, this literature offers an opportunity to reflect on the underlying reasons we need health care feedback process re-evaluations (i.e. racism), important reports and scholarship that must be considered, and potential Indigenous-influenced feedback process redesign that is related to restorative practices and BC specific health system reform. In providing a high-level perspective about restorative practices and Indigenous legal traditions, this review offers considerations for how restorative practice may be integrated and applicable to a Indigenous health care feedbacks, compliments, and complaints process with an Indigenous-influence.

In 2021, the First Nations Health Authority and the Office of the Provincial Health Officer, created the First Nations Population Health and Wellness Agenda (PHWA), a 10-year pathway towards improved services, experiences, and cultural respect and understanding for First Nations in BC. As a living and working document, the PHWA describes:

> *It is our hope that this agenda presents compelling First Nations and Western evidence to further support the recognition of the need to work collaboratively across many systems and silos to achieve health, wellness and reconciliation. We believe that the key factors that will determine our success from 2020-2030 will be our ability to come together to paddle with one heart and one mind to restore First Nations self determination. As we take off on the next 10 years of this journey, we see exciting opportunities on the horizon to do just that. p. 5*

A “one heart one mind” philosophy is echoed amongst and between Indigenous Peoples in BC and the positioning of this philosophy within community is important to acknowledge. For example, *Sayt-K'il'im-Goot* represents one heart, one path, one Nation for Nisga’a peoples, *En Cha Huna* represents a Dakelh acknowledgement that “he/she also lives”, the Halq’eme’ylem say *Lets’emo:t* to acknolwdge “togetherness”, the Nuu-chah-nuth celebrate the oneness of *Heshook-ish Tsawalk*, the Métis say, *Niw_hk_m_kanak*, meaning “all my relations”, and the Inuit term *Qaujimajatuqangit* refers to Inuit “Traditional Knowledge” and includes important principles related to respect, togetherness, and caring, to name a few.[3]

[3] Resource links for Nation One Hear One Mind acknowledgements/associations can be found here: http://www.firstnationsdrum.com/2010/10/sayt-kilim-goot-one-heart-one-path-one-nation/; https://campusguides.ca/2021/09/01/what-makes-unbc-unique-5-things/; http://learningforwardbc.ca/lets-emot-halqemeylem-one-heart-one-mind/; https://www.uvic.ca/news/topics/2016+convocation-fall-2016-educ+ring; https://fngovernance.org/wp-content/uploads/2020/09/paul_chartrand.pdf; https://www.nirb.ca

Understanding the value of "togetherness" with the Halq'eme'ylem word *Lets'emo:t* is explained by Stelkia et. al (2020):

> *For Knowledge Keeper Virginia Peters, "being [Lets'omo:t]" is "working together in a really good way to be stronger" because the more people can "get moving together with a good heart, a good mind, [and] a good spirit," the more they are able to make things "smoother and [then] we can really accomplish a whole lot more." This interconnection is a part of the spiritual and ceremonial roots that ground Stó:lō Peoples' ways of living. p. 363*

The Stelkia et. al (2020) article makes an important contribution to understanding how and why connection to land, water, and territory influences health and wellness with First Nations Knowledge Keepers and youth in BC. At the same time, this article lends insight into the necessity for broader integration and acknowledgement of Indigenous perspectives, worldviews, and knowledge and why the public health experiences of Indigenous peoples must change.

The *In Plain Sight* (IPS) report bolsters the need for awareness and accountability from the Provincial government to reconsider not only how it resolves systemic racism and discrimination in the health care system, but how it can work towards a unification of trust and understanding within health care delivery. In its thorough representation and analysis of truth-telling and stories from Indigenous peoples in BC, IPS provides recommendations for the province to consider moving forward. Specifically, Recommendation 5 speaks to the relevance of an Indigenous-led model for health care feedback:

> *That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly develop a strategy to* ***improve the patient health care feedback processes to address individual and systemic Indigenous-specific racism****. (IPS 2020, p. 62 bolding added)*

Wanda Phillips-Beck (2020) acknowledges that

> Evidence reveals that racism exists within the Canadian healthcare system. Though touted by Canadians to be one of the best in the world, the Canadian Public Health Association acknowledges Canada as a nation where race, culture and religion are persistent determinants of health inequities. Effects are compounded for Indigenous peoples. (p. 2)

She notes, "understanding effects of racism on health behaviours requires an understanding of the history of intergenerational trauma caused by the residential school… and other policies rooted in colonialism" (2020, p. 4).

The report and recommendations related to the Missing and Murdered Indigenous Women and Girls (MMIWG) published in 2018 take note in regard to health-specific targets for Indigenous women and girls. Reflecting on the important work of previous reports and recommendations like the *Highway of Tears Recommendation Report* (1996), Recommendation 8e in the MMIWG Inquiry notes:

> *The need for accessible and culturally appropriate health, mental health, and addictions services for Indigenous women.* p. 71

In their elaboration on the IPS review, the BC Medical Journal (2021) reinforces the need for more specific, gender-based attention for Indigenous women and girls in the health system. As explained by journal authors:

> *It was also important for the review to examine the experiences and outcomes of various subpopulations of Indigenous peoples, including those based on gender, age, and region. Two groups were starkly evident. Indigenous women shoulder a particularly disproportionate burden… a situation brought into sharp focus during the course of the review with the broad media coverage of the treatment of Joyce Echaquan. Indigenous women in BC experience the intersection of gender and race discrimination, involving misogynist stereotypes, deep feelings of unsafety in accessing health services, and the most acute gaps in health outcomes of any population segment examined in the review. (https://bcmj.org/special-feature/plain-sight-elaboration-review)*

It is undeniable that in order to meet the needs for appropriate access and have accountable and transparent treatment, when using public health services, options for improving the patient experience must change and be reflective of Indigenous practices, beliefs, and systems of knowledge. Morden et. al (2020) acknowledge:

> *Systemic racism compromises patient safety and dignity in all areas of health care. According to a 2015 Wellesley Institute report on the role of racism in the health of Indigenous people, experiences and anticipation of racist treatment by health-care providers act as barriers to accessing needed health services for Indigenous peoples.*
>
> *Furthermore… research led by University of B.C. Prof. Annette Browne found that Indigenous participants anticipated that being identified as Aboriginal and poor might result in a lack of credibility and/or negatively influence their chances of receiving help.*
>
> *This was such a common experience that participants actively strategized around how to manage negative responses from health-care providers before accessing care.*
> (https://www.cbc.ca/news/canada/manitoba/mental-health-police-opinion-1.5687195)

It is incumbent on us to see this change and ensure an inclusive and effectively diverse consideration of alternative feedback processes are contemplated.

A Matter of Apology: Contemplating Restorative Practices

In Canada, and in British Columbia specifically, legislation exists to address medical errors in health care to offer a framework for apology and ultimately a healing of trust and relationship. Wilford et. al (2019) explain:

> Medical errors… occur regularly. One report estimates that for every 18 hospitalizations in Canada, one patient will experience harm. Yet, doctors are hesitant to apologize for medical mistakes.
>
> This occurs despite the fact that nine provinces and two territories in Canada have "apology legislation." This legislation allows doctors, and other medical professionals, to apologize to patients when things go wrong without having this used as evidence of fault in court. These laws are designed to transform relationships in medicine for the better by restoring trust between patients and clinicians. (https://theconversation.com/why-is-it-so-hard-for-your-doctor-to-apologize-123337)

Rebuilding trust and relationship in the context of considering the impact of current apology structures is critical. MacDonald and Lavasseue (2018) offer the following:

> Patients we interviewed often spoke of feeling dehumanized in current health care culture. They also emphasized the need to recognize the humanity of clinicians to allow for more open interactions and transparency… If we want to find some meaning in these tragic events, we must remember that we are not different from the patients victimized... Patients are not a small special interest group and we would benefit from remembering that everyone is, in some ways, a patient in waiting. (https://www.cbc.ca/news/canada/manitoba/opinion-levasseur-macdonald-patient-safety-1.4718545)

Scholars are providing current research revealing that we are in a position where, as described by MacDonald, et al (2022), "with crisis comes opportunity for change. The challenges identified… have two elements in common: a lack of transparency and the erosion of trust" (https://theconversation.com/ when-health-care-goes-wrong-its-time-for-transparency-in-patient-safety-184523). Seeking out ways to build trust, and further an understanding for pathways of healing for everyone is necessary.

Christina Krause, CEO, BC Patient Safety & Quality Council, describes why the health care feedback process must improve, and she offers a consideration for doing so. Krause says,

> *Modelling after the restorative justice approach that has been used in the legal system will support re-building trusting relationships so that Indigenous people feel safe to seek and receive care. Establishing an approach based on reciprocal accountability will provide a foundation to honour and build upon existing efforts of Indigenous communities as well as the health care system to help eliminate the systemic Indigenous-specific racism that currently exists. (IPS, p. 45)*

However, it is important to acknowledge that restorative justice and Indigenous legal traditions are not entirely synonymous with one another. Chartrand and Horn (2016) explain:

> *There are important features that make Indigenous legal traditions quite different from restorative justice processes, including how Indigenous legal traditions often use proactive/preventative strategies mediated through kinship networks (Gray and Lauderdale 2007), how they place a high importance on spirituality (Cameron 2005; Borrows 2010), and the* ***historic*** *use of punitive/retributive sanctions (Milward 2012; Napolean and Friedland 2014).* p. 3 bolding added

As described by Petoukhov (2011), "justice scholars such as Griffiths (1996) and Nielsen (1995) view restorative justice as a process that emerged from Aboriginal justice traditions" (p. 43). With this, it is imperative to consider more closely the roots of restorative justice practices and Indigenous legal traditions and how the two justice-related practices may be included and encapsulated within an effective Indigenous restorative health care feedback process.

Restorative Justice

First, it is important to acknowledge that there is no singular definition available when it comes to restorative justice. Petoukhov (2011) identifies that there are many definitions to try and conceptualize key principles of restorative justice, and one working definition he offers is an "eclectic accretion of cultures, practices and experiences" (as cited in Pawlychka 2010: 4). Chartrand and Horn (2016) acknowledge that:

> *Since restorative justice programs entered the Canadian and international scene in the 1970s, victim/offender mediation has been one of the most effective and most widely used program models in Canada (Tomporowski et al. 2011). This model tends to bring the victim and offender together with a trained mediator to discuss the [issue] and develop an agreement that resolves the incident. p. 4*

Ultimately, restorative justice models seek resolve from a particular incident or situation. Referencing Van Ness (2009) and Zehr and Mika (1997), Petoukhov (2011) presents one model of restorative justice by identifying three key restorative justice principles:

1. conceptualizing a wrongdoing as a cause of harm that needs to be repaired
2. relating to the admission of the responsibility by the offender and empowers the victim to express how the harm could be addressed
3. restorative justice seeks "to build and maintain peace" through healing and righting wrongs. (Van Ness 2009; Zehr and Mika 1997) p. 43

In contradiction to Indigenous legal traditions, there may not be sufficient Indigenous representatives from the community as part of the restorative justice practice (Chartrand & Horn, 2001, p. 4). Given the weight of importance for Indigenous representation, self-determining processes, and decolonizing systems, this is important to consider in realizing an appropriate restorative model.

In Canada, and as related to jurisprudence for Indigenous peoples, the 1990 Supreme Court decision of R. vs. Gladue (and Section 718.2(e) of the *Criminal Code*), restorative justice processes may be the more appropriate pathway for Indigenous peoples involved in the legal system (https://www.justiceeducation.ca/about-us/research/gladue-and-aboriginal-sentencing). The Justice Education Society understands that "[s]uch processes focus on healing those affected by the criminal act,

including the offender, and so are more in line with traditional Aboriginal justice" (https://www.justiceeducation.ca/about-us/research/gladue-and-aboriginal-sentencing). Indeed, traditional Aboriginal Justice and Indigenous legal traditions have much to offer grievance and reconciliation efforts.

Indigenous Legal Traditions

Literature shows how, in Canada, Indigenous legal traditions more often encapsulate outcomes of restoration, healing, sharing, peace, learning, and teaching rather than retribution. Petoukhov (2011) cites Ross (2006:12) that one of the points of overlap between restorative and Aboriginal justice values is that instead of punishing the wrongdoer, the focus is on "teaching and healing of all parties involved" (p. 43). Further to this, in the Report of the Aboriginal Justice Inquiry of Manitoba, the Aboriginal Justice Implementation Commission (1999) writes:

> *At the most basic level of understanding, justice is understood differently by Aboriginal people. The dominant society tries to control actions it considers potentially or actually harmful to society as a whole, to individuals or to the wrongdoers themselves by interdiction, enforcement or apprehension, in order to prevent or punish harmful or deviant behaviour. The emphasis is on the punishment of the deviant as a means of making that person conform, or as a means of protecting other members of society.*
>
> *The purpose of a justice system in an Aboriginal society is to restore the peace and equilibrium within the community, and to reconcile the accused with his or her own conscience and with the individual or family who has been wronged. This is a primary difference. It is a difference that significantly challenges the appropriateness of the present legal and justice system for Aboriginal people in the resolution of conflict, the reconciliation and the maintenance of community harmony and good order. (http://www.ajic.mb.ca/volumel/chapter2.html#14)*

The United Nations Declaration on the Right of Indigenous Peoples (UNDRIP), and the Canadian Truth and Reconciliation Commission's (TRC) Calls to Action include how imperative it is restorative practices are embraced. Anaya (2007) explains, "these documents envision a decolonized world, and provide a clear path to achieve that vision, where Indigenous peoples are treated with respect and dignity, which means having their cultural, spiritual, social, political, economic, and legal institutions protected and respected" (https://www.justice.gc.ca/eng/rp-pr/jr/rjilt-jrtja/p6.html). In Volume 6 of the TRC Final Report entitled *Reconciliation*, Hayley Grier-Stewart, representing the Kainai, Siksika, Tsuu T'ina, and Stony First Nations, said,

> *The youth believe that within our communities, we need to teach and create awareness, cultural appreciation, as well as healing and restoration. If we introduce youth to the culture at a young age in our schools, through curriculum and the practice of restorative justice, it will teach the younger generation to be proactive instead of reactive. P. 137 (http://www.trc.ca/assets/pdf/ Volume_6_Reconciliation_English_Web.pdf)*

Specifically, Calls to Action 42 states:

> *We call upon the federal, provincial, and territorial governments to commit to the recognition and implementation of Aboriginal justice systems in a manner consistent with the Treaty and Aboriginal rights of Aboriginal peoples, the Constitution Act, 1982, and the United Nations Declaration on the Rights of Indigenous Peoples, endorsed by Canada in November 2012. p. 4 (http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf)*

And Call to Action 50 explains:

> *In keeping with the United Nations Declaration on the Rights of Indigenous Peoples, we call upon the federal government, in collaboration with Aboriginal organizations, to fund the establishment of Indigenous law institutes for the development, use, and understanding of Indigenous laws and access to justice in accordance with the unique cultures of Aboriginal peoples in Canada. p. 6 (http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf)*

In the spirit of moving forward in a decolonizing trajectory of reconciliation, heeding to these Calls to Action with a Restorative Health care feedbacks and Feedback process for the BCCNM is vital *and* necessary.

Indigenous Restorative Justice and Health care

Literature and resources related to Indigenous Restorative Justice and health care grievance processes continue to emerge. Indigenous-related resolution models for the health care system have an opportunity to transform, reconcile, and build trust in the community while supporting the roles of restorative justice and Indigenous legal traditions. Petoukhov (2011) explains that “Aboriginal justice practices, much like restorative justice, are mainly characterized by the participation of victims, offenders, community members, and a mediator, while the harm is viewed as an injury done to a person by another person” (p. 43). The role of Elders, healing, kinship, restoration, resolution, reconciliation, and witness (to name a few), become paramount when thinking about effective Indigenous restorative justice strategies. As described by Chartrand and Horn (2016):

> *Family group conferencing is based upon the Maori and Samoan tradition of involving extended families in resolving conflicts… In Canada, mediators, or facilitators, assist accused persons and their families to meet with victims, police, and others to discuss and resolve the incident... Lastly, the models most frequently used by Indigenous communities are sentencing circles, releasing circles, and healing circles, which are based upon the cultural traditions of certain Indigenous nations, particularly from western Canada, where families, Elders, and disputants meet to discuss and resolve… conflict. Participants sit in a circle and pass a “talking stick” or “talking feather” to each speaker so that everyone has a chance to speak and be heard, which reflects the Indigenous principle of including all voices. The different “circle” models mentioned above are all procedurally different and are applied at different stages of the… justice process. p. 5*

The Aboriginal Justice Implementation Commission (1999) understands that:

> *Methods and processes for solving disputes in Aboriginal societies have developed, of course, out of the basic value systems of the people. Belief in the inherent decency and wisdom of each individual person implies that any person will have useful opinions in any given situation and should be listened to respectfully. Aboriginal methods of dispute resolution, therefore, allow for any interested party to volunteer an opinion or make a comment. The "truth" of an incident is arrived at through hearing many descriptions of the event and of related, perhaps extenuating, circumstances. (http://www.ajic.mb.ca/volumel/chapter2.html#14)*

In his work, Petoukhov (2011) focuses of six related themes that could be considered in the context of developing an Indigenous influenced health care feedback process. In his research, Aboriginal justice practices and relevance to the work of truth commissions form the basis for his "analysis of the 'restorativeness' of the Canadian TRC" (Petoukhov 2011, p. 46) but can also be utilized in the design and practice for a Indigenous health grievance model. The six themes include:

1. Victim-centeredness
2. Inclusiveness and engagement
3. Negotiations of restorative processes
4. Restoration of victims' identities, respect, and dignity
5. Symbolic/material reparations
6. Truth-seeking and overcoming the denial of injustice (Petoukhov 2011, pps. 45 – 52)

These six themes, as a continuum of subjective and relational cornerstones of trust, truth telling, decolonization, and reconciliation may dramatically influence a new era for health care feedback and feedback with the health care system for Indigenous peoples.

We see similar approaches to other, international models of Indigenous restoration and in New Zealand, the Maori have introduced feedback considerations grounded in Indigenous values. In April 2021, New Zealand announced a "radical shakeup" with their health care system with the establishment of a Maori Health Authority (https://www.theguardian.com/world/2021/apr/21/new-zealand-announces-radical-shakeup-of-health-system-district-health-board-dhb). With this, and as another colonized country that witnesses a disproportionate representation of its Indigenous population being marginalized, suffering from discrimination, and overrepresented in the justice system, the New Zealand landscape of health reform for Maori may soon see an adoption of distinct Maori justice and health-related principles in health service and delivery.

Citing Pratt (1992), Juan Tauri demonstrates how Maori justice, or as described by Annette Sykes (2021) as Tikanga in the Pākehā (non-Indigenous) law, presents differently between Western and Maori cultures:

	European	Maori
Criminal Responsibility	Individual	Collective
Place/Location of Justice	Process Private (Courtroom)	Public (Marae)
Aim of System	Deterrence/retribution	Reintegration/ restore social bonds
Key 'actor' in the system	The state	The Victim

p. 38

The emphasis here demonstrates, like the Indigenous peoples of Canada, the interconnectedness, cohesion, community, and accountability are obvious and Maori law invites a collective practice of restoration into their communities while adhering to traditional principles of justice. Specifically, the restorative practice of *Pou hihiri Pou o te aroha*: Healing and Learning from Harm (watch:https://youtu.be/9rRhculNHVg) has transformed not only the approach to addressing health care grievances in New Zealand, but their outcomes entirely.

In reference to the transformed feedback system implemented in New Zealand, Macdonald, et al (2022) explain:

> This kind of process requires a shift in thinking away from, "What happened and who is to blame?" to "Who has been harmed and what are their needs?" We can move forward from this moment of crisis in a way that promotes just relations of care, concern and dignity. We can move forward in a way that cultivates trust in our beloved, but beleaguered, public health-care system. Restorative justice practices provide an avenue to do so, which we hope can offer a foundation for action. (https://theconversation.com/when-health-care-goes-wrong-its-time-for-transparency-in-patient-safety-184523)

Indeed, it is time to shift the typical way of thinking of health care resolve and move towards a transformative mindset of person-centredness where culture, identity, and tradition leads in healthy experiences for all.

Moving Forward

An Indigenous model for health care feedback is an important tool for consideration as British Columbia continues to renew its relationship with Indigenous peoples, place value on oral, spiritual, and kinship/relational systems, while validating and supporting the practices of their Indigenous legal practices and traditions. Silliboy et al. (2021) describe:

> *It is often surprising to non-Indigenous people that First Nations have their own traditional knowledge regarding health and wellness and most Nations… rely on this knowledge as their primary source of health information. It is a sophisticated network of knowledge-holders, Elders and healers guided by*

> *epistemological and scientific practices based on a worldview of experiences and logical validation who implement traditional knowledge and western-based science to seek solutions in health. p. 2*

This sophisticated knowledge library has much to contribute to the health system and an Indigenous-influenced health care feedback process has the potential to mobilize the wisdom, beliefs, and experiences of the Indigenous peoples while creating enduring relationships within health systems.

