The Canadian Nursing Students' Association

Approved Position and Resolution Statements

Updated: April 2021

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Position Statements 2021

Commitment to All Member's Safety

Approved: January 2021
Approved by: CNSA National Assembly
Submitted: December 18, 2020
Submitted to: Canadian Nursing Students' Association Board of Directors
Submitted by: Shelby Kennedy

Introduction/Background:

There has been a longstanding and unspoken history of assault, abuse, and harassment throughout Canadian Nursing Students' Association (CNSA) events and between members. 2020 brought to light serious public allegations including multiple sexual assaults at a national event, and callouts of systemic racism against members and within the organization. The 2020 Board of Directors (BOD) worked diligently to address these concerns during their term amid a global pandemic, but we must ensure moving forward future boards continue to be aware and proactive of these issues and others affecting our membership.

The Position of the Canadian Nursing Students' Association (CNSA)

As an association we will not tolerate any assault or harm to members during our events or any other involvement within CNSA. This includes but is not limited to physical assault, sexual assault, verbal abuse, bullying or intimidation, harassment or discrimination, or traumatization whether intentional or not (Policies and Procedures 1.5.). As outlined in CNSA's Policies and Procedures, all complaints of such behaviour or activity will be immediately addressed by the BOD in a serious manner to resolve quickly, confidentially, and fairly (Policies and Procedures 1.5.4.). If a conflict of interest with a BOD member occurs, a Board Mediation Committee will be struck. CNSA will also implement disciplinary measures to those found to have violated these policies, for example by expulsion from events, positions, or membership (Policies and Procedures 5.1.1.).

The safety and wellness advocate position on the BOD will ensure these standards are upheld and continue to work on the previous work done by the ad hoc Safety and Wellness Committee to ensure the member's wellbeing is at the forefront of all CNSA does.

Relation to Canadian Nursing School Curriculums

The safety and wellness of nursing students is paramount to the success of nursing education.

Conclusion and Restatement of CNSA Position

This statement has been formatted as a position statement to reinforce CNSA's commitment to member safety. The following items have been completed this term and at present no further recommendations have been made to necessitate a resolution statement for the incoming BOD to address.

- Permanent Safety and Wellness Advocate position created on new Board of Directors
- Updated Policies and Procedures
    - New Accessibility Policy
    - New Cultural Safety and Humility Policy
    - National Conference - strict safety policy for social events, increased focus on accessibility and inclusion during conference. Event safety requirements in place for all conferences.

Resources

The Canadian Nursing Students' Association Governing Documents Policies and Procedures 2020.

Advocating for the Elimination of Weight Bias in Healthcare

Approved: January 2021
Approved by: CNSA National Assembly
Submitted: December 1st, 2019
Submitted to: CNSA Board of Directors 2019-2020
Submitted By: Courtney Blake, North Island College,
Emma Hill Vancouver Island University,
Jessica Wingfield, University of Ottawa

Introduction and Background Information

Weight bias is the presence of negative beliefs that impact an individual's perception of

large folks and leads to prejudice and weight discrimination. The impact that weight bias has on a healthcare provider's ability to provide care has been well documented, including in nurses. Nurses have been cited as viewing large folks as not as good or successful as others, not fit for marriage, messy, not as healthy, awkward, unattractive, ugly, and non-compliant (Fruh et al, 2016; Ward-Smith & Peterson, 2016). Research has also found that primary care physicians spend less time with large folks, have difficulty performing physical examinations on large bodies, view large folks as untidy, less successful, and less healthy, and feel frustrated when treating large folks (Fruh et al, 2016; Ward-Smith & Peterson, 2016).

These negative beliefs about large folks have real-life consequences, contributing to care delivery challenges that require extra time and resources (Garcia et al., 2016; Lumley et al., 2015) and weakened physician-patient relationships that result in less effective counselling about health issues and less willingness to follow medical recommendations (Gudzune, Beach, Roter, & Cooper, 2013). At a societal level, those consequences include social inequalities and increased health disparities (Puhl & Heuer, 2010). Everyone that lives in a culture that stigmatizes large bodies will internalize that weight bias. This leads to poorer psychological well-being, increased risk of depression, poorer body image, and disordered eating (Major, Tomiyama, & Hunger, 2018)

For several years, public health campaigns have unsuccessfully used shame and stigma as a tool to motivate large folks to lose weight (Puhl & Heuer, 2010). These campaigns were built on the belief that weight is entirely within a person's control, that any person who is large is simply lacking motivation or willpower, which has been shown to be empirically false (Fruh et al, 2016; Darling and Serdar Atav, 2019). These campaigns were doomed to fail, as shame and weight-based stigmatization have been shown to lead to increased weight gain, increased disordered eating behaviours, and increased stress-linked illnesses (Fruh et al, 2016; Darling and Serdar Atav, 2019). These campaigns have not only failed to lower the number of large folks, they have significantly contributed to the social stigma aimed towards large folks (Puhl & Heuer, 2010).

When an individual experiences weight discrimination, it can lead to unhealthy eating patterns, eating disorders, reduced physical activity, stress-induced illness, and lower rates of health and preventive care utilization (Puhl & Heuer, 2010). Experiencing weight stigma causes an increase in blood pressure, reduces cognition, and increases food consumption (Sutin, Stephan, & Terracciano, 2015). Experiencing weight stigma also increases the risk of chronic

inflammation, disease burden, shortens life expectancy and is associated with an almost 60% increase in mortality risk (Sutin, Stephan, & Terracciano, 2015). Chronic inflammation, which is strongly linked to 80% of leading causes of death, is strongly triggered by weight stigma and shame (Major, Tomiyama, & Hunger, 2018). Weight stigma has been shown to have a more significant effects on one's health than any other form of discrimination, including age, gender, race, sexuality, income, disability, or ancestry (Sutin, Stephan, & Terracciano, 2015)

Weight discrimination can also lead to a hesitancy to seek medical help for any health related problems, not just weight-related ones (Darling and Serdar Atav, 2019). Large folks often delay seeking treatment due to providers expressed negative attitudes, disrespectful treatment, weighing procedures that caused embarrassment, uninvited weight loss advice, and examining tables/gowns/equipment that were too small to be functional (Fruh et al, 2016).

Nurses are not immune to the influences of a society that inherently devalues large folks. When compared with other health science students, nurses have the highest amount of weight bias and the most negative attitudes towards large folks (Darling and Serdar Atav, 2019). However, nursing students who are more educated on the causes and contributing factors of weight gain have more positive attitudes toward large folks (Fruh et al, 2016; Darling and Serdar Atav, 2019). In addition to a lack of knowledge, several other factors were identified as contributing to negative attitudes, including perceptions of large folks, interactions with large folks, and workload challenges when caring for large folks (Pervez and Ramonaledi, 2017)

Canadian Nursing Students' Association's Current Position on the Issue

The Canadian Nursing Students' Association (CNSA) has made it a significant focus of the association to advocate for issues of social justice, represented through one of the three strategic objectives; Objective B: Influence and advance innovation and social justice in the nursing curriculum and the nursing profession (CNSA, 2016). CNSA knows that the intersection between oppression and health is significant and complex and that nurses play a key role in advocating for their clients when issues of social justice impact their ability to receive care. The issue of weight bias is, at its core, an issue of social justice, as it relates to the inequitable treatment of large folks by societal structures.

CNSA has many policies related to social justice, however, there is no policy currently in existence within CNSA that outlines the organization's understanding of how weight bias interacts with healthcare. There is robust nursing literature that shows how large folks

experience stigma and discrimination, and how experiencing weight bias can drastically affect one's health outcomes.

CNSA recognizes that all health care professionals, including nurses and nursing students, have an obligation to provide the best care possible to everyone they work with, including large folks. In order to fulfill this obligation and practice according to the evidence, nurses and nursing students must evaluate their own perceptions, biases, and attitudes when working with this population, and they must reflect on how those biases can be expressed.

CNSA advocates for a patient-centred approach when reviewing health management strategies. Greater compliance with health recommendations can be achieved when patients feel respected and empowered to have control over their own health (Nicholls, Pilsbury, Blake, & Devonport, 2016; Darling and Serdar Atav, 2019). When nurses focus on what matters to the patient, and not their own preconceived beliefs, the patient develops more trust in the healthcare system and will be more likely to seek medical attention when necessary. CNSA recognizes that provider bias is only one of many factors that affect a patient's reluctance to seek medical attention. Some of these factors can easily be alleviated by adequate access to size appropriate equipment, including chairs, beds, lifts, slings, and clothing.

CNSA acknowledges the efforts of those in the fat activism community to reclaim the word "fat". However, this word still has a significant amount of stigma attached to it, and as such can be harmful when used against people who do not identify as fat. CNSA recommends that nurses avoid using "fat" with their clients unless the nurse knows their client identifies as fat. CNSA also recommends nurses avoid the words "overweight" and "obese", as these words have been used to pathologize bodies that may be otherwise healthy. This may not always be possible in the current healthcare climate, due to institutional structures and the widespread use of oppressive tools such as the BMI scale. However, CNSA encourages nurses to become change agents in their practice and find alternative words to use that both the client and nurse are comfortable with.

Relation to Canadian Nursing School Curriculums

Nursing literature has identified strong links between lack of education and weight bias, particularly regarding nursing students (Darling and Serdar Atav, 2019; Fruh et al, 2016; Gudzune et al., 2013; Pervez and Ramonaledi, 2017). Nursing curriculum across Canada already includes themes of social justice due to the implementation of curriculum surrounding the Social

Determinants of Health. However, increased focus on training nurses to be leaders who support social justice for people of all body sizes is essential to minimizing weight bias (Darling and Serdar Atav, 2019).

A challenge that has been identified within nursing literature is the medicalization of weight and how it is taught in nursing curriculum. Research suggests that because nursing students are taught about some of the physical health effects that can be associated with increased body weight, but not about the devastating impacts of weight bias, this leads to a negative attitude surrounding weight and weight gain and the false perception that increased body weight is the only contributor to adverse health outcomes in large populations (Darling and Serdar Atav, 2019). This means there is a need for nursing curriculum to include education about the impact genetics, environment, income, mental health, physical comorbidities, medications, and stress have on weight gain so that nurses understand that weight gain is not completely related to poor choices about diet and exercise (Darling and Serdar Atav, 2019). Nursing curriculum needs to explore how weight bias contributes to adverse health outcomes, independent of body size.

Many strategies need to be used concurrently in order to reduce weight bias in healthcare. Research has shown that providers who practice according to the Health at Every Size (HAES) principles have increased positive attitudes towards supporting size acceptance and reducing weight bias (Drake and Ogletree, 2018). Nurses must serve as a positive influential voice to reduce weight bias with their interaction and communication with the public, peers, and students. Nurses have a critical role in communicating the importance of eradicating weight stigma and providing the best possible care to large folks (Fruh et al, 2016).

Conclusion and Restatement of the CNSA Position

Negative beliefs about large folks have real-life consequences, including care delivery challenges, poorer mental health, and significantly harmful physiological processes. The issue of weight bias is, at its core, an issue of social justice, as it relates to the inequitable treatment of large folks by societal structures, and nurses play a key role in advocating for their clients when issues of social justice impact their ability to receive care. All health care professionals, including nurses and nursing students, have an obligation to provide the best care possible to everyone they work with, including large folks.

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Resolution Statements 2021

APPROVAL OF BOARD STRUCTURE CHANGES

WHEREAS CNSA recognizes the ongoing concerns of the membership regarding the lack of diversity and representation on the Board of Directors.

AND WHEREAS The increasing attention and awareness surrounding the Black Lives Matter and Indigenous rights movements has encouraged CNSA to create and implement an identity-based caucus model.

AND WHEREAS Shifting the focus from interest-based committees to identity-based caucuses will increase the representation and autonomy of equity-seeking groups within the Board of Directors.

AND WHEREAS CNSA is a working board and lacks the staffing that typically exists within a non-profit organization

NOW THEREFORE BE IT RESOLVED that:

1. The following positions and committees shall be disbanded;
    - 1.1.Positions:
        - 1.1.1. Director of French Advocacy
        - 1.1.2. Diversity Committee Chair
        - 1.1.3. Community and Public Health Committee Chair
        - 1.1.4. Global Health and Outreach Committee Chair
        - 1.1.5. Indigenous Ally
    - 1.2.Committees:
        - 1.1.1. Advocacy Committee
        - 1.1.2. Bilingualism and Translation Committee
        - 1.1.3. Global Health and Outreach Committee
        - 1.1.4. Diversity Committee
        - 1.1.5. Community and Public Health Committee
        - 1.1.6. Education and Research Committee
        - 1.1.7. Career and Leadership Development Committee
        - 1.1.8. Indigenous Health Advocacy Committee

1.1.9. Practical Nursing Committee

2. The following positions and caucuses shall be created;
    2.1.1. Positions:
        2.1.1.1. Elder
        2.1.1.2. Scholarship and Bursary Coordinator
        2.1.1.3. Environmental Sustainability Advocate
        2.1.1.4. Safety and Wellness Advocate
        2.1.1.5. 2SLGBTQ+ Caucus Chair
        2.1.1.6. Francophone Caucus Chair
        2.1.1.7. People of Colour Caucus Chair
        2.1.1.8. Indigenous Caucus Chair
        2.1.1.9. Black Caucus Chair
        2.1.1.10. Diversability Caucus Chair
        2.1.1.11. Men's Caucus Chair
        2.1.1.12. Psychiatric Nursing Director
    2.1.2. Caucuses:
        2.1.2.1. 2SLGBTQ+ Caucus
        2.1.2.2. Francophone Caucus
        2.1.2.3. People of Colour Caucus
        2.1.2.4. Indigenous Caucus
        2.1.2.5. Black Caucus
        2.1.2.6. Diversability Caucus
        2.1.2.7. Men's Caucus

Rationale for Board Structure Changes Resolution

In response to consistent feedback regarding the challenges with CNSA's current governance model, the following changes have been proposed as alternatives to help increase the diversity and representation on the Board of Directors.

Caucuses:

The increasing attention and awareness surrounding the Black Lives Matter and Indigenous rights movements has encouraged CNSA to create and implement an identity-based caucus model. CNSA proposes removing our current model of interest-based committee's and replacing it with identity-based caucuses. This would ensure that the voices of equity-seeking

groups are present at the board level. Shifting the focus from interest-based committees to identity-based caucuses will increase the representation and autonomy of equity-seeking groups within the Board of Directors.

The following include the proposed caucus': 2SLGBTQ+ Caucus, Black Caucus, Diversability Caucus, Francophone Caucus, Indigenous Caucus, Men's Caucus, and People of Colour Caucus.

Our original intention was to have the chairs of each caucus be elected internally within each caucus and then represented on the board as part of their role as caucus chair. However, according to the Not-for-profit act, all voting directors must be elected by the general membership. This means that in order for the chairs of these caucuses to have a vote on the board of directors, they must run for their position during general elections and be elected by the general membership.

With the disbanding of the committees, we would like to maintain some space for members to band together and work on short-term projects that are interest-based. This would be made possible through the creation of working groups. Existing language in the policies will be amended to clarify the role of working groups in CNSA and how members can go about creating a working group

Directors:

CNSA has proposed to keep the Regional Director model to ensure that every nursing student voice is represented geographically across Canada.

The role of DIHA has been transitioned out of EC due to the implementation of identity-based caucuses. We agreed as a board that the function of EC will no longer be representation, which was part of the previous reason the DIHA role was integrated. With this model, the DIHA and Caucus Chair roles would still be separate, meaning an overall increase to 2 Indigenous votes on our board, opposed to the previous 1. We hope that with this increased Indigenous representation in CNSA, future boards will be able to continue to move towards a board model where Indigenous and non- Indigenous systems of governance can co-exist side-by-side.

CNSA proposes establishing a voting seat for Practical Nurses and Psychiatric Nurses on the board. Both of these students have vastly different experiences that deserve to be recognized and represented within our board structure.

The removal of the Director of Language Advocacy directly reflects the establishment of a francophone caucus. If a francophone caucus is not formed, CNSA will keep the Director of Language Advocacy.

Administrative Council (AC):

CNSA would like to change the name of the executive committee to administrative council. We feel this better reflects the responsibilities of the council as well as removes the hierarchy associated with the word "executive". We hope that these changes to name and structure within AC will decrease the hierarchy of our board structure. Having a decreased size within AC will ensure quick mobilization and response times when necessary. AC will still be encouraged to invite all board members to their meetings to ensure all perspectives and identities have the opportunity to be represented at these meetings.

Advocates, & Coordinators, and Officers:

Positions including Administrative Officer (AO), Technology Officer (TO), and Elder are paid and hired positions. The Administrative Officer position is one (1) paid position that is divided between two staff members, who are provided to CNSA by our partner CASN. The AO and TO are already pre-existing positions. The Elder would be a new addition that would be responsible for guidance and support in respect to team dynamic and reconciliation.

New elected non-voting positions include an Environmental Sustainability Advocate who would be primarily responsible for ensuring the organization is always working towards decreasing its carbon footprint. The Safety and Wellness Advocate would be responsible for ensuring that all CNSA materials and events are accessible, safe, and promote continued member wellness. The New Grad Committee Chair position would transform into a New Grad Advocate position that focuses on supporting new grads and providing resources to decrease horizontal violence against new graduates. The Scholarship and Bursary Coordinator would oversee fundraising, awards, and scholarships for the organization. This would include collaboration with the Director of Membership Development for NNSW, and with the National Conference Coordinator (NCC) for National Conference. The NCC position would remain an elected non-voting position on the board of directors.

Inclusive Education on Providing Safe and Competent Care to Transgender Patients

Approved: January 2021
Approved by: CNSA National Assembly
Submitted: December 18, 2020
Submitted to: Canadian Nursing Students' Association Board of Directors 2020/2021
Submitted by: Shelby Kennedy, RN BcSN;

Emma Hill, Vancouver Island University

Introduction/Background:

It is well known that transgender people face discrimination when accessing health care (Brown et al., 2017; Lindroth, 2016; The Trans PULSE Canada Team, 2020b), and concurrently transgender people have higher unmet healthcare needs compared to the general population (The Trans PULSE Canada Team, 2020a). In an American study from 2015, onethird of transgender respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive appropriate care (James et al., 2016). In a Canadian study from 2019, 56% of transgender respondents rated their current mental health as fair or poor (The Trans PULSE Canada Team, 2020a). 1 in 3 had considered suicide in the past year, and 1 in 20 reported attempting suicide in the past year (The Trans PULSE Canada Team, 2020a). These mental health concerns can be attributed to systematic, societal and institutional discrimination of transgender people, such as barriers to employment, housing, adoption, retirement benefits, marriage, and health insurance (The Trans PULSE Canada Team, 2020a). This all comprises the historical oppression and discrimination transgender people have encountered in societal and health care settings (The Trans PULSE Canada Team, 2020a). There is a well-documented link between experiences of discrimination and marginalization and poor physical and mental health outcomes (James et al., 2016). Populations that face widespread stigma and discrimination are more likely to report poor overall health and are more vulnerable to a variety of physical and mental health conditions (James et al., 2016).

Also of importance to note is the difference of transgender people's experiences based on intersectional identities. Systemic racism and its intersection with transphobia requires further research, but initial research of racialized transgender people indicates that "overwhelmingly, [they] reported high levels of discrimination, violence and assault... racialized respondents were more likely to rate their health as poor, and to report living with a disability and/or chronic pain" (Chih et al., 2020).

Nursing schools rarely include content on providing safe and competent care to transgender individuals in the healthcare setting, and this education is both inconsistent and inadequate (Canning & Kennedy, 2019). Nursing students have demonstrated they want to learn more and would like to be better equipped to provide for all patients they encounter (Canning &

Kennedy, 2019). They also recognize the relevance and importance of this topic but often are unsure how to proceed in clinical settings if no education has been provided (Canning & Kennedy, 2019). As well, with no mandated content in curricula any inclusion is left up to individual schools or faculty. Nursing students are grateful for receiving any type of this learning and often seek it from outside their formal education (Canning & Kennedy, 2019).

When health care providers lack education and exposure, they lack understanding. Conversely, education about and exposure of the trans community can lead to a greater understanding of their needs (Canning & Kennedy, 2019). Specifically, when nurses are knowledgeable about and comfortable with a transgender patient, they are able to provide holistic and appropriate care to this population, work to remove inequities in the healthcare system, and prevent discrimination (Canning & Kennedy, 2019). As well, they are able to advocate for their patients and educate other colleagues.

Very little research exists on the implementation of transgender content in nursing curricula on a larger scale or specifically in Canada (Kellett & Fitton, 2017; Yingling et al., 2017). Individual schools have had great success in educating students with a variety of formats having favorable responses from students and faculty (McDowell & Bower, 2016; McNiel & Elertson, 2018; Yingling et al., 2017). Some important notes from these studies include promoting involvement of the transgender community when creating content and curriculum guidelines (Brown et al., 2017). As well, a key factor to consider in implementation of this content is ensuring nursing faculty are prepared to teach on this topic (McDowell & Bower, 2016). Canada has taken the lead in nursing curriculum of other marginalized groups, such as Indigenous people with mandating education regarding specific health needs, history of colonization and involvement of these people. This type of initiative is needed for improving education on other equity seeking groups with their own diverse health care needs and history of discrimination in the health care system and society.

In 2015 a National Nursing Education Framework report was released from the Canadian Association of Schools of Nursing (CASN). CASN establishes and promotes national standards of excellence for nursing education, and is representative of all universities and colleges which offer part or all of an undergraduate or graduate degree in nursing. CASN is also the official accrediting agency for university nursing programs in Canada. Although CASN cannot enforce curriculum in all schools across Canada, many follow this framework, which identifies core expectations for nursing programs and entry level competencies of registered nurses..

Multiple sections of the framework call for education on diverse and equity seeking populations, such as:

1.8 Knowledge of primary health care in relation to health disparities, vulnerable populations, and the determinants of health.

3.1 Holistic and comprehensive assessment of diverse clients, to plan and provide competent, ethical, safe, and compassionate nursing care.

3.12 The ability to promote health of individuals, families, communities, and populations through actions to address health disparities

4.5 The ability to collaborate with diverse clients, adapt relational approaches appropriately and accommodate varying contextual factors in diverse practice situations.

6.5 The ability to advocate for change to address issues of social justice, health equity, and other disparities affecting the health of clients. (Canadian Association of Schools of Nursing, 2015)

CNSA's Current Position on the Topic:

This topic has been a concern for CNSA members for many years. The following position and resolution statements have been passed at previous National Assemblies:

- 2013 Position statement Incorporating LGBTTIQQ2SA Education into Nursing Curriculum in Canada.
- 2017 Resolution statement Incorporating LGBTTIIPQQ2SAA+ Education into Nursing Curriculum in Canada.
- 2020 Position statement Incorporating 2SLGBTIQQA+ Education into Nursing Curriculum in Canada.

By highlighting curriculum content for care of transgender people independently, we wish to acknowledge that discrimination and health inequities of the broader 2SLGBTQ+ community are compounded for transgender people, and that transphobia also exists within the 2SLGBTQ+ community (Canadian Mental Health Association, n.d.). CNSA recognizes the discrimination and inequities that trans people face in the healthcare system and that by providing appropriate education to nursing students, future healthcare professionals will be better equipped to

address these issues and provide safe and competent care to transgender patients.

Rationale

WHEREAS, nursing schools across Canada do not meet the essential components set out by CASN for expectations of baccalaureate programs in regards to diverse populations, such as transgender people.

WHEREAS, transphobia in the healthcare system and inequities in the health of transgender people exist.

WHEREAS, nurses as the frontline of healthcare are in an ideal position to create change and make an impact in ensuring all patients receive equitable, accessible and inclusive health care.

BE IT RESOLVED,
That the CNSA supports the creation of comprehensive and mandated content in Canadian nursing curricula for providing safe and competent care to transgender patients.

BE IT RESOLVED,
That the CNSA supports involvement of the transgender community with lived experience to lead the creation of any nursing curricula.

BE IT RESOLVED,
That the CNSA advocates for these updates to nursing curricula by partnering with national partners such as CASN.

Relation to Canadian Nursing School Curriculums

Content on providing safe and competent care to transgender patients is inconsistent, inadequate, or missing from nursing school curricula across Canada (Canning & Kennedy, 2019). Inclusion of these topics in Canadian nursing schools can be expected to provide a new generation of nurses who are aware of health inequities faced by transgender people, how to provide safe and competent care, and how to better act as advocates for their patients.

Conclusion

To combat transphobia in health care and to work to remove the inequities in the health

of transgender people, nursing students must be educated per a national standard to be able to provide safe and competent care to the transgender community. Nurses are in a unique position to advocate for inclusive care, however, currently there is minimal support and education related to transgender care. With a strong knowledge base and support, nurses and other healthcare providers can positively impact a transgender person's experiences through understanding their care needs and acting as advocates.

Resources

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Position Statements 2020

Advocating for Sexual and Reproductive Education in Nursing Curricula: Supporting Reproductive Autonomy

Approved: January 2020
Approved by: CNSA National Assembly
Submitted: November 27, 2019
Submitted to: Board of Directors, 2019-2020
Submitted by: Jessica Guthier, Thompson River University;
Courtney Blake, North Island College;
Latitia Pelley-George, BScN, RN;
Victoria Marchand, University of Ottawa

Introduction and Background Information

Induced abortions have been legal in Canada since 1988 and are currently governed by the Canada Health Act (Government of Canada, 2019). Furthermore, in section 7 of the Canadian Charter of Rights and Freedoms states every Canadian has the right to "life, liberty, and security of the person and the right not to be deprived thereof" (Government of Canada, 2019). In 1988, when induced abortions were legalized in Canada, the highest courts of our country also ruled that nobody but the pregnant person themselves could decide for or against an induced abortion. To attempt to control a person's reproductive capacity would be to violate that person's right to *life, liberty, and security of the person* (Government of Canada, 2019; LawforAlbertaWomen.ca, 2015).

Access to an induced abortion is both a reproductive and human right, however, there are many people in Canada who do not have reliable access to abortion nor other reproductive services. This is due to the inconsistencies in funding throughout the country, geographical constraints, anti-choice politicians, as well as the ideological alignment of many influential non-profit groups. Many provinces regulate which facilities can provide induced abortions, unnecessarily requiring services to be performed in hospitals and refusing to allow these services to be performed in smaller clinics with equally trained professionals (CBC, 2019). This constraint creates a barrier for people living in rural and remote communities, who would then be required to commute long distances to receive services at a hospital. Huge financial barriers are created for clients when they must travel long distances, additional to possibly having to pay for some or all of the service - as coverage is province dependent. When there are barriers to accessing reproductive services - including legislative barriers, social stigmatization, and

bureaucratic processes - people who require or depend on these services cannot access them. Thus, their reproductive options and bodily autonomy can be limited (Reeves et al, 2018).

There are many fake abortion clinics, often called "Pregnancy Crisis Centers", which cater to vulnerable pregnant populations but refuse to refer their clients to abortion services (ARCC, 2019). These fake clinics provide misinformation about abortion or withhold information in an attempt to exaggerate the dangers of abortions (ARCC, 2019). These clinics are funded primarily by religious organizations and private donors, are not medical clinics, and do not willingly disclose their religious ties (ARCC, 2019). People who are seeking abortion services also face long wait times to receive the services they require, which compromises their eligibility to receive said services (CBC, 2019). For example, many hospitals put early upper limits on how far along in the pregnancy the client can be; cut-offs such as 12 or 18 weeks result in clients learning about their pregnancies and then only having a short amount of time to decide whether or not to access abortion services.

Nurses have a moral, ethical, and professional obligation to advocate for increased access to health care services, regardless of their personal opinions about those services. Nurses know that inadequate access to reproductive services does not lead to less abortions, it leads to less safe abortions. At home remedies become enticing and may seem like viable options, but these can have devastating, and sometimes fatal, effects. Creating barriers to proper reproductive health will only assure that many unwanted pregnancies end in physical illness or pain, psychological and emotional stress, financial challenges, or death of the pregnant person.

Canadian Nursing Students' Association's Current Position on the Issue

As of 2019, the CNSA harbours no definitive position on this issue. While referring to the 1984 to 2006 position and resolution statements, not one mention towards reproductive autonomy was made. Furthermore, recent position and resolution statements also fail to make any mentions to reproductive health, and especially not to induced abortions. Whether this is due to the lack of need historically for CNSA to take a stance, or whether this has been a conscious choice due to the politically heated nature of this topic, is unknown. In January of 2013, CNSA passed a resolution statement encouraging educational institutions to include political education in curriculum, encouraging nursing students to become involved in political activism, and attempting to involve nursing students in their communities at an advocacy level (Gielarowiec, Hardy-Moffat, Telegdi, & Bloomberg, 2013). While resolution statements such as these have inspired students to become involved within the CNSA, it is unclear how involved CNSA students have become in the external political climate.

Indirectly related to this issue is a position statement passed in 2018 regarding rural and remote health equity. Although this position statement speaks more closely to the health discrepancies faced by Indigenous populations and other populations living remotely and rurally, it indirectly speaks in support of reproductive autonomy (Norris, Pelley-George, Gustafson, 2018). This is because remote and rural communities often lack the infrastructure necessary to provide clients with choices and educational supports surrounding their reproductive health.

