International Emergency Nursing xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review

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A B S T R A C T

Background: Emergency departments are primary health care entry points for Indigenous persons in Canada. They are also among the settings where Indigenous patients report access barriers and discriminatory treatment. Cultural competency and cultural safety have been proposed as approaches to improving emergency care.

Objective: To identify and elaborate upon barriers and facilitators of cultural competency and safety in Canadian Emergency Departments.

Methods: We conducted a scoping review to search published and grey literature to identify and extract data on definitions, measures, facilitators and barriers of cultural competency and safety.

Results: Six articles met inclusion criteria. Studies presented perspectives from patients, care providers, health care organizations, and Indigenous knowledge holders. Key themes emerged across studies and stakeholders. These include: Interpersonal relationships between patients and care providers; cultural competency training; Emergency Department capacity; and racism and discrimination.

Conclusion: We recommend that Emergency Department cultural competency and safety initiatives i) be built upon post-colonial understanding and partnerships with local Indigenous communities ii) provide practitioners with competencies in relationship-building and self-awareness iii) orient ED resources and services to meet the needs of patients with limited access to non-emergency healthcare and iv) aim to prevent discrimination.

1. Background

1.1. Canadian EDs and indigenous patients

Fig. 1 The Emergency Department (ED) is a primary point of entry into the health care system for many Indigenous persons in Canada [1–3]. Indigenous patients are also more likely to access emergency care than non-Indigenous patients [4,5]. This has been traced to multiple access barriers, including lack of access to primary or other care services [2] as well as the rate at which Indigenous peoples are regularly "dismissed or disregarded" when attempting to access healthcare [5]. There is also a historic legacy of mistreatment of Indigenous people in the medical system, contributing to a currently disproportionate burden of health issues. For example, the Canadian 'Indian hospitals' of the 20th century, which were designed to confine and isolate Indigenous people while disrupting community efforts to improve health, effectively established enduring race-based health disparities [6].

Although there is no evidence that Indigenous persons misuse the ED, high rates of use have directly contributed to a widespread perception among health care providers and stakeholders that Indigenous patients are 'over users' or 'abusers' of emergency services [2]. This false belief adds to a host of negative or racist attitudes facing Indigenous patients in health care settings, as reflected in reports of discriminatory treatment [7]. As bias against Indigenous persons' impacts quality of care [8], and patient willingness to seek out medical care or continue treatment [1], some care episodes in ED may in fact contribute to, rather than reduce, current health inequalities.

1.2. Cultural competency and safety

Cultural competency and safety are both evolving theoretical and practice frameworks [9]. Transcultural care was first developed by Madeleine Leineinger as an "area of study and practice focused on comparative cultural care (caring) values, beliefs and practices of individuals or groups of similar or different cultures" [10]. Cultural competency was later introduced as an approach to transcultural care by American nurse-practitioner Dr. Josepha Campinha-Bacote. She defines cultural competency as "the process in which the healthcare

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https://doi.org/10.1016/j.ienj.2019.01.004
Received 7 April 2018; Received in revised form 3 January 2019; Accepted 9 January 2019