Adapted from the Justice Education Society's *Aboriginal Restorative Justice Remedies,* the following examples could be considered and modified to a Indigenous desired restoration experience with an Indigenous-influenced health care feedback process for individuals that are seeking restoration as a result of their experiences with public health:

A healing circle:

- Will include members of the community including the offender, Elders, and often the victim if they agree to participate
- Will discuss the incident and how it has affected the victim and the community and the relationships between these and the 'wrong-doer'
- In addition to healing community ties, the circle focuses on the offender and the underlying causes of their offence

Other processes may include:

- Community work service at the direction of an Elder
- Potlatch and other traditional remedies specific to the Nation's customs
- Direct restitution to the victim or the community
- Sometimes unique and creative solutions emerge, such as the offender agreeing to tell the public their story and speak out against the conduct that led to the incident.

https://www.justiceeducation.ca/about-us/research/aboriginal-sentencing/restorative-justice

These processes, which are relational in nature, provide an important option to be considered in the BC health system's feedback experience for the Indigenous peoples. The integration of an Indigenous-influenced feedback process is an integrative model that supports the togetherness of Indigenous and non-Indigenous cultures and worldviews for the benefit of individuals involved in the experience with an ultimate objective of reconciliation and relationship building. Principles of "Two Eyed Seeing" (Iwama, Marshall, Marshall & Bartlett, 2009), and inviting a cohesive use of Indigenous and Western systems, is a respectful approach that honours cultural knowledge and awareness, encourages cultural humility, and provides a foundation for necessary change. Non-Indigenous systems and practices continue to have much to learn from Indigenous ways of knowing and being. Including a health system tool kit using an Indigenous-influenced feedback process is a further opportunity for growth and an important step in redressing systemic racism and discrimination BC's public health care practices through restoration and healing.

While the impact of imperialistic cognitive systems of beliefs continue to permeate and "discredit other knowledge bases and values… to validate one source of knowledge and empower it through public [discourse" (Battiste, 1986), efforts through the creation and delivery of Indigenous-informed health feedback systems have the potential for significant and transformative change. An Indigenous-influenced feedback process may not only become an invaluable model to meet the systemic and harmful experiences of racism in BC's health care system, but the opportunity for education and a reciprocal platform for shared understandings of health literacy and community care, cannot be understated. As strong, resilient, and informed peoples, the Indigenous are change-makers who are visionary and are embracing an opportunity to share their knowledge, culture, and practices for positive influence and change.

The Importance of Data

We cannot overlook the importance in considering the role data has in the consideration of developing an Indigenous-influenced feedback process. In particular, there must be an acknowledgment of the relationship data ownership, understanding, and disclosure has to colonial and racist experiences. Smylie, J. & Anderson, M. (2006) acknowledge:

> *Over the past decade, First Nations, Métis and Inuit governing authorities in Canada have increasingly advocated for the recognition that the right to self-government includes the right to self-governance of population-based information, including health information. For example, the First Nations Regional Longitudinal Health Survey recently conducted by the First Nations Centre at the National Aboriginal Health Organization carefully addressed issues of data ownership, control, access and possession (OCAP) by participant First Nations communities. Over the past decade, First Nations, Métis and Inuit governing authorities in Canada have increasingly advocated for the recognition that the right to self-government includes the right to self-governance of population-based information, including health information. (p. 604)*

Further to this, Robson, et al (2022) explain:

> *…reviews under protection of Section 51 of the Evidence Act (1996) reinforce systemic power imbalances and intergenerational distrust through non-disclosure of appropriate information, publication silence on issues and incidents of anti-Indigenous racism and a lack of effective examination of the role of racism in contributing to harm as experienced by Indigenous patients, particularly Indigenous women. These realities have led to a call for a culture of data sovereignty – the idea that patient- and community-led health organizations and Indigenous governments are the rightful owners of patient records and data regarding patient harm events including experiences of racism and/or medical errors. (https://www.longwoods.com/content/26811/legal-privilege-legislation-consequences-for-patient-safety)*

Indeed, creating opportunity to mitigate these tensions, and offer Indigenous Peoples with the certainty of how their data will be used and respected, can transform data deficit gaps that exist in the Current State.

it is acknowledged that in Canada, there are difficulties in ascertaining the entirety of Indigenous health-related experiences due to data deficits and, in conducting this literature search regarding the participation of Indigenous Peoples in data accumulation, the inherent colonial trends that underscore typical data collecting aspirations must be acknowledged and addressed.

In an article written to offer a methodological framework for a decolonial quantitative political science regarding Indigenous self-identification in a 2019 Native Hawaiian Survey, N. T. Phan and K. L. Lee (2021) demonstrate how reimagining a process to offer Indigenous Peoples an opportunity to participate in qualitative data collection "in ways which are responsive to how Indigenous communities think about themselves, and which are accountable to their needs and struggles" can change the perception and outcome of qualitative data accumulation participation (p. 91). The authors explain:

> *Quantitative methods and Indigenous communities have a historically fraught relationship, not least because quantitative researchers have sometimes insufficiently contended with the role of power, politics, and colonialism in the data-generating process. We identify three broad issues facing quantitative research on Indigenous populations: (1) they insufficiently recognize self-identification heterogeneities among Indigenous populations; (2) they adopt identity categories inherited from the ethnoracial classification systems of settler-colonial states; and (3) they offer inadequate solutions to the methodological biases resulting from undersampling and lack of trust. These issues suggest the importance of amending the status quo of quantitative research on Indigenous populations. (p. 92)*

With this, the role of traditional health care data accumulation practices, inherently colonial in nature, must create space to reimagine a realignment with traditional community data accumulation practices (including the role of oral history, Indigenous sovereignty, culture, and justice), before an appropriate and meaningful data accumulation pathway will emerge that does not only need to satisfy the needs of the provincial government health care system, but Indigenous Peoples and their communities entirely.

Conclusion

This literature review would not be complete without acknowledging the powerful story of the late Keegan Combes and what his experience with the BC health care system has taught us all. Reinforcing the need for cultural safety, cultural humility, and antiracism, Keegan's story bolsters the impetus for dramatic system change in profound and meaningful ways. As stated in the First Nations Health Authority (2022) report titled, *Remembering Keegan*:

> *First Nations and Indigenous people deserve to receive culturally safe health care in their own lands and territories. This includes the best of both traditional and mainstream medicine. Transforming mainstream health services to ensure that they are culturally safe and provide the highest quality health care for First Nations people in BC requires resetting the relationship between First Nations people and the whole health system in ways that are inclusive and respectful of First Nations rights,*

> *perspectives of health and wellness, and that recognize the impacts of colonial history including Indigenous-specific racism and its contribution to less access, poor health services and harmful experiences. It's important that every person working in the health care system knows that they can positively contribute to a new narrative moving forward… It is important that they are heard. There needs to be more clear, transparent and effective processes for people to raise their concerns, and for the adjudication and resolutions of these issues to translate into policy and practice changes that create a safer health care system for Indigenous people. (p. 28)*

Not only is the BCCNM revised feedback process an important part of reconciliation generally, but as a society, as a world, we owe such reparations in the honour and legacy of Keegan and all others who deserve the opportunity of respect, dignity, and concerted care when requiring services from the BC health system.

Future State

The goal of the future state recommendations is the development of a health care feedback process that serves First Nations, Inuit and Métis peoples in British Columbia. The recommendations are a complement to current state process to augment the non-regulatory functions of the college, and perhaps the IDM team. We say 'perhaps' because this could have implications to program design. The 50% of 'early resolution' complaints *could* be better served within the Quality Assurance business area of the college. This is important to consider, but beyond the scope of this review. The need to consider this is included in recommendation #13 (see below).

The recommendations of the future state model are focused on the bookends of the pathway; starting with access and initiation of the process and concluding with a restorative approach to the individual's experiences with the health care system. There are very clear principles that the future state process is abiding by, but the primary purpose of the recommendations is to '**support current improvement efforts through a coordinated and systemic focus. The recommendations are centered on the unique needs and experiences of Indigenous peoples at the core of system design and transformation. [In Plain Sight, pg. 118 full report].'**

Principles of the Future State, as per BC Patient Safety and Quality Council:

1. Be grounded in Indigenous rights, cultural values and traditional protocols;
2. Be Indigenous patient- and family-centered;
3. Take a restorative and accountable approach;
4. Remove unnecessary barriers to engaging in the health care feedback process;
5. Be trauma- and violence-informed;
6. Include Indigenous peoples in leadership and positions supporting the health care feedback process;
7. Be responsive and provide clear, timely feedback;
8. Provide Indigenous patients and families with an Indigenous support person;
9. Provide an opportunity for Indigenous patients to identify their Indigenous/Aboriginal ancestry.

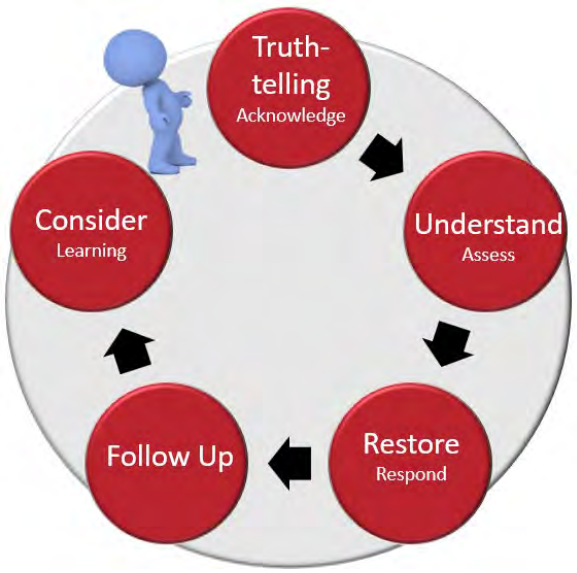
Future State Requirements and Model Components

The feedback journey for Indigenous peoples will consist of 5 phases:

Truth-Telling/Acknowledgement – information is gathered, and a person's truth and experience are acknowledged.

Understanding/Assessment – understanding of the experience using an analysis tool to guide the conversation (purpose is to steer the analysis and aggregation of information on the types of problems experienced by community members to ensure individual restoration and system change)

Resolution/Response – the combination of the person's wishes for resolution in addition to community-defined culturally appropriate approaches to restoration



Follow-up – confirmation on a case-by-case basis that individuals and families felt that the wrongs they experienced were addressed and are satisfied that the process was taken seriously, that they were treated fairly through the health care feedback process, and that they would feel safe accessing services in the future

Consideration – transparency and demonstrable contribution of the experience to overall system change.

Truth-telling Acknowledge	What?	This creates the record
	Why?	So people don't have to keep repeating themselves, and so that the BCCNM leadership know about all encounters (even the ones that don't go any further than truth-telling), and to record all complaints, compliments and requests for information
	How?	Truth-telling record
	Who?	IDM team member receiving feedback

Understand Assess	What?	This classifies and assesses the feedback to properly determine a restorative response
	Why?	Currently, there is no assessment tool used to categorize and assess feedback and determine an appropriate restorative response by health authorities and the care team. It's ad-hoc and inconsistent
	How?	Understanding tool (modeled after the Lets'omo:t Salish Tool for Navigation LSTN)
	Who?	Indigenous case lead/navigator (within IDM team)

Restore Respond	What?	The provision of restoration for the patient
	Why?	Because currently, only high severity, 'formal' complaints, or patients who have access to advocates can be 'heard'. Because restoration is non-existent or slow, not aligned with cultural practices, and has opportunity to provide meaningful healing for both patients and providers
	How?	Restorative Response Form
	Who?	Indigenous case lead/navigator (within IDM team)

Follow-Up	What?	Follow-up with patients; have they received restoration? Was it meaningful?
	Why?	To evaluate the process, capture feedback and try to delineate between racism, cultural safety, and compassion, track how many health care providers received cultural safety training, and what practices have changed as a result of the feedback
	How?	Follow-up/Compassion Survey
	Who?	Indigenous case lead/navigator (within IDM team)

Consider	What?	This codes the complaints in a systematic, objective approach
	Why?	To drive system change. To create a more informative, comprehensive picture, and better reflect the qualitative data than is currently occurring
	How?	Understanding tool (modeled after the Lets'omo:t Salish Tool for Navigation LSTN)
	Who?	Independent Coders

Truth-Telling

The truth-telling phase is formalizing and expanding on the current practice of capturing patient information (demographic, contact information, general feedback concerns) and standardizing it in the following six profiles:

1. Intake lead information profile
    - Purpose: capture the team member who had the first contact with the patient and follow-up if necessary

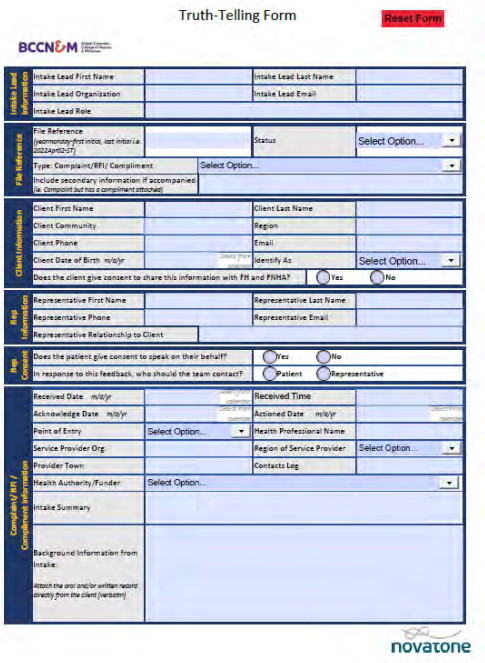
2. File Reference profile
    - Standardizes case nomenclature
    - Case status
    - Case type

3. Client Information profile
    - Includes consent to **share client information profile** with partner organizations (ie. FNHA, MNBC, Regional Health Authorities)
    - Identifies client community or nation and region

4. Representative information profile

5. Representative consent profile
    - Includes consent for the representative to act on the patient's behalf
    - Clarifies follow-up contact preferences (patient or representative)

6. Health care Feedback Information profile
    - Timelines (received, acknowledged, actioned)
    - Service provider information
    - Patient's narrative (written or oral) uploaded to the document



The purpose of the Truth-telling phase is to capture <u>all</u> feedback provided by patients. Currently, most of the documented information is only reflective of 'formal' or more serious incidents that are reported through the IDM case summary spreadsheet.

The truth-telling form has been developed and modified based on the submitted information requirements provided by FNHA in the fall of 2021. The tool can be found in appendix D.

Understanding

The purpose of the Understanding Phase of the process is to improve the ability to assess and understand a health care complaint and provide the culturally appropriate and meaningful resolution for patients and families. An important part of our work was aligning the assessment of a complaint with a response pathway.

The Lets'omo:t Salish Tool for Navigation (LSTN) is the indigenization of the Health care Complaints Analysis Tool (HCAT) that was introduced and endorsed by the Aboriginal Health Steering Committee Feedback and Accountability Sub-Committee in July of 2021. The version that was developed for the Fraser Salish Regional Office and Fraser Health is included in Appendix E.

A recommendation for BCCNM is to consider a unifying Indigenous name for the tool.

To be clear, the LSTN is used in 2 phases of the process; understand and consider, for 2 different purposes:

1. To provide resolution and healing for the patient and their family by meaningfully understanding the experience, and

2. To consider all health care feedback in an aggregate, macro view. This will provide the data and evidence necessary to drive system change and allow for deeper review of qualitative data to learn from specific experiences in a useful way to assess health care quality and safety, both clinically and culturally.

The LSTN used in the understanding phases is simpler and collects fewer data points than the consideration version. The tool includes the following information profiles:

- ☑ Domain: 3 main groupings of problems
- ☑ Category: Sub-categories within each of the 3 main problems
- ☑ Severity
- ☑ Location of care
- ☑ Level of harm
- ☑ Who made the complaint?
- ☑ Gender of patient?
- ☑ Which staff group the complaint refers to?
- ☑ Restorative expectations
    - Identify whether mental health supports are required instead of restoration

Restore

Restoration and culturally appropriate response pathways must include clarity regarding the responsibility and accountability of the parties involved. There is a critical risk of colonial restorative practices undermining and dismissing accountability; **restoration is not a "free pass" to being held accountable for one's actions.**

Caution is urged. In an article written by Michelle Daigle titled *The Spectacle of Reconciliation: On (the) unsettling responsibilities to Indigenous peoples in the academy*[4], the author uses the experience in post-secondary institution to highlight the danger of hollow performances of recognition and remorse. The application to restoration in the healthcare sector is clear. The author states:

> *Responsibilities to Indigenous lands and peoples are contextualized within the spectacle of reconciliation in Canada. In drawing on a range of critical analyses of reconciliation led by Indigenous scholars, I examine how the truth and reconciliation process has naturalized and fetishized Indigenous suffering and trauma while cultivating settler colonial spectacles whereby white settler Canadians engage in hollow performances of recognition and remorse. These spectacular spaces, I argue, become centered and severed from a larger terrain of settler colonial dispossession and violence that Indigenous peoples continue to resist on an everyday basis. I specifically focus on settler colonial spectacles and reconciliation mandates taking shape in Canadian postsecondary institutions. In doing so, I focus on how Canadian universities located on stolen Indigenous lands (actively supportive of the ongoing dispossession of Indigenous lands) continue to be a crucial site of settler colonial relations and a constitutive part of the settler colonial state (abstract).*

The complaints process for people experiencing anti-Indigenous racism in the healthcare sector must not forsake justice for restoration. Proportional consequences for perpetrators of racism is essential. The restoration record must explicitly define the parties responsible for facilitating, resourcing (financial and otherwise), and executing the appropriate response pathway. For example, if a healing circle is requested by a patient, their family, and/or community, the record needs to capture who is responsible for facilitating all parties to attend and its outcome. The most recent example of the Vancouver Police Department officers not attending the Heiltsuk First Nation's apology ceremony in Bella Bella for the handcuffing incident of Maxwell Johnson and his granddaughter is relevant. This will happen in healthcare. Accountability is imperative.

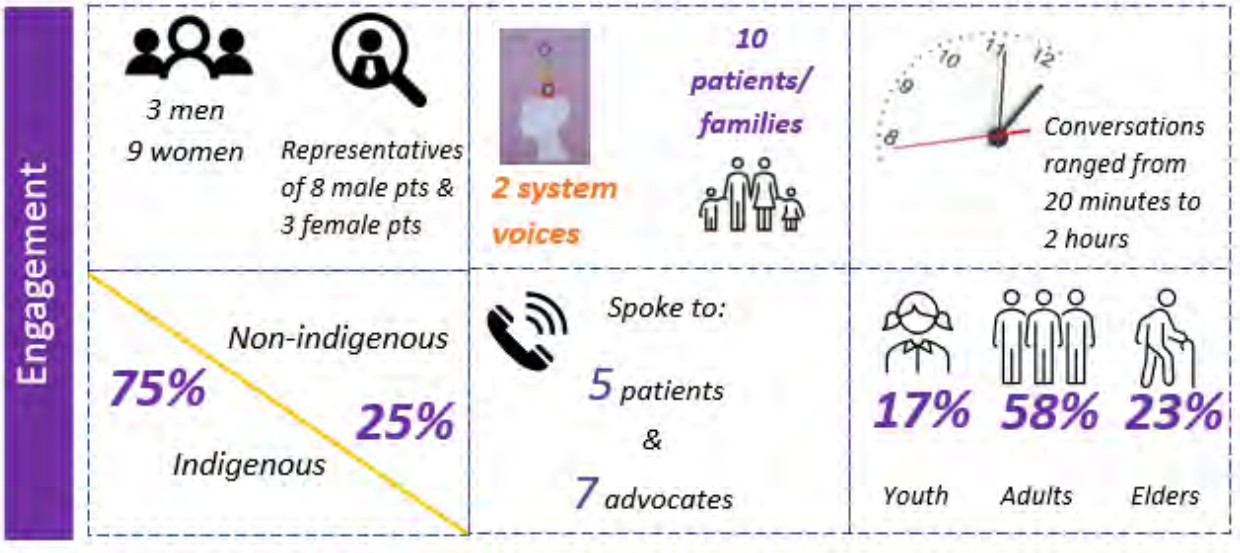
The purpose of the restoration phase of the process is to earn the trust necessary to create a health care system free of systemic racism. Currently, only high severity, 'formal' complaints or patients who have access to advocates can be 'heard'. Restoration is non-existent or slow, not aligned with cultural practices, and has immense opportunity to provide meaningful healing for both patients and providers.

[4] Daigle, M. (2019) 'The Spectacle of reconciliation: On (the) unsettling responsibilities to Indigenous peoples in the Academy'. SAGE Journals. Available at: https://journals.sagepub.com/doi/10.1177/0263775818824342

Past work by the consultants is included in this section. In February and March of 2022, Novatone conducted interviews with First Nations patients and families who had had a negative health care experience. Their names were shared with us by the First Nations Health Authority, Fraser Salish region. The purpose was to hear directly from patients to propose appropriate response pathways. Developing the response pathways was informed by the aggregation of community interviews with Fraser Salish leadership in the first phase of the project and augmented by 12 patients interviews through February and March of 2022. Of the 12 patient cases we reviewed and interviewed, 3 had received some form of resolution, while 9 were still outstanding. **75% of patients had not received even a response regarding their health care complaint.**

The individuals we were able to speak with included the following:

Image 1.8 Patient Engagement



What are the overall themes of what resolution needs to deliver?

1. Address Racism
2. Improve Communication
3. Augment Resources
4. Foster Relationships

What responses were people looking for?