Furthermore, creating a position on this issue falls within CNSA's strategic plan Objective B, Outcome 1: members"[b]e involved in curriculum decisions, planning and review", and Objective B, Outcome #4: "Members of CNSA incorporate research and evidence-based decision making into their current and future practice to positively influence patient outcome" (CNSA, 2016).

Relation to Canadian Nursing School Curriculums

A clear objective of CNSA is to influence and make advancements in innovation and social justice within the nursing curriculum and the nursing profession (CNSA, 2016). A clear objective of nursing schools' curricula is to provide graduate nurses with at least the minimal requirements to allow graduates to perform at a generic level. Curricula and the culture permeating healthcare would have one believe that sexual and reproductive healthcare are niche topics--ones requiring extra certification to be able to address. While it may be true that to provide sound advice and perform thorough assessments regarding sexual and reproductive health, it is in no way true that a graduate nurse should not have the competencies to discuss sexual and reproductive health with their clients. In every healthcare setting, a person's sexual orientation and gender are present. Despite not being the focus of their visit, a client will always carry their sexuality and gender with them and it will influence every decision they make and every experience they have. To provide holistic care, a nurse *must* be willing to address a client's sexual and reproductive needs and, where their own expertise fails, refer them to an appropriate professional.

Moreover, impartiality to all patients to provide excellent care despite personal beliefs is a fundamental belief in the nursing discipline. Whatever a nurses' personal beliefs on sexual and reproductive topics, they must not let it influence the information they provide their patients, the options they present, or the care they provide. Such an important concept is currently being left up to individual universities to decide whether or not to discuss, and that is unacceptable. The CNSA must be a strong advocate that *every* nursing curriculum include education on how to address sexual and reproductive health topics.

Conclusion and Restatement of the CNSA Position

A person's sexuality and gender are their own, and options such as contraception and induced abortions are an important aspect of comprehensive healthcare. No matter a nurses personal beliefs, they must always be willing to provide all possible information with the best interpretation for their client, and treat their clients with autonomy, justice, maleficence, and beneficence. Fostering this mind-set must happen at the undergraduate nurse level, and be declared as a core-competency no-matter where a nurse works. It is far better for a graduate nurse to be prepared to address a client's sexual and reproductive needs and never be asked, than for them to be ignorant of these topics when a client is in need.

Currently, the CNSA has no positions or resolutions specifically targeting this issue--or any reproductive health issues. Some position statements indirectly support adoption of a strong position in favour of reproductive autonomy, as do the CNSA's objectives and outcomes. Lastly, it is written within our very constitution that every person living in Canada has the right to *life, liberty, and security of the person* (Government of Canada, 2019). That means they have an inalienable right to do with their body what they wish. The CNSA must make a stance on this topic and be staunch advocates for patient-centered and holistic care.

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Condemning Conversion Therapy: Supporting 2SLGBTQ+ Health Through Evidence-Based Care

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Submitted to: Board of Directors, 2019-2020
Submitted by: Courtney Blake, North Island College

Introduction and Background Information

Conversion therapy, also known as reparative therapy or sexual orientation change efforts, is the practice of using therapeutic interventions in an attempt to change an individual's sexual orientation to heterosexual (Drescher et al., 2016). It can include religious meditation, aversion therapy, talk therapy, or group therapy (CPA, 2015; Drescher et al., 2016). Conversion therapy has been widely reported to include harmful and abusive methods, such as separating individuals from their social support networks and families, shame, blame, sleep deprivation, verbal abuse, physical abuse, sexual abuse, and emotional abuse. It is primarily funded and supported by religious bodies that reject the validity of non-heterosexual sexual identities. While many organizations that offer conversion therapy deny allegations of abuse, there is no regulatory body to ensure this is true, and many survivors of conversion therapy still report experiencing abusive methods (Stroh, 2019).

Historically, psychoanalysts believed that the cause of homosexuality was poor parenting, an immature or childish personality, or a phobia of heterosexuality, and that there was "no such thing as normal bisexuality" (Drescher et al., 2016). This belief was adopted by many professionals, including psychiatrists, despite contradictory research showing how homosexuality is a natural human variance (Drescher et al., 2016). In the 1970s, mass protests forced the American Psychological Association to re-evaluate the evidence, leading to homosexuality being removed from the DSM -II in 1973 (Drescher et al., 2016). This helped change societal attitudes regarding homosexuality, but it still took almost another 20 years for

the World Health Organization to remove homosexuality from their International Classification of Diseases (ICD-10) (Drescher et al., 2016). Despite the lack of evidence or support, old psychoanalytic theories are still used to this day by social and religious conservatives to support the use of conversion therapy (Drescher et al., 2016).

While 2SLGBTQ+ individuals and organizations have always opposed interventions meant to "cure" them of their sexual orientation, the recent influx of professional organizations and health authorities support has given validity to the concerns raised around conversion therapy. Currently, conversion therapy is opposed by many professional organizations worldwide, including; the World Health Organization, American Academy of Pediatrics, American Psychoanalytic Association, American Medical Association, American Counseling Association, American College of Physicians, American Psychological Association, Canadian Psychiatric Association, Canadian Psychological Association, and the Canadian Association of Social Workers (Human Rights Campaign, n.d.; CPA, 2015).

There is no peer-reviewed evidence to support the theory that an individual can change their sexuality after undergoing conversion therapy (Drescher et al., 2016). Many organizations that offer conversion therapy services instead use anecdotal testimonials as their primary source of evidence. However, there is a wealth of peer-reviewed evidence that shows that conversion therapy can lead to depression, anxiety, distress, suicidal ideation, negative self-image, spiritual distress, impaired ability to maintain relationships, and sexual dysfunction (CPA, 2015; Drescher et al., 2016).

In Canada, there is no federal law regarding conversion therapy, despite a petition submitted to the federal government in March 2019 (Stroh, 2019). However, there are some regulations at the provincial and municipal levels throughout Canada that restrict access to conversion therapy. Ontario is the only province with an outright ban, while Manitoba and Nova Scotia have regulations surrounding who can offer and who can receive conversion therapy (Stroh, 2019). Vancouver is currently the only municipality that has enacted regulations preventing businesses from offering conversion therapy services (Stroh, 2019). While these regulations are better than nothing, anything less than an outright ban leaves room for harm to come to 2SLGBTQ+ individuals.

Canadian Nursing Students' Association's Current Position on the Issue

In 2013, CNSA passed the position statement "Incorporating 2SLGBTIQQA+ Education into Nursing Curriculum in Canada", which recognized the need for nurses to advocate for 2SLGBTQ+ health concepts to be integrated into nursing curriculum and to practice culturally safe care when working with 2SLGBTQ+ populations (CNSA, 2013). Then, in 2017, CNSA passed an

additional resolution statement further emphasizing the need to incorporate 2SLGBTQ+ needs into nursing curriculum in addition to working with local 2SLGBTQ+ organizations (CNSA, 2017).

While these previous statements are strongly linked in concept to this current statement, they differ in that they focus on the ability of nurses to provide culturally safe care to 2SLGBTQ+ individuals, whereas this statement opposes interventions that negatively affect 2SLGBTQ+ individuals. Nursing students must continue to advocate for the integration of culturally safe care into nursing curriculum and nursing practice, but it is just as vital that nurses understand the context and implementation of why and how 2SLGBTQ+ individuals have experienced trauma in the name of health care.

Relation to Canadian Nursing School Curriculums

According to the 2016-2021 strategic plan, one of the priorities of CNSA is to "influence and advance innovation and social justice in the nursing curriculum and the nursing profession" (CNSA, 2016). CNSA has been working diligently with CASN throughout the last six years to stress the importance of integrating 2SLGBTQ+ specific health concepts into nursing curriculum. Understanding the impact of conversion therapy needs to be part of this understanding. Nursing students must recognize the traumatic effects that can occur when an individual undergoes conversion therapy so that they may advocate for their patient if it is presented as a valid therapeutic option. It is also vital that nurses understand the potential harms associated with conversion therapy so that they may provide trauma-informed care when working with individuals who are experiencing adverse outcomes related to these experiences.

Conclusion and Restatement of the CNSA Position

CNSA does not support the use of conversion therapy as a therapeutic intervention, does not support the belief that sexual orientation can be changed, and supports increased legislation aimed towards banning the use of conversion therapy. Conversion therapy can result in serious harm done to the recipient and has no peer-reviewed evidence of any benefit. It is the responsibility of nurses to advocate for the health and safety of their clients, which includes opposing interventions where the benefits do not outweigh the risks. In the case of conversion therapy, the non-existent benefits are vastly outweighed by the negative health outcomes

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Equitable Healthcare and Education for Deaf and Hard of Hearing Populations

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Submitted to: CNSA Board of Directors
Submitted by: Amy Rowe, Queen's University

Introduction and Background Information

It is estimated that 350, 000 Canadians are profoundly deaf and 3.2 million are Hard of Hearing (Canadian Association of the Deaf, 2015). There is no universal sign language, but there are hundreds of sign languages around the world, just as there are spoken languages (Olson & Swabey, 2017). The main sign languages in Canada are American Sign Language (ASL), French

Sign Language (Langue des Signes Francaise) and Indigenous Sign Language (Gessner, Herbert, & Parker, 2017). While some Deaf and Hard of Hearing Canadians receive speech therapy or undergo surgery for cochlear implants, their primary language is ASL (American Psychological Association, 2013).

To provide accessible healthcare, understanding Deaf culture is critical. Direct translation from English is not enough to properly communicate. There is a lack of culturally competent sign language interpreters that understand both medical terminology and Deaf culture (Canadian Hearing Society, 2019). Deaf culture encompasses the rules, traditions and behaviours of Deaf people (Rosen, 2007). Their rich culture impacts the understanding, values and beliefs of Deaf people in healthcare settings (Gallaudet University, 2015). Inaccessible healthcare leads to poor health assessment, limited prevention services, culturally inappropriate treatment, and poor health outcomes (Olson & Swabey, 2017).

According to the United Nations (2018), access to education and health care services is a human right. Yet Deaf and Hard of Hearing populations do not receive equitable healthcare or education in Canada. Deaf and Hard of Hearing Canadians face educational barriers in post-secondary education. Systemic barriers and discrimination prevent nursing and medical students from becoming health care providers and accessing post-secondary education. This population experiences marginalization, poor employment conditions and inadequete mental health resources (Olson & Swabey, 2017).

The Position

The Canadian Nursing Students Association (CNSA) supports and advocates for equitable healthcare for all Canadians (CNSA, 2016). This extends to Deaf and Hard of Hearing Canadians who face healthcare inequalities. The lack of culturally competent medical interpreters is only one problem contributing to disparities in this population. The lack of preventative medicine, poor communication and misdiagnoses contribute to poor health outcomes. These issues are relevant for future nurses to understand.

The CNSA strives to strengthen relationships and create new partnerships (CNSA, 2016). The Canadian Hearing Society and the Canadian Association of the Deaf are key resources for the CNSA to collaborate with. In order to break down barriers this population faces, we all must work together. It is not the responsibility of the Deaf of Hard of Hearing students alone to advocate for inclusion and integration.

The CNSA advocates for cultural safety and accessibility (CNSA, 2016). Providing basic education on Deaf culture and sign language is essential to bridging the gap between hearing nurses and Deaf patients. Nursing students should learn basic, medical signs. Communication

barriers pose safety risks to patients when health care professionals cannot sign basic words. Currently, there is no requirement for nursing schools to provide this type of education. A basic education should be added to nursing curriculum immediately to advance nursing students for their practice. This education will increase nursing students' awareness and promote inclusion for all patients. Deaf and Hard of Hearing individuals should lead the development of culturally appropriate curriculum. By advocating for this curriculum, the CNSA follows its objective of advancing and influencing nursing education (CNSA, 2016).

The CNSA is the national voice of all nursing students, and supports the education of Deaf and Hard of Hearing nursing students. Regardless of hearing function, all students can become nurses and should be encouraged to pursue post-secondary education and qualifications. Providing equal opportunity to nursing students who require interpretation is necessary. Integration of all nursing students who sign is encouraged by the CNSA. It is the responsibility of hearing people to work with Deaf and Hard and Hearing populations to make nursing school accessible. One barrier to nursing is using a stethoscope. However, Deaf doctors in Canada are already using electronic stethoscopes with visual displays (Kozicka, 2014). While there are still many barriers, the CNSA advocates for innovation and research (CNSA, 2016). Finding creative solutions for every barrier is possible and necessary.

Conclusion and Restatement of CNSA Position

In order to address the healthcare inequalities in this population, nursing students need to learn about Deaf culture, inequalities this population faces, and basic sign language. Deaf and Hard of Hearing nursing students should be able to attend nursing school and become healthcare providers. Nurses who are Deaf or Hard of Hearing will improve health outcomes of these populations. To achieve healthcare equity in this population, it is critical to improve nursing curriculum and advocate for future Deaf and Hard of Hearing nursing students.

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Incorporating 2SLGBTIQQA+[1] Education into Nursing Curriculum in Canada

Approved: January 2013
Approved by: CNSA National Assembly
Submitted By: Nicholas Alves, Centennial College; Emilie Hay, McMaster University
Edited By: Courtney Blake, North Island College

Introduction and Background Information

2SLGBTIQQA+[1] (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Questioning, Asexual, Pansexual, and many more)[2] consists of a wide range of genders, sexes, races, ethnic groups and individuals. There are specific vocabulary, terms, facts and training related to 2SLGBTQ+[3] people that are not taught in the nursing curriculum and therefore make it

difficult for nursing students to provide compassionate, holistic, patient-centered care to members of this population.

While the 2SLGBTQ+[3] population has been identified as an equity seeking[4] population, minimal measures are being taken to specifically address their vulnerability (Daley & MacDonnell, 2011). The stigmatization, oppression, and discrimination experienced by this population contribute to a higher rate of substance use and abuse and other health issues (McKay, 2011). 2SLGBTQ+[3] people may seem to represent a relatively low percentage of the population (5-10%), however, in Ontario alone it is estimated that up to 1.25 million people anticipate or face barriers to access health services (Daley & MacDonnell, 2011). 2SLGBTQ+[3] youth are four times more likely to attempt suicide, and three times more likely to have experienced domestic and/or sexual violence[5] than heterosexual youth (Pies, 2011).

Additionally, it is estimated that approximately 57% of transgender people are rejected by their families, 41% have attempted suicide, and 19% reported experiencing homelessness as a result of their gender identity (Pies, 2011)

Canadian Nursing Students' Association's Current Position on the Issue

As the Canadian Nursing Students' Association (CNSA) is the national voice of student nurses in Canada, and one of its underlying principles is to influence and advance innovation in the nursing curriculum, the CNSA believes it is vital for education pertaining to the 2SLGBTQ+[3] population be integrated into nursing curriculum across the nation. Nursing students are responsible for providing appropriate nursing care to all clients, so it is imperative that the specific needs of this population be met (CNSA, 2005). As future professionals in the healthcare setting, advocating for the nursing profession and ensuring quality healthcare for all Canadians is a fundamental part of caring for different minority groups seen within this country.

Although there are currently low numbers of homophobia among nursing students, there are a larger number of students who show ambivalent and heterosexist attitudes towards 2SLGBTQ+[3] people (Lim & Bernstein, 2012). Through proper education and training specific to this population, nursing students can be better equipped to create an environment in which clients feel safe to release any personal information pertaining to their healthcare needs, without feeling judged. Proper education and training will promote sexual orientation and gender identity awareness and allow nursing students to provide culturally competent care by showing openness, using inclusive language, and normalizing disclosure of sexual orientation and gender identity.

Due to large numbers of nurses present in healthcare, and by virtue of their scope of practice, nurses are in a position to bridge the gaps found in health inequities and provide

culturally sensitive care specific to the 2SLGBTQ+[3] community (McKay, 2011). Educating nursing students of inclusive language and knowledge of the unique issues experienced by the 2SLGBTQ+[3] population will help correct the insensitive and uninformed care 2SLGBTQ+[3] people are currently experiencing (Lim & Bernstein, 2012).

Canadian Stakeholder Involvement

The CNSA believes in actively engaging stakeholders, including nursing schools and nursing organizations, in developing new areas of nursing curriculum and practice opportunities to prepare nursing students to provide safe, competent, ethical care for the 2SLGBTQ+[3] community.

Relation to Canadian Nursing School Curriculums

As nursing students are required to learn and care for minority groups, CNSA accept this as their formal position on incorporating 2SLGBTQ+[1] education into nursing curriculum throughout Canada. Regional Directors will support nursing students in promoting this change in their nursing curriculum, and/or program. CNSA will suggest and coordinate educational activities to help promote awareness and bridge this gap in healthcare inequality.

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Edits

1. Changed from LGBTTIIPQQ2SAA+ to 2SLGBTIQQA+ for clarity. The new abbreviation is more widely known within the queer community. Throughout the statement, 2SLGBTQ+ is used as a short form for 2SLGBTIQQA+.
2. Changed acronym and examples;
    a. Removed Transsexual. While this term is still used by some in the 2SLGBTQ+ community, it is an older term that many in the transgender community do not use, as it is often confused with transgender. Transsexual places emphasis on genitalia, specifically in terms of surgical alteration, while transgender instead focuses on the gender identity of the individual, specifically that it differs from the gender assigned at birth. This means that the term transsexual refers to a single group of people, whereas the term transgender is an umbrella term that includes a wide variety of individuals, including those that identify as transsexual. There is significant push within the trans community to move away from conversations surrounding genitalia, as these conversations are highly sensitive and not reflective of the holistic needs of transgender individuals. Additionally, many individuals who identify as transgender find the term transsexual offensive.
    b. Removed Ally. The 2SLGBTQ+ acronym is representative of the various identities found within the queer community, but allyship is an action, not an identity. Being an ally is not something that someone decides for themself, it is decided by members of equity seeking groups, based on the individuals' actions, and whether they have the trust of the community or not. When people use allyship as an identity, the emphasis on behaviours and actions are diminished, and motives are called into question. Additionally, it is well known there is an "A" in the 2SLGBTQ+ acronym, and when people believe that belongs to allies, it erases the identity of Asexual and Aromantic individuals. Allies are also not oppressed in the same manner as 2SLGBTQ+ individuals by means of their heterosexual privilege; including them in discussions of stigma, oppression, and discrimination demeans the experiences of 2SLGBTQ+ people.
    c. Added additional identities: Asexual, Pansexual
3. 2SLGBT to 2SLGBTQ+
4. Vulnerable to equity seeking. "[The term "vulnerable"] is criticized because it under emphasizes the multi-dimensional processes that cause unequal distributions of material, cultural, social and political resources. Furthermore, characterization of susceptibility and vulnerability can be disempowering"

http://nccdh.ca/images/uploads/Population_EN_web2.pdf

5. Change "dating violence and rape" to "domestic and/or sexual violence"

Incorporating Education Surrounding Populations with Diversabilities into Nursing Curriculum

Approved: January 2020
Approved by: CNSA National Conference
Submitted on: Dec 1st, 2019
Submitted By: Courtney Blake, North Island College;
Emma Hill, Vancouver Island University

Introduction and Background Information

According to the World Health Organization, over one billion individuals, 15% of the global population, live with diversabilities (2018). The term diversability refers to diversity in an individuals' level of ability, whether it be neurologic, cognitive, intellectual, physical or developmental (Disabled World, 2019). Compared to the general neurotypical and able-bodied population, individuals with diversabilities who seek healthcare go with their needs unmet and pursue healthcare more often (WHO, 2018). The health of individuals with diversabilities is rarely addressed by health promotion and primary prevention services, increasing their vulnerability to experiencing significant health disparities (WHO, 2018).

Barriers to accessing healthcare services include cost of services, limited accessibility, physical barriers, and the lack of knowledge of healthcare workers (WHO, 2018). Due to a lack of knowledge of healthcare provides, patients may have traumatic healthcare experiences and may encounter negative attitudes from staff (Ali, Scior, Ratti, Strydom & King, 2013). Other significant barriers to accessing healthcare services include difficulty in communicating with healthcare practitioners, miscommunication between healthcare staff and carers of the individual with a disability, and the lack of support for carers in the healthcare system (Ali et al., 2013). According to Connell (1998), patients with disabilities "want someone who seeks to understand not only their disease, but their experience of illness – the composite of the patient's views, feelings, and responses to disease, and its effects on the patient's life and the lives of those with whom they relate" (p. 83). Due to the lack of education of health care provides surrounding individuals with diversabilities, this population faces stigmatization and judgement from their care providers. This cultivates an unsafe space where individuals are treated poorly and are denied care, which can result in premature and potentially avoidable deaths (WHO, 2018).

According to article 25 of the United Nations Convention on the Rights of People with Disabilities (CRPD) (2006);

"[P]ersons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. [This includes providing] persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes… [Health professionals are] require[d] to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care… Discrimination against persons with disabilities in the provision of health insurance, or denial of health care or health services or food and fluids on the basis of disability, shall [be] prevent[ed] and prohibit[ed]". Canada is a signatory member of the CRPD, ratifying their commitment in 2010.

Canadian Nursing Students' Association's Current Position on the Issue

In 2016, CNSA passed the position statement "Accommodation within Clinical Placements for Students with Temporary, Transient, or Sporadic Disability or Injury" (Payette & Delage, 2015). This position statement mainly focused on the rights of students with disabilities who experience barriers to meeting their educational institution's clinical requirements; however, it also outlined CNSA's support of increased awareness of accessibility, disability, and accommodation within the nursing curriculum (Payette & Delage, 2015). This statement is the only current literature within CNSA that supports the inalienable rights of persons with disabilities.

This current position supports CNSA's strategic objective B: "Influence and advance innovation and social justice in the nursing curriculum and the nursing profession". By advocating for positive, evidence-based curriculum change, CNSA is being involved in curriculum decisions, planning and review, and incorporating research and evidence-based decision making into their current and future practice to positively influence patient outcomes (CNSA, 2016). Education regarding the numerous diversabilities and the nursing considerations for these populations is vital for the growth of the nursing profession.

Due to the negative impact that uneducated health professionals can have on the health and mortality of people with diversabilities, CNSA believes that nursing curriculum must include education on how to support the needs of this population.

CNSA recognizes that it is the duty of the nurse to advocate for the unique needs of every patient they support, including patients with a wide variety of abilities and disabilities. However, nurses cannot hope to adequately support people with diversabilities if they are not equipped with the knowledge and tools to do so.

Relation to Canadian Nursing School Curriculums

The current nursing curriculum does not adequately address the unique needs of individuals with diversabilities, and it does not prepare nurses with the knowledge, skill and relational practice to safely care for these individuals. According to Troller et al., "if nurses develop skills and knowledge to modify their assessment and treatment practices, and to manage challenging behaviour, post-registration they will be more likely to detect physical and mental health conditions in this population, deliver more effective treatments, and provide more positive healthcare experiences. In short, they will be in a better position to help address these inequalities" (2017).

A study reviewing nursing textbooks for disability-related content found that the textbooks lacked adequate information on the health needs and nursing considerations when caring for an individual with diversabilities (Smeltzer, Robinson-Smith, Dolen, Duffin & Al-Maqbali., 2010). While some textbooks included more education than others, the consensus of the study was that the available information was not reflective of the population size (Smeltzer et al., 2010).

Health care programs rarely include how to address the needs of people with intellectual disabilities in their curriculum, which leaves graduates unequipped to meet the unique challenges that people with intellectual disabilities face, especially in acute care settings (Trollor et al., 2016), a relevant barrier to all individuals with diversabilities. As the largest profession within health care, nurses are pivotal in ensuring that people with disabilities receive appropriate health care services, including health promotion, disease detection, and treatment (Trollor et al., 2016). However, nurses are among the many health professionals not getting the education required to fulfill this role.

Many countries around the world offer specialized training for nurses who wish to work exclusively with people with diversabilities. Research has shown that a lack of exposure to nursing specialities during undergraduate education leads to a lack of graduate nurses seeking to practice in those areas (Happell, 2010). In Canada, several nursing organizations provide post-baccalaureate education and certification, such as the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN). CNA is the largest organization that offers certification, yet they do not currently provide any resources for nurses seeking to further

their knowledge surrounding people with diversabilities. CASN also offers certifications for nurses in addition to outlining the accreditation framework required of nursing schools, but they offer no material specifically for nurses who support people with diversabilities. There are some private institutions in Canada, for example St. Francis Xavier University, that offer additional education regarding how to best support people with intellectual disabilities through their health care journey, however, many are phasing out their programs due to declining enrollment.

Conclusion and Restatement of the CNSA Position

The CNSA recognizes that adequately preparing nursing students to care for people with diversabilities is not currently a part of the nursing curriculum, which contributes significantly to the inequitable health outcomes experienced by this population. It is crucial for nurses to have the education that ensures patients with diversabilities are receiving safe, compassionate and ethical care that are meeting their specific and complex needs to achieve a positive health outcome.

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In Support of Maximizing Autonomy in End of Life (EoL): MAiD as EoL Care

Approved: January 2020
Approved by: CNSA National Assembly
Submitted: Dec 6, 2019
Submitted to: CNSA Board of Directors
Submitted by: Jessica Guthier, Thompson Rivers University

Introduction/Background Information

Legislation. Medical Assistance in Dying (MAiD) has been legal in Canada since 2016 following the passing of *Bill C-14*, An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying). As well, the unprecedented 2015 decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)* has contributed to the context of policies and culture surrounding MAiD (Canadian Nurses Association, 2017). The term "Medical Assistance in Dying" refers to either administration by a Nurse Practitioner

(NP) or Medical Practitioner (MP) of a substance to a voluntary client that causes their death or their prescription or provision of a substance to a voluntary client so that they may later self-administer and cause their death (Government of Ontario, 2018).
The *Charter of Rights and Freedoms* (henceforth the Charter) has been central in the process of passing *Bill C-14*. If a law is found to infringe on the Charter rights and freedoms, it will be considered "no force and effect." In this way individuals have challenged regulations surrounding MAiD (Farmanara, 2017).

Regulations. While in Canada MAiD is a new legal service, other countries (such as the Netherlands) have been providing this service to their dying citizens for years. Eligibility requirements for Canadians receiving MAiD are stringent:

- at least 18;
- considered competent to make healthcare decisions;
- make the request voluntarily;
- be fully informed on the MAiD procedure and all other options available to alleviate their suffering, including palliative care;
- have a *grievous* and *irremediable* condition, comprised of,
    - an incurable illness, disease, or disability;
    - irreversibly declining in function and condition;
    - unbearable mental or physical suffering caused by their condition or their functional decline;
    - a natural death is anticipatable (Government of Ontario, 2018);

While an NP or MP may provide or prescribe the treatment, a Registered Nurse (RN) or Licensed Practical Nurse (LPN) may also take part in the MAiD process. According to CNA, RNs and LPNs role in this process is to "Directly engage with people and their human condition, assessing suffering and survival while supporting them as they progress through death and dying," (Canadian Nurses Association, 2017). Furthermore, nurses of all designations are the professionals to whom clients talk and question most often; and nurses may be questioned about EoL care, including MAiD (Canadian Nurses Association, 2017). The scope of practice of LPNs and RNs may differ between province and territory, and thus it is imperative nurses understand the regulations of their governing body. Despite a nurse's ability to participate in MAiD, a nurse may also conscientiously object if they wish not to participate (Canadian Nurses Association, 2017).

Ethics. Respecting the autonomy of a capable client means respecting for wishes for death, and that this request does not indicate incapacity (Incardona, Bean, Reel, & Wagner, 2016). This can be difficult when considering the ethical responsibility of nonmaleficence ("to do no harm"). This fiduciary responsibility is brought into conflict because MAiD asks nurses to participate in the death of a client. Moreover, MAiD challenges the notion that death is harmful in all circumstances (Incardona et al., 2016). MAiD reveals that ongoing life may be seen as the more harmful option by the client, given a grievous and irremediable state (Incardona et al., 2016).

Mitigating risk for harm must not result in unnecessary barriers to accessibility; the criteria for MAiD are not *terminal illness* but rather *grievous and irremediable* conditions (Incardona et al., 2016). Barring clients on the basis of their condition, such as chronic or mental illness, infringes upon Sec. 7 and *Bill C-14*. Nonetheless, Conscientious Objection (CO) is an ethical dimension of MAiD that must be considered as well. Allowing for CO is in alignment with the provider's rights under the Charter, in that it protects their autonomy, respects diversity in opinion, and "protects the [provider's] moral integrity" (Incardona et al., 2016).

The Position of the Canadian Nursing Students' Association (CNSA)

The CNSA aims to support students in the journey to becoming licensed nurses by facilitating opportunities for professional development, advocating for quality nursing education and inclusion of students' voices, and promoting nursing research and quality patient care. One manner in which the CNSA achieves this is through the production and adoption of position and resolution statements. As such, current CNSA literature covers a wide range of topics, but perhaps one of the most unaddressed issues in current CNSA publications surrounds End of Life (EoL) care and treatments. According to the author's research, CNSA currently supports two resolution statement on EoL care: *Quality End of Life Care in Nursing Education* and *Mandatory End of Life Education for Nursing Students* (Chafe, Dawe, McGrath, Stapleton, & Trahey, 2015; Soer & Bloomberg, 2013).