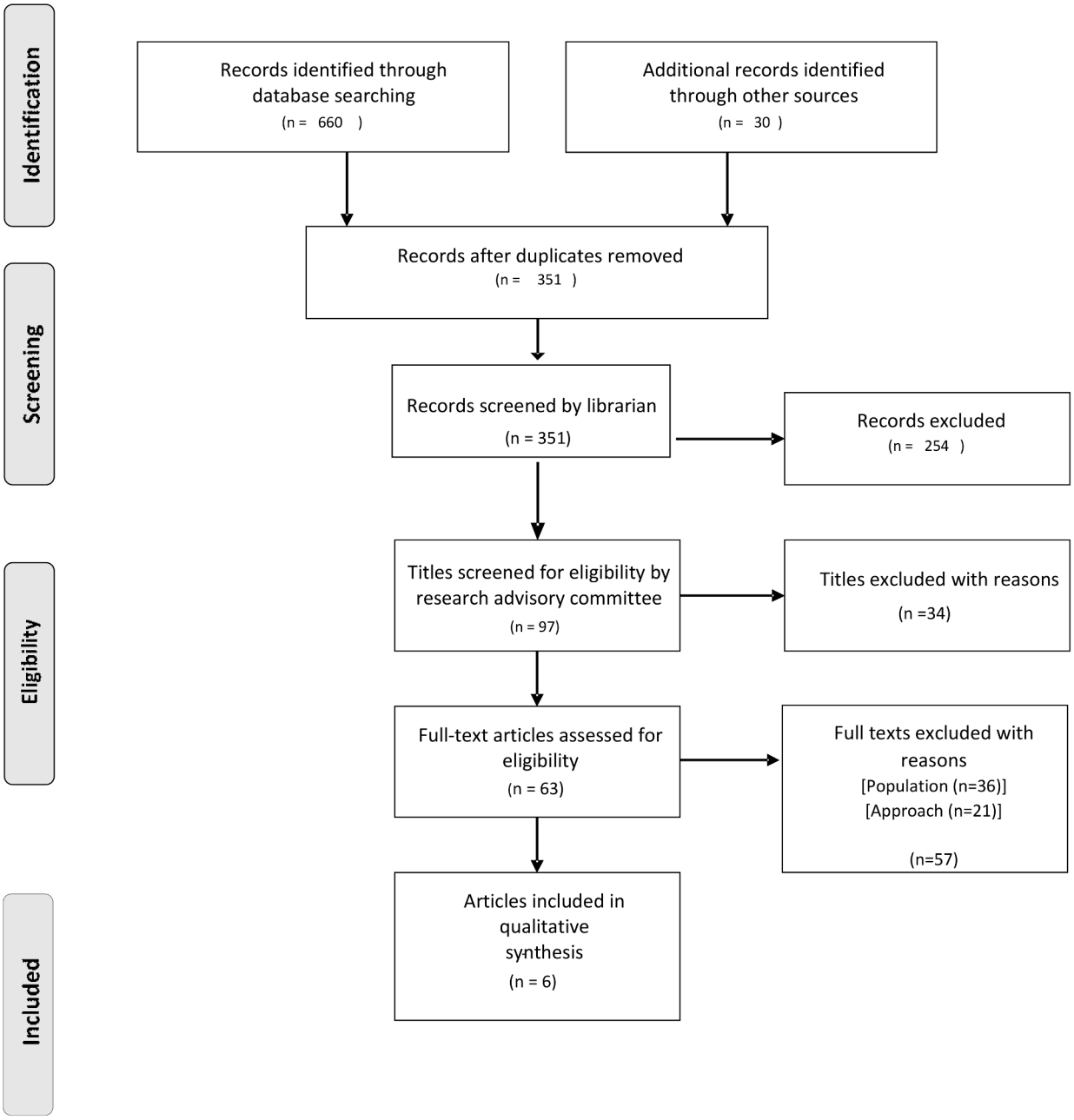

Fig. 1. PRISMA flow diagram.

professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client" [11]. The concept has sparked many additional or alternative models. This includes the theory of cultural safety, developed by Maori nurse Irihapeti Ramsden. This model describes a process of 'cultural awareness' leading to 'cultural sensitivity' and culminating in 'cultural safety' [12]. When a patient experiences cultural safety, previous culturally-related systemic or interpersonal barriers no longer inhibit care access. In the Maori context, and for other Indigenous peoples, this involves awareness and redress of the health implications of colonialism.

In Canada, cultural competency and safety have been introduced into health care practice standards. The Canadian Nurses Association, the Canadian Indigenous Nurses association, and the Canadian Association of Schools of Nursing consider cultural competency an "entry-to-practice level competence" [13]. These organizations advocate for cultural safety in nursing practice as a way to improve care access and enable practitioners to challenge unequal power relations. The Truth and Reconciliation Commission of Canada also calls upon health care professionals to receive training in cultural competency [14], one among many calls to redress the legacy of residential schools and advance the process of reconciliation.

2. Aim

This review aims to identify and elaborate upon barriers and facilitators of cultural competency and safety in emergency departments in Canadian contexts. These findings will be informative for practitioners or hospital administrators who recognize the health system's responsibility to provide effective care across cultures and who wish to redress colonial legacies in health care.

3. Methods

Given the broad nature of the question, and the limited research and

evaluation of this topic, a scoping review was determined to be a feasible research strategy. The methods are derived from the methodology outlined by the Joanna Briggs Institute [15] and includes the following: identifying the research objective and question; outlining the inclusion criteria; identifying search strategies; extracting the results; discussing the results and drawing conclusions, including the implications for future research and practice.