Image 1.9 Restorative Responses

Communication – patients wanted to hear back from the organization they provide their health care feedback to. What did their feedback achieve? What would be addressed? Received as a phone call and verbal update.

Resources – improved access to Indigenous navigators or liaisons. Patients specifically reference the value of an Indigenous person in that role but reported feelings of guilt for taking their time since they seemed so 'busy'. Not enough Indigenous people in those roles.

Apology/Acknowledgement – more than half were seeking a 'meaningful' apology from the health care providers involved in the care. Although patients used the word apology, the explanation around it indicated an expression of responsibility. Paraphrasing from a patient's remarks: ["Saying I'm sorry and showing remorse is nice emotionally" but it doesn't convince you that I accept the harm that I've done to you and that I'm going to change my behaviour going forward. Whether or not I feel that what I did was wrong, I recognize that I hurt you and I take responsibility for that. And now I'm also to take responsibility for adjusting in the following ways to make sure it doesn't happen again. That's the foundation of trust repair.]
Compensation was sought for damaged personal items in 2 cases and delivered in one of them.

Building relationship was expressed in 3 cases. These were mentioned from the perspective of feeling unsafe to access care in the future. Patients brought up the word 'flagged' and being labeled a troublemaker in their file. The opportunity to address this through relationship building was expressed.

In case of the cases, people didn't want anything in return. They just wanted to make sure it didn't happen to someone else.

The current state process stalls at the restoration phase due to a lack of clarity regarding organizational responsibility and authority. The following proposed escalation pathways could address some of these delays.

Escalation Pathways

Restoration is based on the severity assigned during the understanding phase.

Combining the patient's input into resolution with these response pathways will improve the care leads' ability to offer and facilitate the restorative response.

This is the proposed escalation pathway:

Mild Severity (level of harm 0-2)

1. Verbal acknowledgement/apology
2. Occurs over the phone/virtual method
3. Responsible for coordinating: Aboriginal Health Liaisons, Point of Care providers, Indigenous Navigator, case lead
4. Accountable: BCCNM IDM team

Medium Severity (level of harm 3)

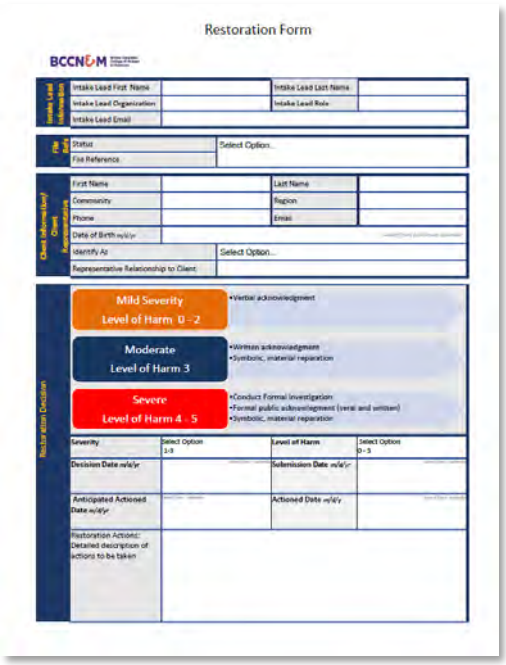
5. Written acknowledgement/apology
6. Personal meeting between patient and circle of care – healing circle if accepted by patient
7. Responsible for coordinating: BCCNM liaison and appropriate regional organizational rep (ie. Wellness Systems and Quality Care Coordinator in the FNHA regional office)
8. Escalation Pathway: BCCNM IDM Directors

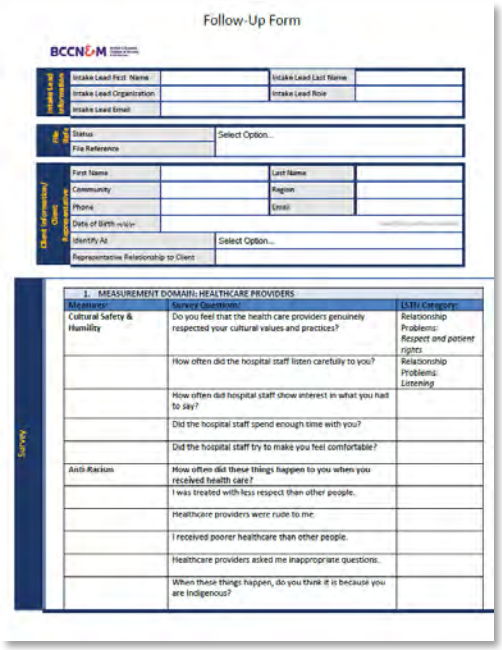
High Severity (Level of harm 4-5)

9. Initiate formal investigation (current registrar and inquiry committee processes)
10. Formal public acknowledgement (written and public)
11. Coordinate symbolic reparations and ceremony
12. Responsibility: BCCNM Directors
13. Escalation Pathway: BCCNM Registrar

Novatone recommends the development of a resolution restoration form that captures the response pathway selected based on the understanding (LSTN application) to the experience.

A proposed tool to capture the response pathway and the follow-up survey is included below. The tools can be found in appendix F & G:





Restoration and Indigenous Cultural Response Pathways

Novatone is recommending the creation of formal partnerships between BCCNM and Indigenous organizations with regional relationships and infrastructure.

The partnerships will support 2 goals:

Recommendations for Partnerships	
Case-Specific Support (micro)	Drive System Change (macro)
Offering Indigenous patients, families and registrants culturally appropriate response pathways for resolution	Key systems partners engaged in a review of disaggregated data as a tool to fight Indigenous-specific racism
Who?	Who?

-

Being able to offer Indigenous patients and registrants a culturally safe and appropriate resolution pathway should be approached through partnerships with regional First Nations, Inuit and Métis organizations such as FNHA and MNBC.

Partnership for the provision appropriate response pathways would include:

- Alternate Dispute Resolution
- Partner-supported resolution with FNHA regional offices, Health Authorities, and patient networks
- Facilitate access to trauma-informed and mental health supports and programs

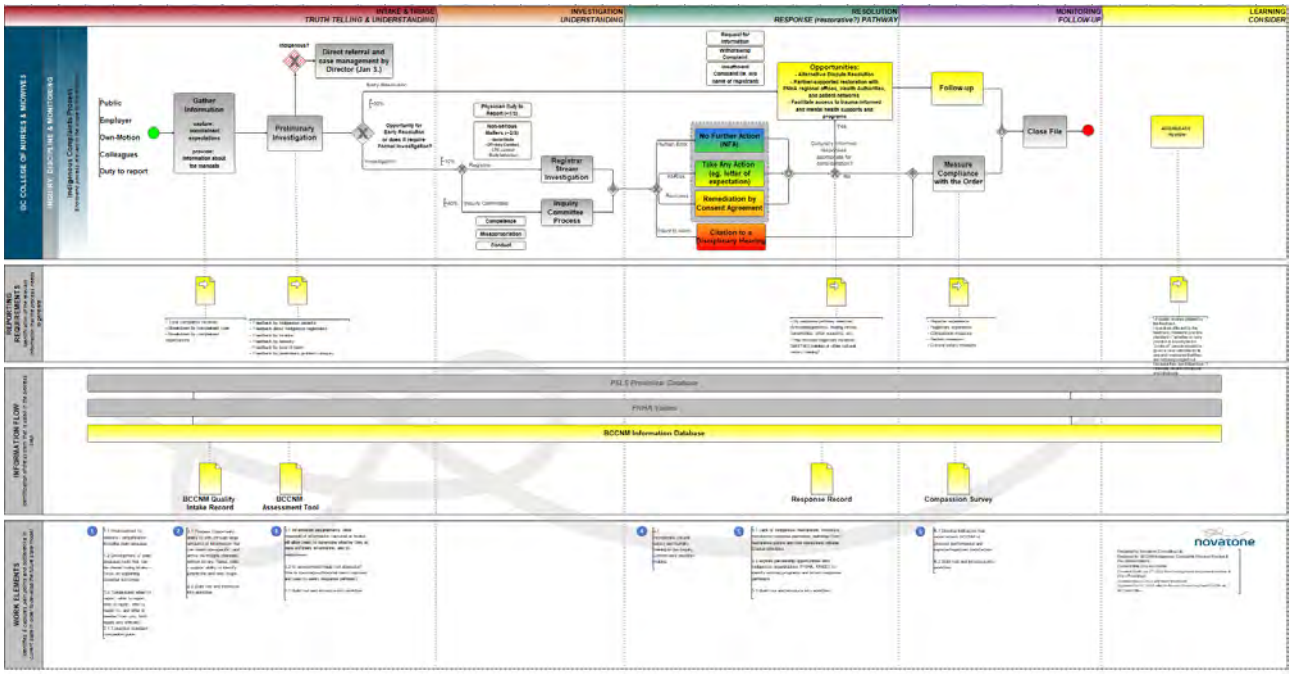
Organizations to approach immediately include:

- Fraser Salish Regional Office
- Northern Health Indigenous Health Office
- BC Mental Health and Substance Use Services

Novatone provided an introduction to FNHA in October 2022. During the discussion, the FNHA VP of Cultural Safety and Humility proposed the establishment of a key systems partners table. The value of such a group would be evident in the consideration phase of the process. Agreement on a set of indicators of disaggregated data to highlight health system performance failures for Indigenous peoples.

Business Transformation Roadmap

The proposed future state process, corresponding to the circular representation of the process presented on page 32, is the following. The model is included in appendix B.



The model is illustrated using business process modeling notation (BMPN) principles. It includes:

- End-to-end phases of the process (truth-telling to consideration)
- Processes within each phase (first swimlane)
- Potential reporting capability based on proposed information requirements
- Tools and the systems where information is entered
- Work elements required to bring BCCNM from current state to future state

Novatone's value-add proposition for this project was the ability to include an information framework reflecting a culturally safe health care feedback process.

The process hinges on 4 instruments or tools akin to transformer stones;

1. The truth-telling record
2. The understanding tool (LSTN)
3. The resolution record
4. Follow-up survey

Each of these tools provide an opportunity for the process to meaningfully capture the information required for the IDM team to do their work, to evaluate the quality and safety of the process, and to meaningfully contribute to provincial efforts to dismantle systemic racism.

Novatone's definition of a process is: a set of data and a path for that data to follow. Based on our previous experience with health care feedback processes, we've identified the following information requirements:

Complaints Process Information Requirements

Information Requirements	Description: *information relevant to a specific organization for process performance evaluation and quality improvement, includes reports such as board & CEO reports, regional reports, internal dashboards, KPIs, etc*	Data Elements Breakdown	Who's responsible?	Where in the process?	How is it being captured?	System?
Total complaints received	Total complaints - in order to measure proportion of indigenous complaints/reporters	C16	IDM intake team	Truth-telling	Truth-telling Form	Manual
Breakdown by reporter type	Differentiate between Indigenous and non-Indigenous reporters	C24-C27	IDM intake team	Truth-telling	Truth-telling Form	Manual
Breakdown by reporter expectations	Opportunity to strenghten the process and provide clarity around expectations and the college's mandate	C95-C102	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback by Indigenous patients	Opportunity to capture region and nation	C19-C20	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback regarding Indigenous registrants		C47, C49	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback by location	Identification of trends and hotspots/blind spots	C48	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by severity		C65-C68	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by level of harm		C79-C84	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by preliminary problem category		C54-C64	IDM intake team	Understanding	HCAT/LSTN	Manual
By response pathway selected	Acknowledgement, healing circle, ceremony, other supports,	C95-C102	TBD	Restore	Restoration	Manual
Has involved registrant received SAN'YAS training or other cultural safety training?	Opportunity to inform the effectiveness of existing training and education programs	TBD	TBD	Restore	TBD	Manual
Reporter experience		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Registrant experience		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Compassion measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Racism Measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Cultural Safety Measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
# quality reviews initiated by the feedback		TBD	Independent coders	Consideration	HCAT/LSTN	Manual

Appendix H includes a proposed information framework that can be shared with the business transformation team at BCCNM.

The process is meant to help the individuals that work in the role of assisting patient and families when they have feedback about their care. The process is **not meant** to replace or automate the experience. Ultimately, IDM team members (investigators, leads, navigators, etc) are the most important part of the process. Their experience, training, compassion, humility and care for people is what makes the greatest difference. The process is intended to support them; give them tools to ensure they capture all the information required and not have to rely on their memory, provide information at their fingertips so they can be efficient and confident in their navigation of the process for the client, offer pathways for resolution that are grounded in cultural practices. But there is no expectation that adherence to the process and its pathways is rigid. It's meant to guide, not lead.

Recommendations for Implementation

1. Include Indigenous peoples at **all** levels of the organization (senior leadership to front-line reporter support) to ensure the cultural transformation required to impart cultural safety, cultural humility and anti-racism in the existing process

   *All levels of leadership must **demonstrably** support the changes through a holistic approach at the organizational level –risk of being interpreted as IDM's singular responsibility*

2. Explore the re-naming of the complaints process (deficit-based) to health care feedback process (strengths-based)[5]. Consider a dual message for complaints (investigative stream) and concerns (currently early resolution cases).

   This recommendation was discussed with the IDM team and concerns were shared regarding the need to maintain the clarity of purpose of the college and contributing to expectations; this is what the college can do in this situation, what are your expectations of us?

3. Review overall use of language within the revised process and tools used to enable the process – could the LSTN be renamed to honour Keegan Combes?

4. Define data ownership, control, access and possession required by the new process (OCAP)

   There is an existing anti-racism data table at the provincial level that is already engaged in this work. The report recommends the alignment of the proposed data framework with this group.

5. Capture the patient's experience verbally through oral or written truth. Address barriers for Indigenous reporting by having IDM staff come to community and use video and/or audio if consent is provided.

6. Capture the patient's experience in their own words without paraphrasing, interpreting, or acting on behalf of. Ensure that the patient record accompanies the case from truth-telling to consideration (end-to-end).

7. Offer an opportunity for self-identification with the following question during truth-telling. Scripting for posing the question to be enhanced with OCAP rules developed by the college (and key systems partners)

   Do you wish to self-identify as an Indigenous person in Canada such as First Nation, Métis or Inuit?

[5] As per BC Patient Safety and Quality Council, "Sharing Concerns: Principles to Guide the Development of an Patient Feedback Process" September 2022, Pg. 5

8. Mandatory cultural safety and humility training for all BCCNM staff

9. Capture and ongoing measurement of BCCNM's maturity continuum to becoming a culturally safe and anti-racist organization[6] See appendix I.
   Based on Crossroads Ministry, Chicago IL: Shared by Indigenous Advisor and Partnership Development & Initiatives, CMO office, FNHA. See Appendix I for an example of the continuum.
10. Adoption of the proposed process and tools required for information capture and navigation; truth-telling record, LSTN/HCAT, restoration form, and follow-up survey.
    Ensure responsibility and accountability are clearly defined in the response pathways, especially when multiple organizations are involved in the response

11. Develop the external organizational partnerships (micro level) that will enable BCCNM to offer culturally appropriate response pathways in the Interior, Northern, Vancouver Coastal, Vancouver Island, and Fraser Salish regions:
    - Métis Nation BC
    - FNHA
    - Regional Health Authorities

12. Develop the external organizational partnerships (macro level) that will enable BCCNM to participate with other key systems partners to a) create clarity of responsibility and functions (between regional health authorities, provincial health services authority, first nations health authority, MNBC, bc health regulators, etc) and b) opportunity for dis-aggregated data review.

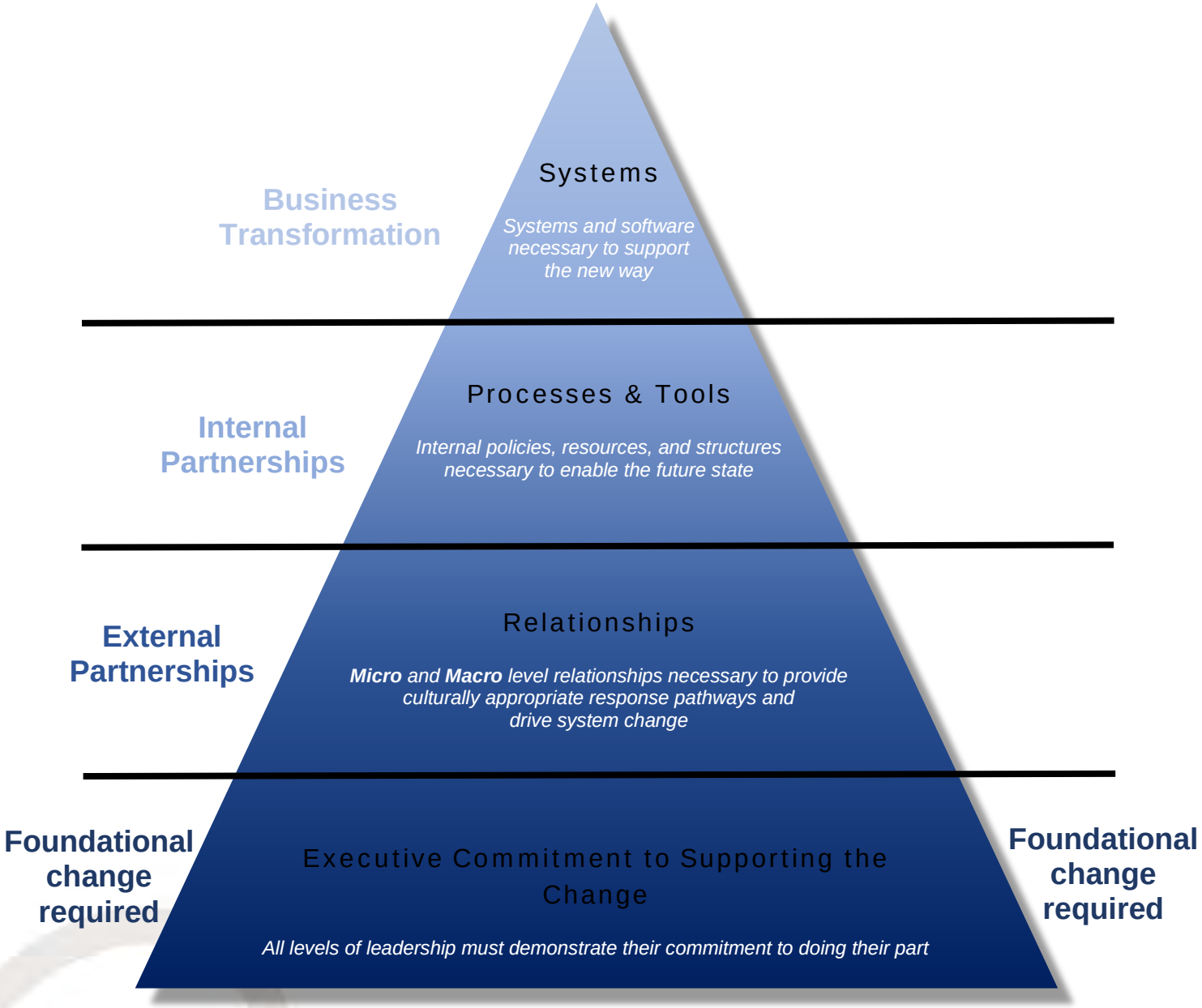
13. Develop internal partnerships between IDM, QA, Education, etc. to explore opportunities to inform and integrate current siloed processes
    Ensure that business transformation business area is aware of proposed changes within IDM, and opportunities for improved integration between other departments; strategic imperative 2 & 5 cannot be approached in isolation

The readiness of the organization predicates an implementation schedule. There is much preparatory work that needs to be done for the college to be able to implement these process changes and productively engage in relationship building.

The following implementation model was conceptualized during an IDM leadership team debrief with BCCNM's Indigenous Advisor and CSH Consultant. Moving from willing to readiness was a statement made during the meeting that made an impression on the consultants. The following pyramid illustrates the building blocks necessary for implementation. The timeline must be defined by the organization.

[6] Crossroads Ministry, Chicago IL: Adapted from original concept by Bailey Jackson and Rita Hardiman, and further developed by Andrea Avazian and Ronice Branding: Further adapted by Melia LaCour, PSESD.

Willingness to Readiness Implementation Plan



Conclusion

From the outset of this work, Novatone Consulting exercised and adhered to the BC Patient Safety and Quality Council's principles to guide the development of the Indigenous patient feedback process and grounded this project in methodological principles of the "Four Rs" — respect, relevance, reciprocity, and responsibility (Kirkness and Barnhardt, 1991). This work demonstrates an opportunity to consider alternative grievance resolution systems for the Indigenous peoples as well as other First Nations in British Columbia and through a summary of current state analysis, a literature review of restorative practices and Indigenous legal traditions, recommendations for future state is presented.

We hope the recommendations will well serve not only Indigenous peoples, but all peoples accessing health services in British Columbia. It is our intention to ensure that the feedback process is fluid, relational, culturally relevant, responsive, and meaningful while being mindful of the poor care and subjective racism Indigenous peoples may experience in the BC health care system. The good work from the FNHA, the TRC, the MMIWG Inquiry, UNDRIP, In Plain Sight, and others, continue to be a driving and important part of the evolution of projects such as these. As we were reminded during the discussion surrounding these recommendations, an Indigenous person is being harmed accessing healthcare at this very moment. Change is urgently required.

Guided by the wisdom and knowledge of Indigenous peoples, Novatone looks forward to the evolution of an effective, transparent, and culturally-informed feedback process entirely.