In this document, CNSA support CNA's statement that to provide quality EoL nurses must meet the needs and respect the wishes of families and individuals (Chafe et al., 2015). As well, CNSA adopts several resolutions including developing a formalized and purposeful position statement supporting quality EoL care education and that CNSA delegates will advocate for the adoption of EoL content in their chapters (Chafe et al., 2015). Given CNSA's resolutions advocating for EoL content in nursing curriculum, it is fitting that CNSA address the largely overlooked topic of MaiD. Providing quality EoL care is encompassing of the family and, most importantly, the client's wishes. Every dying client deserves the right to a dignified death. This

may include palliative care, hospice care, do not resuscitate orders, or receiving MAiD. While all these services and treatments are important, and clients' autonomy should be encouraged when deciding on the EoL care they would like to receive, the scope of this position statement is to support MAiD as a valuable treatment option in EoL care. Thus, the proposed position statement follows: the CNSA supports those clients, deemed competent, to request, receive information on, and have access to MAiD without undue barriers or hardship.

Relation to Canadian Nursing School Curriculums

Invariably, nurses will work with clients at the end of their life, no matter in what area of nursing they work. MAiD is a legislatively new treatment option for nurses, each health authority, provincial/ territorial, and municipal governing body will have its own regulations. As the primary resource for nursing students across Canada, and MAiD being such a new treatment option, CNSA must advocate for this to be included in curriculum in all our chapter schools. Nursing students must be prepared to be competent practitioners, and understand their own morals regarding MAiD— including Conscientious Objection—to allow clients dignified deaths.

Conclusion and Restatement of CNSA Position

The Canadian Nursing Students' Association believes all nursing students have the right and the responsibility to understand EoL options. As our population ages and the incidences of chronic and comorbid conditions increases, this issue will become ever more important. The CNSA will continue to support, advocate for, and provide resources about quality EoL treatment options.

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Resolution Statements 2020

Advocating for Adequate Reproductive Services in Canada

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Approved by: CNSA National Assembly
Submitted: November 27, 2019
Submitted to: CNSA Board of Directors
Submitted by: Jessica Guthier, Thompson Rivers University; Courtney Blake, North Island College

Introduction/Background Information

Induced abortions have been legal in Canada since 1988 and are currently governed by the Canada Health Act (Government of Canada, 2019). Furthermore, in section 7 of the Canadian Charter of Rights and Freedoms states every Canadian has the right to "life, liberty, and security of the person and the right not to be deprived thereof" (Government of Canada, 2019). In 1988, when induced abortions were legalized in Canada, the highest courts of our country also ruled that nobody but the pregnant person themselves could decide for or against an induced abortion. To attempt to control a person's reproductive capacity would be to violate that person's right to *life, liberty, and security of the person* (Government of Canada, 2019; LawforAlbertaWomen.ca, 2015).

Access to an induced abortion is a right, however, there are many people in Canada who do not have reliable access to abortion nor other reproductive services. This is due to the inconsistencies in funding throughout the country, geographical constraints, as well as the ideological alignment of many powerful groups. Many provinces regulate which facilities can provide induced abortions, unnecessarily requiring services to be performed in hospitals and refusing to allow these services to be performed in smaller clinics with equally trained professionals (CBC, 2019). This constraint creates a barrier for people living in rural and remote communities, who would then be required to commute possibly long distances to receive services at a hospital. When there are barriers to accessing reproductive services - including legislative barriers, social stigmatization, and bureaucratic processes - people who require or depend on these services cannot access them. Thus, their reproductive options and bodily autonomy can be limited (Reeves et al, 2018). Additionally, there are many fake abortion clinics, often called "Pregnancy Crisis Centers", which cater to vulnerable pregnant populations but

refuse to refer their clients to abortion services (ARCC, 2019). These fake clinics provide misinformation about abortion or withhold information in an attempt to exaggerate the dangers of abortions (ARCC, 2019). These clinics are funded by religious organizations and private donors, are not medical clinics, and do not willingly disclose their religious ties (ARCC, 2019). People who are seeking abortion services also face long wait times to receive the services they require, which compromises their eligibility to receive said services (CBC, 2019).
Nurses have a moral, ethical, and professional obligation to advocate for increased access to health care services, regardless of our personal opinions about those services. Nurses know that inadequate access to reproductive services does not lead to less abortions, it leads to less safe abortions. At-home remedies become enticing and may seem like viable options, but these can have devastating, and sometimes fatal, effects. Creating barriers to proper reproductive health will only assure that many unwanted pregnancies end in the death or disfigurement of the pregnant person.

CNSA's Position on the Topic

As of 2019, the CNSA harbours no definitive position on this issue. While referring to the 1984 to 2006 position and resolution statements, not one mention towards reproductive autonomy was made. Furthermore, more recent position and resolution statements also fail to make any mentions to reproductive health, and especially not to induced abortions. Whether this is due to the lack of need historically for CNSA to take a stance, or whether this has been a conscious choice due to the politically heated nature of this topic, is unknown. In January of 2013, CNSA passed a resolution statement encouraging educational institutions to include political education in curriculum, encouraging nursing students to become involved in political activism, and attempting to involve nursing students in their communities at an advocacy level (Gielarowiec, Hardy-Moffat, Telegdi, & Bloomberg, 2013). While resolution statements such as these have inspired students to become involved within the CNSA, it is unclear how involved CNSA students have become in the external political climate.

Indirectly related to this issue is a position statement passed in 2018 regarding rural and remote health equity. Although this position statement speaks more closely to the health discrepancies faced by Indigenous populations and other populations living remotely and rurally, it indirectly speaks in support of reproductive autonomy (Norris, Pelley-George, Gustafson, 2018). This is because remote and rural communities often lack the infrastructure necessary to provide clients with choices and educational supports surrounding their reproductive health.

Furthermore, creating a position on this issue falls within CNSA's strategic plan Objective B, Outcome 1: members"[b]e involved in curriculum decisions, planning and review", and Objective B, Outcome #4: "Members of CNSA incorporate research and evidence-based decision making into their current and future practice to positively influence patient outcome" (CNSA, 2016).

Resolution

WHEREAS, the CNSA supports the ongoing health needs of equity-seeking populations, including the special needs of 2SLGBTQ+, women, Indigenous, and racialized groups.

WHEREAS, women may experience systemic barriers in accessing adequate reproductive autonomy.

WHEREAS, a person's reproductive choices are theirs to make and healthcare professionals are there to support and partner with the client, not to act as a barrier to accessing services.

WHEREAS, the resolution statement *Achieving Health Equity in Canada's Rural and Remote Communities* was passed in 2019, highlighting the fundamental need for accessibility equity relating to healthcare needs.

Therefore,

BE IT RESOLVED THAT the CNSA strongly oppose any attempts to restrict access to reproductive health services in Canada, whether through criminalization, delegalization, restricted funding, the spread of misinformation, deliberate falsification of facts, or through participation by political powers in any of these actions.

BE IT RESOLVED THAT the CNSA publicly condemn any of these aforementioned attempts or the attempts of any political or other groups to restrict access to reproductive services: including, but not limited to, induced abortions, STD/STI testing or treatment, pregnancy counselling, adoption services, fertility services, birth control services or treatments, etc.

BE IT RESOLVED, that the CNSA support access to reproductive services as a fundamental right enshrined in Canadian law under *Section 7* (Life, liberty, and freedom of the person).

Relation to Canadian Nursing School Curriculums

A clear objective of CNSA is to influence and make advancements in innovation and social justice within the nursing curriculum and the nursing profession (CNSA, 2016). A clear objective of nursing schools' curricula is to provide graduate nurses with at least the minimal requirements to allow graduates to perform at a generic level. Curricula and the culture permeating healthcare would have one believe that sexual and reproductive healthcare are niche topics - ones requiring extra certification to be able to address. While it may be true that to provide sound advice and perform thorough assessments regarding sexual and reproductive health, it is in no way true that a graduate nurse should not have the competencies to discuss sexual and reproductive health with their clients. In every healthcare setting, a person's sexual orientation, beliefs surrounding reproduction, and gender are present. Despite not being the focus of their visit, a client will always carry these with them and it will influence every decision they make and every experience they have. To provide holistic care, a nurse *must* be willing to address a client's sexual and reproductive needs and, where their own expertise fails, refer them to an appropriate professional.

Moreover, impartiality to all patients to provide excellent care despite personal beliefs is a fundamental belief in the nursing discipline. Whatever a nurses' personal beliefs on sexual and reproductive topics, they must not let it influence the information they provide their patients, the options they present, or the care they provide. Such an important concept is currently being left up to individual universities to decide whether or not to discuss, and that is unacceptable. The CNSA must be a strong advocate that *every* nursing curriculum include education on how to address sexual and reproductive health topics.

Conclusion

A person's sexuality and gender are their own, and options such as contraception and induced abortions are an important aspect of comprehensive healthcare. No matter a nurses personal beliefs, they must always be willing to provide all possible information with the best interpretation for their client, and treat their clients with autonomy, justice, maleficence, and beneficence.

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Inclusive Intake/Patient-History Forms

Approved: January 2019
Approved by: 2019 National Assembly, Canadian Nursing Students' Association
Submitted by: Allison Mosley, University of Lethbridge
Edited by: Jessica Guthier, Thompson Rivers University; Lucia Baffa, Lethbridge University; Jarinca Santos-Macias, York University.
Updated: January 2020

Introduction/Background Information

To begin, the exact number of transgender and non-binary Canadians is unknown. Health

research rarely includes the options for participants to self-identify their gender; which often excludes anyone who does not identify within the binary system of "male" and "female".

2SLGBTQ+[1] people experience stigma and discrimination throughout their lives, including within the healthcare system. This leads to a fear of being mistreated within our medical system. Research suggests that health care providers routinely use the wrong gender pronoun to address transgender and non-binary patients, and often forget to ask individuals for their proper pronouns. Additionally, health care providers have disclosed their patient's gender identity to others without their consent, when it is not necessary for care (Clegg & Pearson, 1996). Experiences such as these create an environment that is unsafe and unwelcoming for queer individuals, as such they may face discrimination in the health care setting. Transgender and other gender identities are unrepresented, and as a result they become systematically disadvantaged and become one of the most marginalized groups. Looking at the social determinants of health, these individuals are at higher risks of experiences adverse health effects, yet are less likely to seek out medical care. Additional challenges queer individuals face include difficulty accessing trans-inclusive/gender inclusive primary and emergency healthcare, transition care, difficulty obtaining referrals and often being denied medical care (Bauer, Hammond, Travers, Kaay, Hohenadel & Boyce 2009; Cobos & Jones, 2009). Additionally, it can be difficult for those that identify outside of the gender binary to receive appropriate care for their sex assigned at birth if there is no way for them to indicate their assigned sex and gender identity are different. Most forms and billing systems are set up in a way that correlates listed "sex" with body parts and only allows sex-specific procedures such as hysterectomies and prostate-treatments to be billed to those of that designated sex (Bauer et al., 2009). This means a client identifying as male may not be eligible for care such as breast and pelvic exams.

The House of Commons approved Bill C-279 (2015), making it illegal to discriminate against Canadians on the basis of gender identity or gender expression. Despite this, those individuals who identify outside the binary and express themselves outside societal norms, still face discrimination in their health care across the country.

Secondly, Canada is a multicultural nation, and therefore, the healthcare system needs to be prepared to provide culturally safe care to our diverse population in order to ensure the provision of effective, equitable, and dignified care. Using an intake form that inquiries about an

[1] 2SLGBTQ+ is an abbreviation for Two Spirit, Lesbian, Gay, Bisexual, Transgender, and Queer. The + allows room for fluidity and growth while recognizing expression is constantly evolving and encompassing of all other expressions.

individual's unique cultural practices and beliefs at the beginning of care can act as a useful tool in guiding culturally safe care.

Cultural safety recognizes the inherent power differentials that exist in our healthcare system as a result of colonization and racism. Furthermore, it addresses the unique health disparities that exist for marginalized populations such as immigrants and refugees, people of colour, First Nations, Inuit, and Métis people, and 2SLGBTQ+ groups (Aboriginal Nurses Association of Canada, 2009; Graves, Like, Kelly & Hohensee, 2007; Vidaeff, Kerrigan & Monga, 2015). Using a cultural safety lens exposes the oppressive historical, political, and social systems that are at the foundation of our healthcare system, and challenges the unequal power relations to improve healthcare access for different populations (Aboriginal Nurses Association of Canada, 2009). Therefore, by recognizing power imbalances, a cultural safety framework promotes respect, support, empowerment, identity, and bridges the gap between marginalized groups and the healthcare system (Phiri, Dietsh & Bonner, 2009). The addition of a section for patients to express their unique cultural practices on an intake form will allow healthcare providers to acknowledge and address the gaps that exist when caring for different populations and discourages assumptions on the part of the professional regarding cultural practices. This section provides an opportunity for individuals to express their unique practices: usage of traditional medicines and healing practices, guidance from spiritual leaders, and wishes surrounding invasive treatments. Such a section will help ensure accuracy and safety when creating a treatment plan that respects an individual's autonomy (Graves, Like, Kelly & Hohensee, 2007). Finally, since culture is a dynamic and changing process this intake form can ensure that healthcare providers are not assuming that all individuals within a culture share the same beliefs, morals, and customs (Phiri Dietsh & Bonner, 2009). The form should not be taken as an end to the investigation of a client's culture, but rather as the starting point of a conversation. However, a prudent professional understands the inherent power differential between themselves and their clients and should not press a client past their point of comfort when asking questions or seeking information (involving experts such as Aboriginal Patient Navigators may be appropriate).

CNSA's Position on the Topic

In 2013 the CNSA passed a position statement on incorporating 2SLGBTQ+ education into Canadian nursing curriculum and a resolution statement: *Rise Up and Eliminate Barriers: Striving*

to Enhance Cultural Competence in Caring for the The 2SLGBTIQQA+[2] *Community* (CNSA, 2013). Furthermore, in 2016 the CNSA passed another resolution statement to build on the 2013 position statement and give a clear sense of direction. Through this resolution statement, we seek to provide further actions that will help meet the advocacy goals of the CNSA and inclusion of equity seeking population, specifically the 2SLGBTQ+ community.

The CNSA has also passed many position and resolution statements on the effect of marginalization in healthcare. This includes a position statement on *Affordable PrEP for All,* as issues of access and HIV affect Indigenous and racialized groups disproportionately (CNSA, 2019). As well, a recently passed position statement titled *Achieving Health Equity in Canada's Rural and Remote Communities*, which makes reference to the Final Report from the Truth and Reconciliation Commission of Canada (CNSA, 2019; Jane Philpott, 2017). Lastly, *Cultural Safety in the Context of Aboriginal Health in Nursing Education* was passed in 2015, and establishes the CNSA's position on including education on caring for people from non-dominant cultures, specifically relating to Indigenous health.

The CNSA believes that a gender and culture inclusive form would allow for the advancement of social justice in the nursing profession. An inclusive form creates a healthcare environment that is welcoming and safe for marginalized individuals. By doing this, the CNSA believes healthcare will move towards greater accessibility for marginalized groups; and while this will not overthrow the roots of racism and colonization in healthcare, it will move the system into a progressive position. As an organization the CNSA supports the ideal that nurses provide unbiased, culturally competent, and appropriate care and that nurses be advocates in countering hegemony in healthcare. Moreover, nursing students are responsible to provide care to all individuals as they are the future of the healthcare system, and they must be fully aware of and oppose these oppressive systems. As such, it is imperative that healthcare facilities support the tools healthcare professionals need in providing such care.

The CNSA believes in actively involving stakeholders as outlined in its Strategic plan. The uptake of an inclusive form requires the support of external organizations such as nursing organizations (CNA, CFNU), provincial bodies, health authorities, and the Ministry of Health.

[2] The 2SLGBTIQQA+ (Two Spirit, Lesbian, Gay, Bisexual, Transgender, Intersex, Intergender, Pansexual, Queer, Questioning, Asexual and Aromantic) community is composed of a diverse group of individuals. The + allows room for fluidity and growth while also recognizing that expression is a constantly evolving process meaning not all expressions may be accurately represented by this acronym.

Engagement with these stakeholders allows for the CNSA to help prepare nursing students to provide safe, ethical, and compassionate care the 2SLGBTQ+community.

Resolution

WHEREAS, the CNSA supports the ongoing health needs of equity-seeking populations, including the special needs of 2SLGBTQ+, Indigenous, and other racialized groups[3].

WHEREAS, different marginalized groups experience higher rates of discrimination and lack of comprehensive care in the healthcare system.

WHEREAS, a resolution statement *Incorporating* 2SLGBTIQQA+[4] *Education into Nursing Curriculum in Canada* was passed in 2016, stating to prioritize incorporating the needs, experiences, and perspectives of 2SLGBTQ+ people and communities into nursing school curricula.

WHEREAS, a resolution statement *Achieving Health Equity in Canada's Rural and Remote Communities* was passed in 2019, and *Cultural Safety in the Context of Aboriginal Health in Nursing Education* was passed in 2015, highlighting the fundamental need for culturally inclusive education in nursing curricula.

Therefore,

BE IT RESOLVED, that the CNSA, as the voice of the new generation of nurses, promote safer spaces for marginalized groups and provide platforms for advocating for the issues faced by these groups within their chapter schools through collective partnerships with professors, nurses, school faculty, and nursing students in order to prioritize public health measures.

BE IT RESOLVED, That the CNSA support the efforts of Canadian nursing students to advocate for gender and culture inclusive intake/patient history forms and language across Canada that address the unique needs of these populations including gender outside the binary, sex at birth, cultural practices, spiritual beliefs, pronouns, and existing disparities through activities such as researching inclusivity initiatives, collaborating with clients to include their voices in form

[3] Henceforth, these groups will be cumulatively referred to as marginalized groups
[4] The '+' allows room for fluidity and growth while also recognizing that expression is a constantly evolving process meaning not all expressions may be accurately represented by this acronym.

change, and petitioning Canadian textbook companies to change the language in their textbooks to be inclusive

BE IT RESOLVED, that the CNSA diversity and community and public health committees prioritize advocating for the inclusion of a gender and culture friendly intake form for those that identify outside of the dominant systems, including advocating for nursing education within community and public health curriculum.

Relation to Canadian Nursing School Curriculums

The Canadian Association of Schools of Nursing (CASN), outlines in their national framework that undergraduate nurse need to have knowledge of primary health care, ethical nursing practice, and social justice (CASN, 2015). Specifically there should be knowledge of health disparities, determinants of health, and holistic care. Gender and cultural identity are key aspects how and as whom an individual identifies. Inevitably, this will affect how they receive care. As future health care providers, nursing students must be prepared to assess diverse client populations and be able to provide them with competing ethical safe and compassionate care (CASN, 2015).

If nurses are uneducated about what gender identity is and its impacts on health, they cannot support their clients appropriately, or provide them with the best care. Furthermore, nurses ignorant to the unique needs of other cultural and racial groups cannot provide appropriate care. Forms and education should use inclusive language and should reflect the reality of 2SLGBTQ+ families by asking about "relationships," "partners," and "parent(s)" rather than labelling as "mother/ father" or "wife/ husband" (Gay and Lesbian Medical Association, 2015). By putting this into practice and educating nurses on its importance we build cultural competency and create safer spacer for these equity-seeking populations.

The CNSA must continue to advocate for the inclusion of 2SLGBTQ+ and culturally competent education in nursing curriculum. The integration for this education gives nurse the capacity to be better leaders and advocates in the advancement of inclusive care. This care include but is not limited to, inclusive language, proper pronouns, the difference between sex and gender, cultural practices and beliefs, appropriate spiritual leaders, how to provide post-partum or palliative care, and only collecting information relevant for care.

Conclusion

As the primary voice for nursing students, the CNSA believes that marginalized populations in Canada have the right to fair and equitable care. These different groups are entirely unique in their needs but face similar struggles of inaccessibility, inappropriate care, and stigmatization. A holistic view on cultural and gender realities in Canada are required in nursing education and within the healthcare system. The uptake of an inclusive intake/history form would allow for a safer space when accessing the health-care system. This would not only allow for more inclusive care but would allow transgender, non-binary, Indigenous, immigrant, refugee, queer, and other groups to be better represented in the medical system.

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Edits

1. Secondly, Canada is a multicultural nation, and therefore, the healthcare system needs to be prepared to provide culturally safe care to our diverse population in order to ensure the provision of effective, equitable, and dignified care. Using an intake form that inquiries

about an individual's unique cultural practices and beliefs at the beginning of care can act as a useful tool in guiding culturally safe care.

2. Cultural safety recognizes the inherent power differentials that exist in our healthcare system as a result of colonization and racism. Furthermore, it addresses the unique health disparities that exist for marginalized populations such as immigrants and refugees, people of colour, First Nations, Inuit, and Métis people, and 2SLGBTQ+ groups (Aboriginal Nurses Association of Canada, 2009; Graves, Like, Kelly & Hohensee, 2007; Vidaeff, Kerrigan & Monga, 2015). Using a cultural safety lens exposes the oppressive historical, political, and social systems that are at the foundation of our healthcare system, and challenges the unequal power relations to improve healthcare access for different populations (Aboriginal Nurses Association of Canada, 2009). Therefore, by recognizing power imbalances, a cultural safety framework promotes respect, support, empowerment, identity, and bridges the gap between marginalized groups and the healthcare system (Phiri, Dietsh & Bonner, 2009). The addition of a section for patients to express their unique cultural practices on an intake form will allow healthcare providers to acknowledge and address the gaps that exist when caring for different populations and discourages assumptions on the part of the professional regarding cultural practices. This section provides an opportunity for individuals to express their unique practices: usage of traditional medicines and healing practices, guidance from spiritual leaders, and wishes surrounding invasive treatments. Such a section will help ensure accuracy and safety when creating a treatment plan that respects an individual's autonomy (Graves, Like, Kelly & Hohensee, 2007). Finally, since culture is a dynamic and changing process this intake form can ensure that healthcare providers are not assuming that all individuals within a culture share the same beliefs, morals, and customs (Phiri Dietsh & Bonner, 2009). The form should not be taken as an end to the investigation of a client's culture, but rather as the starting point of a conversation. However, a prudent professional understands the inherent power differential between themselves and their clients and should not press a client past their point of comfort when asking questions or seeking information (involving experts such as Aboriginal Patient Navigators may be appropriate).
3. The CNSA has also passed many position and resolution statements on the effect of marginalization in healthcare. This includes a position statement on *Affordable PrEP for All,* as issues of access and HIV affect Indigenous and racialized groups disproportionately (CNSA, 2019). As well, a recently passed position statement titled *Achieving Health Equity in Canada's Rural and Remote Communities*, which makes reference to the Final Report from the Truth and Reconciliation Commission of Canada (CNSA, 2019; Jane Philpott, 2017).

Lastly, *Cultural Safety in the Context of Aboriginal Health in Nursing Education* was passed in 2015, and establishes the CNSA's position on including education on caring for people from non-dominant cultures, specifically relating to Indigenous health.

4. The CNSA believes that a gender and culture inclusive form would allow for the advancement of social justice in the nursing profession. An inclusive form creates a healthcare environment that is welcoming and safe for marginalized individuals. By doing this, the CNSA believes healthcare will move towards greater accessibility for marginalized groups; and while this will not overthrow the roots of racism and colonization in healthcare, it will move the system into a progressive position. As an organization the CNSA supports the ideal that nurses provide unbiased, culturally competent, and appropriate care and that nurses be advocates in countering hegemony in healthcare. Moreover, nursing students are responsible to provide care to all individuals as they are the future of the healthcare system, and they must be fully aware of and oppose these oppressive systems. As such, it is imperative that healthcare facilities support the tools healthcare professionals need in providing such care.
5. **WHEREAS,** a resolution statement *Achieving Health Equity in Canada's Rural and Remote Communities* was passed in 2019, and *Cultural Safety in the Context of Aboriginal Health in Nursing Education* was passed in 2015, highlighting the fundamental need for culturally inclusive education in nursing curricula.
6. As the primary voice for nursing students, the CNSA believes that marginalized populations in Canada have the right to fair and equitable care. These different groups are entirely unique in their needs but face similar struggles of inaccessibility, inappropriate care, and stigmatization. A holistic view on cultural and gender realities in Canada are required in nursing education and within the healthcare system. The uptake of an inclusive intake/history form would allow for a safer space when accessing the health-care system. This would not only allow for more inclusive care but would allow transgender, non-binary, Indigenous, immigrant, refugee, queer, and other groups to be better represented in the medical system.

Mental Health First Aid Training For Canadian Nursing Students

Approved: January 2020
Approved by: CNSA National Assembly
Submitted: December 2019

Submitted to: CNSA Board of Directors
Submitted by: Kristen McGregor, Red River College;
Jessica Guthier, Thompson Rivers University;
Emma Hill, Vancouver Island University

Introduction/Background

One in five Canadians will experience a mental health disorder in a year; by the age of 40, 50% of Canadians have had a mental illness (Canadian Mental Health Association, n.d.; Mental Health First Aid Canada, n.d.-b). Although mental illness is prevalent in our Canadian population, it is seldom addressed in society and healthcare and as Mental Health First Aid (MHFA) Canada explains "if I sprain my ankle, chances are you'll know what to do. If I have a panic attack, chances are you won't" (Mental Health First Aid Canada, n.d.-a). As one of the largest professions within healthcare, and most trusted, it is pivotal that canadian nurses are trained adequately in mental health first aid to help this needs of this growing population.

MHFA first originated in Australia and studies conducted to evaluate the training have shown the training to be effective (Kitchener & Jorm, 2008; Mental Health First Aid Australia, n.d.). Preliminary studies on the outcome of MFHA training in Canada have yielded positive results (Government of Canada, 2016).

As with Standard First Aid, MHFA is intended to provide support to an individual until professional help arrives to prevent or attempt to control a crisis (Mental Health First Aid Canada, n.d.-b; Morgan, Ross, & Reavley, 2018). Completion of MHFA training is correlated to the improved confidence of participants in their ability to support somebody experiencing a mental health crisis or exacerbation (Morgan, Ross, & Reavley, 2018). The intent of MHFA training is not to replace seeking professional help but to empower the individual taking the training to have an increased awareness, increased confidence and decrease stigma (Mental Health First Aid Canada, n.d.-b). MHFA helps to decrease stigmatizing attitudes, and positively change nursing students perceptions regarding this equity-seeking population (Gapp, 2019).

CNSA's Current Position on the Topic

The proposed resolution statement addresses CNSA Objective B: *influence and advance innovation and social justice in the nursing curriculum and the nursing profession,* as well as Objective C: *strengthening linkages and creating new partnerships*.

Regarding Objective B, there is potential to address the four outcomes of this objective through curriculum development. Firstly, CNSA may advocate for curriculum development through three avenues: its national presence as an organization, its presence in the Canadian Association of Schools of Nursing (CASN), and through our delegates at the chapter level. Thus, students may be involved in consultations surrounding how and where such training would fit into curricula (as this will be unique to every chapter). Moreover, when delegates involve their members and faculty in such a task, that will have tangible outcomes to their school, it will raise awareness of CNSA goals and values. Lastly, MHFA is evidence-based and invites students to conduct formal or informal research into its benefits to students and its outcomes in practice. In this way, CNSA will be a leader in advocating for and developing evidence-based and best-practice guidelines. Delegates and CNSA members will positively represent nursing as a discipline and a profession and have a tangible impact on client care nationally.

Lastly, regarding Objective C, the three outcomes of this objective may be reached by integrating MHFA training into nursing curriculum. This will be achieved through engaging with external organizations as partners in this process; for example, we may engage with the Canadian Mental Health Alliance or MHFA Canada. As well, our members will have an impact on external organizations through bridging the gap that often exists between students and national nursing organizations, through voicing our values and goals, and by inspiring other healthcare fields to become Mental Health advocates.

Current position statements that are linked to the proposed resolution includes *Incorporation of Mental Health Into All Primary Care,* which was approved during the 2019 CNSA AGM (Canadian Nursing Students' Association, 2019).

Rationale

WHEREAS, the CNSA considers it imperative nursing students have the skills to support individuals experiencing Mental Health crises or exacerbations,

WHEREAS, there are no current national standards for MHFA training in nursing curricula,

WHEREAS, Mental Health curricula and experiences affronted to students may vary by chapter,

BE IT RESOLVED,

That the CNSA support and advocate for MHFA training throughout our membership,

BE IT RESOLVED,
That the CNSA will begin investigating this process through discussions with stakeholders, etc.

Relation to Canadian Nursing School Curriculums

While, mental health education is integrated into nursing curriculums throughout Canada, MHFA training is not a requirement. The necessity for MHFA may be considered similar of Cardiopulmonary Resuscitation training, which is mandated by nursing schools before entering the program and throughout. Curricula would benefit from MHFA through the promotion of preventive and community health, dissemination of mental health resources and research, and through normalizing mental illness among their students to decrease stigma surrounding mental health crises and mental illness. Students would benefit through increased levels of confidence and capability and the transferability of these skills to their personal lives. Moreover, the necessity of this resolution statement can also be linked to the importance of our position on *Incorporation of Mental Health into All Primary Care* (Canadian Nursing Students' Association, 2019).

According to the CASN, there is a necessity for a "Foundational knowledge of the health related needs of diverse clients in rural and urban settings to provide promotive, preventive, curative, rehabilitative, and end-of- life nursing care. Knowledge regarding healthy work environments including collaborative skills, leadership theories, and effective team functioning and conflict resolution. The ability to counsel and educate clients to promote health, symptom and disease management. The ability to facilitate client navigation through health care services. The ability to advocate for change to address issues of social justice, health equity, and other disparities affecting the health of clients." (Canadian Association of Schools of Nursing, 2015).