4. Research question

What is known regarding barriers and facilitators related to Indigenous cultural competency and cultural safety within Canadian Emergency Departments?

4.1. Search strategy

Keywords used to inform our search strings were: Indigenous, Emergency Departments, Health Equity, Discrimination, Cultural Safety/Cultural Competency, Approaches/Interventions, Barriers, Facilitators. A librarian used key terms and suggested search strings synonyms) to search databases of published and grey literature including: Native Health Databases Aboriginal Health Abstract Database, Arctic Health Publications Database, Circumpolar Health Bibliographic Database, MEDLINE (Ovid), EMBASE; EBM Reviews; PsycINFO; PubMed; PubMed Central; CINAHL; MEDLINE (Ebsco); Psychology & Behavioral Sciences Collection; Health Source; HealthSTAR; Web of Science ProQuest Dissertation; Theses Global; National Aboriginal Health Organization (NAHO); National Collaborating Centre for Aboriginal Health (NCCAH); Indigenous Studies Portal (Usask); Northern Affairs; Informit Indigenous Collection; Australian Indigenous Health Infonet; Royal Commission on Aboriginal Peoples; Google; Bing; Canadian Best Practices Portal; Google Scholar; OpenDOAR BASE; MedNar.

Searches were limited to articles written in English, as this is the shared language of the review team. Searches were limited to articles written from 2002 to 2017.

4.2. Inclusion criteria and study selection

Inclusion criteria were based on population, approach, methods and outcomes. The populations of interest were Indigenous patients or care providers working with Indigenous populations. Approaches of interest were hospital-based approaches that address identified components of cultural competency and safety. We did not restrict our search based on methods or publication types. Outcomes of interest were measures or reports of impact on cultural competency or safety initiatives. Following the JBI methodology, inclusion criteria were revised iteratively after increasing familiarity with the literature, and focused on Emergency Department interventions within Canada. Articles in other jurisdictions or in other care settings were excluded. Cultural safety is conceptualized differently between sociographic regions and care environments. Articles were also excluded if the approach was not developed for or by Indigenous peoples or did not specifically address cultural safety or competency. Inclusion criteria are found in Table 1.

4.3. Data extraction and analysis

Data were extracted on the type of clinical setting, definition of cultural competency and/or safety employed by study authors, identified facilitators, identified barriers, and the perspective sharing findings (patient, care provider, Indigenous knowledge-holder, or health system representative). Qualitative content analysis was utilized to track frequency of inductively derived themes. Themes were extracted by a primary researcher (KB) and verified by a second research team member (AP, PM, JM) or collaborator (FA, KW).

Table 1
Inclusion criteria.

Component	Inclusion
Population	- Patients who identify as FNMI, status or non-status - Emergency Departments and emergency department health professionals - Canadian populations
Approach	- Any approaches that address the following components of Culturally Safe Indigenous Care: - Discrimination - Implicit Bias - Institutional Racism - Colonialism - Health Equity - Attitudinal Barriers - Power Differentials and Structures - Service Delivery - Provider Competencies in the areas of: inclusiveness, autonomy, equity, flexibility, empathy, non-judgement, connectedness[1] - Health Professional Knowledge of Indigenous Culture and Indigenous Health issues - Holistic Healing - Traditional Medicine and Practices - Hospital Infrastructure - Intervention at patient, family, community, or health systems level
Method	- Systematic reviews (narrative and *meta*-analyses) - Theoretical frameworks - Individual studies (RCTs, cohort, case control, case studies, process, short- and long-term evaluations) - Qualitative studies (e.g. case studies) - Practice guidelines - Resources, programs and toolkits from respected authorities/ experts - Materials or programs created by first nations communities developed to address emergency healthcare experience/access
Outcomes[2]	- Measures/Reports of approach care provider user experience - Satisfaction with training - Training or staff retention rate - Self-reported changes in knowledge, behaviours, and attitudes - Measures/Reports of cultural safety and patient experience - Wait times - Leaving without treatment - Patient satisfaction - Patient participation in care provision - Patient compliance with care plans - Measures of cultural competency - Health Provider Accountability/Performance Standards - Health Provider Recognition of Self Awareness - Equitable Access to Treatment and Services - Narrative reports and quotes from users or patients - Policy changes and solutions

[1] From the 'Guiding Principles' of the AHP *Cultural Competency Framework*.
[2] Outcomes criteria do not apply to theoretical articles and resource/toolkit documents.