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Appendix A

List of Reviewed Documents & Consultations

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Meeting Log

BCCNM: Complaints Process Review

Developed on: Jun 8,2022
Updated on: Nov 21, 2022

				Project	Projects SMEs						PM	Novatone		
#	Meeting	Meeting Purpose	Date	Executive Director/Deputy Registrar, IDM	Director, IDM (1)	Director, IDM (2)	Director, IDM (3)	CSH Consultant	Legal Counsel	BCCNM exec leadership	Strategy Consultant	Melanie	Helena	Rheanna
20	NH & UNBC Introductions (Health Research Institute Presentation)	Support relationship development between BCCNM and regional Indigenous health delivery organizations for collaboration, welcome BCCNM CSH Consultant and Partnership Development & Initiatives, CMO office, FNHA via the HRI to present *Remembering Keegan: A BC First Nations Case Study Reflection*	17-Jan-23	√				√				√	√	√
19	Steering committee	Review final report - close contract	15-Dec-22	√		√	√	√			√	√	√	√
18	Indigenous engagement group	Share the draft recommendations and receive input	08-Dec-22					√				√		√
17	Steering committee debrief	Discuss the feedback from IDM team to recommendations (with Indigenous Advisor)	29-Nov-22	√		√	√	√			√	√		√
16	Recommendations presentation (in-person)	Present draft recommendations to IDM team and receive input	28-Nov-22	√		√	√	√	√		√	√	√	
15	CSH Consultant and Partnership Development & Initiatives, CMO office,n discussion	To inform emerging recommendations	28-Nov-22	√				√				√		
14	Process review and program future state and business transformation	Project introduction with align with business transformation approach (Executive Director, Regulatory Programs Transformation)	09-Nov-22	√				√				√		
13	Steering committee	Progress review	3-Nov-22 17-Nov-22	√		√	√				√	√	√	√
12	Directors meeting	Overall process discussion and impact of upcoming HPA legislation	27-Oct-22			√	√					√		
11	Legal Counsel - Inquiry Committee follow-up	"How do we ensure our learnings appropriately inform our decision making?"	26-Oct-22						√			√		
10	Steering committee	Current state review (with Indigenous Advisor and CSH Consultant)	20-Oct-22	√		√	√				√	√	√	√
9	BCCNM leadership update	update on project progress overall and alignment with business transformation strategic priority	13-Oct-22	√				√		√		√		
8	IDM Workshop (in-person)	Project introduction, Indigenous landscape, current state review	05-Oct-22	√		√	√					√	√	√
7	Steering committee	Current state review and IDM workshop planning	22-Sep-22	√		√	√				√	√	√	√
6	Current state review with Director, IDM (1)	Provide a project introduction and review current state capture thus far	15-Sep-22				√					√		√
5	Current state interview with Director, IDM (1) (part 2)	Validation of information capture and interpretation from first meeting	13-Jul-22		√							√		√
4	Current state interview with Director, IDM (1)	With Director, IDM (1) leaving BCCNM in July, looking to validate the process model with their feedback and expertise	30-Jun-22		√							√		√
3	Virtual Project Kick Off Meeting #2	Purpose - Discuss the project work & timeline, charter development, process scope discussion	22-Jun-22	√	√	√						√	√	
2	Virtual Project Kick Off Meeting #1	Purpose - Discuss the project work & timeline, charter development, process scope discussion	13-Jun-22	√	√	√						√	√	
1	Pre-Project Connection Meeting	Purpose - Prepare for the 2 kick off meetings	10-Jun-22	√								√	√	

Project Background Documents

BCCNM: Complaints Process Review

Developed on: Jun 13, 2022
Updated on: Nov 21, 2022

#	Background Document	Purpose of Document	Date Provided	Received From	Relevant Content
1	How BCCNP rsolves a Complaint *File Name: 2-Complaint Resolution Process Chart*	Current Process	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
2	Briefing Note Investigation *File Name: 2022 04 11 IDM CEO Report Briefing Note*	In this report, we provide the Board with a summary of recent matters presided over by the Inquiry and Discipline Committees	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
3	Inquiry Committee Guidelines *File Name: 1-Inquiry-Committee-Guidelines-2020-01-28*	Inquiry Committee Guidelines	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
4	Inquiry Committee Decision Algorithm *File Name: 3-IC_Algorithm_FINAL*	Inquiry Committee Decision Algorithm	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
5	Regulatory Decision Pathyway *File Name: 5-NCSBN Regulatory Decision Pathway*	The Regulatory Decision Pathway (RDP) is designed for board of nursing (BON) discipline decisions in cases of practice errors or unprofessional conduct	07-Jun-22	Executive Director/ Deputy Registrar, IDM	Note from Executive Director/ Deputy Registrar, IDM: a decision-making tool from NCSBN which we have incorporated into our process
6	Inquiry Committee Disposition Table *File Name: 6-Disposition Table*	Disposition of Complaints - Inquiry Committee Options	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
7	Presentation to Board - The Life of an Inquiry File *File Name: 8-The Life of an Inquiry File*	2 recent reports including stats and other data and comparisons to previous years – this one is a recent report to the Board.	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
8	Triage Flow Chart *File Name: 2022 02 23 Triage Flow Chart*	Written triage flow	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
9	IDM Team Update Report *File Name: 2022-05-06-IDM-team-Update*	2 recent reports including stats and other data and comparisons to previous years – this one is the data	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
10	Investigator Orientation Package *File Name: Investigator Orientation Package*	Inquiry & Discipline - Orientation Package for new Investigators	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
11	Inquiry Committee Guide *File Name: Inquiry Committee Guide - 2019 05 02*	Inquiry and Discipline Guide: An Overview	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
12	Triage Decision Support Tool *File Name: Triage Decision Support Tool*		07-Jun-22	Executive Director/ Deputy Registrar, IDM	
13	JKG Supsension Precedent *File Name: 2022 03 09 JKF Supsension precendent*	Note from Executive Director/Deputy Registrar, IDM: The Suspension Precedent Guide may not be required for your review right now, but I am including it. It guides decision making and advice given.	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
14	Dismantle Racism in Health Care: First Anniversary Report from Health-system Leaders	BCCNM's progress report (along with other colleges) with respect to BCCNM's commitment to disrupt anti-Indigenous racism can be found here: https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=357	07-Jun-22	Executive Director/ Deputy Registrar, IDM	
15	Report - BCCNM's Commitment to Action - Constructive disruption to Indigenous-specific racism amongst BC Nurses and Midwives		07-Jun-22	Novatone	Melanie's Research
16	Practice Standard for all BCCNM Registrants - Indigenous cultural safety, cultural humility, and anti-racism		24-Jun-22	Novatone	Melanie's Research
17	Practice Standard Companion Guide		22-Sep-22	Executive Director/ Deputy Registrar, IDM	Shared once available in september
18	BCPSQC Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process	https://bcpsqc.ca/resource/sharing-concerns-principles-to-guide-the-development-of-an-indigenous-patient-feedback-process/	25-Oct-22	Indigenous Advisor	
19	British Columbia Cultural Safety and Humility Standard	Provides guidance to health and social services organizations to address Indigenous-specific racism in their service delivery and provide more culturally safe services to First Nations, Métis, and Inuit peoples and communities	01-Oct-22	CSH Consultant	

Appendix B

BCCNM Level 2 & 3 Future State Process

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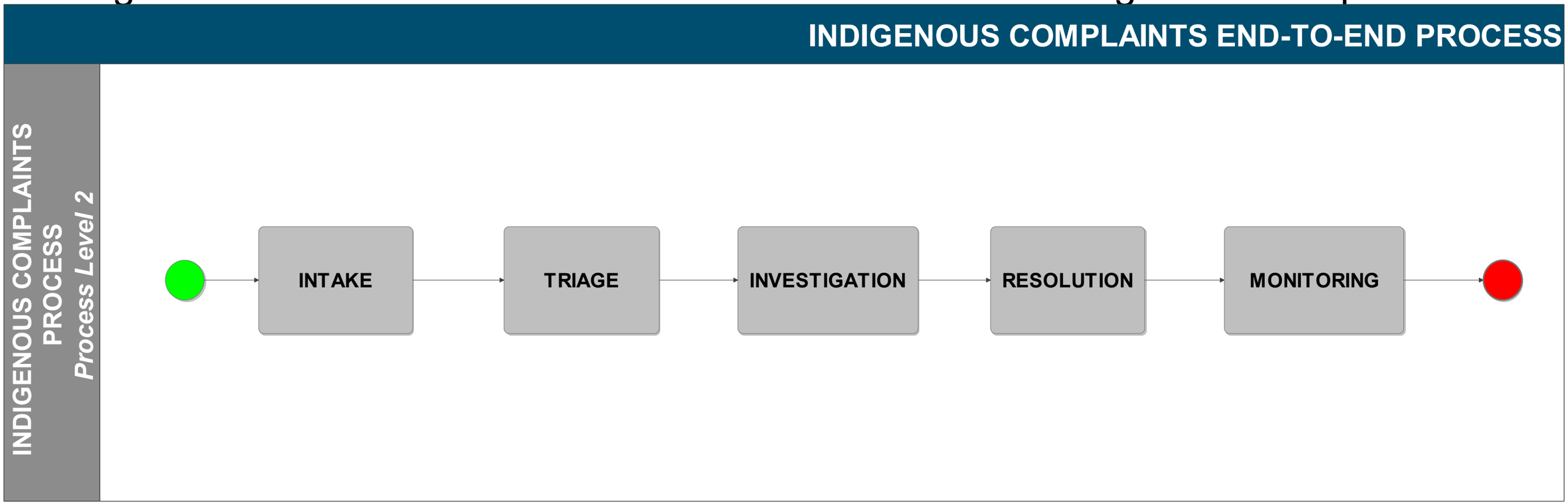
College of Nurses & Midwives: Current State Model of the Indigenous Complaints Proce



BC College of Nurses & Midwives: Current State Model of the Indigenous Complaints Process

BC COLLEGE OF NURSES & MIDWIVES
INQUIRY, DISCIPLINE & MONITORING
Indigenous Complaints Process
End-to-end process relevant to the scope of this initiative

INTAKE | TRIAGE | INVESTIGATION | RESOLUTION | MONITORING

1. Lack of Self-Identification
2. Lack of trauma-informed approach
3. Insufficient follow-up
4. Lack of Indigenous Restoration

Public
Employer
Gather Information
Preliminary Investigation

~50% Early Resolution
- Request for Information
- Withdrawing Complaint
- Insufficient Complaint (ie. w/o name of registrant)

Capture: complainant expectations
Provide: information about the mandate

Close File

~10% Registrar
- Physician Duty to Report (~1/3)
- Non-serious Matters (~2/3)
  - Social Media
  - Difficulty Conduct
  - LTC context
  - Rude behaviour

Registrar Stream Investigation

~40% Inquiry Committee
- Competence
- Misappropriation
- Conduct

Formal Investigation

- Human Error → No Further Action (NFA)
- At-Risk → Take Any Action (eg. letter of expectation)
- Reckless → Remediation by Consent Agreement
- Intent to Harm → Citation to a Disciplinary Hearing

Measure Compliance with the Order

INFORMATION FLOW
Identification of the systems/data used at the process step

Identify System Create Case File
Identify System Create Case File
Identify System
Identify System
Identify System

REPORTING REQUIREMENTS
Identification of the relevant information that the process needs to generate

Total Case Files from Public
? COUNT (#)
data from 2021

Total Case Files from Employer
? COUNT (#)
data from 2021

Total Case Files
875 COUNT (#)
data from 2021

Total Early Resolution
475 COUNT (#)
data from 2021

Total Registrar
100 COUNT (#)
data from 2021

Total Inquiry Committee
300 COUNT (#)
data from 2021

Total Human Error
? COUNT (#)
data from 2021

Total At-Risk
? COUNT (#)
data from 2021

Total Reckless
? COUNT (#)
data from 2021

Total Intent to Harm
? COUNT (#)
data from 2021

Types of Non-Compliance
- ? Failure to complete remediation within specific timeline COUNT (#)
- ? Failure to disclose consent agreement information to Employers COUNT (#)
- ? Failure to comply with limit or condition COUNT (#)
- ? Positive biological test COUNT (#)
- ? Failure to report for biological testing COUNT (#)
- ? Failure inform College of change in employment status COUNT (#)

data from 2021

WORK ELEMENTS
Identifies & captures pain points and bottlenecks in current state in order to develop the future state model

1. 1.1 Lack of Self-Identification; will be addressed by introducing self-identification data field in the intake form
   Risk Mitigation: Literature review around how to introduce self-identification in a safe, respectful way
2. 2.1 Lack of trauma-infromed approach; will be addressed by proposing trauma-informed education and training
   Risk Mitigation: Literature review around effective approaches to trauma-informed training
3. 3.1 Insufficient follow up for early resolution action
4. 4.1 Lack of Indigenous Restoration; Introduce restorative response pathways

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Prepared by Novatone Consulting Ltd.
Prepared for: BCCNM Indigenous Complaints Process Review & Recommendations
Current State process model
Created Draft Jun 27, 2022 from background documents review & kick off meetings

Appendix C

Oct 5th, 2022 Workshop Presentation

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Respect, Responsibility, Relevance and Reciprocity: Indigenous Considerations for the Complaints Process

BC College of Nurses and Midwives
Project: Reviewing BCCNM's current complaints process with a cultural safety and humility lens

Current State Review & Gap Analysis
Emerging Future State

Date Presented: October 5, 2022

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BC College of Nurses & Midwives

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WORKSHOP AGENDA

Respect, Responsibility, Relevance and Reciprocity: Indigenous Considerations for the Complaints Process
Wednesday, October 5, 2022
9:00 am – 4:30 pm

Workshop Purpose: Achieve and validate a common understanding of the current state complaints process at the BC College of Nurses and Midwives within the Inquiry, Discipline and Monitoring (IDM) team

Workshop Objective: Working from a draft 'straw dog' illustration, validate the current state complaints process and identify gaps and pain points that contribute to the existence of systemic racism within the system. In addition, participants will be asked to identify the information vital to evaluating whether the recommended changes in the process will enable the college to report on progress towards BCCNMs commitment to action in the disruption to Indigenous-specific racism amongst B.C. Nurses and Midwives.

Time	Agenda Item	Lead
9:00-10:00a (60 min)	**Welcome and Introductions** • Opening Prayer • Current landscape for Indigenous patients in BC when it comes to complaints processes • 'In Plain Sight' Findings • Goal for BCCNM's review of its complaints process	Elder or Knowledge Keeper Rheanna, Novatone Melanie, Novatone Etienne, BCCNM
10:00-10:30a (30 min)	**Approach: Methodology & Principles of the Future State** • Fit with Practice Standard and BCCNM Principles • Indigenous methodology and principles (4Rs)	Melanie, Novatone Rheanna, Novatone
10:30-10:40a	**Break – 10 min**	
10:40-12:00 (80 min)	**Validate Current State Process** • Indigenous complainants/reporters • Indigenous registrants	Melanie, Novatone
12:00-1:00p	**Lunch – 60 min**	
1:00-2:30p (90 min)	**BREAK OUT SESSION: Capture Gaps and Pain Points** • Resources, • Skills, • External & Internal Resources to Support CSH	Melanie, Novatone Rheanna, Novatone Etienne, BCCNM
2:30-2:40p	**Break – 10 min**	
2:40-3:25p (45 min)	**BREAK OUT SESSION: Capture feedback for process changes and to inform recommendations**	Melanie, Novatone Rheanna, Novatone Etienne, BCCNM
3:25-4:10p (45 min)	**BREAK OUT SESSION: Capture reporting requirements specific to Indigenous racism within the process** • Phased transition: tools & manual processes to automation & systems • Impact of change: priorities, timing, momentum, fatigue	Melanie, Novatone Rheanna, Novatone Etienne, BCCNM
4:10-4:30p (20 min)	**Next Steps & Wrap Up**	Melanie, Novatone Etienne, BCCNM
4:30p	**Close**	

BCCN&M British Columbia College of Nurses & Midwives

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Considering the past…

when moving forward

BCCNM, October 5, 2022

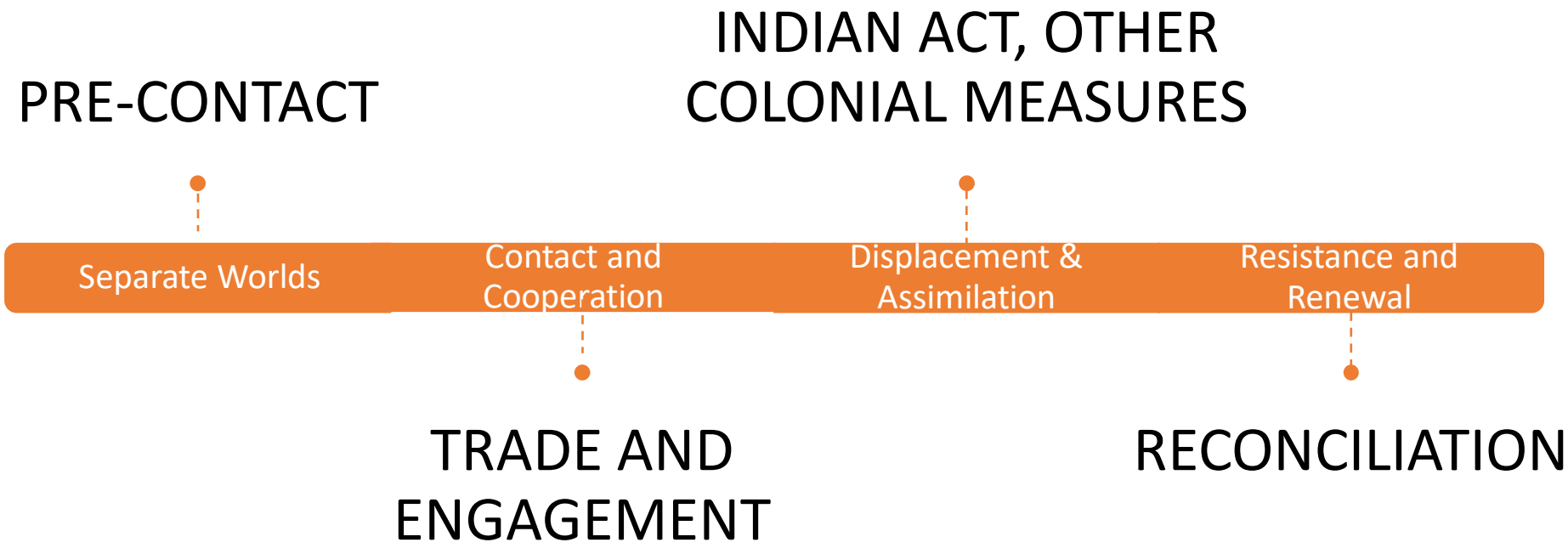
Indigenous history, terminology, and important influences

Indigenous history in Canada:

1. Phases of Indigenous relations
2. Thinking about treaties
3. Terminologies encountered
4. Considering current influences

Phases of Historical Relations

(1996 Royal Commission Aboriginal People)



Numbered Treaties in Canada

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First Nations in British Columbia

More than 204 Nations

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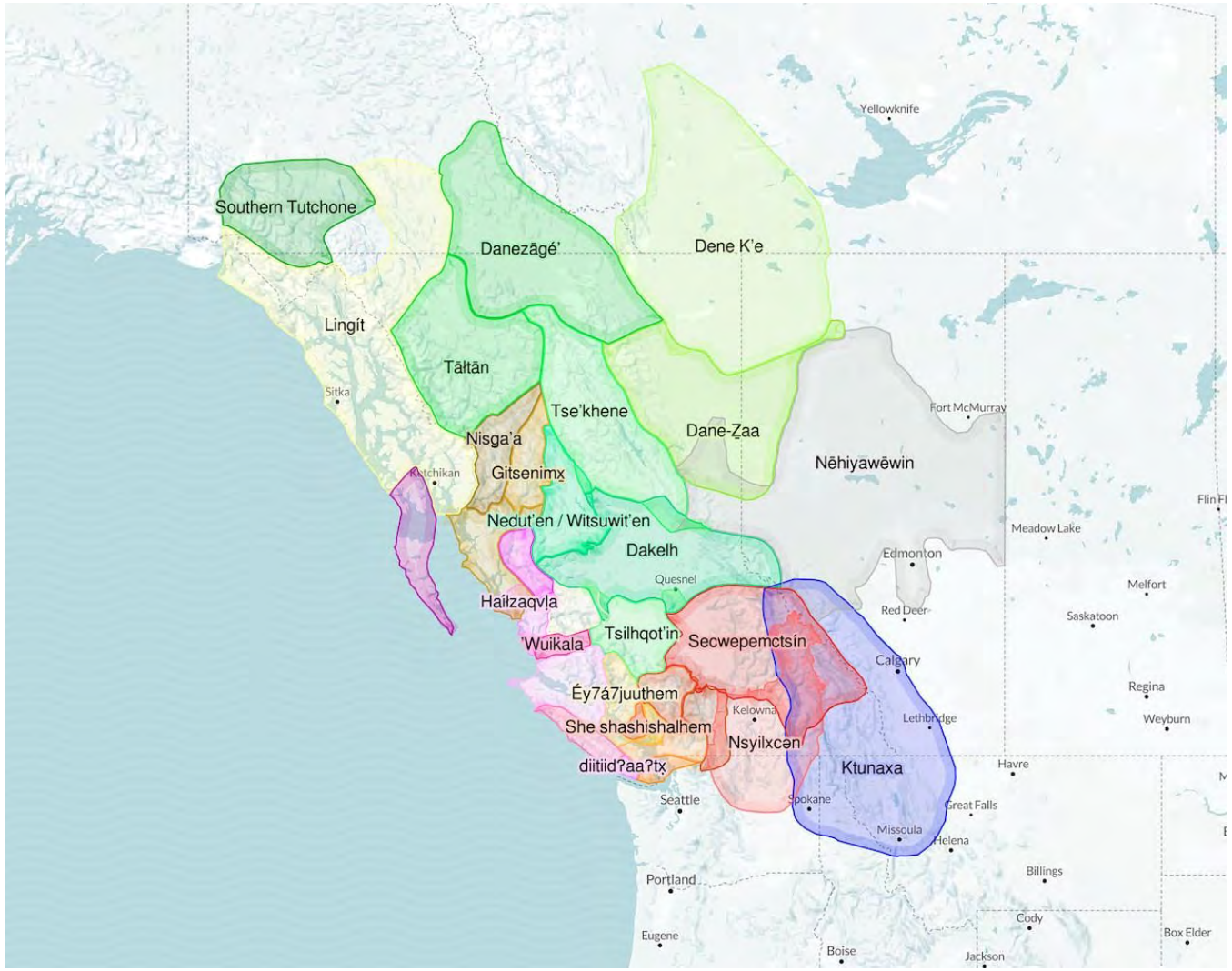

First Nations Languages in BC

There are **more 34** First Nation languages in British Columbia, Other Indigenous languages are also spoken in B.C., including Michif, the Métis language and Inuktitut.