Conclusion

Half of all Canadians will live with a mental illness or experience a mental health crisis throughout their life. The stigma surrounding mental health means that while all of us experience varying levels of mental illness and wellness and maximum and minimum mental disorder, many of us will not discuss it (Halter, Pollard, & Jakubec, 2019). Equipping nursing students with MHFA will increase awareness of mental health disorders, normalize mental health issues and reduce stigma, and improve capability during a crisis. This training would be

complementary to mental health education already in place in curricula. Therefore, be it resolved that the CNSA support and advocate for MHFA training throughout our membership and be it further resolved that the CNSA will begin investigating this process through discussions with stakeholders, etc.

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Establishing a New Graduate Committee Chair

Approved: January 2020
Approved by: CNSA National Assembly
Submitted: December 15th, 2019
Submitted to: Board of Directors
Submitted by: Latitia Pelley-George, BScN, RN; Jessica Sadlemyer, Vancouver Island University; Tessera Ball, Red River College; Emma Hill, Vancouver Island University; Courtney Blake, North Island College; Victoria Marchand, University of Ottawa

Introduction/Background Information

Healthcare is facing a critical nursing shortage, contributing factors include: an aging patient population that is increasingly complex, an aging workforce, and high levels of nurse burnout (Haddad & Toney-Butler, 2019). Nurses and midwives account for almost 50% of healthcare workers across the globe - it is estimated that an additional 9 million nurses and midwives will be needed by 2035 to meet Sustainable Development Goal Number 3, *Health and Wellbeing* (WHO, 2020). Attrition rates in Canadian new graduate nurses have averaged 20-27% annually, costing the healthcare system $25,000 per nurse and hindering our ability to meet growing demands within healthcare (CNA, 2009). With these alarming statistics in mind, the CNSA would be remiss to overlook this opportunity to support new graduate nurses - defined as novice nurses within the first 3 years of experience - as they transition into practice (Laschinger, Grau, Finegan & Wilk, 2010). Adjusting from a nursing student to a new graduate nurse can be challenging due to limited support, changing environment, low self esteem, and experiences of vicarious trauma (Romyn et al., 2009).

Throughout Canada, there are limited opportunities available to new graduate nurses for engaging in advocacy and leadership. Some provincial nursing organizations have created programs to assist new graduate nurses, but many of these initiatives focus solely on peer support, gaining employment or are limited to a specific geographical location. (Association of Registered Nurses of Manitoba, 2016; British Columbia Nurses Union, 2018; Ministry of Health and Long Term Care, 2017)

CNSA's Position on The Issue

In May 2019, the CNSA Board of Directors (BOD) unanimously approved the creation of the ad-hoc New Graduate Committee. Unfortunately, due to lack of resources the CNSA BOD has

been unable to facilitate the recruitment of new graduate nurses, which is ultimately the first step. CNSA recognizes the importance of supporting new graduate nurses in the workplace through their transition period, and empowering them in leadership roles.

Rationale

There is a need to support our new graduate nurses during the first several years of practice so that they can confidently meet the required nursing competencies set out by their regulatory bodies. Newly graduated nurses also offer a unique perspective on the future of healthcare and fresh eyes for possible solutions. This has been an ongoing discussion by all major Canadian nursing groups including the Canadian Nurses Association (CNA), the Canadian Federation of Nurses Union (CFNU), and the Canadian Association of Schools of Nursing (CASN). However, these organizations often fail to engage with new graduate nurses. For example, there is a lack of involvement of new graduate nurses in the WHO led Nursing Now Campaign (n.d). This position will create a safe place for new graduate nurses to come together to discuss common difficulties with integrating into the profession. A New Graduate Advocacy Committee will also allow a platform for nursing organizations and associations to easily engage with new graduate nurses.

Resolution

WHEREAS The CNSA recognizes the need for further support for new graduate nurses as they enter the profession.

WHEREAS The CNSA can allow a platform for collaboration between the professional bodies and new nurse graduates.

THEREFORE;

BE IT RESOLVED that the CNSA creates a New Graduate Advocacy Committee Chair position to support new graduate nurses.

BE IT FURTHER RESOLVED that the committee chair be a new graduate no more than 24 months out at the beginning of their term.

Conclusion

With the current nursing shortage and alarmingly low retention rates for new graduate nurses, the CNSA will be fulfilling a need for increased new graduate advocacy and opportunities within nursing leadership professional bodies in Canada. The New Graduate Advocacy Committee will be able to provide a consistent point of contact for the creation of further new graduate advocacy positions within the current structure of nursing bodies in Canada.

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Supporting Harm Reduction Strategies in Response to the Opioid Crisis

Approved: January 2018

Approved by: 2018 National Assembly, Canadian Nursing Students' Association
Submitted by: Mary Jane Butler, Western Regional School of Nursing; Josh Duncan, North Island College; Caitlyn Patrick, Sault College; Logan Tullett, Ryerson; Kyle Warkentin, University of the Fraser Valley
Edited by: Jessica Guthier, Thompson Rivers University
Updated: January 2020

Introduction/Background Information

Canada is facing an overdose epidemic; the solution, supervised consumption. These sites employ harm reduction strategies as well as connecting individuals with addiction services (PHAC, 2008). Supports available are grounded in evidence, best-practice guidelines, and harm reduction philosophy: needle exchange programs; supervised injection sites; HIV, HSV, and other testing; safe injection and harm-reduction education; and street outreach (Fast et al., 2008).

Fentanyl is a cost effective and powerful synthetic opioid that is commonly used as a cheap 'cutting' agent to increase supply for illicit drug suppliers. Fentanyl has been found in cocaine, counterfeit oxycodone tablets, and heroin, among others (Frank & Pollack, 2017; London Free Press, 2017). *Carfentanil*—which is 100x stronger than fentanyl and 10,000x more potent than morphine—has been found in two separate drug investigations completed by the Public Health Agency of Canada in Ontario. *Carfentanil* found to be disguised as other, less potent substances. Potent opioids can easily suppress the respiratory system and result in fatal overdoses – especially in opiate naïve persons (London Free Press, 2017). Additionally, dangers associated with injected substances not only stem from the risk of developing HSV, but also bacterial infections (e.g. *necrotizing fasciitis*) , skin lesions, movement disorders, gastrointestinal complications, and psychological conditions (Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014). Opioid and substance-related morbidity and mortality serve as foundations for the supervised consumption movement. The point of intervention focuses on reducing the harms associated with substance use without further stigmatizing an already marginalized population (Small, 2012).

Education and sample-testing at supervised consumption sites (SCS) recognizes that many who are dying from fentanyl overdoses are consuming these substances unwittingly (Frank & Pollack, 2017). Moreover, access to trained professionals and Naloxone (Narcan) at consumption sites allows for the reverse of potentially fatal overdoses; meanwhile, providing

Naloxone education and supply for individuals empowers them to step in during overdoses when a professional is not present (Frank & Pollack, 2017; London Free Press, 2017).

SCS are places where individuals can use their personally sourced illicit substances while under professional supervision, while also having access to health professionals (often advance-practice nurses) and referrals as needed for social services, health services, and addiction services. The goals of such programs are designed to increase access to healthcare and addiction services, reduce the incidence of overdose mortality, and reduce the spread of blood-borne infections (PHAC, 2008). Nonetheless, one underlying issue with supervised consumption sites is that if individuals are unable to receive services in a timely fashion, they are more likely to avoid using these facilities in the future (Bell & Globerman, 2014).

The Position of the Canadian Nursing Students' Association (CNSA)

The CNSA strongly supports the need for more supervised consumption sites across Canada as a public health measure and will promote this intervention in nursing venues across the country. In addition, the CNSA commits to supporting community groups who are working towards opening supervised injection sites. While explicit mention to supervised consumption sites has not been made in past CNSA documents, the CNSA strongly supports harm reduction measures. An exemplar position statement was approved in 2019 regarding affordable PrEP access for all (CNSA). Previously, the CNSA has supported a harm-reduction approach through a position entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013). Acceptance of this updated statement, which builds on that passed in 2013, addresses the current public health issues surrounding opioid use in particular.

In addition, CNSA stands with other national organizations and aims to support this evolving public health issue. The Coalition of Nurses and Nursing Students for Supervised Injection Services and the Community Health Nurses of Canada have lain foundations through past documents and resources, and the CNSA supports these this position.

Relation to Canadian Nursing School Curriculums

Community nursing practice offers students the opportunity to use their assessment skills to work in community settings that may or may not involve clients who use drugs. The inclusion of this topic within the nursing curriculum would provide nursing students the opportunity to expand their knowledge base on how to effectively market health promotion initiatives in public and political spectrums. Thus, nursing students can increase public awareness and the scope of

care. Additionally, students will learn how to network with community organizations and build their ethical and professional identity.

In addition to the health-related benefits to this curriculum proposal, students can also develop a better understanding of economics and public spending which could reinforce their stance that public health initiatives have a positive return on capital investment. More specifically, the *Economic Burden of Illness in Canada* report stated that the cost of harm reduction by means of prevention would save Canada millions over the long run. This results from a divergence of money and resources used to treat chronic conditions, such as hepatitis, later (PHAC, 2014).

Lastly, a harm reduction curriculum within nursing education has the potential to build off the 2013 resolution statement regarding the inclusion of 2SLGTBQ+ education. As many nursing students may already know, gender and ethnic minorities face systems of oppression and marginalization that results in these minorities being disproportionately represented in the substance using community. In this vein, such curriculum inclusion builds upon past work of the CNSA to advocate for marginalized and equity seeking populations.

Rationale

WHEREAS, Canada is facing a crisis of opioid overdoses.

WHEREAS, the CNSA supports harm reduction as a valid public health and safety measure.

WHEREAS, a resolution statement has not yet come forward to address the 2013 CNSA Position Statement entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013).

Be it Resolved, That the CNSA, as the voice of the new generation of nurses, promote safe injection services within their chapter schools through collective partnerships with professors, nurses, school faculty and nursing students in order to prioritize public health measures.

Be It Further Resolved, That the CNSA support the efforts of Canadian nursing students to advocate for increasing the number of safe injection sites across Canada that follow and adhere to institutional protocols and nursing CNO standards of practice.

Be it Further Resolved, That the CNSA advocate for the inclusion of safe injection practices as a legitimate harm reduction approach in nursing education within community and public health curriculum.

Conclusion

The lack of accessibility for minority and substance-using communities within primary health care settings often results in them being disproportionately represented in overdose incidences. As morbidity and mortality related to opioid overdoses continue at epidemic rates, healthcare professionals must adapt their practices to be inclusive, non-judgmental, and employee harm-reduction philosophy. This position statement builds upon other documents passed by the CNSA regarding ethnic and cultural minorities, accessible healthcare and primary health care, and other supervised consumption positions.

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Edits

1. Canada is facing an overdose epidemic; the solution, supervised consumption. These sites employ harm reduction strategies as well as connecting individuals with addiction services (PHAC, 2008). Supports available are grounded in evidence, best-practice guidelines, and harm reduction philosophy: needle exchange programs; supervised injection sites; HIV, HSV, and other testing; safe injection and harm-reduction education; and street outreach (Fast et al., 2008).
2. Fentanyl is a cost effective and powerful synthetic opioid that is commonly used as a cheap 'cutting' agent to increase supply for illicit drug suppliers. Fentanyl has been found in cocaine, counterfeit oxycodone tablets, and heroin, among others (Frank & Pollack, 2017; London Free Press, 2017). *Carfentanil*—which is 100x stronger than fentanyl and 10,000x more potent than morphine—has been found in two separate drug investigations completed by the Public Health Agency of Canada in Ontario. *Carfentanil* found to be disguised as other, less potent substances. Potent opioids can easily suppress the respiratory system and result in fatal overdoses – especially in opiate naïve persons (London Free Press, 2017). Additionally, dangers associated with injected substances not only stem from the risk of developing HSV, but also bacterial infections (e.g. *necrotizing fasciitis*) , skin lesions, movement disorders, gastrointestinal complications, and psychological conditions (Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014). Opioid and substance-related morbidity and mortality serve as foundations for the supervised consumption movement. The point of intervention focuses on reducing the harms associated with substance use without further stigmatizing an already marginalized population (Small, 2012).
3. Education and sample-testing at supervised consumption sites recognizes that many who are dying from fentanyl overdoses are consuming these substances unwittingly.
4. Moreover, access to trained professionals and Naloxone (Narcan) at consumption sites allows for the reverse of potentially fatal overdoses; meanwhile, providing Naloxone

education and supply for individuals empowers them to step in during overdoses when a professional is not present (Frank & Pollack, 2017; London Free Press, 2017).

5. The CNSA strongly supports the need for more supervised consumption sites across Canada as a public health measure and will promote this intervention in nursing venues across the country. In addition, the CNSA commits to supporting community groups who are working towards opening supervised injection sites. While explicit mention to supervised consumption sites has not been made in past CNSA documents, the CNSA strongly supports harm reduction measures. An exemplar position statement was approved in 2019 regarding affordable PrEP access for all (CNSA). Previously, the CNSA has supported a harm-reduction approach through a position entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013). Acceptance of this updated statement, which builds on that passed in 2013, addresses the current public health issues surrounding opioid use in particular.
6. In addition, CNSA stands with other national organizations and aims to support this evolving public health issue. The Coalition of Nurses and Nursing Students for Supervised Injection Services and the Community Health Nurses of Canada have lain foundations through past documents and resources, and the CNSA supports these this position.
7. The inclusion of this topic within the nursing curriculum would provide nursing students the opportunity to expand their knowledge base on how to effectively market health promotion initiatives in public and political spectrums. Thus, nursing students can increase public awareness and the scope of care. Additionally, students will learn how to network with community organizations and build their ethical and professional identity.
8. The lack of accessibility for minority and substance-using communities within primary health care settings often results in them being disproportionately represented in overdose incidences. As morbidity and mortality related to opioid overdoses continue at epidemic rates, healthcare professionals must adapt their practices to be inclusive, non-judgmental, and employee harm-reduction philosophy. This position statement builds upon other documents passed by the CNSA regarding ethnic and cultural minorities, accessible healthcare and primary health care, and other supervised consumption positions.

Position Statements 2019

Achieving Health Equity in Canada's Rural and Remote Communities

Approved by: CNSA Board of Directors
Submitted: December 7th, 2018
Submitted to: Board of Directors
Submitted by: Chloe Norris - Conestoga College (in collaboration with McMaster University);
Latitia Pelley-George - Dalhousie University;
Leanna Gustafson - University of Regina & Saskatchewan Polytechnic- Saskatoon

Introduction and Background Information

All Canadians should respond to the Final Report of the Truth and Reconciliation Commission of Canada (TRC), which calls for addressing the inequities of health care that Indigenous people experience in Canada (Jane Philpott, 2017). In order to receive certain medical treatment, many residents in rural and remote communities must leave their homes to receive access to the care they deserve. In Nunavut for instance, a resident must leave their community to receive radiation, chemotherapy treatment, neonatal services, or alcohol and drug addictions treatment (Aningat, 2018). Nurses often have an awareness about how the complexity of Indigenous health issues is connected to consequences stemming from government decisions (social and political) but the roles and influences of nurses in addressing these issues are uncertain (Rahaman, Holmes, Chartrand, 2016).

Nurses are often the primary health care providers for the delivery of essential health services within rural and remote Indigenous communities. Barriers to continuing education, overwork, burnout, large professional responsibility and lack of support from management are just some of the challenges that contribute to poor retention of rural and remote nurses which leads to further inequities within Indigenous communities (Rahaman, Holmes, Chartrand, 2016). Inequities in Northern rural and remote communities root from a lack of consistent and effective health services (Aningat, 2018). The astounding numbers show that 83.6% of Canadians in a National average have regular contact with a physician compared to 23.8%, 44.2%, and 75.1% of Nunavut, Northwest Territories, and Yukon residents respectively (Aningat, 2018). Change in nursing curriculum is evidently needed and more awareness on these inequities is imperative for these communities.

Canadian Nursing Students' Association's Current Position on the Issue

The association passed a position statement in 2015, "Cultural Safety in the Context of Aboriginal Health in Nursing Education" (CNSA, 2015). This demonstrates that the CNSA advocates for inclusion of cultural safety, specifically Indigenous health cultural safety, in nursing education. A better way to advocate for Indigenous health cultural safety is by having more students exposed to the health inequities that Indigenous communities face. By increasing the number of students being exposed to cultural safety and the important discussions through their curriculum and in their classrooms, more awareness is brought forward about the issue and health equity is more achievable. This ties into CNSA's strategic plan Objective B, Outcome #1: "Be involved in curriculum decisions, planning and review", and Objective B, Outcome #4: "Members of CNSA incorporate research and evidence-based decision making into their current and future practice to positively influence patient outcome" (CNSA, 2016).

Relation to Canadian Nursing School Curriculums

Nurses are an extension of the state health care system, and they must provide responsive and relevant health services within isolated Canadian Indigenous communities. However, there remains to be a lack of consensus about nurses' roles in these Northern health centres, where high expectations, lack of clear directions, and poor documentation burden staff, all affecting the effectiveness of care. There is not enough being done in nursing schools to advance the unique specialty of rural and remote nursing and primarily Indigenous communities are suffering. The CNSA supports educational institutions in their development of more rural and remote placement opportunities in nursing school for students to gain knowledge and experience about primary health care and Northern rural and remote outpost nursing.

One of CNSA's objectives is to influence and make advancements in innovation and social justice within the nursing curriculum and the nursing profession (CNSA, 2016). By allowing nursing students to take part in clinical placements in rural and remote Northern communities, it will create an influence and advancement in social justice. In a study, it was shown that 67% of students were gainfully employed in an area where they did a clinical placement (Wareing, et. al, 2017, p. 229). By increasing clinical placements in Northern communities, the retention of student nurses after they graduate is increased and the number of nursing vacancies is decreased. An advantage of having clinical placements in Northern communities is that new graduates will have already been introduced to the culture and the way of life of the Indigenous people in Northern Canada. The new graduates will be known to the residents of the community and would not be an outsider coming into their community for the first time.

Conclusion and Restatement of the CNSA Position

Nursing schools need to do more to prepare novice nurses for the realities of primary health care in rural and remote communities. There is not enough being done in nursing schools to advance the unique specialty of rural and remote nursing and primarily Indigenous communities are suffering. Addressing the inequities in health care for Indigenous populations living in rural and remote communities in Canada must become a priority. Nursing programs should have the option to participate in a high-quality rural clinical and educational experience to all nursing students that support experiential learning. This ensures students attain competencies to provide culturally safe care within rural and remote communities in Canada.

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Affordable and Accessible PrEP For All

Approved by: CNSA Board of Directors
Submitted: December 7, 2018
Submitted to: CNSA Board of Directors
Submitted by: Courtney Blake - North Island College
Allison Mosley - University of Lethbridge

Introduction/Background Information

HIV is a syndrome caused by a virus called the Human Immunodeficiency Virus. It attacks the body's immune system by hijacking white blood cells, leaving people vulnerable to secondary infections. Without treatment, an HIV infection will lead to a more severe syndrome called AIDS. There is currently no cure or vaccine for HIV, but with the right treatment and behavioural intervention, someone with HIV can expect to live a long life (Canadian AIDS Treatment Information Exchange [CATIE], 2018).

In February 2016, Health Canada approved the use of pre-exposure prophylaxis (PrEP) to help prevent the contraction of HIV (CATIE, n.d). Using PrEP has been shown to be up to 92% effective at preventing new HIV infections in adults who are at high risk when used in conjunction with behavioural interventions (CATIE, 2018). Despite the efficiency of PrEP, rates of HIV infection in Canada have recently been on the rise. These rates were on the decline from the 1980s until 2014. Since 2014, there has been a 5% increase of HIV infections in Canada, representing just under 3000 new cases (Government of Canada, 2016). In Saskatchewan, rates of HIV diagnoses are 2.4 times higher than the rest of Canada (HIV Prevention and Control Report, 2017).

HIV disproportionately affects equity-seeking populations. Indigenous populations are 2.7 times more likely to be affected than non-Indigenous populations. People who use injection drugs are 59 times more likely to be affected than people who do not inject drugs (Government of Canada, 2016). LGBTQ2S+ men and trans women are 131 times more likely to be affected than heterosexual men (Government of Canada, 2016).

Stigma surrounding HIV and the people who are at an increased risk of getting HIV affects the availability of PrEP. Some care providers refuse to explore PrEP as an option due to concerns about the individual's ability to adhere to the behavioural interventions used in tandem with PrEP (Staples, Sanyal, Khatura, Mishra & Kumar, 2015). These care providers assume that the idea of PrEP will encourage high-risk individuals to develop a false sense of security leading to increased risk-taking behaviours, promiscuity, decreased screening, and decreased use of protective measures. However, there is no evidence to support these assumptions (Staples et al., 2015). Societal perceptions impact the quality of care these individuals receive. There is currently a lack of knowledge surrounding PrEP and addressing social prejudices may be vital in expanding its use (Knight, Small, Carson, & Shoveller, 2016). Low adoption rates, use of PrEP,

and the high costs for clients reflect that market access of PrEP is significantly driven by strong prevailing societal views despite regulatory approvals and national recommendations supported by clinical evidence (Staples et al., 2015).

The Position

The CNSA believes that it is imperative that all individuals have the right and ability to access PrEP. As an organization, CNSA supports equitable health care for equity-seeking populations and takes into account social inequalities. CNSA supports the notion that PrEP should be affordable and supports incorporating it into routine HIV prevention and treatment strategies, free of cost to the individual.

The CNSA aspires to influence and to advance innovation and social justice in the nursing curriculum and the nursing profession. The CNSA also has a core mandate to be the primary resource for nursing students. Therefore, the CNSA supports the education of nursing students regarding PrEP use, access, and the health inequities that can prevent appropriate PrEP usage- such as perceived risk, lack of support, lack of healthcare access, and the social determinants of health. Advocacy for this education may improve health promotion and health outcomes for populations that are disproportionately affected by health inequities.

The CNSA stands in support of The Canadian Association of Nurses in HIV/AIDS Care (CANAC) in its commitment to fostering excellent HIV/AIDS care in nursing and for the prevention of the spread of HIV (CANAC, 2018). The CNSA works in tandem with organizations on the point of care to support equity seeking populations in receiving PrEP. As future health care providers, we as nurses must recognize the complex and dynamic knowledge around HIV prevention and care.

Relation To Canadian Nursing School Curriculums

According to Canadian Association of Schools of Nursing (CASN) it is essential for nursing programs to prepare their students so that they understand primary health care in regard to health disparities, equity-seeking populations, and the social determinants of health (CASN, 2015). Many equity-seeking populations such as people who use injection drugs, Indigenous people and LGBTQ2S+ individuals are at a higher risk of contracting HIV. Nurses have a responsibility to support all patients throughout their healthcare journey and to advocate for the reduction of barriers to accessing healthcare.

There are currently several barriers individuals must overcome to access PrEP. CASN (2015) states that nurses must possess the ability to counsel and to educate clients to promote health, prevent disease, and manage symptoms. When nurses are uneducated about the benefits of PrEP as a successful tool for preventing and treating HIV, they cannot adequately support their clients to receive the most beneficial care.

CNSA must advocate for the inclusion of HIV education surrounding prevention and disease management at all levels; primordial, primary, secondary and tertiary, quaternary. The integration of this education will allow nursing students to be leaders in health promotion. The inclusion of this curriculum would also allow for knowledge expansion and better awareness about the evidence-informed practice of disease prevention.

Conclusion

The CNSA believes that (PrEP) should be available and affordable for equity-seeking populations across Canada. The CNSA as an organization will continue to advocate for equitable health care for these individuals, provide resources to nursing students on the topic of HIV/AIDS, and engage in research about HIV prevention and treatment.

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Incorporation of Mental Health Into All Primary Care

Approved by: CNSA Board of Directors
Submitted: December 7, 2018
Submitted to: CNSA Board of Directors
Submitted by: Allison Mosley of University of Lethbridge

Introduction/Background Information

It is estimated about 1 in 3 Canadians will experience a mental illness in their lifetime (Government of Canada, 2018). As well, the Center for Addiction and Mental Health (CAMH), reports that in any year up to 1 in 5 Canadians will experience mental illness or addiction, and by age 40 that will increase to 1 in 2 (CAMH, 2018). Currently, over half of Canadians consider anxiety and depression to be an epidemic in Canada (CMHA, 2018a). The first point of contact with the healthcare system for many Canadians is the primary care practice, this includes those with mental health problems and addictions (Kates, 2017). Despite this, many primary care providers report a lack of knowledge, and a lack of training as barriers to confidence in delivering mental health care (Kates, 2017).

Despite the high prevalence, a significantly large portion of those with mental illness still go untreated, and a large majority will receive no treatment over the course of a year (Kates, 2017). 1.6 million Canadians report unmet mental health care treatment needs every year (CMHA, 2018a). There is still stigma among the general population, but also among healthcare providers regarding individuals with mental illness and addiction. Canada is in the midst of an opioid crisis, and those who face addition, also face multiple barriers and discrimination when trying to access health care.

Although Canada had taken steps to improve its mental health framework, there are still

gaps in health care delivery and in collaboration. An integrated approach would allow health care providers to better meet the needs of Canadians- including raising awareness of prevention strategies, earlier diagnosis, early intervention and better access to treatment/recovery options.

The Position

The position of the Canadian Nursing Students' Association (CNSA) has been in supporting and advocating for equitable mental health care for all Canadians. The CNSA understands that mental health and physical health are closely connected and deserves to be treated equally. As an organization, the CNSA believes that regular contact with primary care teams can help prevent and improve mental and physical conditions. The CNSA supports barrier free, accessible primary care for Canadians with mental health as a core competent. The CNSA believes that primary health care providers should be knowledgeable and confident in providing high quality care to those with mental health problems and illnesses.

The CNSA supports the education of nursing students on these topics through its core principle of influencing and advancing nursing education. Topics and perspectives such as mental health promotion, trauma informed care, and stigma as a barrier are key for future nurses to understand. Advocacy for greater inclusion of mental health education could improve health promotion and general health knowledge. It would also aid in nurses entering practice being prepared to provide holistic care to individuals, resulting in better health outcomes.

The CNSA also stands in support of the Canadian Mental Health Association, who is a nationwide leader in mental health efforts and seeks to facilitate resources and support for those living with mental illness (CMHA, 2018b). The CNSA believes that as future nurses and as socially responsible health care providers, we cannot ethically allow the health care system to fail in addressing mental health needs.

Relation To Canadian Nursing School Curriculums

In 2014 the Canadian Association of Schools of Nursing (CASN) created a mental health and addictions core competency guide (CASN, 2014). However, there are still undergraduate students who feel mental health education is not being adequately covered in their programs. The integration of mental health curriculum into all areas of care allows students to meet the competency outlines, such as demonstrating knowledge about the mental health spectrum and providing ethical care to all clients.

As previously described, future nurses need to be prepared to provide holistic care. Inclusion of mental health topics, perspective and approaches will increase awareness of this equity-seeking population and will better prepare nurses providing primary care. It will give nurses knowledge on prevention, stigma and the recovery model, which allows them to be a collaborative member of the primary care team.

Conclusion and Restatement of CNSA Position

The CNSA believes in the importance of incorporating mental health care and services into care delivered by primary care providers. Furthermore, the CNSA supports education for students regarding mental health and illness perspectives to deliver holistic care.

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Resolution Statements 2019

Quebec to Join Atlantic Regional Conference

Submitted: December 7th, 2018
Submitted to: CNSA Board of Directors
Submitted By: Latitia Pelley-George, Atlantic Regional Director, Dalhousie University;
Ashley Pelletier-Simard, Director of Bilingualism and Translation, Dalhousie University;
Erin McConnell, Research and Education Committee Chair, Dalhousie University;
Anisha Mehreja, Quebec Regional Director, McGill University

Background

For several years, Quebec and Ontario have hosted their Regional Conference and Regional Executive Meetings together. In 2017-2018, the position of Quebec Regional Director on the Canadian Nursing Students' Association Board of Directors was unfilled. This left Quebec to be overseen by the Ontario Regional Director (Canadian Nursing Students' Association, 2018). Despite the close proximity of Quebec and Ontario, their culture and issues are vastly different.

In 1969, The Official Languages Act was passed, making Canada a bilingual country and New Brunswick the first and only bilingual province (Office of the Commissioner of Official Languages, n.d.a). In 1974, The passing of the Official Languages Act also made Quebec's official language French (Office of the Commissioner of Official Languages, n.d.b). Currently, approximately 17.5% of the total Canadian population is proudly bilingual (Lepage & Corbeil, 2013). In 2011, the provinces who reported the highest number of bilingual individuals were Quebec, with 42.6%, and New Brunswick, with 33.2% (Lepage & Corbeil, 2013). In contrast, Ontario reports only 11% of the province's population as bilingual (Lepage & Corbeil, 2013). Based on these statistics, Quebec would benefit from sharing their conference with the Atlantic Region, as it would allow francophone and bilingual students to explore their culture and language in a safe environment and collaborate with individuals of similar interests.