5. Results

Based on initial search criteria, forty-three articles were selected for review. By study population, twenty-two articles from Australia and New Zealand (six ED, sixteen non-ED) and five articles from the United Stated (three ED, two Non-ED) were identified. Sixteen articles were from Canada (six ED, ten non-ED). In order to present findings that are the most relevant to our research question, the six articles pertaining to Canadian Emergency Departments were selected for in-depth analysis. The remaining thirty-seven non-Canadian or non-ED articles were analysed for background and contextual information and, when relevant, referenced in the discussion section.

5.1. Patient perspectives on barriers and facilitators

Three articles presented Indigenous patient perspectives on emergency care experience. These include a study on experience of 4 Inuit

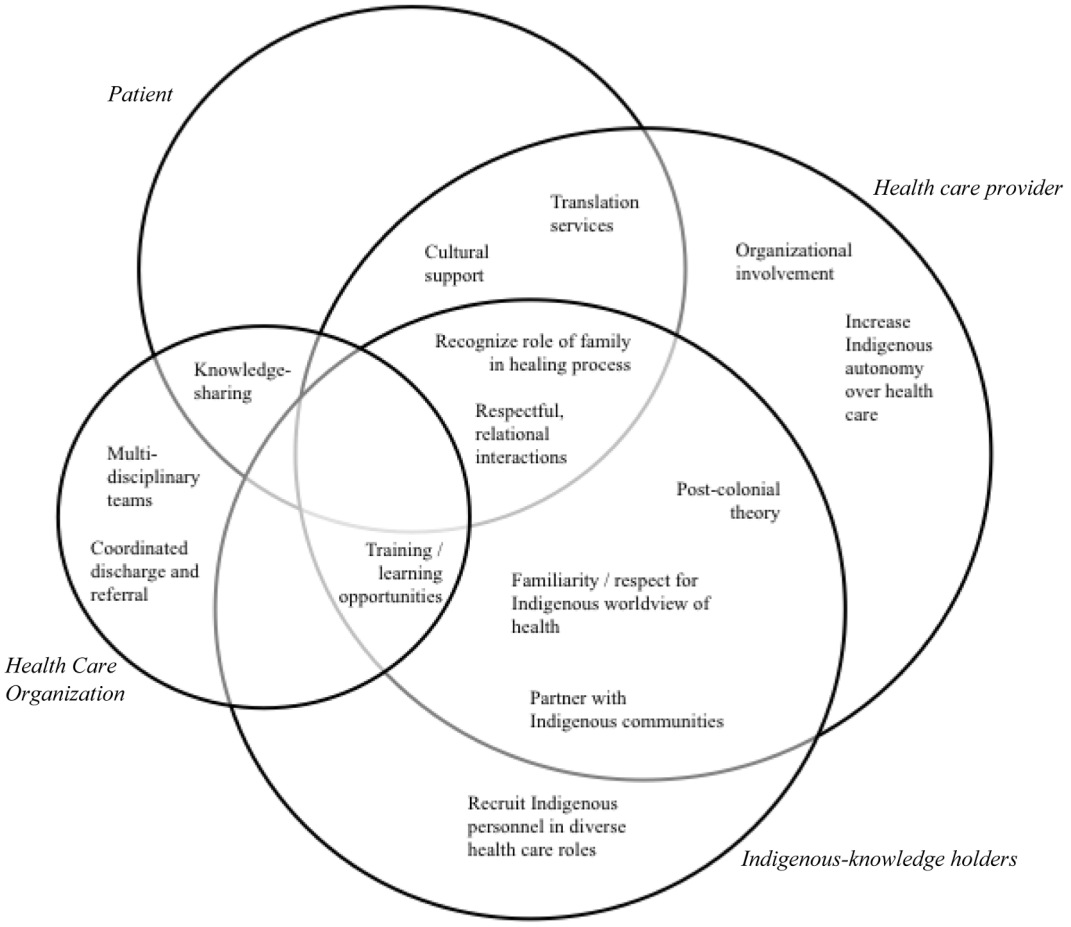

Fig. 2. Facilitators by perspective.

patients from Nunavik (Northern Quebec) presenting at a metro ED (16), interviews with self-identified 'Aboriginal' patients at a metro ED in western Canada [1], and interviews with First Nations patients in one urban ED and in one rural ED where an Aboriginal Community Health Representative had worked for 6 months [17].