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Terminology

- First Nation, Métis, and Inuit are the three categories included regarding Aboriginal peoples of Canada.
- “Aboriginal” has significance in the Constitution Act of 1982.

Indigenous	First Nations
Aboriginal	Métis
Native	Inuit
	*Indian

*See *Indian Act* of Canada

Indigenous “Status” in Canada

Indigenous	First Nations
Aboriginal	Bill C-31
Status First Nation	Bill C-3
Registered First Nation	Treaty First Nation
Non-status First Nation	Modern Treaty First Nation
Inuit	Band Membership
Métis	

First Nations

- Status, non-Status, Treaty First Nations.
- Federal vs. Provincial government roles and responsibilities.
- Urban vs. on-reserve experiences and realities.
- Role of the *Indian Act* legislation
- Important to dispel “myths” about First Nations/Indigenous Peoples.

Métis

- Métis identity as *Indigenous* identity
- Sociopolitical definitions… (Big “M” vs. little “m”).
- Links are within kinship and community.
  - Self-identifies
  - Distinct from other Aboriginal peoples
  - Historic Métis ancestry
  - *Connection to Métis community*

*Not governed under Indian Act, included in Section 35 of *Canadian Constitution*, see 2016 *Daniels* decision.

Inuit

- 1939 Inclusion in Section 91(24) of the *Constitution*.
- Four regions:
  - Inuvialuit Settlement Region
  - Nunavut
  - Nunavik (northern Quebec)
  - Nunatsiavit (northern Labrador)

  - Federal government holds responsibility.
  - No “Status Cards” but from 1941 to 1978 Inuit were forced to wear “Eskimo identification discs”.

Other words to consider

Elders

Indigenous knowledge

Traditional knowledge

Knowledge holders/keepers

Matriarchs

Feasts

Clans

Tribes

Decolonization

Reconciliation

Restoration

Sovereignty

Self-determination

Human Rights

Cultural humility

Cultural Safety

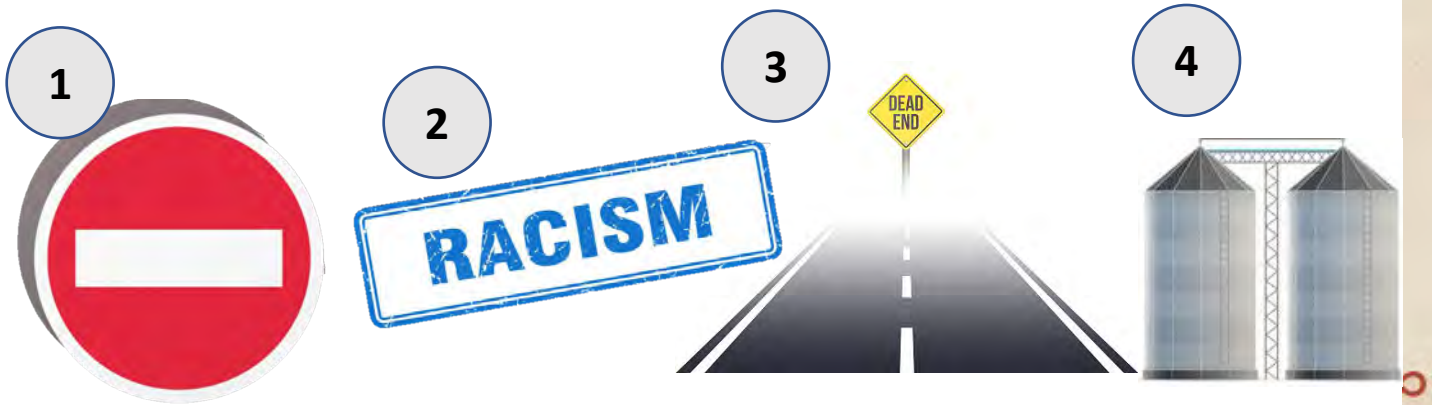
In plain sight (2020) and…

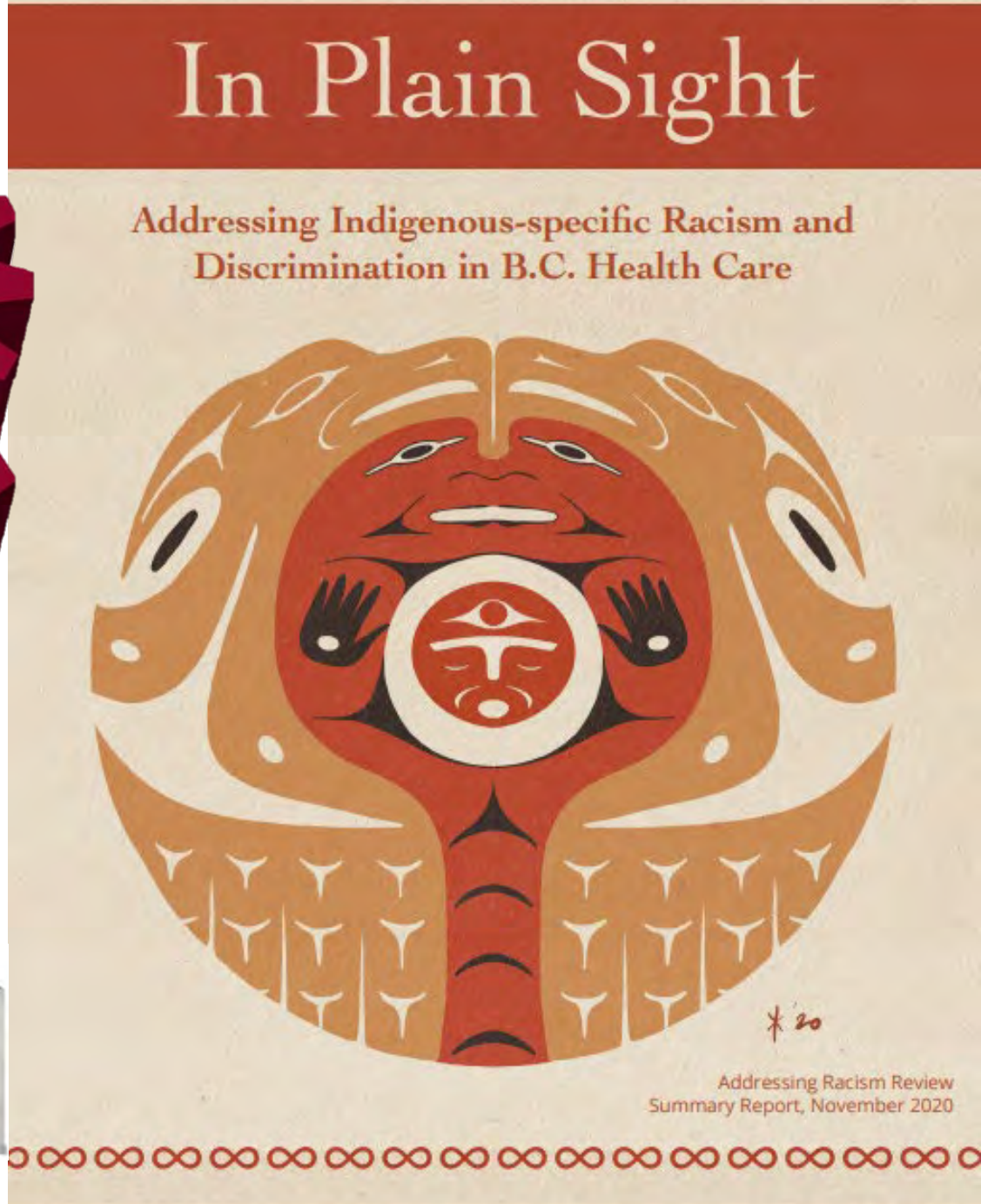
- Truth and Reconciliation Commission Canada (2015)
- United Nations Declaration on the Rights of Indigenous Peoples (2016)
- Declaration on the Rights of Indigenous Peoples Act, British Columbia (2019)
- Declaration on the Rights of Indigenous Peoples Act, Canada (2021)

Low Number of Complaints Filed. IPS was investigated through the summer/fall of 2020. Over the past 3 years, only 355 complaints involving Indigenous people were identifiable

What's wrong with processes?

1. Inaccessible
2. The types of complaints Indigenous people have filed are most commonly connected to matters related to racism, including negative interactions, stereotypes, denial of treatment and cultural unsafety
3. Most complaints are racism and discrimination aren't meaningfully addressed [2-fold … not identifying indigenous patients, and if it did, process doesn't follow up]
4. Current improvement efforts are uncoordinated and lack a systemic focus [the needs of patients aren't at the core of system design and transformation. Efforts are independent and isolated from one another.]





Gap Analysis *Why don't Indigenous People us the existing complaints process?*

Would take too much effort or energy

Wouldn't be taken seriously

Would receive worse treatment from health staff in the future

Expect poor treatment throughout the complaint process

Submitted a complaint in the past and it didn't make a difference

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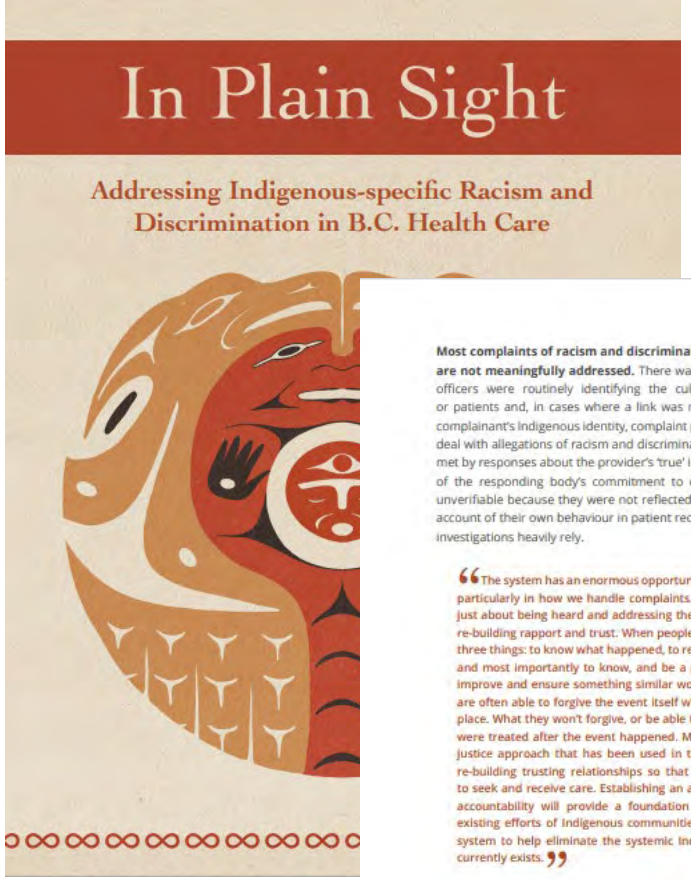
Gap Analysis

I don't know how to let someone know

I don't understand how to let someone know

Maybe I won't let anyone know



What We Found

Most complaints of racism and discrimination by Indigenous individuals are not meaningfully addressed. There was little evidence that complaints officers were routinely identifying the cultural identity of complainants or patients and, in cases where a link was made between poor care and a complainant's Indigenous identity, complaint processes appear ill-equipped to deal with allegations of racism and discrimination. Such complaints are often met by responses about the provider's 'true' intentions and broad statements of the responding body's commitment to cultural safety, or found to be unverifiable because they were not reflected in the health provider's written account of their own behaviour in patient records on which many complaints investigations heavily rely.

"The system has an enormous opportunity and obligation to improve, particularly in how we handle complaints. A complaints process is not just about being heard and addressing the issue raised, it is also about re-building rapport and trust. When people experience harm, they want three things: to know what happened, to receive an appropriate apology and most importantly to know, and be a part of, what will be done to improve and ensure something similar won't happen to others. People are often able to forgive the event itself when these three things are in place. What they won't forgive, or be able to move on from, is how they were treated after the event happened. Modelling after the restorative justice approach that has been used in the legal system will support re-building trusting relationships so that Indigenous people feel safe to seek and receive care. Establishing an approach based on reciprocal accountability will provide a foundation to honour and build upon existing efforts of Indigenous communities as well as the health care system to help eliminate the systemic Indigenous-specific racism that currently exists."

~ Christina Krause

Current improvement efforts are uncoordinated and lack a systemic focus. There are a range of organization-specific initiatives and pilot projects to improve the complaints process for Indigenous peoples, and an impending transformation effort related to regulatory college complaints processes. These efforts and complaints processes remain independent and isolated from one another, and do not centre the unique needs and experiences of Indigenous peoples at the core of system design and transformation.

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Which door is the right door? Confusing

There are a lot of doors a patient can go through to submit feedback

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Fraser Health

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Managing Care Complaints Received at Fraser Health PCOO

This is the potential start of the formal process for a person who self-identifies as Indigenous at Fraser Health

Fraser Health

Image redacted due to copyright

This is the internal view of the Fraser Health PCQo process – a formal process that connects with PSLS

PCQO Complaints Management Algorithm (Intake to Closure)

Fraser Health

Patient View

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Image redacted due to copyright

FNHA


Patient View
Delivered Programs and Services
Funding Recipients
Health Benefits
Health System Partners
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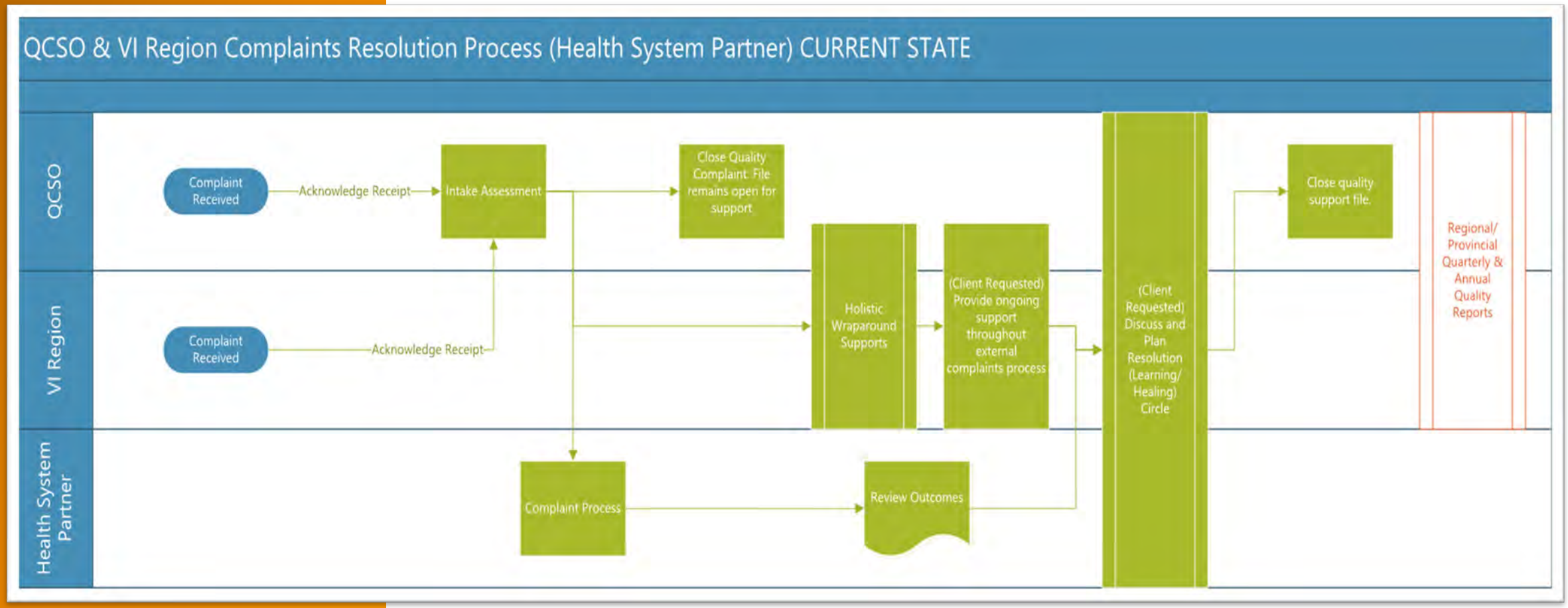
FNHA



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Other health authorities have their own processes – this is Interior Health's process

Health Authorities:

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Interior Health

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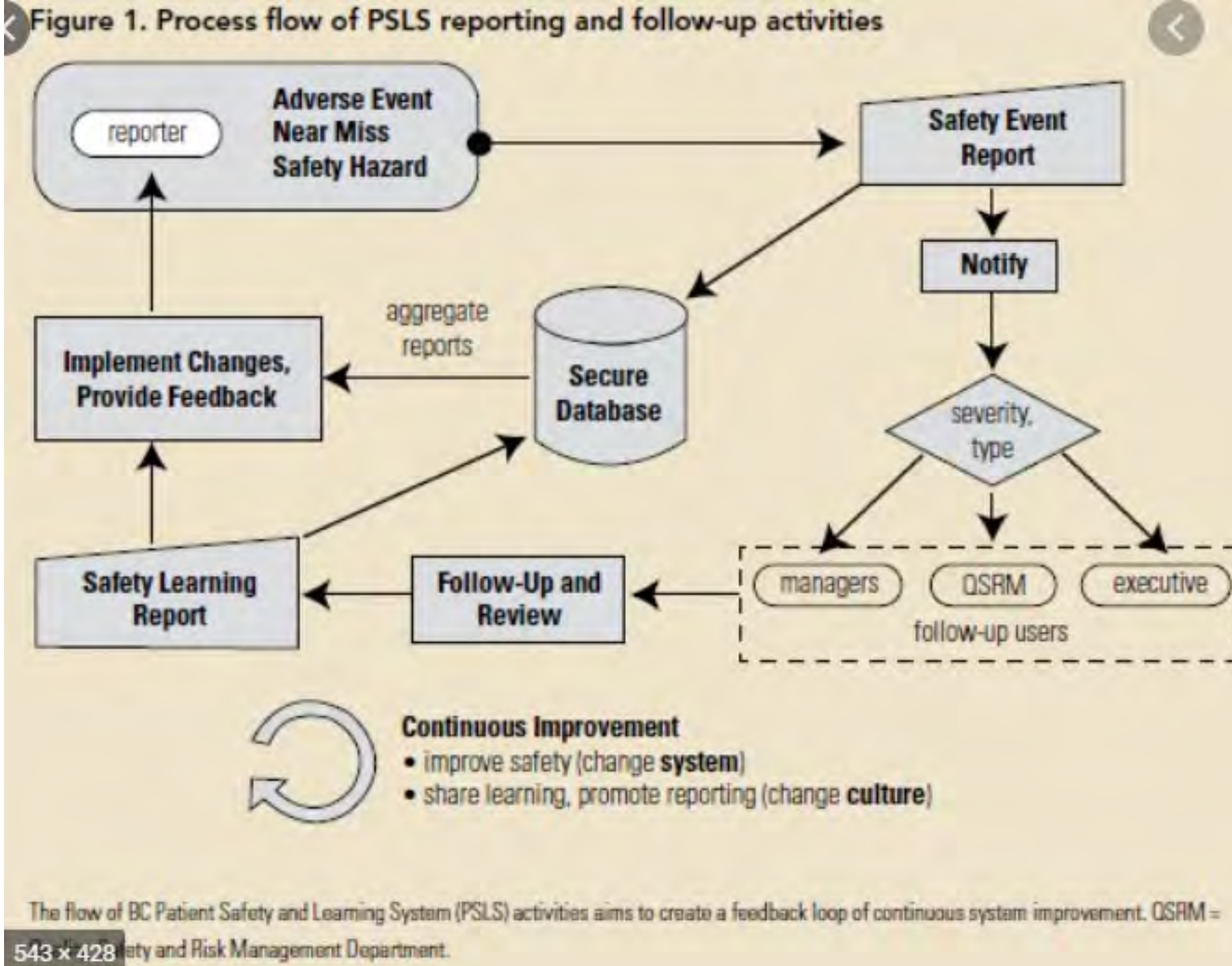
Patient Safety Learning System