The Atlantic region consists of Nova Scotia, Prince Edward Island, New Brunswick, Newfoundland and Labrador and Nunavut. Approximately 16.3% of the Atlantic region is bilingual (Lepage & Corbeil, 2013), a higher percentage of bilingual individuals than Ontario, and the region includes the province with the largest bilingual population second to Quebec. Quebec

and New Brunswick, and by extension all Atlantic provinces, share a common culture more so than Quebec and Ontario. New Brunswick and Quebec share unique lifestyles and experiences. New Brunswick has always been considered a part of Atlantic Canada and should remain with the Atlantic region as New Brunswick's Acadian population has strong roots with the other Atlantic provinces. New Brunswick also has several Anglophone schools who may be at a disadvantage if New Brunswick was to be separated from the rest of Atlantic region, with which they share a similar culture and lifestyle. With this change, CNSA would be fulfilling its objectives to be the primary resource for nursing students through further supporting francophone students; by encouraging collaboration on advancement in nursing curriculum with regards to francophone content and the current National Council Licensure Examination for Registered Nurses (NCLEX-RN) landscape, and strengthening the linkage between the Quebec and Atlantic region as well as their respective stakeholders. Therefore, Quebec should join Atlantic Regional Conference (ARC) to become Atlantic/Quebec Regional Conference (AQRC).

Links to Canadian Nursing Students' Association Mandate and Current Position on the Issue

While the CNSA does not currently have a position statement on the addressed issue, the association should consider its current mandate and core values to facilitate the joining of the two regions for future conferences. The CNSA seeks to strengthen linkages and create new partnerships with student nurses throughout Canada. Joining Quebec and the Atlantic region, specifically New Brunswick, is in alignment with the CNSA's governing objectives, goals, and core values. Allowing francophone students to share their cultural values, personal experiences, and future career opportunities in a bilingual setting plays an essential role in diversifying and enhancing new affiliations. In order to influence and advance innovation and social justice in nursing curriculum and the nursing profession, French advocacy and representation at a regional conference is essential. As stated earlier, New Brunswick has 33.2% bilingual representation (Lepage & Corbeil, 2013). Proficiency in French allows social justice for the considerable French speaking population within the Atlantic region as it facilitates an accurate understanding and valuable communication with students about their concerns. Furthermore, bilingual representation on behalf of CNSA within the Atlantic region promotes inclusivity and advocacy in nursing by supporting diverse populations within Canadian nursing schools.

The Resolution

WHEREAS, New Brunswick and Quebec have the largest population of bilingual people in Canada; and

WHEREAS, New Brunswick is known to be part of the Atlantic Provinces; and

WHEREAS, CNSA values supporting francophone students, advancement in francophone curriculum, and strengthening and creating new linkages throughout Canada; therefore,

BE IT RESOLVED that Quebec remain an independent region but join the Atlantic region for conferences and regional executive meetings.

BE IT FURTHER RESOLVED that Quebec shall join the Atlantic Regional Conference to become the Atlantic/Quebec Regional Conference (AQRC).

BE IT FURTHER RESOLVED that the roles of Quebec Regional Director and an Atlantic Regional Director remain separate but share the role of maintaining bilingualism amongst the regions and recruiting more Francophone and bilingual chapter schools in collaboration with the Director of Bilingualism and Translation.

Relation to Canadian Nursing School Curriculums

Francophone students in Quebec have limited employment opportunities within Ontario. New Brunswick can offer prospective unilingual francophone nurses careers that are enriching as well as respectful of the French language. They can also offer language classes to build on their English while still cherishing francophone heritage. This understanding can lead to positive employment outcomes for francophone nurses who are looking to explore Canada. New Brunswick nursing students will also benefit from sharing their conference with Quebec. They will be exposed to Quebec culture which can help broaden their appreciation of Acadians in the Maritimes. Francophone students can also support one another through the unique challenges faced by this population, such as studying and writing the NCLEX-RN in French. Joining Quebec's Regional Conference with the Atlantic Regional Conference will allow these provinces to celebrate Acadian and Quebecois culture and allow for both populations to grow stronger together.

Conclusion

In conclusion, by Quebec joining the Atlantic region for Regional Conferences and Regional Executive Meetings it will enhance the inclusivity of francophone culture. Currently, Quebec only has one chapter school, primarily due to students feeling misplaced among the

abundance of Anglophone schools. By Quebec joining the region with the most bilingual population, it will increase inclusivity, foster francophone advocacy, and create an opportunity for francophone students to thrive and become the best nursing leaders. Quebec will remain its own region but will combine with the Atlantic region for conferences to facilitate a safe environment for francophone students from both Quebec and New Brunswick. It will allow for better collaboration and strengthen linkages between the regions.

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Establishing a Committee Chair Position for Practical Nurse Advocacy

Approved by: CNSA Board of Directors
Submitted: December 7th, 2018
Submitted to: Board of Directors
Submitted by: Michaila Stiles, Vancouver Island University

Jessica Sadlemyer, Vancouver Island University

Introduction/background information

According to the Canadian Institute for Health Information (CIHI) there are over 100 000 licenced practical nurses in the nursing workforce (CIHI; 217). In Ontario, this designation is referred to as registered practical nurses and in Quebec as infirmier(ère) auxiliaire; hereafter these designations will be referred to jointly as practical nurses (PN). Collectively, they represent approximately 27% of regulated nurses in Canada (CIHI; 2017). Practical nurses are becoming an increasingly important part of the interdisciplinary healthcare team. The cumulative growth in the supply of PNs from 2007 to 2016 has increased by 49%, compared to 8.9% for registered nurses (RN) and nurse practitioners (CIHI, 2017). In 2016, there were 10,000 new RN graduates and nearly 8,000 new PN graduates holding a licence to practice.

Mutual trust and respect influence intraprofessional RN-PN collaboration, which in turn affects work satisfaction and patient care (Huynh, Alderson, Nadon, & Kershaw-Rousseau, 2011; Kalisch, Lee, & Salas, 2010). A major factor in limited and uncollaborative interactions is due to time constraints, a systemic factor that students do not encounter as much (Huynh, Alderson, Nadon, & Kershaw-Rousseau, 2011). Intraprofessional mutual trust and respect begins in the educational period, and the CNSA can advance the relationships between RN and PN students by providing increased involvement and networking opportunities within the family of student nurses.

In June of 2018, the Canadian Nurses Association (CNA) voted to pass a landmark resolution that CNA "work with *nurses of all government legislated designation* to foster and promote a sense of professionalism and pride as a nurse" (emphasis added, p. 13, 2018b). The expected outcome of this resolution is to demonstrate solidarity and inclusion with other nursing designations, including PNs. Since its founding over 100 years ago, CNA has been the national voice of RNs and nurse practitioners, and, with this resolution, CNA can review its governance to expand its member base (2018a).

While PN students are welcome to join CNSA, without a national association, there is not a unified national voice to advocate on behalf of this large branch of the nursing family. In this transition period before CNA updates its governance to reflect the 2018 resolution change, CNSA can cultivate lasting relationships with and advocacy for PN students.

Information on CNSA's position

The Canadian Nursing Students' Association (CNSA) represents 57 schools of nursing nationwide, with 24 of them offering practical nursing studies. However, as of the 2018 membership year, only 6 chapter members included PN students under their membership.

In August of 2018, at the CNSA board of directors meeting, the board determined a need to address the lack of representation and input from PN students in the decision making and planning of the organization. The board voted to approve the creation of an ad-hoc Practical Nursing Advocacy Committee, that was subsequently filled. This committee's goals and objectives include engaging and representing the voice of PN students. This ad-hoc committee is directly related to CNSA's governing objective A: to be the primary resource for nursing students (Canadian Nursing Students Association [CNSA], 2016).

Rationale

WHEREAS CNSA's objective is to be the primary resource for nursing students, and;

WHEREAS CNSA's outcome is to provide accessible and relevant information and services our members, and;

WHEREAS CNSA's outcome include engaging nursing students, and;

WHEREAS There is a determined need to increase PN student representation in CNSA, therefore;

Resolution

Be It Resolved That CNSA adopts a Practical Nursing Advocacy Committee Chair to advocate for and promote CNSA involvement with practical nursing students across Canada.

Conclusion

As the national voice of nursing students, CNSA has an active dedication to the positive promotion of nurses and the nursing profession. CNSA board members have

determined a need for increased PN student representation in the decision making and planning of the organization. CNSA has committed to be the primary resource for nursing students and thus establishing a position for PN student advocacy better equips CNSA to be the primary resource for PN students. With this, the organization will foster intraprofessional collaboration between RN and PN students in preparation for collaboration as regulated nurses.

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Inclusive Intake/Patient-History Forms

Approved by: CNSA Board of Directors
Submitted: December 7, 2018
Submitted to: CNSA Board of Directors
Submitted by: Allison Mosley of University of Lethbridge

Introduction/Background Information

The exact number of transgender and non-binary Canadians is unknown. Health research

rarely includes the options for participants to self-identify their gender; which often excludes anyone who does not identify within the binary system of "male", and "female".

LGBTQ2S+[5] people experience stigma and discrimination throughout their lives, including within the healthcare system. This leads to a fear of being mistreated within our medical system. Research suggests that health care providers routinely use the wrong gender pronoun to address transgender and non-binary patients, and often forget to ask individuals for their proper pronouns. Additionally, health care providers have disclosed their patient's gender identity to others without their consent, when it is not necessary for care (Clegg & Pearson, 1996). Experiences such as these create an environment that is unsafe and unwelcoming for queer individuals, as such they may face discrimination in the health care setting. Transgender and other gender identities are unrepresented, and as a result they become systematically disadvantaged and become one of the most marginalized groups. Looking at the social determinants of health, these individuals are at higher risks of experiences adverse health effects, yet are less likely to seek out medical care. Additional challenges queer individuals face include difficulty accessing trans-inclusive/gender inclusive primary and emergency healthcare, transition care, difficulty obtaining referrals and often being denied medical care (Bauer, Hammond, Travers, Kaay, Hohenadel & Boyce 2009; Cobos & Jones, 2009). Additionally, it can be difficult for those that identify outside of the gender binary to receive appropriate care for their sex assigned at birth if there is no way for them to indicate their assigned sex and gender identity are different. Most forms and billing systems are set up in a way that correlates listed "sex" with body parts and only allows sex-specific procedures such as hysterectomies and prostate-treatments to be billed to those of that designated sex (Bauer et al., 2009). This means a client identifying as male may not be eligible for care such as breast and pelvic exams.

The House of Commons approved Bill C-279 (2015), making it illegal to discriminate against Canadians on the basis of gender identity or gender expression. Despite this, those individuals who identify outside the binary and express themselves outside societal norms, still face discrimination in theri health care across the country.

CNSA's Position on the Topic

In 2013 the CNSA passed a position statement on incorporating LGBTQ2S+ education into Canadian nursing curriculum and a resolution statement as follows; Rise Up and Eliminate

[5] LGBTQ2S+ is an abbreviation for Lesbian, Gay, Bisexual, Transgender, Queer, and Two-Spirit. The + allows room for fluidity and growth while recognizing expression is constantly evolving and encompassing of all other expressions.

Barriers: Striving to Enhance Cultural Competence in Caring for the The LGBTIIPQQ2SAA+[6] Community (CNSA, 2013). Furthermore, in 2016 the CNSA passed another resolution statement to build on the 2013 position statement and give a clear sense of direction. Through this resolution statement, we seek to provide further actions that will help meet the advocacy goals of the CNSA and inclusion of equity seeking population, specifically the LGBTQ2S+ community.

The CNSA believes that a gender inclusive form would allow for the advancement of social justice in the nursing profession. An inclusive form creates a healthcare environment that is welcoming and safe for queer individuals. By doing this, this CNSA believes there will be a decrease in discrimination and social exclusion in healthcare and provides inclusive. As an organization the CNSA supports the ideal that nurses show clients they are respected for who they are and do not have to fear discrimination, and provide culturally competent care to all patients. Nursing students are responsible to provide care to all individuals as the future health care workers. Therefore, it is imperative the specific needs of unique population are met for ethical care. The inclusivity of gender diverse populations is fundamental for the care of minority populations.

The CNSA believes in actively involving stakeholders as outlined in its Strategic plan. The uptake of an inclusive form requires the support of external organizations such as nursing organizations (CNA, CFNU), provincial bodies and the Ministry of Health. Engagement with these stakeholders allows for the CNSA to help prepare nursing students to provide safe, ethical and compassionate care the LGBTQ2S+community.

Rationale

WHEREAS, the CNSA supports the ongoing health needs of equity- seeking populations needs, including the special needs of the LGBTQ2S+, and;

WHEREAS, the LGBTQ2S+ community experiences higher rates of discrimination and lack of comprehensive care in the healthcare system, and;

[6] The LGBTIIPQQ2SAA+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Intergender, Pansexual, Queer, Questioning, Two Spirit, Asexual and Aromantic) community is composed of a diverse group of individuals. The + allows room for fluidity and growth while also recognizing that expression is a constantly evolving process meaning not all expressions may be accurately represented by this acronym.

WHEREAS, a resolution statement Incorporating LGBTIIPQQ2SAA+ Education into Nursing Curriculum in Canada was passed in 2016, stating to prioritize incorporating the needs, experiences, and perspectives of LGBTQ2S+ people and communities into nursing school curricula, therefore;

Be it Resolved, That the CNSA, as the voice of the new generation of nurses, promote safer spaces for transgender, non-binary and other gender identities within their chapter schools through collective partnerships with professors, nurses, school faculty and nursing students in order to prioritize public health measures, and;

Be It Further Resolved, That the CNSA support the efforts of Canadian nursing students to advocate for gender inclusive intake/patient history forms and language across Canada that address the unique needs of these populations including gender outside the binary, sex at birth, and pronouns through activities such as researching inclusivity initiatives, collaborating with LGBTQ2S+ patients to include their voices in form change, and petitioning Canadian textbook companies to change the language in their textbooks to be inclusive, and;

Be it Further Resolved, That the CNSA diversity and community and public health committees prioritize advocating for the inclusion of a gender friendly intake form for those that identify outside of the binary system, including advocating for nursing education within community and public health curriculum.

Relation to Canadian Nursing School Curriculums

The Canadian Association of Schools of Nursing (CASN), outlines in their national framework that undergraduate nurse need to have knowledge of primary health care, ethical nursing practice, and social justice (CASN, 2015). Specifically there should be knowledge of health disparities, determinants of health, and holistic care. Gender identity is a key aspect of who an individual is and identifies as. This will affect how they receive care. As future health care providers, nursing students must be prepared to assess diverse client populations and be able to provide them with competing ethical safe and compassionate care (CASN, 2015).

If nurses are uneducated about what gender identity is and its impacts on health, they cannot support their clients appropriately, or provide them with the best care. Forms and education should use inclusive language, such as asking about "husband/wife" or "mother/father," and should reflect the reality of LGBTQ2S+ families by asking about

"relationships," "partners," and "parent(s)" (Gay and Lesbian Medical Association, 2015). By putting this into practice and educating nurses on its importance we build cultural competency and create safer spacer for these equity-seeking populations.

The CNSA must continue to advocate for the inclusion of LGBTQ2S+ education in nursing curriculum. The integration for this education gives nurse the capacity to be better leaders and advocates in the advancement of inclusive care. This care include but is not limited to, inclusive language, proper pronouns, the difference between sex and gender, and only collecting information relevant for care.

Conclusion

As the primary voice for nursing students, the CNSA believes that the LGBTQ2S+ population has the right to fair and equitable care. This population requires specialized education in nursing curriculum and unique care within our healthcare system. The uptake of an inclusive intake/history form would allow for a safer space for those identify outside the binary when accessing the health-care system. This would not only allow for more inclusive care but would allow transgender persons, non-binary and other gender identities to be better represented in the medical system.

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Position Statements 2018

Equitable Healthcare for Prisoner Populations

Approved by:CNSA Board of Directors
Submitted: December 1, 2017
Submitted to: CNSA Board of Directors
Submitted by: Mary Jane Butler of Western Regional School of Nursing

Introduction/Background Information

Around the world, incarcerated persons are known to be at increased risk of physical and mental health issues. When social determinants of health are compared to the general population, these persons can be considered vulnerable, and even prior to incarceration can have difficulty in accessing primary health care (CFPC, 2016). Being of the understanding that a majority of the prison population will return to the general population once time is served, it is obvious that prisoner health is directly related to the health of the community (CFPC, 2016; WHO, 2007).

The United Nations Standard Minimum Rules for the Treatment of Prisoners, also known as the Mandela Rules, outline the basic rights for incarcerated persons. Rule 24, dictates that prisoners should not encounter bias in accessing health care due to their imprisonment and should have the same access to treatment as one would have in the community. Rule 24 also states that public health agencies should be closely involved in prisoner health due to the community health risks for tuberculosis, HIV, and substance abuse, once the incarcerated re-enter the general population (UN, 2015). Currently in Canada, only Alberta, British Columbia, and Nova Scotia, follow the World Health recommendations of issuing health care delivery under the ministry of health; all others use stand-alone health services run by the ministry of justice (CFPC, 2017; BC Mental Health and Substance Use Services, 2017).

Solitary confinement during incarceration has detrimental effects on prisoner health as well. Solitary confinement takes away control, isolates from social contact, and reduces environmental stimuli dramatically. This results in anxiety, depression, anger, paranoia, psychosis, and self-harm. As well, persons in solitary confinement are seven times more likely to attempt suicide (WCPJS, 2016). Solitary confinement both worsens and creates mental health

issues in prisoners, which comes with physical consequences as well (WCPJS, 2016). Solitary confinement has been condemned internationally, yet, Canada still uses this measure in its prisons, which will worsen the overall health of the prison populations and therefore the Canadian public by extension (WCPJS, 2016).

The Position

The position of the CNSA has been in supporting and advocating for equitable health care for all Canadians. This belief naturally extends to Canadians in confinement, which we believe should be under the appropriate supervision of the Ministry of Health.

The CNSA supports the education of nursing students on these topics through its core principle of influencing and advancing nursing education. Topics regarding Mandela Rules, justice, and specific health care needs of this vulnerable population, both within and beyond the prison system, would be key for the future nurses of Canada. Advocacy for greater inclusion of this issue in nursing education could improve health promotion and community health knowledge, as well as social education outcomes for students.

The CNSA also stands in support and in partnership with the West Coast Prison Justice Society for their goal of abolishment of solitary confinement due to its devastating effects on persons' mental, physical, and social health. The CNSA believes that as future socially responsible health care providers, we cannot ethically endorse the use of solitary confinement under any circumstance.

Relation to Canadian Nursing School Curriculums

Currently, public and community health curriculum does not adequately address the needs of the incarcerated person, nor does it adequately prepare nurses for the impact on the health of the public in relation to prisoner health. Nursing curriculum should address prisoner health, prisoner rights, the UN Mandela Rules, and the responsibilities of the health care provider in care and ethics with regards to this vulnerable population.

As previously described, provisions for health care for incarcerated populations betters the health of all Canadians. Inclusion of prisoner health topics in nursing education will increase awareness of this vulnerable population, and will better prepare the future nurse for the special responsibilities both ethically, and in basic care, that these persons require both during, and after, incarceration.

Conclusion and Restatement of CNSA Position

The CNSA believes in equitable health care for all Canadians even while incarcerated - this includes ensuring health care is delivered by the Ministry of Health. The CNSA further believes that education for chapter schools regarding Mandela Rules and the complex topic of prisoner health should be included in nursing curricula. With the partnership of the West Coast Prison Justice Society, we will stand for the abolishment of solitary confinement in Canada.

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Resolution Statements 2018

Supporting Harm Reduction Strategies in Response to Opioid Crisis Through Improved Curriculum and Advocacy

Approved by:CNSA Board of Directors
Submitted: December 1, 2017
Submitted to: CNSA Board of Directors
Submitted by: Mary Jane Butler of Western Regional School of Nursing, Josh Duncan of North Island College, Caitlyn Patrick of Sault College, Logan Tullett of Ryerson, Kyle Warkentin of University of the Fraser Valley

Introduction/Background Information

As opioid use continues to impact communities across Canada, access to primary health care for individuals using intravenous drugs has become a greater concern. Structural supports grounded in best practice and harm reduction, including supervised locations and nurse-delivered safe use education, promote better health among people who inject drugs (Fast, Small, Wood, & Kerr, 2008).

Fentanyl is a synthetic opioid, commonly used as a low-cost additive to create more product for illicit drug suppliers and has been found in cocaine, counterfeit oxycodone tablets, and heroin (Frank & Pollack, 2017; London Free Press [LFP], 2017). Carfentanil -which is 100 times stronger than fentanyl and 10,000 times more powerful than morphine - was found in two drug investigations by the Public Health Agency of Canada in Ontario this year hidden in substances (LFP, 2017). These opioids suppress respirations, resulting in fatalities – especially in opiate naïve persons, unaware of the hidden potent drug in what they believe to be their usual street fare (LFP, 2017).

Education and testing samples at safe injection sites (SISs) is an approach that recognizes many who are dying from fentanyl overdoses are unknowingly using it (Frank & Pollack, 2017). These stable environments provide education on naloxone kits, have naloxone and emergency aid readily available in case of overdose, and could potentially decrease fatalities, reduce or reverse overdoses, and improve public health outcomes (Frank & Pollack, 2017; LFP, 2017).

SISs provide drug users with medical supervision and services while using personally sourced illicit substances, increasing access to health care and addiction services while reducing overdose-related deaths and bloodborne infections (PHAC, 2008). Currently, SISs have increased wait time for services, leading to a decrease in facility use, negating their intended purpose (Bell & Globerman, 2014). SISs focus on reducing the harms associated with drug use, without exclusion from healthcare (Small, 2012).

CNSA's Position on the Topic

It is our position within the CNSA that we strongly support the need for more supervised injection sites across Canada as a public health measure and will promote this intervention in nursing venues across the country as per the 2013 position statement Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites. The prior statement calls for active promotion of this intervention, however, no resolution statement has since been brought forward to take action on this approved position.

In addition, the CNSA commits to supporting community groups who are working towards opening supervised injection sites. The promotion of harm reduction by these means will serve as a primary resource for nursing students in guiding their education curriculum in the areas of health promotion. This can be done by utilizing evidence based practice on how to effectively implement interventions during times of crisis within community settings. In addition, it would provide ongoing guidance on this evolving public health issue, provide connections to valuable community partners and key stakeholders, and engage us in active discussions with community members on how to address this current health related crisis. Finally, given that access to primary care services, such as SIS's, for vulnerable populations is a social justice issue, advocating for its inclusion in nursing curriculum would influence and advance innovation and social justice in the nursing curriculum and the nursing profession. This would involve advocating for the inclusion of safe injection sites in community health curriculum as a form of harm reduction as a means to combat the current opioid crisis in Canadian provinces.

Rationale

Whereas, Canada is facing a crisis of opioid overdoses.

Whereas, the CNSA supports harm reduction as a valid public health and safety measure.

Whereas, a resolution statement has not yet come forward to address the 2013 CNSA Position Statement entitled Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites.

Be it Resolved, That the CNSA, as the voice of the new generation of nurses, promote safe injection services within their chapter schools through collective partnerships with professors, nurses, school faculty and nursing students in order to prioritize public health measures.

Be It Further Resolved, That the CNSA support the efforts of Canadian nursing students to advocate for increasing the number of safe injection sites across Canada that follow and adhere to institutional protocols and nursing CNO standards of practice.

Be it Further Resolved, That the CNSA advocate for the inclusion of safe injection practices as a legitimate harm reduction approach in nursing education within community and public health curriculum.

Relation to Canadian Nursing School Curriculums

As student leaders and future health care professionals, we have the responsibility to uphold the standards of professional practice and conduct, the importance and value of higher education, and public advocacy, all of which are objectives defined in the CNSA. As seen in the nursing curriculum across Canadian universities and colleges, community nursing practice offers students the opportunity to use their assessment skills to work in community settings that may or may not involve patients who use drugs. Considering that we as students learn during our schooling that we have the ethical responsibility to inform our patients about accessible health care services, the inclusion of harm reduction education and safe injection sites across Canada would allow us to better address the social determinants of health that impact our patients' individual health needs (CHNC, 2011).

The inclusion of this topic within the nursing curriculum would provide nursing students the opportunity to expand their knowledge base on how to effectively market health promotion initiatives in public and political spectrums, thereby increasing public awareness and the scope of care. Furthermore, students will learn how to network with community organizations and build their own personal brand and the brand of the organization they are representing both from an ethical and professional standpoint.

In addition to the health-related benefits to this curriculum proposal, students can also develop a better understanding of economics and public spending which could reinforce their stance that public health initiatives have a positive return on capital investment. More specifically, the Economic Burden of Illness in Canada report stated that the cost of harm reduction by means of prevention would save Canada millions over the long run, rather than focusing their attention on treating chronic conditions such as hepatitis in association with drug use outcomes (PHAC, 2014).

Lastly, a harm reduction curriculum within nursing education has the potential to build off the 2017 resolution statement Incorporating LGBTTIPQQ2SAA+ Education into Nursing Curriculum in Canada. It would allow students to expand their knowledge base on how gender identity and sex correlate to drug use prevalence in Canada and drive students to develop assessment and evaluation tools on how to address these issues from an unbiased standpoint, free of stigmatization.

Conclusion

Given that Canada is enduring epidemic levels of opioid overdoses and that the CNSA supports harm reduction strategies, the CNSA resolves to promote safe use services within their chapter schools, promote valued partnerships in this field, and advocate for increased safe sites for all Canadians. The CNSA will also advocate for inclusion of safe injection/use sites as a legitimate harm reduction approach in nursing education within the community and public health curriculum during this time of need.

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Position Statements 2017

Global Health in Undergraduate Nursing Education- An Essential Component

Approved by: 2017 National Assembly, Canadian Nursing Students' Association
Submitted: December 2nd, 2016
Submitted to: CNSA Board of Directors
Submitted with revisions: January 4th, 2017
Submitted with revisions to: CNSA Board of Directors
Submitted by: Global Health Committee 2016-2017
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Special thanks to: Kyle Warkentin, Langara College, Global Health Committee Member

Introduction

Presently in Canada, the vast majority of nursing stakeholders at the provincial and territorial level have explicitly named global health as an entry-to-practice competency required by future nurses (Association of Registered Nurses of Newfoundland and Labrador, 2013; Association of Registered Nurses of Prince Edward Island, 2011; College and Association of Registered Nurses of Alberta, 2013; College of Registered Nurses of British Columbia, 2015; College of Registered Nurses of Manitoba, 2013; College of Registered Nurses of Nova Scotia, 2015; College of Nurses of Ontario, 2014; Registered Nurses Association of the Northwest Territories and Nunavut, 2014; Nurses Association of New Brunswick, 2013). However, there are two territorial and provincial stakeholders with notable absences of global health competencies in their entry-to-practice standards. Both the Saskatchewan Registered Nurses Association (SRNA) and Yukon Registered Nurses Association (YRNA) do not explicitly mention global health or global health research in their entry-to practice competencies (SRNA, 2013; YRNA, 2013).

Provincial nursing stakeholders often use terms including the need to possess "understanding" or "knowledge" about global health in their practice. These terms do not easily translate into action by nurses or working towards a goal of having nurses and nursing students truly engaged with global health at the local or international level. The Canadian Nurses Association's (CNA) (2009) position on global health asserts that nurses must possess more than knowledge (or understanding) of global health and related concepts. The Canadian Nursing Students' Association (CNSA) believes that knowledge and research in global health must lead to action, not merely an understanding. This will enable nurses to take an active role in promoting health for all, and advocating internationally and locally. Nursing students must learn to recognize, develop, and implement global health principles within their everyday practice in every all settings.

Background

Global health has many definitions but is 'an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide' (Wilson et al., 2016). Nurses can play a critical role in the provision of global health, achieving health equity, and ensuring universal access to health care services worldwide (ibid). However, this requires nursing education to include global health content in order to educate and prepare nursing students to work in an increasingly globalized world. As a result, there has been an increased awareness regarding the importance of global health education for students in health care professions (ibid).

Nursing education needs to challenge future nurses to engage with communities outside the biomedical setting and prepare them to be global citizens (Turale, 2015). Nursing educators stress that nursing students not only need to be aware of global health issues, but must also learn strategies to facilitate health equity and tackle social justice issues (Wilson, 2016). Despite the call for more global health in entry-to-practice nursing education, the fundamentals of global health continue to be absent from nursing programs curricula across Canada (Chavez, Bendery, Hardiez, & Gastaldo, 2010). Most Canadian nursing students report little or no formal education regarding content necessary to developing a global health perspective (Chavez et al., 2010).

The CNA has developed a three-stage curricular reform approach to implementing global health content in nursing programs. Most Canadian nursing programs have already utilized "addon," the first stage where global health content is added into the current curriculum without

major changes (CNA, 2008). The second stage is "infusion," where global views are a core component of the course (ibid). The third stage is "transformation," often viewed as an immersion experience where nursing students participate in a global experience (ibid). Though the third stage is the most difficult to implement, the CNA notes it produces the greatest results in terms of global health education (ibid).

During the 2016 year, the CNSA completed a survey-based exploration of current academic global health opportunities available at current chapter schools. We received responses from 26 chapter schools from each CNSA region. These schools represent a great diversity in the nursing programs offered and populations of nursing program cohorts. We found that over 80% of respondents reported being dissatisfied with the academic global health opportunities available at their current institution for entry-to-practice nursing students. Additionally, over 95% of respondents reported that they were not aware of any formal recognition offered for involvement in academic global health at their institutions available to nursing students (i.e. independent or embedded certificates, minors).

Canadian Nursing Students' Association (CNSA) Position

The CNSA believes it is imperative for all Canadian nursing students to be exposed to academic global health within their entry-to-practice curriculum. CNSA supports the notion that global health content should be compulsory within nursing programs across Canada. Recognizing that global health is not only within an international context but also within our local environment, CNSA believes all nursing students should be learning about global health throughout their program beginning in the first year of their respective programs.