All three reports found that cultural safety included patients feeling valued and respected. This was facilitated through cultural helpers [17], support from another person with their cultural and/or linguistic background [16], or "brief supportive interactions" with hospital staff [1]. Patients also reported that family members provided mental (i.e. decision making support) and spiritual support in the healing process [16]. Clear communication on the "realities of ED" also contributed to patient's sense of cultural safety [16].

Barriers identified by patients include concerns over stereotyping and discrimination [1,17], differences in communication styles or lack of adequate communication [16,17], lack of alternative care options [1,17], alienation or feeling far from home [16,17], lack of social services in ED setting [1], busyness and lack of privacy in ED [16], patient financial constraints [16], mistrust of the medical system [17], not being actively involved in care plans [17], and concern over institutional policies (eg: prescription policies, policies on mental health and confinement [1])

5.2. Staff perspectives on barriers and facilitators

Three articles presented staff perspectives on providing care for Indigenous patients; a background paper on principles of cultural safety in Canadian EDs [3], a report on the experiences of ED nurses participating in a cultural safety initiative in a western coastal hospital [18], and findings from interviews with urban ED hospital staff [1].

Staff training was viewed as an enabler for cultural safety [3,18]. Trust and relationships, cultural support, family inclusion, community partnerships, and organization-wide commitment to cultural safety were also identified as facilitators [3].

ED physicians recognize that Indigenous patients face discrimination and on-going experiences of trauma [3] which impedes culturally safe care. Practitioners also identified that insufficient resources in the ED [1], policy constraints [1], and poor care continuity [1], had negative implications on cultural competency.

5.3. Indigenous knowledge holder perspectives on barriers and facilitators

The initial search strategy targeted patient and care provider populations. However other perspectives along the care continuum appeared throughout the research. For instance, we identified perspectives from Indigenous 'knowledge-holders', or individuals who have knowledge of Indigenous culture and ways of being. These include Indigenous researchers [17,1], Indigenous practitioners (eg: health care providers [3], cultural helpers [17], educators [18], etc.), and Elders [17].

Facilitators from this perspective include adopting a post-colonial framework [18,17,1], appreciation for Indigenous culture [18], acknowledging the role of family [18], recognizing the importance of brief and supportive interactions [1], Indigenous staff working in hospitals [17], communicating and understanding the realities of the ED [17], staff education on cultural safety [17], and partnerships with Indigenous communities [17]

Indigenous researchers identified a detachment between patient needs and the services that the ED "as it was structured" could provide (1). They also found that ED staff may not be fully aware of the greater

contexts of Indigenous patient's lives (1). Other barriers identified by Indigenous knowledge holders include historical distrust between Indigenous communities and the health care system [17] as well as "tacit and overt" discrimination [1].

5.4. Health organization perspectives on barriers and facilitators

Two articles presented what we label "the health organization perspective". This is the perspective of those in a health care organization who, through knowledge translation or policy decisions, influence care provision. The articles were a review of in-hospital strategies to improve care for Indigenous patients [2], and feedback from hospital administration regarding the success of a cultural competency and safety training program impacting emergency nursing practice in the hospital [18].

Facilitators from this perspective included providing cultural competency training [18] and improving efficiency and flow of patients through the ED [2]. Tactics included the use of multidisciplinary teams, sharing knowledge of ED realities, enhancing referrals and access to primary care and specialist services.

The principal barriers identified from this perspective include racism and stereotyping experienced by Indigenous patients seeking care in the ED, lack of access to primary care and the presence of health disparities [2].

Fig. 2 demonstrates the overlap between the diverse perspectives with regards to facilitators of cultural safety. Themes near the centre of the image are identified facilitators across perspectives. Facilitators near the edges are presented by one group. For example, health care organizations, health care providers, and Indigenous knowledge holders identified the value of training and learning opportunities for staff. On the other hand, organization-wide support for initiatives was identified (in this review) only by health care providers.

Similarly to Fig. 2 and 3 shows similarities and gaps across perspectives in terms of barriers to cultural safety. Discrimination was identified as a barrier from all perspectives. Many unique barriers were identified by patients, such as feeling of alienation, financial barriers, and system navigation, which were not identified by other perspectives from the literature.

6. Discussion

The results from this review indicate that many factors combine to create conditions that either impede or facilitate cultural competency and cultural safety in Canadian Emergency Departments (EDs). Several key factors were presented from multiple viewpoints and are discussed here.