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Regulatory bodies have their own processes

College of Physicians and Surgeons of BC

Images no longer in use

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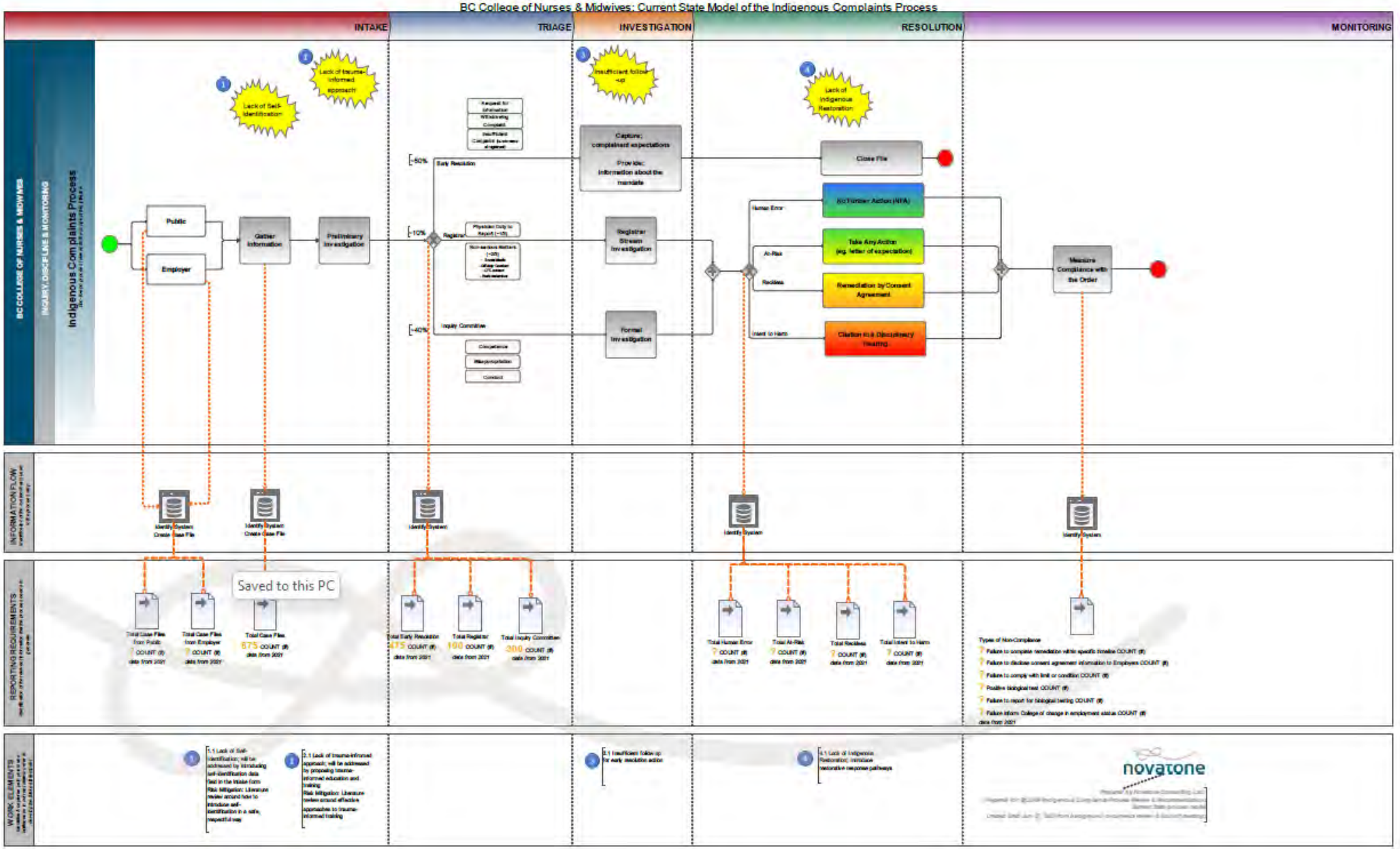
BCCN - Current State Process



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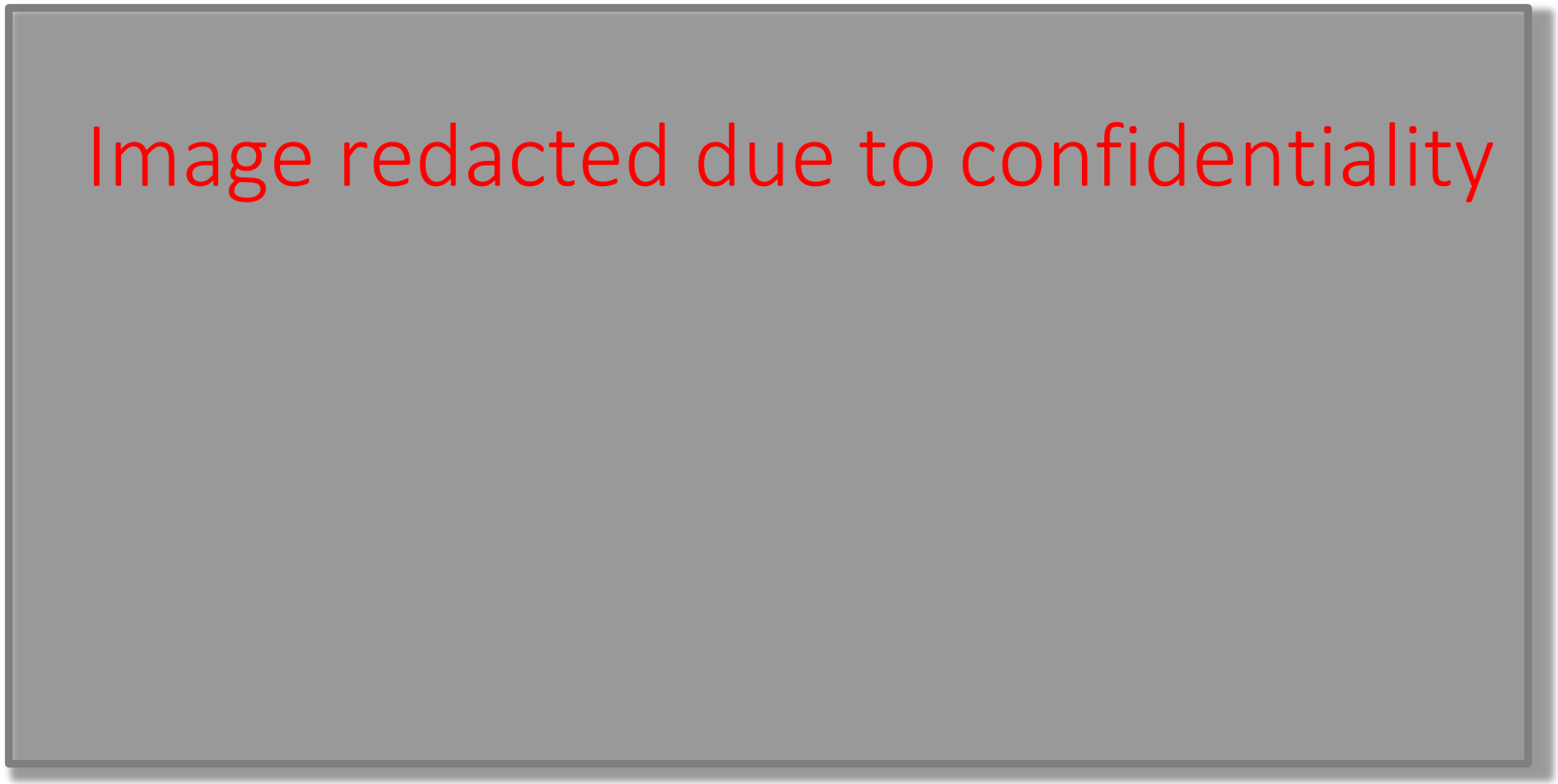
BCCNM - Baseline Metrics



1. **Total # of Cases (2015-2022)**: 2112

2. **Total # Cases (Jan 2020 – Jun 2022)**: 887

3. **What are the cases about?**
   - Conduct 76%
   - Competence 15%
   - Health 15%
   - Blanks 3%

4. Of the 887, 18 were possibly related to **Indigenous-specific racism**

5. **Who is making the complaints:**
   - Public 14/18
   - Employer 3/18
   - Colleague 1/18

6. **Where are the complaints occurring?**
   - ED 25%
   - Off Duty 22%
   - General 17%

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BCCNM - Key Words?

- Indigenous
- First Nations
- Aboriginal
- Discriminate/ed/ion
- Racist/racism/racial
- Safety
- Culture
- Cultural
- Disrespect/ed/ful

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There are too many doors for people to consider

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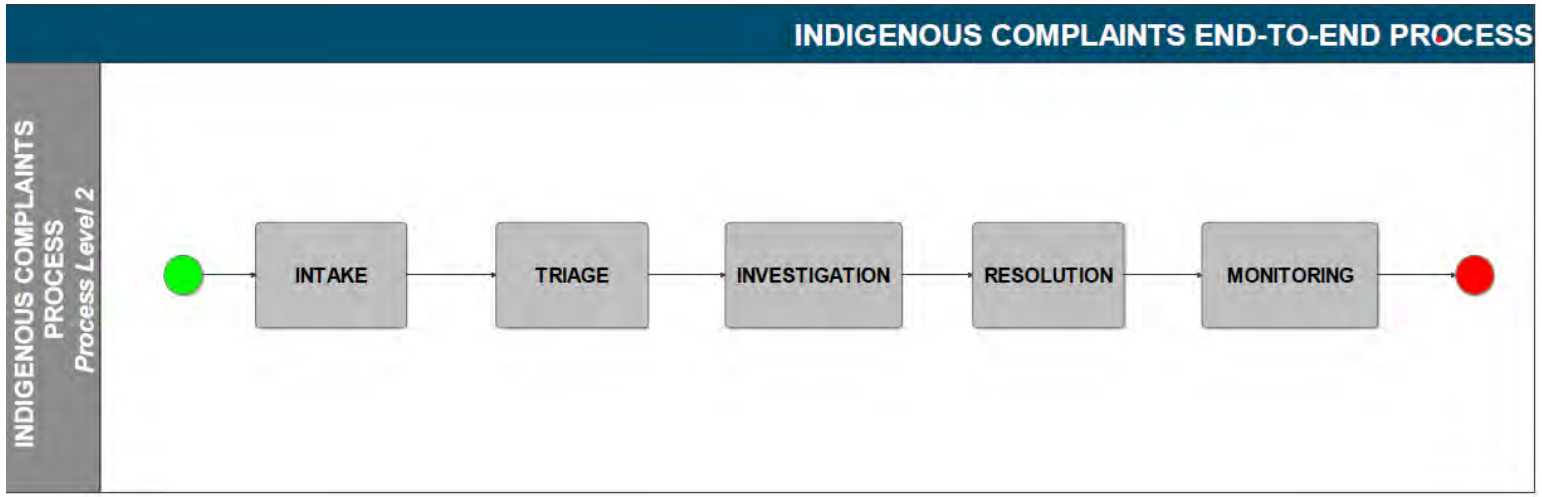
Goals

Goal for BCCNM is to use the complaints information to inform education, which will result in eliminating Indigenous-specific racism in the BC healthcare system.

Colonial, western, linear process



Wholistic, relational, culturally informed process

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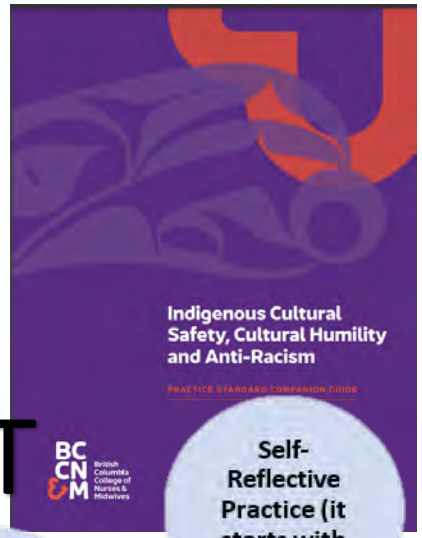
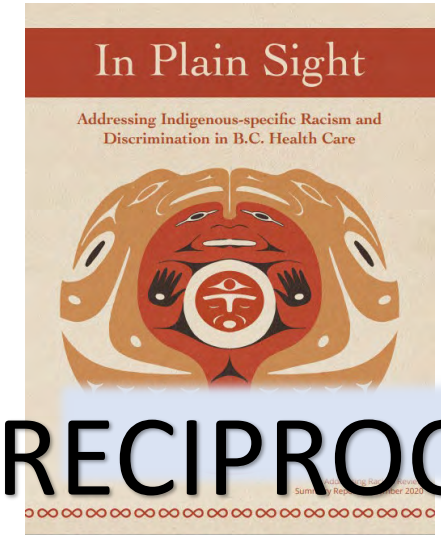
Dismantle Racism in Health Care: First Anniversary Report from Health-system Leaders





Methodology & Principles of the Future State

RESPECT

RECIPROCITY

RESPONSIBILITY

RELEVANCE

Principles

4Rs

In summary, the methodological principles of the Four Rs in the creation of an Indigenous complaints process inclusive of the practice standards of the BCCNM reflect:

Respect. All 6 BCCNM practice standards reflect the necessity to be intentional to including the knowledge of Indigenous Peoples in BC in the BCCNM complaints process redesign. Honouring and maintaining respect is important.

Relevance. Introducing Indigeneity in the feedback process must be community-driven and Nation-based. This includes honouring traditional protocols, Indigenous systems of knowing and legal traditions, as well the authentic experiences of Indigenous people and their communities. Relevance must be rooted in an overall approach to achieving an effective feedback process.

Reciprocity. Reciprocity, a traditional concept for Aboriginal people (Archibald, 2008; Atleo, 2004; Atleo, 2010), reflects that the "giving and taking" between Indigenous and non-Indigenous systems must be meaningful. Being without prejudice to Indigenous interests and increasing Indigenous decision-making and control exemplifies authentic reciprocal relationships. Such relations have the potential to be enduring and irreplaceable.

Responsibility. The last of the "Four Rs" is responsibility. Responsibility is a value that is inherent in Indigenous knowledge and within oral traditions (Archibald, 2008). Embracing the importance of being responsible to the health and well-being of First Nations, Inuit and Métis can enrich and sustain relations for optimal outcomes as related to the BCCNM feedback process.

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Questions?

Appendix D

Truth-Telling Form

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Truth-Telling Form

Reset Form

BCCN&M British Columbia College of Nurses & Midwives

Intake Lead Information	Intake Lead First Name		Intake Lead Last Name	
	Intake Lead Organization		Intake Lead Email	
	Intake Lead Role			

File Reference	File Reference *(yearmonday-first initial, last initial i.e. 2022Apr02-ST)*		Status	Select Option...
	Type: Complaint/RFI/ Compliment	Select Option...		
	Include secondary information if accompanied *(ie. Complaint but has a compliment attached)*			

Client Information	Client First Name		Client Last Name	
	Client Community		Region	
	Client Phone		Email	
	Client Date of Birth *m/d/yr*	*Select from calendar*	Identify As	Select Option...
	Does the client give consent to share this information with FH and FNHA?	◯ Yes ◯ No		

Rep Information	Representative First Name		Representative Last Name	
	Representative Phone		Representative Email	
	Representative Relationship to Client			

Rep Consent	Does the patient give consent to speak on their behalf?	◯ Yes ◯ No		
	In response to this feedback, who should the team contact?	◯ Patient ◯ Representative		

Complaint/ RFI / Compliment Information	Received Date *m/d/yr*	*Select from calendar*	Received Time	
	Acknowledge Date *m/d/yr*	Select from calendar	Actioned Date *m/d/yr*	Select from calendar
	Point of Entry	Select Option...	Health Professional Name	
	Service Provider Org.		Region of Service Provider	Select Option...
	Provider Town		Contacts Log	
	Health Authority/Funder	Select Option...		
	Intake Summary			
	Background Information from Intake: *Attach the oral and/or written record directly from the client (verbatm)*			

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Appendix E

LSTN Manual & Coding Form

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Fraser Salish Healthcare Feedback Analysis Tool

Listening Letso’mo:t

Lets’omo:t Salish Tool for Navigation (LSTN)

First Nations Health Council

FRASER SALISH REGION

AN OVERVIEW: The Lets'omo:t Salish Tool for Navigation (LSTN)

The LSTN is an adaptation of the Healthcare Complaints Analysis Tool (HCAT) developed in 2015 at the London School of Economics and Political Science by Dr. Alex Gillespie and Dr. Tom Reader. It is the first tool for analyzing healthcare complaints in a standardized and meaningful way through which information in a complaint can be captured and reliably assessed. It is free for practitioners and researchers alike to use. Novatone confirmed and received consent from the authors to adapt the HCAT into the LSTN for the purposes of creating a culturally appropriate assessment tool for the Fraser Salish peoples of British Columbia.

To view the HealthCare Complaint Analysis Tool (HCAT) manual, please use this link: **HCAT Manual**

Table 1 outlines the core coding taxonomy. Using the taxonomy, analysts identify and code the types of problems reported by patients in a letter of complaint. Analysts then assess the severity of the problems reported in the letter of complaint, identify where in the care process problems were experienced, and report on the level of harm experienced by patients.

Table 1. LSTN Domains and problem category definitions

CLINICAL PROBLEMS	
Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie. doctors, nurses, radiologists, and allied health professionals)	**Quality:** Clinical standards of healthcare staff behaviour
	Safety: Errors, incidents, and staff competencies

MANAGEMENT PROBLEMS	
Issues relating to the environment and organization within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)	**Environment:** Problems in the facilities, services, clinical equipment and staffing levels
	Institutional Processes: Problems in bureaucracy, waiting times, and accessing care

RELATIONSHIP PROBLEMS	
Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends	**Listening:** Healthcare staff disregard or do not acknowledge information from patients
	Communication: Absent or incorrect communication from healthcare staff to patients
	Racism, Respect and patient rights: Disrespect or violations of patient rights by staff

General Guidelines

Prior to using the LSTN, assessors should:

- understand what a healthcare complaint is
- understand the utility and purpose of analysing complaints
- be familiar with the three-level hierarchy of "domains", "problem categories," and "indicators"
- know how to use the indicators to identify a problem category and severity
- understand how to apply the coding framework to analyze a patient letter of complaint
- understand what a "location of care" is, and how to code it
- understand the meaning of patient harm

General Training *to be completed before using the LSTN*

The Lets'omo:t Salish Tool for Navigation (LSTN) was derived (with permission) from the Healthcare Complaints Analysis Tool (HCAT) which is a method for systematically analyzing complaints, and grouping key insights reported within thousands of experiences reported by patients every year to healthcare institutions.

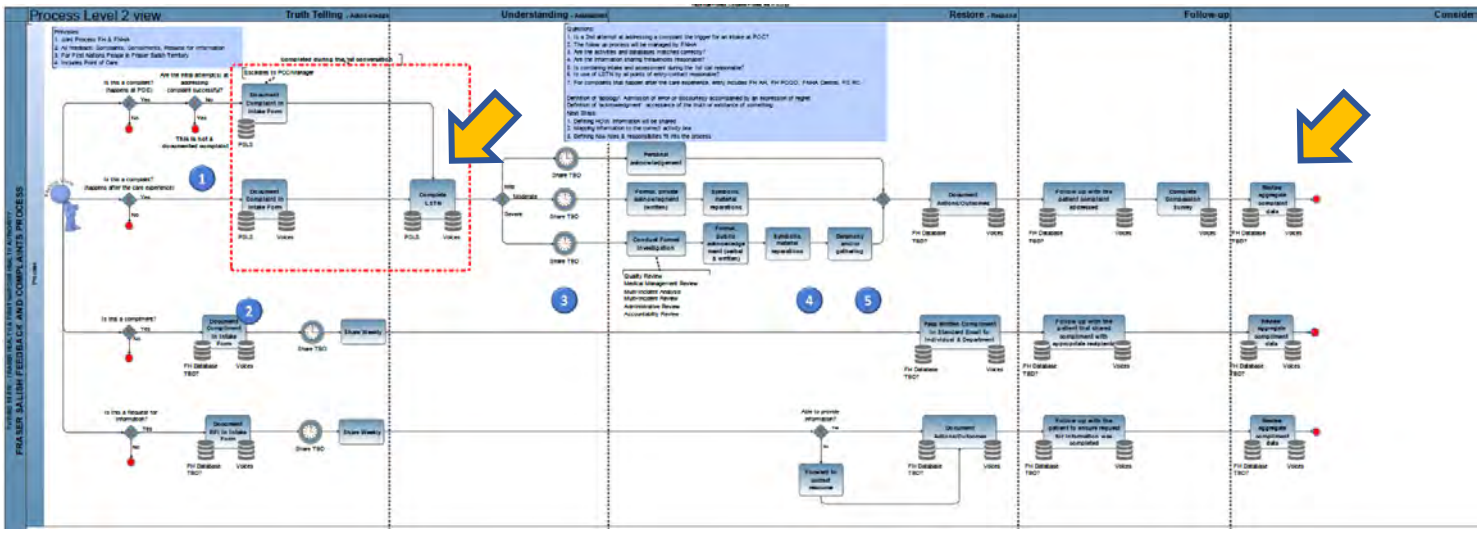
The tool reliably determines the problems reported in complaints at three-levels of specificity; to grade their severity, the harm caused to patients, and where in the hospital system problems occurred.