Mill, Astle, Ogilvie, and Gastaldo (2010) support this notion arguing that nursing in higher education has "shared responsibilities for examining global challenges," (p. E2). In an increasingly globalized health care context, nursing students no longer only have the responsibility of learning about their immediate communities, but have a responsibility to be leaders, teachers, caregivers, and innovators in our global community (Mill et al., 2010). CNSA aspires to be the primary resource for nursing students across Canada and thus will continue to promote global health opportunities for nursing students across Canada through regional and national conferences, and committee work. CNSA supports building strategic, ethical, and mutual partnerships with various global health organizations to better facilitate opportunities in global health for CNSA members. Such organizations with similar objectives include the Canadian

Society for International Health (CSIH), the Canadian Coalition for Global Health Research (CCGHR), and the newly founded Global Association for Student and Novice Nurses (GASNN).

Relation to Curriculum

According to Canadian Association of Schools of Nursing (CASN, 2015), it is essential for nursing programs to prepare their students so that they can demonstrate an ability to conduct holistic and comprehensive assessments of various patients with unique healthcare needs. In particular, students should have adequate knowledge of the relationship between primary health care, health disparities, the social determinants of health, and the healthcare needs of equity seeking groups across the world (ibid).

Without the inclusion of global health in entry-to-practice nursing education, our profession could face barriers in the provision of culturally competent care that meets the unique needs of the Canadian population or within our global context (Lim et al., 2013). According to Gahagan (2016), nursing curricula in North America are lacking a true understanding of competent and effective action towards global health disparities across the world. Additionally, marginalized populations often experience discrimination and stigma within the healthcare system and from healthcare providers (ibid). The universities that do have active global health curricula within their nursing programs offer few opportunities, which usually consist of support courses, or electives.

Conclusion

Global health must be a priority in every educational nursing institution, integrated by all nursing educators, and understood and acted upon by all nursing students. Canada's nursing stakeholders have a general lack of harmonization in the practice standards that they expect nursing students to be exposed to in relation to global health through their entry-to-practice education. While Canadian nursing stakeholders mention and encourage global health knowledge and understanding, but this is not sufficient because this does not often translate into nurses taking action (CNA, 2009). As one examines the evidence that exists relating to nursing and global health, it seems irrational for Canadian nursing program curricula to not teach these concepts as global health and nursing as inextricably linked. CNSA believes that nursing students must receive comprehensive, culturally safe, and evidence-informed global health education throughout their nursing program, as well as opportunities to engage in global health on an international and local scale. CNSA believes that our health is the planet's health

and that the nursing profession can no longer dissociate the health of our local and global communities in nursing education.

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Canadian Nursing Curriculum At Risk

The effects and implications of the National Council Licensure Examination - Registered Nurse (NCLEX-RN®)

Approved by: 2017 National Assembly, Canadian Nursing Students' Association
Submitted: December 1st, 2016
Submitted to: Board of Directors
Submitted by: 2016-2017 Canadian Nursing Students' Association Board of Directors

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Background

In 2011, the Canadian Council of Registered Nurse Regulators (CCRNR), which consists of Canada's provincial/territorial regulatory bodies, decided that the American NCLEX-RN® would be
Canada's new entry-to-practice nursing exam (Quebec and Yukon excluded) in a new contract with the

National Council of State Boards of Nursing (NCSBN). Since January 2015 the trusted and established Canadian Registered Nurse Examination (CRNE) has been replaced by the American NCLEX-RN® as the approved entry-to-practice nursing exam for Canadian nursing graduates. Despite promises that the new exam would reflect Canadian nursing curriculum and competencies in both official languages, exam writers have expressed that the exam is heavily American-based and not applicable in the context of the Canadian health care system (McGillis Hall, Lalonde, Kashin, 2016). Two years later justifiable concerns continue since the adoption of the NCLEX-RN® as the new standard for nursing competency, and they are as follows: (a) proper consideration of Canadian health care system values; (b) consideration of cultural competence with respect to Canada's First Nations, Inuit, and Métis populations; (c) proper reflection of Canadian nursing programs; and (d) representation of Canada's two official languages (CNSA, 2016).

Through these voiced concerns, students have begun to see a change in their curriculum. Many students have reported the addition of NCLEX-RN® preparatory materials to their required resources and those materials being used as evaluative components (Stinnissen, 2016; Bourque, 2016; Patrick, 2016). Students have noticed the addition of these materials has taken away portions of their curriculum that they deem necessary and important to their Canadian nursing education as a whole (Stinnissen, 2016; Bourque, 2016; Patrick, 2016). Some students have even indicated that their clinical time is being reduced in order to complete these newly added evaluative components (Stinnissen, 2016; Bourque, 2016; Patrick, 2016). The Canadian Association of Schools of Nursing (CASN)'s Executive Director, Cynthia Baker, states that "Canadian nursing education is highly respected internationally and we should not be changing that to fit the needs of the U.S." (Barton, 2016). In the end, instead of acquiring important Canadian nursing knowledge, students wanting to become a Canadian Registered Nurse (RN) are focusing the latter portion of their education on passing an exam with specific American content (Stinnissen, 2016; Bourque, 2016; Patrick, 2016); an exam which does not effectively test Canadian nursing's own competencies (CASN, 2012; CASN, 2015a; CASN, 2015b; CASN, 2015c).

Canadian Nursing Students' Association (CNSA) POSITION

The Canadian Nursing Students' Association believes that nursing schools should not adapt our highly respected Canadian curricula to fit the needs of this new exam which may result in decreased educational standards than those under the previous exam (Barton, 2016). In addition, students should not be required to purchase mandatory NCLEX-RN® preparatory materials that are arranged and forced onto students by these educational institutions.

Moreover, there has been no evidence to suggest that using any specific preparatory material is correlated with increasing NCLEX-RN® pass rates (Wiltshire, 2016). Nursing students are currently reporting an increase in the use of NCLEX-RN® preparatory materials as part of their evaluative components. Students have also reported that they feel this increased presence in NCLEX-RN® materials has taken away from other valuable learning opportunities that they would have normally had in previous years (Patrick, 2016). Students of earlier years have come forward to the later years reporting that they are not receiving the same education their peers did just a year before them. Furthermore, accessibility to learning is reduced when students are expected to bring a laptop to classes in order to participate or write exams using these mandatory NCLEX-RN® preparatory materials (Patrick, 2016). Members of the Canadian Nursing Students' Association have seen a major shift in how NCLEX-RN® is being incorporated into the curriculum and we, as an organization, believe this is limiting students from fully learning the competencies that lie outside the scope of the examination. Those competencies that are outside the scope of testable material are at risk of being deemed less important and are currently being phased out by some universities to accommodate NCLEX-RN® materials. The CNSA believes that in order to create competent, well-rounded Registered Nurses we must develop holistic nursing education that encompasses every aspect of becoming a Canadian Registered Nurse and not just the portions that are covered on this exam.

In addition, CNSA is committed to working in collaboration with the Canadian Association of Schools of Nursing (CASN) and other valued stakeholders to ensure that the future of our nursing education is not at stake due to this exam. CNSA will encourage CASN to take a firm stance against the implementation of these preparatory materials into our curriculum and encourage educational institutions to comply with this stance. In addition, CNSA will recommend that during CASN accreditation this will be taken into consideration.

Relation to Canadian Nursing School Curriculum

The Canadian nursing curriculum is highly respected internationally and certain competencies embedded within it are at risk of being forgotten with the implementation of NCLEX-RN® materials. Canadian nursing students are now at risk of missing out on valuable learning opportunities in the classroom and in clinical placements as a result of these recent implementations. Students are being forced to focus more of their time on NCLEX-RN® preparatory materials, taking away from their studies that truly educate them to become competent Canadian RNs. Canadian curriculum is at risk of harmonization with American curriculum when distinct differences are evident and importantly define our healthcare system

and the diverse individuals we serve as Canadian nurses (CASN, 2012; CASN, 2015a; CASN, 2015b; CASN, 2015c).

Conclusion

The Canadian Nursing Students' Association believes that nursing schools should not adapt their highly respected Canadian curricula to fit the needs of this new exam which may result in decreased educational standards than those under the previous exam (Barton, 2016). In addition students should not be required to purchase specific mandatory NCLEX-RN® preparatory materials that are forced on the students and selected by their educational institutions.

There is evidence of the implementation of mandatory preparatory materials across jurisdictions, and its effects on students' education and learning opportunities. CNSA does not support educational institutions forcing these materials upon students. While it is important that educators provide the support and necessary tools for their students to succeed, this should not come at the cost of the core foundations of our Canadian nursing curricula. The disappearance of Canadian nursing content from our curricula is alarming and cannot be allowed to continue. We encourage nurse educators in each educational institution to consider an appropriate amount of NCLEX-RN preparatory materials integration into the curriculum in a collaborative manner, including but not limited to consultation and discussion with your student body and fellow nurse educators. However, we implore educators to ensure that students' grades and valuable clinical experiences are not negatively impacted by this integration. Ultimately, we are committed to minimizing the negative impacts of mandatory NCLEX-RN® integration on our nursing curriculum and continuing to uphold the quality of our Canadian nursing education.

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Resolution Statements 2017

Synergy of Professional Nursing Roles

Approved by: 2017 National Assembly, Canadian Nursing Students' Association
Submitted: December 2, 2016 - Revised December 23, 2016
Submitted to: CNSA Board of Directors - National Assembly
Submitted by: Megan Bruce, MacEwan University

Special Thanks: Fred Entz, Saskatchewan Polytechnic/University of Regina (SCScBN)

Introduction and Background

Historically, there have been many changes to the Canadian health care system and the nursing profession within that system. One of those changes is the shift towards replacing Registered Nurses (RN) with Registered Psychiatric Nurses (RPN) and Licensed Practical Nurses (LPN) (also called Registered Practical Nurses in the Province of Ontario) (Duncan, Rodney, & Thorne, 2014). Aside from this, there is a paucity of research on whether or not RPNs are replacing RNs. Unfortunately; this staffing mix has resulted in multiple challenges. One of the most significant challenges has been the "lack of clarity in how nurses…can be supported to work together and value their different roles and contribution" (Duncan et al., 2014, p. 626). Ultimately, this confusion has led to a lack of cohesion among nurses, which has negatively impacted patient care and the working environment (Duncan et al., 2014). RNs, with some exceptions in Québec, receive their Baccalaureate education at a college or university. LPNs typically receive their Diploma education at a college, and RPNs can either receive their education through a diploma, degree program or technical school in western Canada. Nurses across Canada have struggled to achieve distinction between these different nursing roles (Limoges & Jagos, 2015).

In 2010, The World Health Organization (WHO) published a Framework for Action on Interprofessional Education and Collaborative Practice where "collaboration in education and practice [is recognized] as an innovative strategy that will play an important role in mitigating the global health workforce crisis" (WHO, 2010, p. 7). Though the WHO supports interprofessional education, there has been a lack of education to address the absence of role clarity among nurses (Limoges & Jagos, 2015). Not only are practicing nurses struggling to understand the different roles of nurses, but according to

Linoges and Jagos (2015), nursing students across Canada have expressed that because the education for RNs and LPNs are completely segregated, they feel as if they have little knowledge on how to effectively work together with other nurses that have a different educational background. Additionally, students sense the tensions among the various nursing roles in the workplace, public and media sources and as a result, have started to consider the apparent lack of cohesion as acceptable (Linoges & Jagos, 2015). Thus, nursing students need to be provided proper interprofessional education and opportunities to operate as change agents in restoring harmonious working relationships among nurses and promoting equality and equity in the workplace among the many different professions they work with (Linoges & Jagos, 2015).

According to the WHO (2010), in order to achieve the ultimate goal of interprofessional education, an advocate is needed to champion the movement towards the long-term goal of having a workforce that effectively participates in collaborative practice (WHO, 2010). WHO (2010) encouraged the application of interprofessional collaboration by "identifying and supporting interprofessional education and collaborative practice champions, ensuring appropriate collaborative practice-friendly policies are in place, and sharing the positive outcomes of successful collaborative programs" (p. 40). The Canadian Nurses Association (CNA) is one of the national nursing stakeholders who have championed the movement towards collaborative practice with their intention on creating a draft code of ethics (draft April 29, 2016) that will include and speak to both RN and LPN roles in practice.

Links to CNSA's Mandate and Current Position

CNSA currently does not have a Position Statement on the issue regarding interprofessional education for RN, LPN, and RPN students. There is, however, a desire within the CNSA mandate to facilitate the recruiting of LPN and RPN members. CNSA has consistently been lacking in advocating for interprofessional education among RN, LPN, and RPN students. According to CNSA By-Law NO.1 section 4.01.4, CNSA membership is open to RN, LPN, and RPN students (2016). Though this is true, CNSA currently has a minimal amount of LPN and RPN student members and historically has primarily focused on advocating for RN students. In accordance with the CNSA (2016) Strategic Plan 2016-2021, ensuring RN, LPN and RPN students have equal representation and access to services will meet the objective of being the primary resource for Canadian nursing students . CNSA can be one of the primary driving forces behind advocating and lobbying for appropriate Canadian nursing education stakeholders to increase implementation of interprofessional education in all nursing student curricula across Canada (CNSA, 2016). Lastly, CNSA can create new partnerships by building relationships with LPN and RPN stakeholders across Canada to ensure further professional collaboration (CNSA, 2016). This

will facilitate a strong educational and practical foundation for future Canadian nurses to work well with different roles of the nursing profession and provide excellent patient care.

Rationale

Whereas, CNSA's strategic plan for 2016-2021 objective A is to be the primary resource for Canadian nursing students (2016); and

Whereas, CNSA's strategic plan for 2016-2021 objective B is to influence and advance innovation and social justice in the nursing curriculum and the nursing profession (2016); and

Whereas, CNSA's strategic plan for 2016-2021 objective C is strengthening linkages and creating new partnerships (2016); and

Whereas, CNSA stakeholders such as CNA have taken action towards collaborative practice by drafting a new Code of Ethics that includes both RNs and LPNs (draft April 29, 2016); and

Whereas, CNSA By-Law NO.1 section 4.01.4 states that RN, LPN, and RPN students can be members of CNSA; and

Whereas, the WHO identifies the need for a champion to lead the movement towards interprofessional education; therefore

Resolution

Be It Resolved, That CNSA ensures equity and equality of RN, LPN, and RPN students within the association

Be It Further Resolved, That CNSA actively pursues the creation of new partnerships with LPN and RPN stakeholders across Canada

Be It Further Resolved, That CNSA advocates and lobbies for interprofessional education throughout RN, LPN, and RPN nursing student programs across Canada

Relation to Canadian Nursing School Curriculums

According to the Canadian Association of Schools of Nursing (CASN) in their National Nursing Education Framework for Baccalaureate education under Domain 4: Communication and Collaboration, section 4.2 states that students should be well prepared on how to educate and communicate with all members of the interprofessional team (2015). In practice, nurses constantly work with other members of the health care team to ensure excellent patient care. It is important that all nursing students are educated on how to effectively and professionally communicate with all healthcare professionals. Domain 5: Professionalism, section 5.3 outlines the importance of nursing programs preparing their students to act as role models for the interprofessional nursing team (CASN, 2015). The nursing profession needs more nurses to be courageous in fostering collaborative practice. It is imperative that nursing students be inspired and challenged during their nursing education to facilitate and participate in advocacy for all segments of the nursing profession. Lastly, Domain 6: Leadership, section 6.3 states that students need to be educated on the ability to collaborate with, and act as a resource for LPNs and other members of the interdisciplinary team (CASN, 2015). RNs acting as leaders in this area are essential to ensure progression of the nursing profession and to promote collaborative practice.

When comparing the education standards in place for RN, RPN and LPN regulators, they have similar outlooks on collaborative practice. The Registered Psychiatric Nurse Regulators of Canada (RPNRC), published the Registered Psychiatric Nurse Entry-Level Competencies (2014) that states RPN students need to be educated to accept leadership responsibility in coordinating collaborative practice within the healthcare team and must engage in professional communication with stakeholders (p. 15). Similarly, the Canadian Council of Practical Nurse Regulators (CCPNR) outlines the importance of educating LPNs to work collaboratively with other healthcare professionals to ensure achievement of care outcomes in their Entry-to-Practice Competencies for Licensed Practical Nurses (2013). This document outlines the importance of LPN students receiving support and guidance on how to work in cohesion with other healthcare members (CCPNR, 2013). It is easy to draw parallels between the competencies for both LPNs and RPNs when examined against the RN education framework.

Conclusion

CNSA is the national voice for nursing students in Canada and therefore has the obligation to ensure there is equity and equality among RPN, LPN, and RN students. The resolution being proposed is for CNSA to be one of the driving forces or champions behind advocating for interprofessional education. It is important that all nursing students receive

clarity on their own role as well as understand other nursing disciplines; thus, working with stakeholders across the country that represent these disciplines is of utmost importance. In addition, advocating for interprofessional education in all nursing curricula must be a key component of CNSA's approach to this issue. This will ensure that at graduation they are prepared to practice collaboratively and ultimately improve patient care.

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Incorporating LGBTTIIPQQ2SAA+ Education into Nursing Curriculum in Canada

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Introduction and Background

Despite advances in LGBTQ+ human rights in Canada, our education and healthcare systems still operate under cissexist and heterosexist structures, which lead to health disparities for the LGBTQ+ community (Daley & McConnell, 2011; Morrison & Dinkel, 2012). Disparities include higher rates of mood and anxiety disorders, suicidal ideation, preventable cancers, sexually transmitted infections (STIs), and substance use (Makadon et al., 2015; AAMC, 2014). For example, trans women of colour are more likely to be uninsured and denied care by healthcare providers, and are twice as likely to experience physical and sexual violence compared to cisgender women (AAMC, 2014).

Conservative estimates place the number LGBTQ+ Canadians at 1-10% of the population (Statistics Canada, 2015; Troute-Wood, 2015). However, the specific care needs of the LGBTQ+ community are not addressed consistently in nursing curriculums. According to a study by Obedin-Maliver et al. (2011), on average, only five hours of instruction were dedicated to LGBTQ+ content in medical education programs across the United States and Canada. Such limited instruction is insufficient considering the diverse and complex healthcare needs and

lived experiences of members of the LGBTQ+ community, who often face healthcare providers who are unprepared to meet their needs (Compton & Whitehead, 2015). Thus, the lack of education on LGBTQ+ healthcare needs has a direct impact on patient care. It is imperative that nursing students receive preparation to care for equity-seeking groups. As frontline workers, nurses are in optimal positions to act not only as care providers, but also as patient advocates (Lim, Brown, & Jones, 2013).

1 The LGBTIIPQQ2SAA+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Intergender, Pansexual, Queer, Questioning, Two Spirit, Asexual and Aromantic) community is composed of a diverse group of individuals. While limiting, in this statement we refer to this population as the LGBTQ+ community and use a plus sign to indicate its expanding nature (Taylor, Jantzen, & Clow, 2013).

Mandate and Current Position of The Canadian Nursing Students' Association (CNSA)

In January 2013, the CNSA National Assembly passed a position statement on incorporating LGBTIPQQ2SAA education into Canadian nursing curriculum (CNSA, 2013). Through this resolution statement, we seek to build on the priorities outlined in the 2013 position statement by providing current and future CNSA board members with a clearer sense of direction, as no action specific to this document has been taken since 2013. Engagement in the process of curriculum revision is in accordance with CNSA's (2016) Strategic Plan 2016-2021. In its strategic plan, CNSA (2016) prioritized active participation in advocacy processes regarding curriculum advancements and revision, with a focus on equity-seeking groups who experience health disparities. Moreover, in their strategic plan, CNSA pledged to utilize its board position on the Canadian Association of Schools of Nursing (CASN) to advocate for the development of curricula that addresses the specific needs of the LGBTQ+-identified individuals. Through collaboration with CASN, as well as postsecondary institutions across the country, CNSA would meet their governing objective to guide innovation in nursing curriculum.

Additionally, a clearly-defined partnership with provincial interest groups, such as the Rainbow Nursing Interest Group (RNIG) through the Registered Nurses Association of Ontario (RNAO), and community-specific non-profit organizations that are affiliated with the LGBTQ+ community, such as the 519 (in Toronto), the Pride Centre of Edmonton, and QMUNITY (in Vancouver) would meet CNSA's governing objective of strengthening linkages and creating new partnerships. As a group, RNIG facilitates the development and dissemination of evidenceinformed care and research, thereby supporting the further education of nursing students regarding the LGBTQ+ community (RNIG, n.d.). RNIG, through RNAO, also works to

challenge the invisibility and silencing of the LGBTQ+ community through advocacy (RNIG, n.d.). Thus, a partnership with another advocacy group would fulfill CNSA's governing objective as the primary voice and resource for nursing students.

Along a similar vein, community-specific non-profit organizations, such as those mentioned above, are committed to improving the health of their diverse community members, as well as the development of community initiatives aimed at building collective strength (The 519, n.d.; The Pride Centre of Edmonton, n.d.; QMUNITY, n.d.). CNSA's advocacy for nursing students, including LGBTQ+ nursing students, will be better informed by local, context-specific community perspectives and experiences. Collaborating with local community organizations would represent a continued fulfillment, and subsequent expansion, of CNSA's governing objectives with regards to being the primary voice of nursing students and advancing innovation in nursing curriculum.

Rationale

Whereas, The ongoing development of nursing school curricula to reflect the health-care needs of Canadian populations is essential for best practice.

Whereas, The health-care needs of LGBTQ+ people in Canada have been historically marginalized in the healthcare system and in nursing educational curricula.

Whereas, LGBTQ+ people experience higher rates of discrimination and violence within the healthcare system and from healthcare professionals.

Whereas, LGBTQ+ communities across Canada have specific and unique health-care needs requiring comprehensive evidence-based education.

Resolution

BE IT RESOLVED That, CNSA urges the Canadian Association of Schools of Nursing (CASN) to prioritize incorporating the needs, experiences, and perspectives of LGBTQ+ people and communities into nursing school curricula.

BE IT RESOLVED That, CNSA support the efforts of nursing students across Canada to advocate for the inclusion of courses and materials specific to the health-care needs of LGBTQ+ people and communities.

BE IT RESOLVED That, CNSA's Diversity Committee prioritize advocating for nursing school curricula to meet the educational needs of nursing students related to LGBTQ+ healthcare, by working with various stakeholders of the LGBTQ+ population, including but not limited to the following: RNIG, the 519, the Pride Centre of Edmonton, and QMUNITY.

Relation to Canadian Nursing School Curriculums

According to CASN (2015), it is pertinent for nursing programs to prepare their students so that they can demonstrate an ability to conduct holistic and comprehensive assessments of various patients with unique healthcare needs. In particular, students should have adequate knowledge of the relationship between primary health care and health disparities, the social determinants of health and the healthcare needs of equity seeking groups such as the LGTBQ+ population in Canada (CASN, 2015).

As stated by Lim, Brown and Jones (2013), undergraduate nursing programs lack the integration of LGBTQ+ related health content within their curricula, which results in knowledge gaps regarding the needs of this population. A lack of education in regards to LGBTQ+ health can pose a barrier to accessible healthcare for this population as healthcare providers are not equipped with the training or knowledge that is necessary for the provision of culturally competent care that meets their needs (Lim et al., 2013). According to Colpitts and Gahagan (2016), the cisheteronormative lens of Canada's healthcare system serves to disadvantage the LGBTQ+ population as their health needs are assumed to be similar to those of individuals who are heterosexual and cisgender. Consequently, their specific needs are not met and are rendered invisible. Additionally, LGBTQ+ populations often experience discrimination and stigma within the healthcare system and from healthcare providers (Colpitts & Gahagan, 2016). Based on the research, it is evident that there is a need for the inclusion of LGBTQ+ health information within the educational curricula of nursing schools across Canada. The implementation of LGBTQ+ course material in undergraduate nursing programs can raise awareness of the vast health disparities that are experienced by this population, and subsequently, empower students to take a proactive role in promoting LGBTQ+ health and providing culturally sensitive care.

Conclusion

As CNSA is the primary voice for nursing students, we feel that the LGBTQ+ population must be recognized as a vital part of our healthcare system which requires unique and specialized education in nursing programs across Canada. Partnerships with CASN, RNIG, and LGBTQ+ organizations would help to propel post-secondary institutions across the nation to challenge how their current curriculum is not meeting the needs of the LGBTQ+ community. This movement would assist in providing LGBTQ+ people with respect and equity in the healthcare system.

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Establishing a Voting Director Position for Indigenous Health Advocacy

Approved by: 2017 National Assembly, Canadian Nursing Students' Association

Submitted: December 2nd, 2016
Submitted to:Board of Directors
Submitted by: Danielle Bourque, University of Alberta
Leah Carrier, Dalhousie University
Grant MacNeil, Mohawk College McMaster University Collaborative

Introduction and Background

Indigenous populations within Canada are defined as First Nations, Inuit, or Métis peoples (The Aboriginal Affairs and Northern Development in Canada, 2014). Indigenous peoples continue to experience poor health outcomes, a disproportionate burden of disease, and health disparities that are rooted in health inequalities (National Collaborating Centre for Aboriginal Health, 2011). Within Canada and internationally, the colonization of Indigenous populations has been recognized as a key determinant of health and plays a fundamental role in the overall health of Indigenous peoples (Allen & Smylie, 2015). This cultural oppression, coupled with colonial action, has resulted in the loss of traditional practices, the loss of connection to the land, language, health, and the degradation of the Indigenous population as a whole (Aboriginal Nurses Association of Canada, 2009). The implementation of residential schools in Canada has been recognized as an act of cultural genocide with rippling multigenerational effects and resulted in deeply painful impacts on the physical, emotional, spiritual, and mental health of survivors, their families, and communities (Allan & Smylie, 2015). The legacy of colonialism continues to have a deep impact on Indigenous culture and people, and has a direct connection and incessant influence on the poor health status of Indigenous people today (Mowbray, 2007).

According to literature, a means to counter the colonization process that continues to play a role in the determinants of health for Indigenous Peoples has identified self-determination as a key concept (Allan & Smylie, 2015; ANAC, 2009; Mowbray, 2007). Indigenous self-determination is to be understood as a way to level the balance of power between indigenous peoples and the nation-states in which they live and interact (Mörkenstam, 2015). Self-determination does not describe one specific arrangement as it takes different forms in different contexts. In this context, the term self-determination refers to the representation of Indigenous people at all political levels (Mowbray, 2007).

In 2010, the Government of Canada redacted its opposition and fully endorsed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which speaks of the right of selfdetermination of Indigenous Peoples. In endorsing UNDRIP, Canada reaffirmed its

commitment to build on its relationship with Indigenous peoples to improve the health and wellbeing of Indigenous populations based on respect and a desire to move forward in partnership (Indigenous and Northern Affairs Canada, 2012). Furthermore, the release of the Truth and Reconciliation Commission (TRC) report highlighted the inclusion of UNDRIP in nursing curricula in Call to Action number twenty-four (TRC, 2015). Therefore, there is an ethical obligation to support reconciliation and restorative justice, leading to the improved health and right to self-determination of Aboriginal people, which is congruent with the Code of Ethics for Registered Nurses to promote equity and justice (ANAC, 2009; Canadian Nurses Association, 2008; TRC, 2015).

In 2015, CNSA passed a resolution statement establishing an ad-hoc Indigenous health advocacy committee. The purpose of this resolution was that "CNSA create a sustainable voice that represents and advocates for Aboriginal nursing students" (CNSA, 2015a). Creating an Indigenous Advocacy committee within CNSA was an excellent first step toward committing to action on advocating for the issues that are faced by Indigenous peoples. However, under our current structure the Indigenous Health Advocacy Chair has no voting rights and is not guaranteed attendance at board meetings, which potentially removes the indigenous voice from the table.

Links into CNSA's Mandate and Current Position

As of 2015, CNSA has taken a position to address Indigenous nursing and the inclusion of Indigenous health by incorporating cultural safety to support the health of Indigenous populations (CNSA, 2015b). In accordance with CNSA's (2016) Strategic Plan 2016-2021, the establishment of a voting director position dedicated to Indigenous health advocacy would meet Objective A of being the primary resource for nursing students. Amending our existing documents to replace the Indigenous Health Advocacy Committee Chair position with a voting director position would promote Indigenous ways of knowing and ensure our organization is taking action on the recommendations from the Truth and Reconciliation Commission, specifically call to action number 24 which speaks to nursing schools implementing UNDRIP (TRC, 2015). By ensuring that our organization allows for the right to selfdetermination, we can act as the primary resource for indigenous nursing students.

Furthermore, the amendment to include voting rights for this position is congruent with Objective B, to influence and advance innovation and social justice in the nursing curriculum and the nursing profession. By solidifying an Indigenous voting voice within CNSA, the organization

and the students CNSA represents can begin to recognize and address the unique health status of Indigenous populations in Canada and advocate for broader change within the healthcare system. Moreover, CNSA can further rectify historical and continuing injustices faced by indigenous people through appropriate representation and restorative justice. Creating a voting position on the CNSA Board of Directors would not only help progress and innovate nursing curriculum, but also create a stronger and more sustainable voice for Indigenous People and Indigenous Nurses.