6.1. Interpersonal relationship between the patient and care provider.

As Fox and Schulz explain, "Relationships are a significant dimension of Indigenous health" [18]. Indigenous patients and knowledge-holders echo this statement throughout the review. Authors reference individual relationships between family members [16], relationships between communities and institutions [17], and, critically, the relationship between the care provider and the patient [1,3,17,18]. Relational approaches, "friendly" or welcoming environments appeared to change the trajectory of care experiences in the literature.

From health care provider perspectives, interactions with patients were not generally discussed in the context of a relationship. The evidence from these articles indicates that practitioners are aware of technical skills, material resources, and social services that improve quality of care [1], but their interpersonal relationships with patients

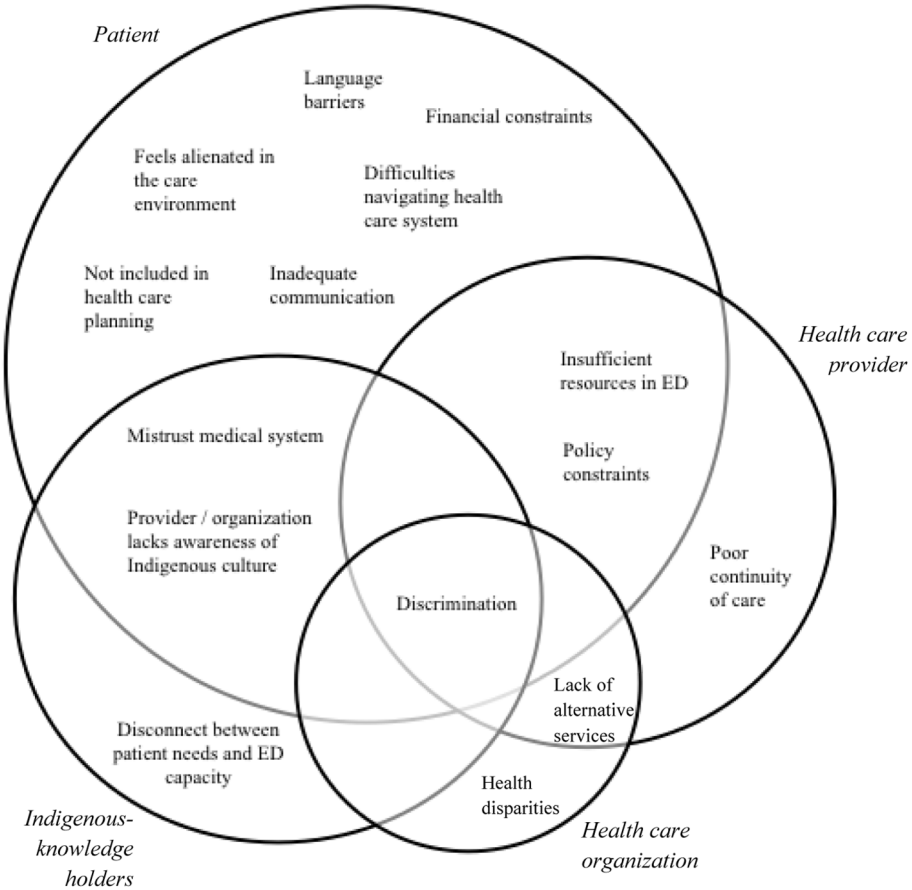

Fig. 3. Barriers by perspective.

are not equally emphasized. This indicates that Indigenous patients and non-Indigenous health care providers may approach healing processes from different vantage points, particularly when it comes to the role of relationships.

Indigenous knowledge-holders, in this case cultural competency educators, note that pre-existing attitudes shape the relationship prior to direct clinical contact. Educators in a cultural safety initiative note that several Caucasian ED RNs believed that they would automatically be seen as 'unbiased' and 'allies' by Indigenous patients [18]. Non-Caucasian RNs expressed surprise that their counterparts were "unaware of the power differential that non-Caucasian patients experienced while in their care" [18]. This finding suggests that Caucasian providers, and non-Caucasian patients (including Indigenous patients), may differ in respect to initial characterizations of their relationship with one another. The study found that after nurses reflected on power dynamics (i.e.: between care-providers and patients, and between non-Indigenous and Indigenous persons in Canada) they reported a shift in practice [18]. For example, they became able to "use a variety of relationship-building skills" and "adapt communication styles to communicate effectively" during clinical encounters [18]. Awareness of bias and power-dynamics, accompanied by skills training, may therefore lead to improved relationships.