The LSTN is used for two purposes, in two different phases of the process.

1. To provide restoration for the patient and their family, within the Understanding Phase
2. To aggregate complaints and use the information to drive system change and improvement to services for Indigenous Peoples in British Columbia, within the Consideration Phase

In the first instance, the tool is used by quality care leads within Fraser Health and FNHA to help identify the appropriate restorative pathway for a person and their family. In the second instance, the tool is used by independent coders to assess safety and quality and ultimately analyze healthcare feedback in a rigorous and meaningful way. The goal is to provide longitudinal data on healthcare feedback trends by First Nations peoples in the Fraser Salish region.

The process illustrated below shows with 2 distinct arrows where the LSTN will be employed in the process.



Any person codifying complaints using the LSTN should complete the training as listed below and periodic training refreshment is recommended to ensure that coders remain calibrated.

1. Read the LSTN Manual in its entirety, paying special attention to page four.
2. Complete all the online training available at [Healthcare Complaints Analysis Tool]
3. Follow the LSTN Process, Step-by-Step Guide and LSTN Coding Form to complete as many practice cases (previously received written complaints from patients) as possible.

TIPS:

- Ensure complete understanding of the coding phases as detailed on Pages 4 and 5 of Step-by-Step Guide.
- The LSTN is reliable (i.e., that two people will code the same written complaint similarly). This reliability is achieved, in part, by requiring coders to focus on the text within each complaint (not judgements or inferences). To facilitate sticking closely to the text, assessors should become familiar with the type of words that indicate each of the main problem categories.

A STEP-BY-STEP GUIDE

When using Lets'omo:t Salish Tool for Navigation, the information reported in a healthcare complaint should be taken at face value and evaluated in a way that is non-judgmental of either patients or healthcare staff. From the perspective of patients, information provided in a letter of complaint usually reflect an upsetting or concerning experience, and whilst the system makes assessments of the types and severity of those experiences (in comparison to the range of problems raised by many patients), no judgement is made about the intentions of the complainant, their right to complain, or the importance attached by the complainant to the issues they describe.

Conversely, because healthcare complaints are written from the perspective of patients and families, relatively little insight can be provided on the perspective of healthcare staff who feature in a complaint (eg, on the wider system pressures influencing their behaviour), and thus the behaviour of specific staff members or groups is not examined. In the Lets'omo:t Salish Tool for Navigation's Truth Telling Phase it is critical to confirm the identity of the respondents stated in the feedback i.e., physicians, nurses, administration.

The coding process should be strictly empirical, that is, focused on the actual words used in the letter of complaint, rather than extrapolation, interpretation, judgements, or inferences.

The data entry for LSTN is most efficiently done via a computer, however, it can also be done using pen and paper. The following guide will, for ease of reference, assume that the pen and paper recording sheet at the end of this document is being used.

Coding a healthcare complaint using LSTN involves five-phases (A-E), each of which aredescribed in the sections below (see table 2 for a summary).

Table 2. Five phases for coding a healthcare complaint

A. Identifying the presence of problem categories (and, if required, sub- categories) within the letter of complaintusing the coding taxonomy, and assessing their severity
B. Specifying the location of care at which problems occurred
C. Indicating the level of harm arising from the reported problem
D. Providing descriptive information about the letter of complaint
E. Providing descriptive information about restorative expectations

Section A: Identifying problems and assessing severity

The first stage in coding a healthcare complaint using LSTN is the identificationof problems contained with a letter of complaint, and an assessment of their severity. The healthcare complaint coding taxonomy identifies three distinct domains (clinical, management and relationship) of healthcare complaint, comprising seven problem categories and 36 sub-categories.

To facilitate the identification of problems within a healthcare complaint, exemplar indicators have been developed for each. These are specified in greater detail in figures A1-A3 on the following pages, and are to be used to guide:

1) the identification of problem categories in a patient letter of complaint, and; 2) the assessment of problem severity.

Severity ratings should be independent of outcomes (ie, harm). The severity ratings are not comparable

across problem categories. Rather severity ratings should be based on theindicators provided in the following pages.

These severity indicators, which are based on the 36 sub-categories, were developed through iterative coding of a UK national sample of healthcare complaints (n = 1081),which entailed mapping severity for each problem category, and thus identifying independent severity distributions within eachproblem category and sub-category.

REMINDER: The information reported in the healthcare complaint should be taken at face value and evaluated in a way that is non-judgemental of either patients or healthcare staff. The coding process should be strictly empirical, that is, focused on the actual words used in the record of complaint, rather than extrapolation or interpretation.

To analyze a healthcare complaint, thefollowing steps should be undertaken:

1. Read through the letter of complaint without coding anything
2. On second reading, identify the problem category (and, if required, sub-category) being complained about using the problem definitions and the keywords.
3. For each problem category identified, use the severity indicators in figures A1-A3 todetermine the severity level. The indicators are exemplars of (1) low, (2) medium, and (3) high severity problems for eachproblem category. Severity ratings should be independent of harm.

    i. If a problem category is not identified and attributed at severity score, it is automatically rated as 0 (not present).

    ii. If one problem category is present at multiple levels of severity, only the highest level of severity should be recorded.

    iii. If one event (eg, surgical complication) relates to multiple problem categories(ie, safety, communication) then all relevant problem categories should be recorded.

    iv. Should further analysis be required, problems categories may also be coded in terms of the sub-categories that comprise them. Although each sub-category has an indicator at each severity level, the reliability of coding severity at this fine-grained level has yet to be established.

4. Use SECTION A on the LSTN form, at the end of this manual, to record the problem and severity coding.

A1. Clinical Problems. Issues relating to quality and safety of clinical and nursing care providedby healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)

Quality: Clinical standards of healthcare staff behavior · Sub-categories: Neglect – Hygiene & personal care; Neglect – Nourishment & hydration; Neglect – general; Rough handling & discomfort; Examination & monitoring; Making &following care plans; Outcomes & side effects. · Keywords: "not provided", "was not done", "did not follow guidelines", "poor standards", "should have", "not completed", "unacceptable quality", "not successful", "delayed", "inadequate", "inappropriate".		
1. Low severity	**2. Medium severity**	**3. High severity**
Delay changing dirty bedding	Patient dressed in dirty clothes	Patient left in own waste in bed
Isolated lack of food or water	Nothing to eat or drink for one day	Patient dehydrated/ malnourished
Wound not dressed properly	Seeping wound ignored	Infected wound not tended to
Rough handling patient	Patient briefly without pain relief	Force feeding baby, resulting in vomiting
Patient monitoring delayed	Patient not monitored properly	Discharge without sufficient examination
Patient not involved in care plan	Aspect of care plan overlooked	Failing to heed warnings in patient notes
Patient left with some scarring	Patient required follow-up operation	Patient left with unexpected disability
Safety: Errors, incidents, and staff competencies · Sub-categories: Error – diagnosis; Error-medication; Error – general; Failure to respond; Clinician skills; Teamwork. · Keywords: "incorrect", "medication error", "did not notice", "mistake", "failed to act", "wrong", "poor coordination", "unaware", "missed the signs", "diagnosis".		
1. Low severity	**2. Medium severity**	**3. High severity**
Slight delay in making diagnosis	Clinician failed to diagnose a fracture	Clinician misdiagnosed critical illness
Slight delay administering medication	Staff forgot to administer medication	Incorrect medication was administered
Minor error in recording patient progress	Delay noticing deteriorating condition	Onset of severe sepsis was not identified
Not responding to bell (isolated)	Not responding to bell (multiple)	Not responding to heart attack
A minor error filling-out the patient notes	Clinician overlooked information (eg, previous experience of an illness)	Clinician overlooked critical information (eg, serious drug allergy)
Minor misunderstanding among clinicians	Test results not shared with clinicians	Failure to coordinate time-critical decision

A2. Management Problems. Issues relating to the environment and organization within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)

Environment: Problems in the facilities, services, clinical equipment, and staffing levels · Sub-categories: Accommodation; Preparedness; Ward cleanliness; Equipment;Staffing; Security. · Keywords: "not available", "shut", "not enough", "dirty", "shortages", "broken", "poor equipment", "soiled", "used before", "poorly signed".		
1. Low severity	**2. Medium severity**	**3. High severity**
Noisy ward surroundings	Patient was cold and uncomfortable	Fleas, bed bugs, rodents
Patient bed not ready upon arrival	Patient placed in bed in corridor	Patient relocated due to bed shortage
Dirt on main floor	Blood stains in bathroom	Overflowing toilet, feces on floor
Parking meter not working	A temporary malfunction in an IT system	Medical equipment malfunctioned
Midwife repeatedly called away	Specialist not available	Severe staff shortages
Argument between patients	One patient bullying another patient	Patient assaulted by another patient
Institutional Processes: Problems in bureaucracy, waiting times, and accessing care · Sub-categories: Delay – access; Delay – procedure; Delay – general; Bureaucracy; Visiting; Documentation. · Keywords: "delayed", "postponed", "cancelled", "lost", "not admitted", "administrative problems", "not referred", "confused notes", "more paperwork", "unaware of me".		
1. Low severity	**2. Medium severity**	**3. High severity**
Difficulty phoning healthcare unit	Waited in emergency room for hours	Unable to access specialist care
Non-urgent medical procedure delayed	Medical procedure delayed	Acute medical procedure delayed
Phone calls not returned	Complaint not responded to	Emergency phone call not responded to
Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
Visiting times unclear	Visiting unavailable	Family unable to visit dying patient
Patient notes not ready for consultation	Patient notes temporarily lost	Another patient's notes used as basis for consultation

A3. Relationship Problems. Issues relating to the behaviour of any member of staff towards the patient or their family/friends

Listening: Healthcare staff disregard or do not acknowledge information from patients · Sub-categories: Ignoring patients; Dismissing patients; Token listening · Keywords: "I said", "I told", "ignored", "disregarded", "battled to be heard", "notacknowledged", "excluded", "uninterested" and "not taken seriously", "neglected".		
1. Low severity	**2. Medium severity**	**3. High severity**
Staff ignored question	Staff ignored mild patient pain	Staff ignored severe distress
Patient's dietary preferences were dismissed	Patient-provided information dismissed	Critical patient-provided information repeatedly dismissed
Question acknowledged, but not responded to	Patient anxieties acknowledged, but were not addressed	Patient pain acknowledged, but no follow through on pain relief
Communication: Absent or incorrect communication from healthcare staff to patients · Sub-categories: Delayed communication; Incorrect communication; Absent communication. · Keywords: "no-one said", "I was not informed", "he/she said 'X'", "they told me", "no-oneexplained", "contradictory", "unanswered questions", "confused", "incorrect".		
1. Low severity	**2. Medium severity**	**3. High severity**
Short delay communicating test results	Long delay communicating test results	Urgent test results delayed
Patient received incorrect directions	Patient received conflicting diagnoses	Patient given wrong test results
Staff did not communicate a ward change	Staff did not communicate care plan	Dementia patient discharged without the family being informed
Racism, Respect and patient rights: Disrespect or violations of patient rights by staff · Sub-categories: Disrespect; Confidentiality; Racism; Rights; Consent; Privacy. · Keywords: "rude", "attitude", "humiliated", "disrespectful", "scared to ask", "embarrassed", "inappropriate", "no consent", "abused", "assaulted", "privacy", "safe/safety", "discriminated".		
1. Low severity	**2. Medium severity**	**3. High severity**
Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence
Private information divulged to the receptionist	Private information divulged to family members	Private information shared with members of the public
Staff member lost temper	Patient intimidated by staff member	Patient discriminated against
Unclear information for consent	Consent was obtained just prior to a procedure, giving nodiscussion time	Do-not-resuscitate decision without obtaining consent
Lack of privacy during discussion	Lack of privacy during examination	Patient experienced miscarriage without privacy

Section B: Specifying the locations of complained about

The second stage in coding a healthcare complaint is the specification of the location of care to which a patient's poor healthcare experience refers. **Only code stages when a problem category is identified within that location of care**. Healthcare complaints can focus on a single event within one location of care (eg. emergency), or to multiple events that occur across an entire institution. Within LSTN, nine (9) generic locations of care are identified (and a sixth"other" category). The locations of care are listed in table 3.

Table 3. Locations of Care

1. Emergency:	This refers to feedback about care delivered/provided in the emergency department
2. Acute Care:	This refers to feedback about care delivered/provided in acute care (ie. when the person has been admitted and is an 'inpatient')
3. Mental Health & Substance Use Facility:	This refers to feedback about care delivered/provided in a mental health and substance use facility
4. Home & Community Care:	This refers to feedback about care delivered/provided by home and community care services (ie. H&CC nurse or administrator for assessment)
5. Long-term Care:	This refers to feedback about care delivered/provided in a long-term care facility
6. Public Health:	This refers to feedback about care delivered/provided in a public health clinic or office (ie. a vaccine clinic)
7. Primary Care:	This refers to feedback about care delivered/provided in primary care (eg. Doctor's office, primary care home, virtual doctor of the day)
8. Ambulatory Care:	This refers to feedback about care delivered/provided in ambulatory care
9. Admission:	This refers to feedback about care delivered/provided during the registration/admission process in a facility
10. Unspecified/Other:	Where it is not possible to determine the location of care, or it does not fit into the above categories

For the letter of healthcare complaint, indicate in SECTION B of the LSTN form (see page 12 and 13) which locations of care the problems identified in Section A referred to. Multiple locations of care can be selected if the complaint refers more than one. In the case that it is not possible to determine the stage of care, please indicate "other".

Section C: Level of harm reported in the complaint

The third stage in coding a healthcare complaint is to specify the level of harm experienced as reported in the Truth Telling Phase Intake Form and letter of complaint. Harm is rated using the UK's National Reporting and Learning System used in to classify harm reported in critical incidents and Trauma-Informed Practice, a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma.

Assessments of harm should focus on the overall harm caused to patients by the problems raised in the letter of complaint. e.g., If the patient dies, but the complaint is about dignity after death, then the harm relates only to the consequences of the lack of dignity. It is also important to note that harm is independent from problem severity. e.g., A patient describing a severe safety problem (e.g. a medication error) may not have experienced harm due to the error being identified.

A useful rule of thumb is "If the patient had not been in care when this incident occurred, could the harm have been treated at home or in a minor injury unit?" If the answer is 'no' the incident is more likely to be moderate than minimal or minor harm.

Table 4. Patient harm

	Physical	Emotional/Psychological/Spiritual
0. N/A	No information on harm is reported	
1. Minimal harm	Minimal intervention or treatment required • a bruise or graze • fatigue • headaches	Minimal healing/support required • Fear • Frustration • Guilt • Helplessness • Hopelessness • Stress
2. Minor harm	Minor intervention or treatment is required • Sprain • Insomnia	Minor healing/support required • Fear • Frustration • Guilt • Helplessness • Hopelessness • Stress ***Key words/phrases:*** *"They don't care", "I don't think that they listen", "Nobody will help", "I feel hopeless", "I feel helpless"*
3. Moderate harm	Significant intervention required • Grade 2-3 pressure ulcer • Healthcare acquired infection	Significant healing/support or treatment required • Fear • Frustration • Guilt • Helplessness • Hopelessness • Stress ***Key words/phrases:*** *"troublemaker", "I don't want to get in trouble", "I was afraid to complain", "Fear chart will be flagged in facility", "I didn't feel safe"*
4. Major harm	Patient experienced, or faces, long-term incapacity • Dislocation • Fracture • Haemolytic transfusion • Wrong medication side effect	Patient experienced, or faces, long-term incapacity e.g. • Acute stress disorder • Post Traumatic Stress Disorder (terrifying memories, nightmares, or flashbacks)
5. Catastrophic harm	Death or multiple/permanent injuries • Wrong-site surgery • Paralysis	Death or permanent or chronic mental health problems

Section D: Descriptive details

The fourth stage in coding a healthcare complaint is to specify basic descriptive details in relation to the complaint. These are defined in table 5. Record these details in SECTION D of the LSTN form.

Table 5. Hospital complaint details

1. Who made the complaint?	Indicate whether the complaint was made by a patient, family member, lawyer, or other third-party
2. What is the gender of the patient?	Indicate whether the patient complaining (or being complained on the behalf of) is male or female
3. Which staff groups does the complaint refer to?	Report whether staffing group or groups complained about are Administrative, Healthcare assistants, Medical Staff, Nursing Staff, Pharmacists, Physiotherapists, or unspecified/other

Section E: Restorative details

The fifth stage in coding a healthcare complaint is to specify basic descriptive details in the restorative expectations (eg. Provider feedback, family and provider meeting, verbal apology, written apology, support to file a formal complaint, education & training, financial compensation, reprimand/disciplinary action).

Section F: Mental Health Supports

The final stage in coding a healthcare complaint is to specify if mental health supports have been requested or are required.

Lets'omo:t Salish Tool for Navigation (LSTN)
Understanding Phase
Coding Form

Instructions

A. Use the manual to identify severity ratings for each problemcategory (from 0, not evident, to 3, high severity)
B. Please indicate the location of care
C. Categorize the level of harm experienced by patient
D. Please provide descriptive information on the complaint
E. Please capture individual's expectations for restoration
F. Please capture if there are mental health supports requested/required

Reference Number
(yearmonday-first initial, last initial i.e. 2022Apr02-ST)

(A) Domain	Category	Severity (0-3)
CLINICAL PROBLEMS Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)	**Quality:** *Clinical standards of healthcare staff behaviour*	
	Safety: *Errors, incidents,and staff competencies*	
MANAGEMENT PROBLEMS Issues relating to the environment and organization within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)	**Environment:** *Problems in the facilities, services, clinical equipment, and staffing levels*	
	Institutional Processes: *Problems in bureaucracy,waiting times, and accessing care*	
RELATIONSHIP PROBLEMS Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends	**Listening:** *Healthcare staff disregard or do not acknowledge information from patients*	
	Communication: *Absent or incorrect communicationfrom healthcare staff to patients*	
	Racism, Respect and patient rights: *Disrespect or violations of patient rights by staff, racism, and discrimination*	
Unspecified/Other		

(B) Location of care?	Tick relevant location
1. Emergency	
2. Acute Care	
3. Ambulatory Care	
4. Mental Health & Substance Use Facility	
5. Home & Community Care	
6. Long-term Care	
7. Public Health	
8. Primary Care	
9. Administration	
10. Unspecified/ other	

(C) Please indicate the level of harm reported by the patient (1) minimal to (5) catastrophic: *(use 0 for n/a or unspecified)*

Definitions:
Admin: any person not providing clinical care (ie. registration clerk)
Medical: GP, NP, Specialist
Nursing: RN, LPN, ED Registration/Admission
Other: OT, PT, Care Aide

(D) Please provide further details of:

1. Who made the complaint?

☐ Family Member ☐ Patient ☐ Unspecified/other

2. Gender of patient?

☐ Female ☐ Male ☐ Unspecified/other

3. Which staff group(s) does the complaint refer to?

☐ Admin ☐ Medical ☐ Nursing ☐ Unspecified/other

(E) Please indicate restorative expectations: *ie. Provider feedback, family and provider meeting, verbal apology, written apology, support to file a formal complaint, education & training, financial compensation, reprimand/disciplinary action, mental health supports*

(F) Mental Health Supports

☐ Yes ☐ No ☐ N/A

Lets'omo:t Salish Tool for Navigation (LSTN)

Consideration Phase

Coding Form

Instructions

A. Use the manual to identify severity ratings for each problemcategory (from 0, not evident, to 3, high severity)
B. Please indicate the location of care
C. Categorize the level of harm experienced by patient
D. Please provide descriptive information on the complaint
E. Please capture individual's expectations for restoration
F. Please capture if there are mental health supports requested/required

Reference Number
(yearmonday-first initial, last initial i.e. 2022Apr02-ST)

(A) Domain	Category	Sub-Category	Severity (0-3)
CLINICAL PROBLEMS Issues relating to quality andsafety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)	**Quality:** *Clinical standards of healthcare staff behaviour*		
	Safety: *Errors, incidents, and staff competencies*		
MANAGEMENT PROBLEMS Issues relating to the environment and organization within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)	**Environment:** *Problems in the facilities, services, clinical equipment, and staffing levels*		
	Institutional Processes: *Problems in bureaucracy,waiting times, and accessing care*		
RELATIONSHIP PROBLEMS Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends	**Listening:** *Healthcare staff disregard or do not acknowledge information from patients*		
	Communication: *Absent or incorrect communication from healthcare staff to patients*		
	Racism, Respect and patient rights: *Disrespect or violations of patient rights by staff, racism, and discrimination*		