Rationale

WHEREAS, CNSA's objective is to be the primary resource for nursing students; and,

WHEREAS, Object C outcome 2 of CNSA's strategic plan for 2016-2021 states that CNSA Board of Directors and its members are involved with stakeholders and their advancement in the nursing profession

WHEREAS, Research identifies that there are unique disparities among Indigenous populations, and as a result there is an identified need to empower the self-determination of Indigenous Nurses and Indigenous Nursing Students; and

WHEREAS, The need for culturally safe practice, in the context of Indigenous Culture, needs to be directed by an Indigenous representative; and

WHEREAS, The Canadian Nurses Association (2014) has passed multiple motions and resolutions that identify Indigenous Health as a priority;

WHEREAS, The need for an Indigenous member being a voting member is imperative to promoting cultural safety; therefore

Resolution

BE IT RESOLVED That CNSA amend 7.02 from the CNSA Bylaws to state "The board shall consist of 13 directors who shall each be associates of the Corporation, as follows:"

BE IT FURTHER RESOLVED That CNSA amend 7.02.1 from the CNSA Bylaws to state "seven persons elected by the chapter members to the positions of:"

BE IT FURTHER RESOLVED That CNSA amend 7.02.1 to now include " (g) Director of Indigenous Health Advocacy"

BE IT FURTHER RESOLVED That CNSA amend the CNSA Rules and Regulations, Part 5: Power and Duties of the Board of Directors and Committee Chairs to state "The Board of Directors shall consist of 13 elected members and four appointed members and shall be comprised of:1) seven persons elected by the national assembly to the position of:"

BE IT FURTHER RESOLVED That CNSA amend the CNSA Rules and Regulations, Part 5:Power and Duties of the Board of Directors and Committee Chairs to now include " g. Director of Indigenous Health Advocacy"

BE IT FURTHER RESOLVED That CNSA amend the CNSA Rules and Regulations, Part 5: Power and Duties of the Board of directors to remove " f. Indigenous Advocacy Committee chair"

BE IT FURTHER RESOLVED That CNSA amend the CNSA Rules and Regulations, Part 5:Power and Duties of the Board of Directors and Committee Chairs to Add "Director of Indigenous Health Advocacy shall: Serve as Chair of the Indigenous Advocacy Committee; Be Indigenous (aboriginal, Metis, Inuit, or First Nations). In the absence of an Indigenous candidate, a non-indigenous candidate will be eligible for the position of Director of Indigenous Health Advocacy; Act as the primary liaison between Canadian Indigenous Nurses Association (C.I.N.A) and CNSA; Maintain contact and build relationships with principal Indigenous Nursing stakeholders and student committees nationally and internationally; Liaise with all key national stakeholders that are committed to or represent Indigenous Health and Advocacy;
Attend all C.I.N.A. meetings (if financially feasible); and prepare a report for each BOD and National Assembly meeting, and attend the National Assembly

BE IT FURTHER RESOLVED that CNSA amend the CNSA Rules and Regulations, Part 5: Power and Duties of the Board of directors to remove "Indigenous Advocacy committee chair" and following duties

Relation To Canadian Nursing School Curriculums

The Truth and Reconciliation Commission recommends that all nursing and medical schools in Canada implement courses for students to learn about health issues that are relevant to Canada's
Indigenous peoples (TRC, 2015). The Truth and Reconciliation Commission further states that a comprehensive Indigenous Health curriculum should include education about the history of residential schools in Canada, treaties and Indigenous rights, Indigenous practices and teaching, and the implementation of United Nations Declaration on the Rights of Indigenous Peoples (ibid). The TRC recommendations are important as CNSA advocates for the inclusion of Aboriginal Health in Canadian nursing curricula to enhance the cultural competence of nurses (CNSA, 2015b). Additionally, it would further support and enact the position CNSA took on cultural safety in the context of Indigenous Health as previously mentioned. Having an Indigenous voting voice on the CNSA Board of Directors would support the principles of this position statement by adopting the TRC recommendations, which advocates for Indigenous self-determination and inclusion of cultural safety in nursing curricula.

Conclusion

By establishing an Indigenous voting position, CNSA will have a better stance as an organization to advocate for the calls of the Truth and Reconciliation commission to include Indigenous health issues in curriculum. This aligns with our previous position statement about cultural safety passed in 2015. The proposed resolution would address sustainability issues with the current committee chair position, such as the Indigenous representative being unable to vote or the potential for the representative to be unable to attend all board meetings. CNSA has committed to being the primary resource for nursing students and establishing a voting position for an Indigenous Health Advocacy Director would allow the organization to be the primary resource for Indigenous students.

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Key resources to ensure the ongoing provision of health services in French

Approved by: 2017 National Assembly, Canadian Nursing Students' Association
Submitted: December 2, 2016

Submitted to: Board of Directors
Submitted by: Peter Stinnissen, Sault College
Caitlyn Patrick, Sault College
Marilyn Morand, McGill University

Special thanks to: Josée Joliat, Université Laurentienne

Issue

Canadian residents are privileged to live in a country with two official languages, namely French and English. This linguistic duality has resulted in the country becoming home to a diverse and inclusive population. According to the data obtained through Statistics Canada's 2011 census, nearly 7 million people claim to speak French at home (Statistics Canada, 2015). There are currently only seven universities in Canada (not counting Québec) which offer a nursing program with courses in French. Considering that the country boasts such a larger number of French-speaking people (7 million), this number is very low! According to a special report from the Office of the French Language Services Commissioner of Ontario, "Linguistic and cultural barriers have many negative effects on the quality of the services and the efficacy and efficiency of the health system... Linguistic and cultural barriers also reduce the probability of compliance with treatment and users' satisfaction with the care and services they receive." (page 7) For the wellbeing of Canada's Francophone patients, it is critical that our country's health system be able to offer quality healthcare services in French. Patients are not the only ones impacted; it has been found that the lack of French language services also touches the health system as a whole, its professionals and its varied establishments.

Immediately following the January 2015 introduction of the new NCLEX-RN entry-to-practice exam, Francophone students enrolled in the country's nursing programs expressed their dismay with the new tool, specifically citing the lack of preparatory material in French. The students' fears were founded, as illustrated when the 2015 results were published by the Canadian Council of Registered Nurse Regulators (CCRNR): the average pass rate for Canadian students taking the exam for the first time was 69.7%, a rate that dropped to 27.1% in the case of Francophone students, thereby constituting an unacceptable and unjustifiable variance. Based on numerous interviews of recent graduates, a research team led by Linda McGillis-Hall concluded that the very low passing rate among students who took the NCLEX-RN exam in French was due to the poor quality of the exam's translation into French as well as a blatant lack of preparatory material (Hall, Lalonde and Kashin, 2016).

At this time, nursing students enrolled in French-language programs must either rely on resources that were not specifically developed for the NCLEX-RN exam or attempt to study using some of the numerous English resources available. To date, these students have mostly opted to turn to preparatory material in English. Studying in this manner, in a language that is neither their mother tongue nor the language of their nursing program, creates a great deal of confusion, exasperation, anxiety and stress among the students in question; it also requires a significantly greater effort (Radio-Canada, 2016).

CNSA's position

In its strategic plan, the CNSA first claimed to want to ensure that "...accessible and relevant information and services are provided to our members." (CNSA, 2016) This will require that the organization improve access to adequate preparatory material by its Francophone members, as this group needs effective tools to complete their nursing studies and begin to practise. The CNSA then identified a second objective, namely to "...Influence and advance innovation and social justice in the nursing curriculum and the nursing profession" (CNSA, 2016). In this specific case, the lack of preparatory material in French reflects a violation of Francophone students' ability to access resources in their mother tongue, which happens to be one of Canada's two official languages. This motion is specifically aligned with the strategic plan's third objective, which concerns the development and strengthening of partnerships with CNSA stakeholders. The organization hopes to achieve this by collaborating with Francophone university programs, the CNFS (Consortium national de formation en santé) and provincial nursing orders that have been calling for additional resources in French since the NCLEX's rollout in 2013.

Study programs at Canada's schools of nursing

As noted by Hall, Lalonde and Kashin (2016), a failure to act quickly will likely result in highly detrimental long-term impacts on the Francophone identity and culture in the health sector. It is almost certain that some students avoid following a French-language nursing program, given that many of the resources required to successfully pass the entry-to-practice exam are not available in that language. In a Radio-Canada broadcast that aired in 2016, a nursing school student insisted that she would never have entered a French-language program had she known that she would have to subsequently relearn all of the material - in English - to be able to pass the exam. There is thus a real risk that Francophones in the health sector will

lose their linguistic identity (that of the often-forgotten minority in Canada) if they decide to practise solely in English.

At this time, there are no preparatory resources for the NCLEX-RN exam in French. To address and find a solution to this crucial matter, Laurentian University, University of Ottawa, Université de Moncton and Université de St-Boniface are all cooperating with the CNFS to develop preparatory modules for their students. According to the dean of the Laurentian University School of Nursing, there are at this time four modules completed (and available to students) and four more in the process of being prepared. The four finalized modules are the only resources available to help these students prepare for the newly introduced evaluation mechanism. These universities, moreover, were never informed that they would be responsible for developing their own preparatory material for the NCLEX exam (Hall, Lalonde and Kashin, 2016).

Rationale

Whereas the CNSA's objective is to serve as the primary resource for nursing students;

Whereas the CNSA, as regards the national entry-to-practice exam, seeks to defend the interests of its Francophone members from outside Québec;

Whereas the main outcome of objective A of the CNSA's Strategic Plan 2016-2021 consists of ensuring that members can readily access relevant information and services;

Whereas no resources have been developed to enable Francophone students enrolled in nursing programs to prepare for the entry-to-practice NCLEX exam in French.

Resolution

It is resolved that the CNSA support the development of quality preparatory material in French that will allow Francophone students completing an undergraduate nursing program outside Québec to successfully complete the NCLEX exam in their mother tongue.

It is resolved that the CNSA increase awareness of the lack of such material and that it partner with organizations and institutions in an effort to develop the necessary resources.

Conclusion

In closing, it bears reiterating that the inequity between various groups of nursing students as regards the entry-to-practice exam is unacceptable; these particular students cannot adequately prepare themselves in the language of their choice, i.e., the language in which they completed their entire training. This is quite simply because there are no preparatory resources in French. To better defend the interests of a large percentage of its members while also acknowledging Canada's special demographics, this notice of motion calls upon the CNSA to join the other groups that are already lobbying for the development of such resources, which are indisputably necessary to ensure ongoing French-language learning in the nursing sector. Francophone students, in other words, must have the same opportunity as their peers to successfully complete the entry-to-practice NCLEX exam.

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Position Statements 2016

Our Planet's Health is Our Health
Environmental Stewardship and Implications on Human Health

Submitted: December 4, 2015, Revised Submission- January 8, 2016
Submitted to: Board of Directors
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BACKGROUND

The impacts of health service delivery upon our environment have long been factors that nursing students across the country evaluate and try to improve upon for patients in their care. Often what we do not critically analyze enough are the ecosystems or natural environments in which we develop, live, work and deliver care. Health care in Canada is a major contributor of greenhouse gas emissions producing about 2.1 per cent of Canada's total greenhouse gas emissions yet is defended on the basis of infection control (Hancock, 2001; Shaner-McRae, McRae & Jas, 2007). The International Council of Nurses (ICN) (2008), states that nurses worldwide have shared responsibility to protect our natural environment. The Canadian Nurses Association (CNA) (2008) state every nurse should have a practical understanding of engagement in environmental health issues and have committed to the importance of the intersections of the health care sector and environmental responsibility through a joint position (CNA, 2009).

The Lancet (2015) states that we are seeing and feeling the effects of climate change already and that future predictions demonstrate an alarming and "potentially catastrophic risk to human health" (p. 1861). The Lancet Commission on Health and Climate Change (2015) predicts ill health effects such as increased heat stress, drought, floods, increased frequency of intense storms, pollution, spread of disease vectors, increased parasitic disease, food insecurity and under-nutrition, increase of tropical disease in more northern locations, displacement and migration, and ill mental health if the global average temperatures rise is more than 2 degrees Celsius (p. 1861; Barlow, 2008).

A recent study released by the Canadian Public Health Association (Hancock et al 2015) updates past reports and 'considerably expands the Canadian Public Health Association's 1992 report on human and ecosystem health, but with a heightened sense of urgency, because of the relentless, dramatic, and compounding impact of human activity on our ecosystems since then.' The report provides an overview of the ecological determinants of health, implications for public health and an agenda for action.

Canadian Nursing Students' Association (CNSA) POSITION

The Canadian Nursing Students' Association (CNSA) believes it is imperative that all Canadian nursing students take personal and professional responsibility for negative impacts of health care service delivery on the environment that contribute to negative health outcomes, directly and indirectly. This action is not only imperative, but must be undertaken in a timely manner to reduce negative impacts on our natural environment. To do otherwise would result in serious negative health outcomes that will occur worldwide and impact vulnerable populations. Vulnerability to climate change is linked to the ability of populations to cope and adapt to extreme weather events, leaving the poorest and most poverty-stricken communities most at risk, as well as older adults, women, children and those with comorbid conditions (Smith et al., 2014).

Nursing students have a unique responsibility as future health care leaders. They will deal first hand with patients and communities experiencing negative health outcomes stemming directly from the impacts of poor environmental responsibility practices and a lack of action on climate change mitigation and adaptation.

CNSA believes nursing students can have a positive impact at the individual patient level, helping to promote positive environmentally-responsible actions through education on

consumerism, food choices, transportation and waste reduction, toxics reduction and energy consumption practices. Nursing students also must lead by example, exercising sound judgment and subscribing to practices that do not negatively impact the environment.

CNSA believes nursing students should be involved in lobbying at all levels of policy. Canadian nursing students are well educated with knowledge bases in health science, political science, and social sciences and should be reaching out to municipal, regional, provincial, and federal governments to ensure sound environmental stewardship practices are not only prioritized, but acted upon for the health of Canada's population and our global community. Nursing students should also reach out to provincial regulatory and professional associations to ensure the nursing profession is doing its part to foster the widest possible opportunities for stakeholders to deliver sustainable health care practices.

CNSA strives to be the primary resource for nursing students across Canada and will advocate for education around environmental stewardship training and health to be included in chapter schools across Canada. CNSA will provide learning opportunities for nursing students across Canada through regional and national conferences and committee work.

Sound environmental stewardship requires strong strategic partnerships and collaboration with a wide range of stakeholders. CNSA will seek to create and nurture new partnerships with organizations that have aligning interests such as the Canadian Nurses Association (CNA) associate group Canadian Nurses for Health and the Environment, the Canadian Coalition for Green Health Care, and Healthcare Without Harm for collaboration on future advocacy, education and research.

Relation to Canadian Nursing School Curriculum

Global health and the determinants of health are included in entry-to-practice competencies at the provincial level throughout Canada. However, upon evaluation of the inclusion of climate change and environmental sustainability content in 42 Bachelor of Science in Nursing programs across Canada, Kennedy and Power (2011) found that less than half (42%) of schools included these topics in their curriculum. As the primary resource for nursing students across Canada, and climate change being one of the largest and most significant current threats to public and global health, CNSA must advocate for this to be included in curriculum in all our chapter schools. Nursing students must be prepared to be competent practitioners who will be

providing care to those suffering from ill health associated with poor environmental stewardship and the degredation of our natural environment.

Conclusion

The Canadian Nursing Students' Association believes all nursing students must take personal and professional responsibility for the impacts their care delivery has on the natural environment that ultimately can lead to negative health outcomes. CNSA as an organization will continue to further advocate, provide resources to nursing students and engage in research around the natural environment and health.

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Position Statements 2015

Cultural Safety in the Context of Aboriginal Health in Nursing Education

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Julia Hensler Baratto, and Dawn Tisdale, from North Island College
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Introduction and Background

Canada is categorized as a first world country, however the health disparities of Aboriginal people associated with social, economic, cultural and political inequities result in the Aboriginal population of Canada being rated as 3rd world status with outcomes of ill health and social suffering (Adelson, 2005). According to Kurtz, Nyberg, Van Den Tillaart and Mills (2013), prior to colonization Aboriginal people had an active lifestyle, healthy traditional diets and spiritually rich traditional approaches to health that suggests longevity, good health and thriving populations. Colonization resulted in population collapse from epidemics, loss of traditional diets, cultural practices and in some cases the denial of health services to Aboriginal people leading to endemic disease and health issues (First Nations Health Authority, 2014). Residential schools led to loss of culture and resulted in high mortality rates, high incidents of abuse, and poor health impacting future generations. (Kurtz et al., 2013; Aboriginal Nurses Association of Canada, 2009). As the Aboriginal population continues to grow, so do the inequities they face, which is one of our nation's serious shortcomings (Institute on Governance, 2013).

Aboriginal populations in Canada are growing at a rate six times higher than nonAboriginal populations. Colonization, racism and residential school trauma has uniquely affected Aboriginal peoples' determinants of health (Canadian Nurses Association [CNA], 2014; Canadian Federation of Nurses Unions [CFNU], 2011). Aboriginal people living in Canada are more likely to be unemployed, subject to poor living conditions and have been victimised by abuse and violent crimes (Canadian Human Rights Commission, 2010). Furthermore, Aboriginal people have an increased incidence of obesity, cancer, hepatitis, HIV, and poor mental health (Canadian Human Rights Commission, 2010).

There is an ethical obligation to support reconciliation and restorative justice, leading to the improved health and right to self-governance of Aboriginal people, which is congruent with the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2008; Mahara, Duncan, Whyte & Brown, 2011). Canadian nurses need to be aware of the unique context of Aboriginal people in order to provide adequate, culturally safe and competent care to promote the health of Aboriginal people.

Stakeholder Information

The Canadian Nurses Association ([CNA], 2014b) passed two motions from the floor at the annual general meeting "to ensure that aboriginal cultures, histories and contexts are alive and accurately reflected throughout all nursing programs" (p.1) and "that CNA continue to show leadership in ensuring that aboriginal context and cultural safety competencies are represented… in educational program approval and accreditation processes across Canada" (p.1).

A review of policies and positions from national and provincial nursing associations, colleges, and unions has revealed multiple stakeholders. The majority of provincial regulators require cultural safety and the ability to engage in culturally safe relationships as an entry-to-practice competency and several of these provincial regulators also require additional knowledge of disparities encountered by Aboriginal people (Registered Nurses Association of Northwest Territories and Nunavut [RNANTN], 2014; Nurses Association of New Brunswick [NANB], 2013; College of Registered Nurses of Nova Scotia [CRNNA], 2013; College of Registered Nurses of British Columbia [CRNBC], 2014; College of Nurses of Ontario, 2014; Association of Registered Nurses of Newfoundland and Labrador, 2013, Association of Registered Nurses of Prince Edward Island, 2013; Saskatchewan Registered Nurses Association, 2013; College and Association of Registered Nurses of Alberta, 2013).

The Registered Nurses Association of Ontario (2011) has been noted to take political action, requesting that the provincial and federal government take action against the critical living situations in the Aboriginal community of Attawapiskat, Ontario.

Another stakeholder is the Canadian Association of Schools of Nursing, who was noted as a collaborator in the Aboriginal Nurses Association of Canada (2009) document that published a framework for cultural competence in nursing education that identifies that all new graduate nurses need to understand the socio-political relations between government and Aboriginal

people. It identifies five core competencies for nurses, while advocating for a safe learning environments for students to attain these competencies.

Canadian Nursing Students' Association Position

The Canadian Nursing Students' Association (CNSA) advocates for the inclusion of Aboriginal health and ways of knowing into Canadian nursing curricula to enhance the cultural competence of new graduate nurses. CNSA takes the position that incorporation of Aboriginal cultural competence supports the health of Aboriginal people and allows new graduate nurses to meet their entry-level competencies in most Canadian provinces and territories. This position is congruent with CNSA's objective to influence and innovate nursing curriculum in Canada.

Relation to Canadian Nursing Schools' Curriculum

Stansfield and Brown (2013) state that Indigenous knowledge (IK) and epistemologies are grounded in hermeneutic phenomenology, which focuses on how individuals are affected by their context and how their context affects them. The incorporation of Indigenous knowledge into nursing curriculum provides nurses with broader, non-linear perspectives, which are centered in relational philosophies and different ways of knowing (Stansfield & Brown, 2013). The inclusion of Indigenous knowledge into nursing curriculum could promote nursing research that is evidence-based knowledge grounded in Indigenous values and principles. Indigenous knowledge can be incorporated into health policies that improve understanding of health issues that affect aboriginal people, protect Aboriginal traditions and healing practices and foster participation of Aboriginal people in the delivery of health care through increased research and partnerships (National Aboriginal Health Organisation, 2011).

The Canadian Association of Schools of Nursing (2014) states that knowledge of the history, nursing and health care in the context of Aboriginal peoples is an entry-to-practice level competency. Ensuring that nursing curriculum includes Aboriginal education and promotes cultural safety, is in line with the entry-to-practice competencies set out by CASN and by several provincial regulators (CRNBC, 2014; RNANTN, 2014; NANB, ND; CRNNA, 2013). Including education about the disparities faced by Aboriginal people and promoting the value of Indigenous knowledge in all nursing curriculum would allow graduates of these programs to meet the entry-to-practice requirements in all Canadian provinces.

Additionally CNA (2014b) supports cultural competency in the context of Aboriginal people to be included in Canadian nursing curriculum, registration and accreditation processes.

Hence, CNSA takes this position that Aboriginal cultural safety shall be included in nursing education so that its associates may be fit to meet any of these registration standards and be culturally safe in the context of the Aboriginal people.

Conclusion

CNSA advocates for the inclusion of cultural safety in the context of Aboriginal people in nursing education. This is congruent with CNSA's objective to support innovation in nursing curriculum. Additionally, this is reflective of the values expressed by several stakeholders across the nation including CNA, CASN, and many of the provincial and territorial regulators. CNSA believes that if nursing students receive aboriginal education in their curriculum, this will promote the cultural safety nursing students will require to meet entry-to-practice competencies and adhere to the ethical standard of Canadian nursing practice.

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Nursing Leadership Development

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Carly Whitmore, RN BScN
Replaces Current Statement: Leadership Development, 2009

Introduction and Background

Nursing is a dynamic profession which is as political as it is a discipline involving learned skill sets and differing types of knowing. Nursing combines education, research, and knowledge translation while requiring critical thinking, advocacy, and above all else, leadership. The link

between nursing leadership and positive outcomes for patients, organizations, and healthcare workers is well established and long standing (Laschinger et al., 2008). According to the Canadian Nurses Association, "Canada's health system requires a steady supply of visionary and energetic nursing leaders across the domains of the discipline who are credible, courageous, visible and inspiring to others and who have the authority and resources to support modern, innovative, and professional nursing practice" (Canadian Nurses Association, 2009, p. 1).

While much research and knowledge has been collated into the concept of leadership itself, little has been done in order to advance leadership skills and opportunities for nursing student leaders. The landscape of nursing is changing, with a projected nursing shortage in the coming years due to a mass exodus of retiring nurses, a dilution of expertise and thus, leadership knowledge, will also occur (Morrow, 2008). As experienced nurses and nurse leaders begin to shift towards retirement and away from clinical practice, the need for nurse leaders will be thrust upon the new generation.

Canadian Nursing Students' Association Position

That the Canadian Nursing Students' Association strongly support the need for, and encouragement of, mentorship programs and initiatives aimed at educating nursing students and new graduate nurses on the skills, resources, and opportunities required to develop into successful nurse leaders. Further, that the Canadian Nursing Students' Association continue to credit itself as a resource for future nurse leaders and push for greater recognition from schools of nursing as a resource for leadership development through involvement in the association and its activities.

Relation to Canadian Nursing Schools' Curriculum

Leadership, as a competency, skill, and personal attribute, is a guiding principle in nursing education in Canada. It is outlined in curriculum, stressed in association policy and frameworks, and is emphatically situated throughout the competencies that guide nursing practice. Leadership theories are taught and tested and yet leadership opportunities, such as those granted through involvement with the Canadian Nursing Students Association (CNSA) are not credited or recognized as such.

Provincial and territorial regulatory bodies such as the College of Nurses of Ontario shape and guide the required knowledge, skills, and competencies required in order to practice within a particular geographical location. Leadership, as a term, is often and clearly referenced in these

guiding documents. Through the inclusion of leadership education for nursing students and an emphasis on opportunities in curriculum, nursing students will be better prepared to confront the leadership needs of the nursing landscape that they are entering.

Nursing leadership is the lynchpin in nursing care delivery - whether it be patient safety, future models of care, or research knowledge translation. With an ever changing healthcare horizon, and a potentially crippling loss of nursing experience through generational retirement, it is imperative that schools of nursing begin to prepare nursing students to be effective and visionary nurse leaders (Huston, 2008).

Conclusion

Nursing is never static, always changing, and forever expanding. The new generation of Canadian nurses and nursing students will be faced with challenges and adversity. It is imperative that CNSA continues to support programs and initiatives aimed at educating nursing students and new graduate nurses in order to assist in the development of successful and effective nurse leaders.

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Also see: Conference Time Equals Clinical Time, 2002

Nursing Students Concerned with Release of First Round of NCLEX-RN Results

[October 21st, 2015]

As the national voice of nursing students across Canada, the Canadian Nursing Students' Association (CNSA) is concerned for our current and future nursing students following the release of the preliminary National Council Licensure Exam - Registered Nurse (NCLEX-RN®) results. As there has been a concerning decrease in passing averages both provincially and nationally, CNSA is advocating for our 29,000 members across Canada who are the future of health care. The nursing community must ensure that all students are being examined using a proper assessment tool that effectively measures our Canadian entry-to-practice competencies and is equitable for our bilingual nation. With a nursing shortage that has lead to serious implications to the health care system, we must address these concerns with urgency and strength.

Background

In 2011, Canada's ten regulatory bodies announced the formation of a contract approving the National Council of State Boards of Nursing (NCSBN), the current administrator of the American NCLEX-RN®, to be the new administrator of Canada's entry-to-practice nursing exam. As of January 2015, the NCLEX-RN® has replaced the long-standing Canadian Registered Nurse Examination (CRNE) as the official entry-to-practice examination for nursing students. Well-founded concerns from Canadian stakeholders regarding the harmonization of the NCLEX-RN® are related to the following national elements: (a) appropriate reflection of the Canadian health care system values; (b) consideration of cultural competence with respect to Canada's First Nations, Inuit, and Métis populations; (c) proper reflection of Canadian nursing programs; and (d) representation of Canada's two official languages. Despite these concerns from stakeholders, the NCLEX-RN® was officially implemented in Canada with less than desirable outcomes for our students. Nationally, 4,701 nursing students wrote the NCLEX-RN® between the months of January and June 2015. The pass rate for candidates who wrote during this period is 70.6%, which is lower than the American pass rate of 78.3% (http://www.ccrnr.ca/assets/main-report-canadian-nclex-rn-pass-rate-analysis-q1-q2-2015.pdf). Considering the pass rate is approximately 10% lower than the previous CRNE, the CNSA feels immediate actions must be taken to ensure all Canadian nursing students are being fairly examined and provided with the proper preparation resources.

Progress

CNSA has worked hard to be a resource and support for our members by offering the document, "Tips for Nursing Students: Preparing to Write the NCLEX-RN®," which includes

general information about the exam, question structure/format, and tips when writing a computer-adaptive test (CAT). Both a resolution and position statement on NCLEX-RN® advocacy were passed at our 2013 and 2015 National conferences, which has engaged our members in the conversation of entry-to-practice examination, and encouraged our stakeholders and schools to have an active role in these changes. These statements have helped shape the activities, goals, and objectives of our organization, and have created a dialogue with our regional and national stakeholders around the introduction of the NCLEX-RN®. Understanding the financial responsibility that comes with purchasing NCLEX-RN® prep resources, we have also provided our members with a discount on Lippincott NCLEX-RN® materials. Companies who prepare NCLEX-RN® preparation tools are also offered the opportunity be a part of our Regional and National conferences in order to provide information and resources to our members, while answering questions and concerns at the same time.

Recommendations

The NCLEX-RN® constitutes a major change in entry-to-practice in Canada, and it is critical that all stakeholders in the nursing profession adapt and change their policies to reflect this fundamental shift. Considering the recent exam results and how they will affect our students and the health care system, CNSA feels there are actions that need to be taken immediately. What has been most evident and alarming is the low pass rate (54.3%) in provinces with Francophone students, and the lack of preparation support and resources for this population. CNSA requests the immediate creation of proper NCLEX-RN® preparation tools for Francophone students, as well as a third party revision of the current NCLEX-RN® to ensure proper translation into the French language and provide equal opportunity for success to all Canadian nursing students. We are proud to be a bilingual country and a bilingual national association, therefore CNSA will continue to advocate for our Francophone students regarding the NCLEX-RN®.

The limited amount of attempts Canadian nursing students are able to write the NCLEXRN® is another urgent issue to address. Since the NCLEX-RN® was introduced in Canada, nursing students are allowed a maximum of three attempts to write and pass the NCLEX-RN®. If a student were to be unsuccessful after three attempts, the regulating body of that province/territory has the ability to review the application and determine whether extenuating circumstances exist that would allow the student another attempt to write. Otherwise, nursing students are required to complete another approved or equivalent nursing program before another attempt may be made. In the United States, the NCSBN's policy allows students to rewrite the NCLEX-RN® up to eight times in one year, with no more than one attempt being

made in a forty-five day period, yet individual jurisdictions are able to create policies of their own. In thirty-nine out of fifty states, students are able to rewrite the exam an unlimited number of times, with no need for students to retake a nursing program such as in Canada. Most nursing programs in Canada are a four year commitment. While working through the challenges of the NCLEX transition into Canada, asking students to retake their nursing degree is an unreasonable and financially devastating scenario, which will continue to add strain onto our already taxed health care system. CNSA recommends that provincial regulators increase the number of writing attempts for the NCLEX-RN® as is offered to American nursing students while we continue to navigate between the shift in exams. We feel a maximum of three attempts is not supporting nursing students through this transitional period, and consideration of change in policy is a top priority.