6.2. Cultural competency training

Training was identified as an enabler of cultural safety, however caution is necessary with this approach. The wider body of literature contains examples of how certain course designs may be detrimental to cultural competency by providing only superficial knowledge or by contributing to beliefs that Indigenous cultural competency training is a niche or irrelevant issue [20].

A training program designed specifically for ED nurses within a specific hospital avoided these pitfalls [18]. This design allowed for integration of local knowledge and tailored skills development. Modules were delivered by Indigenous educators in short periods between shift change and addressed issues such as the health and societal implications of historic colonial policies (residential schools, anti-potlach laws, etc.), compassion fatigue and high stress levels among nurses, and the emotional and cognitive challenge of addressing unrecognized personal biases.

Practitioner perspectives similarly advocate for training which provides information on historical legacies [3,17], facilitates self-reflection on personal biases and attitudes [3,17]' provides tools for confronting compassion fatigue [3], and educates practitioners on their role as advocates for social justice and health equity [17].

Although the patient perspective on cultural competency training was less explored, one patient described being more satisfied with care in an agency where "the people … are trained to deal with [Indigenous patients]…like human beings" [17].

These perspectives suggest that culturally safe care, which humanizes patients, requires cultural competency training that humanizes practitioners. Practitioners operate in cognitively and emotionally challenging environments. Training must respond to these challenges by providing relevant support and skills. As described by the various perspective here, effective ED cultural competency training provides historical and local contexts for Indigenous health issues, and provides tools to enhance practitioners' self-awareness and interpersonal skills.

6.3. ED capacity

The literature describes various stressors in the ED for both staff and patients. These include nurses being too busy to provide comprehensive information to patients [16], lack of necessary resources and social services [1], long waiting periods before patients are able to see a practitioner [17], and institutional pressures to speed up triage and discharge [2]. Resulting tensions are exacerbated because EDs are structured to provide urgent and acute care, but patients often present with chronic health concerns or issues which require specialized treatment [1,17].

As a way to reduce the discrepancy between needs and available resources, some authors suggest that hospitals may be able to introduce strategies to improve the flow of patients in the ED, such community-based interventions and channels to non-urgent or specialized care from the ED [2]. While these strategies can ensure patients arrive at the best-suited care setting, the ED should not be seen as a 'wrong' turn in the patient pathway to care. High ED use among Indigenous patients is driven by lack of alternative care options [1,2]. Responsibility for delivering health services to under-serviced and marginalized populations, which includes many Indigenous people, has fallen to EDs. In order to meet the needs of these patients, and in the absence of systemic reforms that would prevent under-service (and which are beyond the scope of this review), ED policies and services must address social and chronic health issues while maintaining the department's focus on emergency medicine.

The literature provides several examples of structural changes attuned to this need. These measures include placing a designated cultural support staff or Indigenous community health representative in the ED, increasing the number of Indigenous personnel in diverse health roles [17], creating designated cultural spaces for patients and their family members [3], and placing multi-disciplinary teams in triage [2]. These adaptations help the ED offer a broad-gauge response to patients' immediate needs and also acts as a coordination point between patients and the wider health system. Further dialogue between ED practitioners, Indigenous knowledge-holders, patients and other health system operatives should inform future strategies of this nature.

While these strategies present promising avenues for ED facilities to become more culturally competent, the literature indicates that patient capacity, in terms of power or readiness to access care, is also an underlying, yet underexplored, issue. "Participants clearly state that accessing care includes first overcoming inhibitions against seeking care" [17]. Strategies to enhance patient capacity, which may include health education or navigation skills, were not discussed in the literature but are important pathways for future research.

6.4. Racism and discrimination

Each perspective represented here recognized discrimination and racism as barriers to culturally competent and culturally safe care in EDs. Different perspectives describe various causes of discrimination. Patients express fear of compounded discrimination when they belong to more than one stigmatized group. For example, Indigenous patients who are impoverished and also experience addictions "expressed similar concerns about the intersecting assumptions that could shape providers' interactions with them" [1]. Physicians mention unrecognized internal biases among providers that lead to cognitive errors in diagnostic and treatment decisions [3]. Indigenous knowledge-holders describe institutional racism, where an organization's policies or normative standards lead to unfair treatment [17].