(B) Location of care?	Tick relevant location
1. Emergency	☐ Admission ☐ Examination
2. Acute Care	☐ Ward ☐ Procedure ☐ Discharge
3. Ambulatory Care	☐ Admission ☐ Examination
4. Mental Health & Substance Use Facility	☐ Admission ☐ Ward ☐ Procedure ☐ Discharge
5. Home & Community Care	☐
6. Long-term Care	☐
7. Public Health	☐ Admission ☐ Examination
8. Primary Care	☐ Admission ☐ Examination
9. Administration	☐
10. Unspecified/ other	☐

(C) Please indicate the level of harm reported by the patient (1) minimal to (5) catastrophic: *(use 0 for n/a or unspecified)*

(D) Please provide further details of:

1. Who made the complaint?

☐ Family Member ☐ Patient ☐ Unspecified/other

2. Gender of patient?

☐ Female ☐ Male ☐ Unspecified/other

3. Which staff group(s) does the complaint refer to?

☐ Admin ☐ Medical ☐ Nursing ☐ Unspecified/other

(E) Please indicate restorative expectations: *ie. Provider feedback, family and provider meeting, verbal apology, written apology, support to file a formal complaint, education & training, financial compensation, reprimand/disciplinary action,*

(F) Mental Health Supports

☐ Yes ☐ No ☐ N/A

Definitions:
Admin: any person not providing clinical care (ie. registration clerk)
Medical: GP, NP, Specialist
Nursing: RN, LPN, ED Registration/Admission
Other: OT, PT, Care Aide

Appendix F

Restoration Form

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Restoration Form

BCCNM British Columbia College of Nurses & Midwives

Intake Lead Information				
Intake Lead First Name		Intake Lead Last Name		
Intake Lead Organization		Intake Lead Role		
Intake Lead Email				

File Refe	
Status	Select Option...
File Reference	

Client Information/ Client Representative			
First Name		Last Name	
Community		Region	
Phone		Email	
Date of Birth *m/d/yr*	*Select from pulldown calendar*		
Identify As	Select Option...		
Representative Relationship to Client			

Restoration Decision

Mild Severity Level of Harm 0 - 2	•Verbal acknowledgment
Moderate Level of Harm 3	•Written acknowledgment •Symbolic, material reparation
Severe Level of Harm 4 - 5	•Conduct Formal Investigation •Formal public acknowlegment (veral and written) •Symbolic, material reparation

Severity	Select Option 1-3	**Level of Harm**	Select Option 0 - 5
Decision Date *m/d/yr*	*Select from calendar*	**Submission Date** *m/d/yr*	*Select from calendar*
Anticipated Actioned Date *m/d/yr*	*Select from calendar*	**Actioned Date** *m/d/y*	*Select from calendar*
Restoration Actions: Detailed description of actions to be taken			

Appendix G

Follow-Up Survey

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Follow-Up Form

BCCN&M British Columbia College of Nurses & Midwives

Intake Lead Information				
Intake Lead First Name		Intake Lead Last Name		
Intake Lead Organization		Intake Lead Role		
Intake Lead Email				

File Refe	
Status	Select Option...
File Reference	

Client Information/ Client Representative				
First Name		Last Name		
Community		Region		
Phone		Email		
Date of Birth *m/d/yr*	*Select from pulldown calendar*			
Identify As	Select Option...			
Representative Relationship to Client				

Survey

1. MEASUREMENT DOMAIN: HEALTHCARE PROVIDERS		
Measures:	**Survey Questions:**	**LSTN Category:**
Cultural Safety & Humility	Do you feel that the health care providers genuinely respected your cultural values and practices?	Relationship Problems: *Respect and patient rights*
	How often did the hospital staff listen carefully to you?	Relationship Problems: *Listening*
	How often did hospital staff show interest in what you had to say?	
	Did the hospital staff spend enough time with you?	
	Did the hospital staff try to make you feel comfortable?	
Anti-Racism	**How often did these things happen to you when you received health care?**	
	I was treated with less respect than other people.	
	Healthcare providers were rude to me.	
	I received poorer healthcare than other people.	
	Healthcare providers asked me inappropriate questions.	
	When these things happen, do you think it is because you are Indigenous?	

2. MEASUREMENT DOMAIN: HEALTHCARE SYSTEM/MANAGEMENT		
Measures:	**Survey Questions:**	**LSTN Category:**
Cultural Safety & Humility	Did you feel welcome in the hospital/healthcare unit where you received your care?	
	Do you feel your culture and traditions are adequately represented in the hospital/healthcare unit's physical environment where you received your care (e.g. Indigenous art displays)?	
	Was the intake process culturally safe?	
	Were you able to access traditional medicine and wellness practices?	
	Did you receive culturally safe support to access and navigate the healthcare services you needed?	
Anti-Racism	**How often did these things happen to you when you received health care?**	
	I had to wait longer than other people.	
	I had difficulties accessing the care I needed.	
	When these things happen, do you think it is because you are Indigenous?	
	How much do these things affect your life?	
Compassion	Do you feel that your health care provider cared about your emotional and mental well-being?	
	Did your health care provider show you care and compassion?	
	Do you feel your health care provider was considerate of your personal needs?	

Appendix H

Information Framework

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Complaints Process Information Requirements

Information Requirements	Description: *information relevant to a specific organization for process performance evaluation and quality improvement, includes reports such as board & CEO reports, regional reports, internal dashboards, KPIs, etc*	Data Elements Breakdown	Who's responsible?	Where in the process?	How is it being captured?	System?
Total complaints received	Total complaints - in order to measure proportion of indigenous complaints/reporters	C16	IDM intake team	Truth-telling	Truth-telling Form	Manual
Breakdown by reporter type	Differentiate between Indigenous and non-Indigenous reporters	C24-C27	IDM intake team	Truth-telling	Truth-telling Form	Manual
Breakdown by reporter expectations	Opportunity to strenghten the process and provide clarity around expectations and the college's mandate	C95-C102	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback by Indigenous patients	Opportunity to capture region and nation	C19-C20	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback regarding Indigenous registrants		C47, C49	IDM intake team	Truth-telling	Truth-telling Form	Manual
Feedback by location	Identification of trends and hotspots/blind spots	C48	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by severity		C65-C68	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by level of harm		C79-C84	IDM intake team	Understanding	HCAT/LSTN	Manual
Feedback by preliminary problem category		C54-C64	IDM intake team	Understanding	HCAT/LSTN	Manual
By response pathway selected	Acknowledgement, healing circle, ceremony, other supports, etc.	C95-C102	TBD	Restore	Restoration Form	Manual
Has involved registrant received SAN'YAS training or other cultural safety training?	Opportunity to inform the effectiveness of existing training and education programs	TBD	TBD	Restore	TBD	Manual
Reporter experience		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Registrant experience		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Compassion measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Racism Measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
Cultural Safety Measure		C117-C129	TBD	Follow-up	Follow-up survey	Manual
# quality reviews initiated by the feedback		TBD	Independent coders	Consideration	HCAT/LSTN	Manual
Thematic review of trends, hotspots and blindspots		All	Independent coders	Consideration	HCAT/LSTN	Manual
practices affected by the feedback	related to practice standard 4: whether or not a practice is a workplace's "protocol", people should be given a clear rationale for its use and reassured that are not being singled out because they are Indigenous.	TBD	Independent coders	Consideration	HCAT/LSTN	Manual

Complaints Process Information Framework

The purpoes of an information framework is to define the standard data set that is needed to run the business, evaluate the performance of the
The framework organizes unique data elements into categories of information and links it to the tool that organizes the data, the system where the

Process	Profile	Unique Data Elements	BCCNM Truth-telling Form Quality Intake Record	HCAT/LSTN	Restoration Form	Follow-up Survey	Expanded HCAT/LSTN
Truth-telling	Intake lead information	Intake lead First Name	X		X	X	
Truth-telling	Intake lead information	Intake lead Last Name	X		X	X	
Truth-telling	Intake lead information	Intake lead organization	X		X	X	
Truth-telling	Intake lead information	Intake lead role	X		X	X	
Truth-telling	Intake lead information	Intake lead email	X		X	X	
Truth-telling	File Reference	Status: open	X		X	X	
Truth-telling	File Reference	Status: review	X		X	X	
Truth-telling	File Reference	Status: action	X		X	X	
Truth-telling	File Reference	Status: closed - no contact	X		X	X	
Truth-telling	File Reference	Status: closed - resolved	X		X	X	
Truth-telling	File Reference	YYYYMONDATE -First Initial/Last Initial of client (ie. Complaint by received by Jane Doe on Sept 22, 2020 would be 2020SEP22 - JD)	X		X	X	
Truth-telling	Client Information	First Name	X		X	X	
Truth-telling	Client Information	Last Name	X		X	X	
Truth-telling	Client Information	Community	X		X	X	
Truth-telling	Client Information	Region	X		X	X	
Truth-telling	Client Information	Phone	X		X	X	
Truth-telling	Client Information	Email	X		X	X	
Truth-telling	Client Information	Date of Birth	X		X	X	
Truth-telling	Client Information	Identify as Indigenous/Aboriginal: First Nations	X		X	X	
Truth-telling	Client Information	Identify as Indigenous/Aboriginal: Métis	X		X	X	
Truth-telling	Client Information	Identify as Indigenous/Aboriginal: Inuit	X		X	X	
Truth-telling	Client Information	Identify as Indigenous/Aboriginal: No	X		X	X	
Truth-telling	Client representative information	Representative first name	X		X	X	
Truth-telling	Client representative information	Representative last name	X		X	X	
Truth-telling	Client representative information	Representative phone	X		X	X	
Truth-telling	Client representative information	Representative email	X		X	X	
Truth-telling	Client representative information	Representative relationship to client	X		X	X	
Truth-telling	Client consent	Does the patient give consent to speak on their behalf? Yes	X		X	X	
Truth-telling	Client Consent	Does the patient give consent to speak on their behalf? No	X		X	X	
Truth-telling	Client Consent	In response to this feedback, who should the team contact? Patient	X		X	X	
Truth-telling	Client Consent	In response to this feedback, who should the team contact? Representative	X		X	X	
Truth-telling	Complaint/RFI/Compliment Information	Received date	X				
Truth-telling	Complaint/RFI/Compliment Information	Acknowledge date	X				
Truth-telling	Complaint/RFI/Compliment Information	Date actioned	X				
Restoration	Complaint/RFI/Compliment Information	Date responded	X				
Follow-up	Complaint/RFI/Compliment Information	Date closed	X				
Truth-telling	Complaint/RFI/Compliment Information	Point of entry - email	X				
Truth-telling	Complaint/RFI/Compliment Information	Point of entry - phone	X				
Truth-telling	Complaint/RFI/Compliment Information	Point of entry - other	X				
Truth-telling	Complaint/RFI/Compliment Information	Health Authority/funder:	X				
Truth-telling	Complaint/RFI/Compliment Information	Service provider organization:	X				
Truth-telling	Complaint/RFI/Compliment Information	Health professional name:	X				
Truth-telling	Complaint/RFI/Compliment Information	Region of service provider:	X				
Truth-telling	Complaint/RFI/Compliment Information	Community of service provider:	X				
Truth-telling	Complaint/RFI/Compliment Information	Provider town:	X				
Truth-telling	Complaint/RFI/Compliment Information	Contacts log:	X				
Truth-telling	Complaint/RFI/Compliment Information	Intake summary:	X				
Truth-telling	Complaint/RFI/Compliment Information	Background information from intake:	X				
Understanding	Domain and Problem Category	Clinical Problem		X			X
Understanding	Domain and Problem Category	Clinical Problem - Quality		X			X
Understanding	Domain and Problem Category	Clinicial Problem - Safety		X			X
Understanding	Domain and Problem Category	Management Problem		X			X
Understanding	Domain and Problem Category	Management Problem - Environment		X			X
Understanding	Domain and Problem Category	Management Problem - Institutional Processes		X			X
Understanding	Domain and Problem Category	Relationship Problem		X			X
Understanding	Domain and Problem Category	Relationship Problem - Listening		X			X
Understanding	Domain and Problem Category	Relationship Problem - Communication		X			X
Understanding	Domain and Problem Category	Relationship Problem - Racism, Respect and Patient Rights		X			X
Understanding	Domain and Problem Category	Unspecified/other		X			X
Understanding	Severity Rating	Severity - 0, not evident		X			X
Understanding	Severity Rating	Severity - 1		X			X
Understanding	Severity Rating	Severity - 2		X			X
Understanding	Severity Rating	Severity - 3, high severity		X			X
Understanding	Location of care	Emergency		X			X
Understanding	Location of care	Acute Care		X			X
Understanding	Location of care	Ambulatory Care		X			X
Understanding	Location of care	Mental Health & Substance Use Facility		X			X
Understanding	Location of care	Home & Community Care		X			X
Understanding	Location of care	Long-term Care		X			X

Understanding	Location of care	Public Health		X			X
Understanding	Location of care	Primary Care		X			X
Understanding	Location of care	Administration		X			X
Understanding	Location of care	Unspecified/other		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (1) Negligible		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (2)		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (3)		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (4)		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (5) Catastrophic		X			X
Understanding	Level of harm	Level of Harm Reported by the Patient (0 or N/A or Unspecified)		X			X
Understanding	Please provide further details of: Who made the complaint?	Who made the complaint? Family member		X			X
Understanding	Please provide further details of: Who made the complaint?	Who made the complaint? Patient		X			X
Understanding	Please provide further details of: Who made the complaint?	Who made the complaint? Unspecified/other		X			X
Understanding	Please provide further details of: Gender of the patient?	Gender of patient? Female		X			X
Understanding	Please provide further details of: Gender of the patient?	Gender of patient? Male		X			X
Understanding	Please provide further details of: Gender of the patient?	Gender of patient? Unspecified/other		X			X
Understanding	Please provide further details of: Which staff group does the complaint refer to?	Which staff group(s) does the complaint refer to? Administration		X			X
Understanding	Please provide further details of: Which staff group does the complaint refer to?	Which staff group(s) does the complaint refer to? Medical		X			X
Understanding	Please provide further details of: Which staff group does the complaint refer to?	Which staff group(s) does the complaint refer to? Nursing		X			X
Understanding	Please provide further details of: Which staff group does the complaint refer to?	Which staff group(s) does the complaint refer to? Unspecified/other		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Provider feedback		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Family and provider meeting		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Verbal apology		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Written apology		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Support to file a formal complaint		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Education and training		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Financial compensation		X			X
Understanding	Restorative expectations	Please indicate restorative expectations: Reprimand/disciplinary action		X			X
Restoration	Restoration Decision	Severity: Mild			X		
Restoration	Restoration Decision	Severity: Moderate			X		
Restoration	Restoration Decision	Severity: Severe			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (1) Negligible			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (2)			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (3)			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (4)			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (5) Catastrophic			X		
Restoration	Restoration Decision	Level of Harm Reported by the Patient (0 or N/A or Unspecified)			X		
Restoration	Restoration Decision	Decision date: m/d/yr			X		
Restoration	Restoration Decision	Submission date: m/d/yr			X		
Restoration	Restoration Decision	Anticipated action date: m/d/y			X		
Restoration	Restoration Decision	Actioned date: m/d/y			X		
Restoration	Restoration Decision	Restoration actions: detailed description of actions to be taken			X		
Follow-up	Survey: Cultural Safety & Humility	Do you feel the healthcare providers genuinely respected your cultural values and practices?				X	
Follow-up	Survey: Cultural Safety & Humility	How often did the hospital staff listen carefully to you?				X	
Follow-up	Survey: Cultural Safety & Humility	How often did the hospital staff show interest in what you had to say?				X	
Follow-up	Survey: Cultural Safety & Humility	Did the hospital staff spend enough time with you?				X	
Follow-up	Survey: Cultural Safety & Humility	Did the hospital staff try to make you feel comfortable?				X	
Follow-up	Survey: Anti-racism	How often did these things happen to you when you received health care? I was treated with less respect than other people				X	
Follow-up	Survey: Anti-racism	How often did these things happen to you when you received health care? Healthcare providers were rude to me				X	
Follow-up	Survey: Anti-racism	How often did these things happen to you when you received health care? I received poorer care than other people				X	
Follow-up	Survey: Anti-racism	How often did these things happen to you when you received health care? Healthcare providers asked me inappropriate questions				X	
Follow-up	Survey: Anti-racism	How often did these things happen to you when you received health care? When these things happen, do you think it is because you are Indigenous?				X	
Follow-up	Survey: Compassion	Do you feel your healthcare provider cared about your emotional and mental well-being?				X	
Follow-up	Survey: Compassion	Did your healthcare provider show you care and compassion?				X	
Follow-up	Survey: Compassion	Do you feel your healthcare provider was considerate of your personal needs?				X	

Consideration	Location of Care - Tick relevant location	Emergency: Admission					
Consideration	Location of Care - Tick relevant location	Emergency: Examination					
Consideration	Location of Care - Tick relevant location	Acute Care: Ward					
Consideration	Location of Care - Tick relevant location	Acute Care: Procedure					
Consideration	Location of Care - Tick relevant location	Acute Care: Discharge					
Consideration	Location of Care - Tick relevant location	Ambulatory Care: Admission					
Consideration	Location of Care - Tick relevant location	Ambulatory Care: Examination					
Consideration	Location of Care - Tick relevant location	Mental Health & Substance Use Facility: Admission					
Consideration	Location of Care - Tick relevant location	Mental Health & Substance Use Facility: Ward					
Consideration	Location of Care - Tick relevant location	Mental Health & Substance Use Facility: Procedure					
Consideration	Location of Care - Tick relevant location	Mental Health & Substance Use Facility: Discharge					
Consideration	Location of Care - Tick relevant location	Public Health: Admission					
Consideration	Location of Care - Tick relevant location	Public Health: Examination					
Consideration	Location of Care - Tick relevant location	Primary Care: Admission					
Consideration	Location of Care - Tick relevant location	Primary Care: Examination					

Appendix I

Continuum of becoming an anti-racist organisation

https://med.umn.edu/sites/med.umn.edu/files/continuum_of_becoming_an_anti-racist_organisation.pdf

novatone

Continuum on Becoming an Anti-Racist Multicultural Organization

MONOCULTURAL ⟹ MULTICULTURAL ⟹ ANTI-RACIST ⟹ ANTI-RACIST MULTICULTURAL

Racial and Cultural Differences Seen as Deficits ⟹ Tolerant of Racial and Cultural Differences ⟹ Racial and Cultural Differences Seen as Assets

Exclusive An Exclusionary Institution	2. Passive A "Club" Institution	3. Symbolic Change A Compliance Organization	4. Identity Change An Affirming Institution	5. Structural Change A Transforming Institution	6. Fully Inclusive Anti-Racist Multicultural Organization in a Transformed Society
• Intentionally and publicly excludes or segregates African Americans, Native Americans, Latinos, and Asian Americans • Intentionally and publicly enforces the racist status quo throughout institution • Institutionalization of racism includes formal policies and practices, teachings, and decision making on all levels • Usually has similar intentional policies and practices toward other socially oppressed groups such as women, gays and lesbians, Third World citizens, etc. • Openly maintains the dominant group's power and privilege	• Tolerant of a limited number of "token" People of Color and members from other social identify groups allowed in with "proper" perspective and credentials. • May still secretly limit or exclude People of Color in contradiction to public policies • Continues to intentionally maintain white power and privilege through its formal policies and practices, teachings, and decision making on all levels of institutional life • Often declares, "We don't have a problem." • Monocultural norms, policies and procedures of dominant culture viewed as the "righ" way" business as usual" • Engages issues of diversity and social justice only on club member's terms and within their comfort zone	• Makes official policy pronouncements regarding multicultural diversity • Sees itself as "non-racist" institution with open doors to People of Color • Carries out intentional inclusiveness efforts, recruiting "someone of color" on committees or office staff • Expanding view of diversity includes other socially oppressed groups *But...* • "Not those who make waves" • Little or no contextual change in culture, policies, and decision making • Is still relatively unaware of continuing patterns of privilege, paternalism and control • Token placements in staff positions: must assimilate into organizational culture	• Growing understanding of racism as barrier to effective diversity • Develops analysis of systemic racism • Sponsors programs of anti-racism training • New consciousness of institutionalized white power and privilege • Develops intentional identity as an "anti-racist" institution • Begins to develop accountability to racially oppressed communities • Increasing commitment to dismantle racism and eliminate inherent white advantage • Actively recruits and promotes members of groups have been historically denied access and opportunity *But...* • Institutional structures and culture that maintain white power and privilege still intact and relatively untouched	• Commits to process of intentional institutional restructuring, based upon anti-racist analysis and identity • Audits and restructures all aspects of institutional life to ensure full participation of People of Color, including their world-view, culture and lifestyles • Implements structures, policies and practices with inclusive decision making and other forms of power sharing on all levels of the institutions life and work • Commits to struggle to dismantle racism in the wider community, and builds clear lines of accountability to racially oppressed communities • Anti-racist multicultural diversity becomes an institutionalized asset • Redefines and rebuilds all relationships and activities in society, based on anti-racist commitments	• Future vision of an institution and wider community that has overcome systemic racism and all other forms of oppression. • Institution's life reflects full participation and shared power with diverse racial, cultural and economic groups in determining its mission, structure, constituency, policies and practices • Members across all identity groups are full participants in decisions that shape the institution, and inclusion of diverse cultures, lifestyles, and interest • A sense of restored community and mutual caring • Allies with others in combating all forms of social oppression • Actively works in larger communities (regional, national, global) to eliminate all forms of oppression and to create multicultural organizations.