Enduring colonial myths about Indigenous people not understanding personal health management, or being undeserving recipients of care, are still present in contemporary health interactions [1]. Post-colonialism as a theoretical approach enables healthcare providers to better understand the ongoing role of colonialism in producing health inequities [21]. A lack of post-colonial understanding can lead to practitioners misunderstanding the causes behind frequent ED use, high rates of chronic illnesses, or overt mistrust of medical institutions and practitioners. This can further entrench existing stereotypes about Indigenous patients being "dependent" on "the system," or "difficult to deal with" [1].

The strategies described earlier in the discussion; relationship-building, cultural competency training, and enhanced ED capacity, may all interrupt prejudiced behaviours. However, given the prominent and

pervasive nature of this barrier, more direct approaches may be necessary. Eliminating racism and discrimination from care will require individuals to recognize the effects of colonialism, become aware of their own conscious and unconscious biases, and recognize institutional policies or cultural norms that perpetuate discrimination. Effective strategies of this nature may require further research and evaluation.

6.5. Perspectives and voice

In the 6 articles characterizing the Canadian ED context, diverse perspectives were represented. Some factors were discussed from more than one perspective with multiple interpretations, although many factors were presented from only one viewpoint. For example, patients expressed that miscommunication due to linguistic or cultural differences was a barrier, but care providers or institutions did not raise this as an issue. Categorizing findings by perspectives shows that multiple viewpoints must be explored in order to identify common understandings between stakeholder groups, as well as to identify potentially overlooked elements of culturally competent and safe care.

7. Limitations

This analysis does not attempt to reveal all that is known regarding Indigenous cultural competency and safety in Canadian Emergency Departments. Additional factors or research may be present but not found through this review process.

Due to the small sample of articles and the diversity of included Indigenous populations (Inuit, Cree, Saanich, and others), findings from this review may not all be transferrable to other EDs. Individual nations and Indigenous communities in Canada will have their own cultural values, norms, and contextual determinants of health. Likewise, individual hospital cultures and resources are relevant to cultural competency and considerations for local factors should influence the design of cultural competency or safety programs.

The current body of literature on cultural competency and safety is also limited by the narrow range of view points considered. Viewpoints of health care organizations were less prevalent in the literature, and conclusions with regard to this perspective are therefore limited. Contemporary research also focuses on provider capacity in Indigenous cultural competency, whereas patient-centered strategies to improve cultural safety are almost non-existent. The literature search also did not reveal Indigenous models of emergency care (with the exception of a web page for on-site emergency care service run and operated by Samson Cree Nation [19]) and how these might complement existing models. Further exploration of organizational approaches to cultural competency and safety and Indigenous models of care are avenues for future research.

8. Conclusion

This review explored barriers and facilitators to cultural competency and safety in Canadian EDs, a high-use service setting. A variety of inter-related factors combine to create or impede culturally competent and safe care. These include, but are not limited to, the practitioner-patient relationship, cultural competency training, ED capacity, and racism and discrimination. Health care providers, Indigenous patients, health care organizations, and Indigenous knowledge-holders all bring distinct and unique understandings of ED care, with some synergy between these voices. Based on these findings, we recommend that ED cultural competency and safety initiatives be built upon post-colonial understanding and partnerships with local Indigenous communities; provide practitioners with competencies in relationship-building and self-awareness; orient ED resources and services to meet the needs of patients with limited access to non-emergency healthcare; and ultimately aim to reduce racism and discrimination. Indigenous patient empowerment and strength building are also areas for future exploration, and should concurrently support cultural safety initiatives. Local efforts to improve Indigenous cultural competency and safety must be attuned to multiple perspectives- those of front-line staff, patients, Indigenous knowledge holders and organizational leadership. This review may serve as a summary of evidence for future research or for hospital staff teams attempting to improve emergency care experiences with Indigenous partner organizations.

Conflict of interest

None declared.

Ethical statement

This is an original manuscript. It is unpublished and not under consideration by another journal.

Funding source

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Acknowledgements

The research team acknowledges Marcus Vaska, Alberta Health Services Knowledge Resource Services Librarian, for providing assistance with the search strategy and database search. Also, Kienan Williams and Folake Arinde, Research specialists with Alberta Health Services, for verifying extracted data, and Deb McNeil, former Director of Research and Innovation, Population Public and Indigenous Health at Alberta Health Services, for supporting this work.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ienj.2019.01.004.

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