Lastly, CNSA urges all educational institutions to incorporate study guides and preparation support for the NCLEX-RN® into their curriculum to ensure they are using current practices that best support our students. This is important while Canada uses the NCLEX as their entry to practice examination. Anecdotal evidence from schools across the country has shown that schools that have integrated NCLEX-RN® preparation into their curriculum and ensured students are equipped to use study tools and strategies, have had higher pass rates. It is also important that the efficacy of these study tools, programs and strategies are grounded in evidence.

Moving forward, we will continue our collaboration with our national stakeholders – the Canadian Nurses Association (CNA), the Canadian Association of Schools of Nursing (CASN), and the Canadian Federation of Nursing Unions (CFNU) – to ensure continued advocacy for our nursing students regarding our national licensure exam. We are encouraged by our stakeholders in the nursing community who have rallied in support of Canadian nursing students through their dedication in working together for the benefit of our future health care leaders. It is our hope that these recommendations will help to give Canadian students fair and equal opportunity to succeed when preparing for and writing the NCLEX-RN®. We strongly believe in our members and their abilities, and we hope they can be confident that CNSA will be their advocate throughout this transition.

Canadian Nursing Students' Association Board of Directors 2015-2016

The Transitional NCLEX-RN® Examination for Canadian Candidates

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Lauren C. Pekalski from Sault College

Introduction and Background

In 2011, Canada's ten regulatory bodies announced the formulation of a contract approving the National Council of State Boards of Nursing (NCSBN), the current administrator of the American NCLEX-RN® examination, to be the new administrator of Canada's entry-to-practice nursing exam (CNSA, 2013). As of January 2015, the NCLEX-RN® will replace the long-standing Canadian Registered Nurse Examination (CRNE). Well-founded concerns from Canadian stakeholders regarding the harmonization of the NCLEX-RN® exam are related to the following national elements: (a) appropriate reflection of the Canadian health care system values; (b) consideration of cultural competence with respect to Canada's unique Inuit/First Nation/Northern population; (c) proper reflection of Canadian nursing programs; (d) the consideration of Canada's bilingual population; (e) potential outflow Canadian RNs and emigration to the United States and; (f) the privacy of Canadian nurses personal information (CNA, 2011; Canadian Association of Schools of Nursing [CASN], 2012; Registered Nurses' Association of Ontario [RNAO], 2012). Despite these concerns, there is strong evidence to support the applicability of the 2013 NCLEX-RN® Test Plan to the Canadian testing population. Studies revealed a 98% congruency in nursing practice and competencies between the United States and Canada (NCSBN, 2013a; NCSBN, 2014a). With this decision, a strong and growing partnership with our American counterpart will assist us in making certain our voices are heard.

The direct involvement of Canadian representatives in the NCLEX-RN® Item Development Program symbolizes a positive step forward in Canada's newly founded affiliation with the NCSBN. Canadian regulatory bodies are now active participants in reviewing operational NCLEX items to ensure item congruency with regulatory nurse practice acts and entry-level scope of practice (NCSBN, 2013a). This synergistic relationship supports an effort to ensure that the NCLEX-RN® examination will provide Canadian students with a fair, valid, and psychometrically sound measurement of minimal nursing competencies that are required for safe and effective practice (NCSBN, 2013b)

Canadian Nursing Students' Association Position

As the official representative of Canadian nursing students, CNSA will continue to research and seek ways to increase suitability of the NCLEX-RN® for Canadian students. CNSA can also work towards a potential relationship with different stakeholders such as the Canadian Council of Registered Nurse Regulators (CCRNR) to propose solutions to issues that may arise subsequent to the inaugural writing of the NCLEX-RN® examination. CNSA can advocate for Canadian students to be guided and prepared for exams that consist of computer-adaptive-testing (CAT) and various question formats through CNSA's relationship with CASN. This can allow for the creation of partnerships with Canadian nursing schools and the encouragement of integration of such testing into the programs.

CNSA welcomes invitations to be active participants in the annual consultation processes regarding improvements and the continued applicability of selected survey questions for the NCLEX-RN®. CNSA will continually advocate for increasing numbers of Canadian nurse representation to participate in NCLEX-RN® item development panels and support equal inclusion in all aspects of exam planning, item construction, sensitivity screening, and design. It is our ultimate hope for Canadian nurses to be equal partners in the triennial RN practice analysis cycle to ensure that systematic, comprehensive, and defensible methods are used to establish equitable content for the NCLEX-RN® Test Plan (CCRNR, n.d; Williams & Doyoung, 2014). CNSA will continue to be the primary resource for orienting nursing students to this paradigm shift from the traditional handwritten exam delivery model to the computerized model utilized with the NCLEX-RN® (NCSBN, 2013a). This entails ensuring that nursing students are adequately prepared by remaining at the forefront of current events, disseminating information, providing updates, and offering suggested resources such as the CNSA's NCLEX Tips for Nursing Students fact sheet. In the spirit of strengthening linkages and harmonization with stakeholders, CNSA will strive to join the collaborative efforts of advancing and innovating nursing programs and research relative to the NCLEX-RN®. To respect the needs of French-speaking Canadian NCLEX-RN® candidates, equitable services will be offered in both languages. CNSA will join stakeholders' efforts to ensure that Canada's distinctive bilingual nature is respected and upheld throughout each step of the NCLEXRN® process (CNSA, 2014).

CNSA welcomes information from the Office of Privacy Commissioner in Canada with regards to compliance of Canadian privacy legislation, as well as other industry standards (College of Registered Nurses of Nova Scotia [CRNNS], 2012). CNSA will stay abreast of current events relating to the collection of data and personal information by the NCSBN, advocating for

storage that is held to the highest global security standards, including all requirements to uphold national and provincial privacy legislation (CRNNS, 2012).

Relation to Canadian Nursing Schools' Programs

CNSA believes that changes to nursing school programs, available resources, and preparation practices for the NCLEX-RN® can ensure that students are granted equitable opportunities to succeed (CNSA, 2013). CNSA will liaise with stakeholders and interested parties to encourage the implementation of NCLEX-RN® preparatory courses into Canadian programs to prepare students for success. Implementing standardized testing in schools using various platforms to practice CAT methods with alternative NCLEX-RN® question formats has traditionally been met with great success (Alameida et al., 2011; CNSA, 2013; Coons, 2014; Herrman & Johnson, 2009; Hyland, 2012; Schooley & Dixon Kuhn, 2013). A repertoire of strategies being utilized by schools of nursing in response to the increasing need for preparation for the NCLEX-RN® includes identifying at-risk students, designing course-type interventions, tracking student progression, recommending review courses, providing personal supports, using simulation lab scenarios, and holding test anxiety workshops (Herrman & Johnson, 2009; Lavin & Rosario-Sim, 2013). It is recognized that many Canadian schools of nursing are in support of utilizing reliable commercial products that are purported to prepare students for the NCLEX-RN® (Alameida et al., 2011; Nelson, McFetridgeDurdle, & Bradley, 2012).

Educators are encouraged to become familiarized with the NCLEX-RN® Test Plan, its corresponding content distribution, and examination delivery methodology. Detailed test plans include itemwriting exercises, which provide step-by-step instruction on how to develop test questions (CCRNR, n.d.). Educators can subscribe to NCLEX-RN® Program Reports, which will provide a comparative review of each program's performance that is designed to help educators and administrators identify their program's areas of strength and weakness (NSCBN, 2014b).

Conclusion

Although the loss of the uniquely Canadian-developed CRNE has raised valid concerns, CNSA ultimately remains dedicated to serving the best interests of all current and future Canadian nursing students (CNSA, 2013). To ensure the needs of students remain at the forefront of future developments, CNSA will continue to maintain a spirit of inquiry by perpetually igniting requests for the truth, transparency, evidence-informed data, and further

knowledge while simultaneously engaging with active stakeholders to uphold the strength of our commitment to the Canadian nursing profession.

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Accommodation within Clinical Placements for Students with Temporary, Transient, or Sporadic Disability or Injury

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Matthieu Payette; McMaster University, Conestoga, and Mohawk College Collaborative
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Introduction and Background

In Canada, students of schools of nursing are required to complete institution designated number of clinical hours to satisfy course requirements for graduation as directed through the Canadian Association of Schools of Nursing (CASN). Injury or temporary, transient, or sporadic disabilities can hinder students in completing the designated clinical hours, resulting in delayed or denial of timely completion of course requirements. Within the Manitoba Human Rights Commission (1998), "A disability becomes a handicap when it interferes with the activity to be done, but it is often possible to remove the handicap by making adjustments in the work or living environment". Policies for accommodation for workers with disabilities, whether temporary, sporadic, or permanent are part of all provincial human rights codes and the Canadian Human Rights Act (CHRA). Additionally, policies and guidelines for accommodations exist within institutions such as the Canadian Labour Congress and various provincial nursing labour organizations. According to the Ontario Human Rights Commission Guideline on Accessible Education (2009), education is considered a service whereby "education providers have a duty to accommodate the needs of students with disabilities to allow them access to educational services equally, unless to do so would cause undue hardship" (p. 5). Focus on the definition of disability should be the effects of preference, exclusion, or differential treatment due to physical limitation, an ailment, or otherwise perceived limitation (Ontario Human Rights Commission, 2009).

Legislation such as provincial and territorial human rights codes and acts prohibit actions that discriminate against those with disabilities. Each policies' aim is to recognize the dignity and worth of every person and to provide equal opportunities without discrimination. Denial of ability to complete course requirements due to disability, whether temporary or permanent is in violation of the CHRA. All individuals have an equal opportunity to make for themselves the lives they wish to have and their needs accommodated without being hindered by discriminatory practices such as those based on disability (Canadian Human Rights Act, 2014). While various policies and legislation are in place regarding equal access within educational institutions, normative assumptions of what constitutes a capable nurse can influence decisions regarding what individuals are able to participate within clinical nursing placements (Ryan, 2011).

Canadian Nursing Students' Association Position

The Canadian Nursing Students' Association (CNSA) supports the development and implementation of a process of accommodation within Canadian schools of nursing for clinical placements due to permanent, temporary, transient, or sporadic disability, whether it be physical, mental, or otherwise. Further, the Canadian Nursing Students' Association encourages

a greater emphasis on the inclusion of education within Canadian schools of nursing surrounding the topics of accessibility, disability, and accommodation within the profession of nursing.

Relation to Canadian Nursing Schools' Curriculum

CNSA is governed by three objectives and goals. These include: being the primary resource for nursing students, influencing and advancing nursing curriculum and research, and strengthening and creating stakeholder relations (Canadian Nursing Students' Association, 2011). The topic of accommodation due to injury or disability is relevant within schools of nursing because nursing students need to be aware of what accessibility, disability, and accommodation involve. Terms which are used within nursing education in relation to patient populations but rarely in relation to nurses or nursing students. This knowledge gap leads to a lack of information thus, loss of potential advocacy in the case of nursing student injury or disability. Disability or physical frailty are overt structures within the application process which can discourage individuals from applying to nursing education. While covert structures, such as unequal access to clinical components within the curriculum due to disability, may lead to difficulty or failure to complete the program and may be less likely to succeed in their attempt to become a nurse (Ryan, 2011).

Faculty may require education on what constitutes a disability and how to best support students with a disability. Education of nurse faculty and students on identification of varied accommodations such as use of assistive devices can help students with disabilities be more successful in the program. This would involve the realization that there are multiple different methods of properly accomplishing a task while still maintaining the required principles or standards, and the requirement of various types of classroom learning (Aschcroft et al, 2008). In order to shift the perspective of equal access within the clinical component of nursing education, steps must be taken to encourage nurse educators to further investigate and implement new legislation outlining a policy for accommodation in clinical practice. The benefits of including access to information about accommodation and disability within the curriculum will aid in addressing the perceptual biases which may be held by both faculty and students regarding those individuals with disabilities (Ashcroft et al, 2008).

Conclusion

Every nursing student must complete an institution designated number of clinical hours to satisfy course requirements for graduation. The denial to participate within clinical

placements will directly hinder a student's ability to complete their education and thus enter the profession. The creation of a clinical accommodation process and inclusion of education surrounding accessibility will ensure that the primary governing objections of CNSA are being met. This will also allow for students to advocate for inclusion of such processes within each individual school of nursing. This will aid in the creation of an inclusive environment which provides a discrimination free curriculum where every individual is capable of continuing their education with equitable access to all opportunities within the nursing profession.

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Resolution Statements 2015

Creating a Partnership for Aboriginal Health Promotion

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Julia Hensler Baratto, and
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Introduction and Background

The Aboriginal Affairs and Northern Development in Canada (2014) define Aboriginal as being First Nations, Inuit, or Métis people. According to Statistics Canada (2014) 4.3% of Canadians self-identify as Aboriginal. This statistic is limited to people who self-identify as Aboriginal, and therefore the amount of Aboriginal people in Canada are likely underrepresented (Aboriginal Affairs and Northern Development in Canada, 2014). Since 1996, there has been a 20.1% increase in Aboriginal people compared to a 5.2% increase of nonAboriginal people in Canada (Statistics Canada, 2014).

According to Kurtz, Nyberg, Van Den Tillaart and Mills (2013), prior to colonization Aboriginal people had an active lifestyle, healthy traditional diets and spiritually rich traditional approaches to health that suggest longevity, good health and thriving populations. Colonization resulted in population collapse from epidemics, loss of
traditional diets, loss of cultural practices, and in some cases the denial of health services to Aboriginal people, leading to endemic disease and health issues (First Nations Health Authority, 2014). Residential schools led to loss of culture and resulted in high mortality rates, high incidents of abuse, and poor health impacting future generations (Kurtz et al., 2013; Aboriginal Nurses Association of Canada, 2009). As the Aboriginal population continues to grow, so do the inequities they face, which rate as one of our nation's most serious shortcomings (Institute on Governance, 2013).

Colonization resulted in the creation of the Canadian Constitution Act. While section 35 of Constitution acknowledges previously identified Aboriginal rights, it does not define them

(Government of Canada, 2014). There is an ethical obligation to support reconciliation and restorative justice, leading to the improved health and right to self-governance of Aboriginal people, which is congruent with the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2008; Mahara, Duncan, Whyte & Brown, 2011).

Links to CNSA's Mandate and Current Position

As of 2014, CNSA has not taken a position addressing Aboriginal nursing or Aboriginal health promotion. In accordance with CNSA's (2011) Strategic Plan 2011-2016, creating a new partnership with the Aboriginal Nurses Association of Canada (A.N.A.C.) will address the disparities that Aboriginal people encounter, the lack of representation of, or the lack of mentorship available to, Aboriginal nursing students. CNSA (2011) prioritizes collaborating with external organizations and inviting the participation of stakeholders. By creating a new relationship with A.N.A.C., CNSA would be meeting this objective. Furthermore, such a relationship would allow CNSA to meet their objective of being the primary resource for Aboriginal nursing students. Furthermore, creating a partnership with A.N.A.C. would promote indigenous knowledge and support nursing students to develop culturally safe practices.

Rationale

Whereas, CNSA's objective is to be the primary resource for nursing students; and,

Whereas, Priority C of CNSA's strategic plan for 2011-2016 states that CNSA shall aim to participate at stakeholder events and stakeholders participate at CNSA events, while paying attention to building relationships with stakeholders as well as joining stakeholder committees; and

Whereas, A.N.A.C. aims to support nursing students of Aboriginal descent, while developing meaningful mentorship relationships; and

Whereas, There is an identified need to empower the self-governance of Aboriginal nurses and Aboriginal nursing students; and

Whereas, Research identifies that there are unique disparities among Aboriginal populations; and

Whereas, The Canadian Nurses Association (2014) has passed multiple motions and resolutions that identify Aboriginal Health as a priority; therefore

Resolution

BE IT RESOLVED that CNSA create a new partnership with Aboriginal Nurses Association of Canada (A.N.A.C.)

BE IT FURTHER RESOLVED that CNSA create a sustainable voice that represents and advocates for Aboriginal nursing students

BE IT FURTHER RESOLVED that CNSA advocate for the inclusion of Aboriginal education and Indigenous knowledge throughout Canadian nursing programs

Relation to Canadian Nursing School Curriculums

The Canadian Association of Schools of Nursing ([CASN], 2014) state that knowledge of the history, nursing and health care in the context of Aboriginal peoples is an entry-to-practice level competency. Ensuring that nursing curriculum includes Aboriginal education and promotes cultural competence is in line with the entry-to-practice competencies set out by CASN and by several provincial regulators (CRNBC, 2014; RNANTN, 2014; NANB, ND; CRNNA, 2013). Including education about the disparities that Aboriginal people face in Canadian nursing curriculum would allow graduates to meet the entry-to-practice requirements.

Additionally CNA (2014) is in support of Aboriginal cultural competence to be included in Canadian nursing curriculum, registration and accreditation processes. The new partnership with A.N.A.C. could provide an optimal environment to increase the knowledge of Aboriginal health disparities and assist in the promotion of Aboriginal health and Aboriginal nursing. This increase can occur through this relationship because it connects with A.N.A.C. objectives, which CNSA could further support. These objectives include the development and encouragement of courses in the educational system on Canadian Aboriginal health, Indigenous knowledge, culturally safety in nursing and the health care system and/or other educational resources and supports; to consult with government, nonprofit and private organizations in developing programs for applied and scientific research designed to improve health and well-being in Aboriginal peoples; and to promote awareness in both Canadian and International Aboriginal

and non-Aboriginal communities of the health needs of Canadian Aboriginal people (Aboriginal Nurses Association of Canada, 2010). There is currently no past or current CNSA position on Aboriginal Health and curriculum.

Conclusion

A relationship between A.N.A.C. and CNSA would promote Aboriginal health and breakdown barriers that Aboriginal people face. The resolution being proposed is to enter into a partnership with A.N.A.C. and to work with CASN to advocate for further integration of Aboriginal Health into nursing education. By doing this, CNSA would show their support for increased health equity for Aboriginal people. As Canadians and future nurses, it is important to focus on and continue down the road to restorative justice, equity and reconciliation.

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Quality End of Life Care in Nursing Education

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Jaime Chafe,
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Introduction / Background

The registered nurse's scope of practice includes providing quality end of life care to patients. This care is "best provided through the collaborative practice of an interdisciplinary team to meet the physical, emotional, social, and spiritual needs of the person and their family" (CNA, 2008). Registered nurses are an integral part of the interdisciplinary team and play an important role in end of life care. There is evidence to suggest that novice nurses are feeling uncomfortable with or lacking the knowledge and skills needed to provide end of life care to their patients (Brajtman, Fothergill-Bourbonnais,

Casey, Alain, & Fiset, 2007). In 2011, the Canadian Association of Schools of Nursing (CASN) began a two-year pilot project to incorporate end of life care education into undergraduate nursing programs (Vogel, 2011).

Whereas, despite improvements in the teaching and learning opportunities surrounding end of life care, evidence suggests that new nursing graduates feel uncomfortable with or lack the required knowledge/skills to provide the quality level of end of life care that is expected of them (Brajtman et al., 2007)

Whereas, Canadian nurse educators have identified barriers to teaching end of life care, including a lack of a formal plan to integrate teaching of end of life care into the current curriculum, as well as a lack of adequate time to incorporate this topic into already overcrowded clinical and theory courses (Brajtman, Fothergill-Bourbonnais, Fiset, & Alain, 2009).

Whereas, registered nurses spend more time with patients at the end of life than any other health care discipline thus it is imperative that nursing students be educated so they can provide high-quality, holistic end of life care (Wallace et al., 2009).

Whereas, registered nurses must convey respect, preserve dignity, and recognize the intrinsic worth of each person while promoting the right to informed decision-making during end of life care (CNA, 2008).

Whereas, registered nurses have the duty to establish, maintain, and promote the standards of practice of the profession and provide care in a manner that fosters respect and dignity to patients at the end of life (ARNNL, 2013),

Whereas, registered nurses have the responsibility to practice the use of effective therapeutic communication techniques when providing quality end of life care to support both the patient and the family (Arnold & Boggs, 2007)

Whereas, quality end of life care is a priority for registered nurses when caring for patients at the end of life (While, 2012) and requires a coordinated process, which covers important care tasks, in order to provide quality end of life care (Covington, 2013)

Resolution

BE IT RESOLVED, that CNSA refer to the documents, "Providing Nursing Care at the End of Life" (CNA, 2008) and "Palliative and End of Life Care: Entry-to-Practice Competencies and Indicators for Registered Nurses" (CASN, 2011) to develop a CNSA position statement on the importance of formalized, purposeful nursing education curriculum content that addresses quality end of life care.

BE IT FURTHER RESOLVED, that CNSA use that position statement to encourage official delegates to advocate for formalized, purposeful nursing education curriculum content that addresses quality end of life care.

Conclusion

There is evidence to suggest that student nurses are feeling uncomfortable with or lacking the knowledge and skills needed to provide end of life care to their patients As the voice of nursing student across Canada, we would like CNSA to create a position statement on the importance of formalized, purposeful nursing education curriculum content that addresses quality end of life care and use that statement to advocate to include this topic within the nursing curriculum.

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Promoting Gender Equalization in Nursing Programs

Submitted: January 2015
Submitted to: CNSA National Assembly
Submitted by: Christena Peters, Ryan Brockerville, and Ryan FitzGerald from Memorial University of Newfoundland School of Nursing

Introduction / Background

Gender equalization is an apparent problem in nursing programs across Canada. This may be due to the fact that the nursing profession is predominantly female, but it may also be due to the difficulty in recruiting males into the profession because of the stigmatization and perceived stereotypes of male nurses (CNA, 2010; Meadus & Twomey, 2011; Bartfay, Bartfay,

Clow, & Wu, 2010). The male population is underrepresented in the nursing profession, yet male nurses are needed to increase diversity and promote inclusiveness. The CNSA prides itself on the values of inclusiveness and diversity, and therefore the CNSA should raise the profile of this issue to bring awareness to a national level.

Whereas, we consider the Canadian Nursing Student's Association (CNSA) to be the national voice of Canadian nursing students who represent students' interests to federal, provincial, and international governments and other health care organizations (CNSA, 2013),

Whereas, incentives to promote gender equalization are offered to females in other professional programs with high male representation, such as the Women in Engineering Mentoring Initiative in Ontario (Ontario Ministry of the Environment, 2013),

Whereas, nursing remains the only profession where men have retained their minority status since the turn of the century. Other professions, such as teaching, library science, and social work have broken through these barriers (Bartfay et al., 2010).

Whereas, males are currently a minority in Canadian nursing programs and only 6.4% of Canadian Registered Nurses are male (CNA, 2012).

Whereas, common perceived barriers to promoting gender equalization include sexual stereotypes, lack of recruitment strategies, a female-oriented profession, and lack of positive male role models in the mass media (Meadus & Twomey, 2007).

Whereas, there is a need for more male role models in the profession to act as mentors for prospective male nursing students and ultimately, promote male student retention (Bartfay et al., 2010) and negative stereotypes are affecting the recruitment and retention of males in Canadian nursing programs (Bartfay et al., 2010).

Whereas, nurses are required to provide a client-centered practice (ARNNL, 2013), and honor a patient's gender preference for a nurse (CNA, 2010).

Resolution

BE IT RESOLVED, that CNSA liaise with the Canadian Association of Schools of Nursing to promote gender equalization in nursing programs, in an effort to promote a more gender-balanced student body.

BE IT FURTHER RESOLVED, that CNSA empower delegates of the chapter schools to inform their regions of this CNSA resolution in an effort to promote gender equalization in nursing programs.

Conclusion

Recruiting males into the nursing profession is difficult and we would like the CNSA to liaise with CASN and empower delegates to promote gender equalization in nursing programs in an effort to promote a more gender-balanced student body.

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Position Statements 2014

Creating an Empowering Environment for Nursing Students to Eliminate Bullying in the Nursing Profession

Submitted By:
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Background

Workplace bullying is defined as harassing, offending, socially excluding someone or negatively affecting someone's work (Lutgen-Sandvik, Tracy, & Alberts, 2007; Waschgler, Ruiz-Hernández, Llor-Esteban, & Jiménez-Barbero, 2013). This kind of bullying, when carried out in the healthcare sector by a colleague is known as lateral or horizontal workplace bullying/violence and when carried out by a superior is known as vertical workplace bullying/violence (Waschgler et al., 2013). Many other terms exist to describe this behaviour in literature, including "nurses eating their young", verbal abuse, disruptive behaviour, and incivility (Sauer, 2012).

Bullying can include overt behaviours such as physical aggression. Yet covert behaviours are more prevalent and appear in many forms including social isolation, being ignored or ostracized, undermining of professional status, tampering with tools or equipment people need to do their jobs, feeling intimidated, micromanagement of one's work duties, and personal attacks on credibility (Rayner & Keashly, 2005).

The participants in a study by Baker (2012) reported their first exposure to bullying occured while they were students in nursing school; that in turn had devastating effects on self-confidence and self-image (Baker, 2012). While bullying in the nursing profession was first defined in the mid 1960s, there is very little research about the efficiency of specific interventions to address the problem (Anno, Nuechterlein, Dyette, & Bonie, 2013). It seems odd that a profession based on the principles of providing care, compassion and empathy often turns a blind eye to nurse-on-nurse bullying and the victimization of its members (Baker, 2012).

Predominance of bullying

A study by Laschinger, Grau, Finegan, and Wilk (2010) which looked at the link between bullying and burnout among newly graduated nurses in Canada, found that one-third (33%) of the new graduates in their sample were bullied. Another study that looked at the rate of bullying experienced by undergraduate nursing students in Canada found that 88.7% of respondents had experienced bullying at least once in a clinical setting, with 77% of students reporting that they experienced bullying behaviours in their first year of study (Clarke, Kane, Rajacich, & Lafrenier, 2012, p. 273-274). The most frequently reported bullying behaviour experienced by students was feeling that their efforts were undervalued (60% of respondents), followed by being told negative remarks about becoming a nurse (45% of respondents) (Clark, et al., 2012, p. 273). Qualitative investigations of nursing students' perceptions of vertical violence have revealed that being ignored, being treated as incompetent, being blamed unfairly for mistakes, and being publicly humiliated are the most frequent occurrences (Thomas & Burk, 2009). The suppressed anger of bullied nursing students has also been shown to be a significant outcome of unresolved bullying incidents (Thomas & Burk, 2009). This last finding is concerning, because it can be argued that this is how the cycle of bullying is instilled and perpetuated, even before nursing students graduate and begin to practice.

Nursing students' perceptions of horizontal violence change over the period of their education (Curtis, Bowen & Reid, 2007). Second year students tend to be overwhelmed by bullying behaviour and are unable to understand why the situation is occurring or how to deal with it. By their third year, students accept their experiences with horizontal violence as being unavoidable and view them as situations to learn from by deciding to be different when they became RNs. However, research shows that some students take on the negative behaviours they experience or witness, and perpetuate the cycle of violence (Curtis et al., 2007). Other studies find that many student nurses accept horizontal violence as a "rite of passage," and repeat these behaviors in their future careers (Hinchberger, 2009).

It is important to stop the cycle of bullying. The journey of accomplishing this starts with nursing students and creating an empowering and supportive environment where their experiences can be addressed.

The Canadian Nursing Students' Association's (CNSA's) Position

As identified in the Canadian Nursing Students' Association (CNSA) Nursing Students' Bill of Rights and Responsibilities, "students have the right to supportive, educational and safe

teaching and learning environments" (2011). CNSA supports the development and implementation of policies within educational institutions and workplace organizations to ensure a transparent procedure exists for the reporting of bullying and the zero tolerance that should exist towards it. Students should be informed of these policies in order for a conversation to begin about this topic.

Canadian Stakeholder Involvement

A systematic review of successful policies addressing nurse-to-nurse bullying was conducted by Coursey, Rodriguez, Dieckmann, and Austin (2013), revealing a need for a multi-faceted approach that must support a change in the behaviour and culture of institutions in order to affect a sustainable decrease in the rate of lateral and horizontal violence. CNSA supports a nation-wide exploration of strategies involving provincial and territorial nursing bodies, to determine what strategies exist in Canada to address nurse to-nurse violence, and which among them are effective in curbing the incidence and prevalence of bullying in the nursing field. This is especially important in order to uphold the Workplace Violence and Workplace Harassment Acts that exist across provincial and territorial governments in Canada.

Nursing Curriculum

CNSA supports educational institutions in their development of an empowering environment where clinical instructors or supervisors advocate for their students, and include bullying as an open topic of discussion in clinical debrief sessions. It is also the responsibility of educational institutions to support students who are subjected to bullying behaviour (Clarke, et al., 2012). In addition, equipping clinical instructors with the tools to tackle reported and observed bullying incidents is essential (Clarke, et al., 2012). This can be accomplished, in part, through policy development and implementation on bullying reporting mechanisms.

The importance of reporting is predominant in studies, some of which show that while 66% of the student participants discussed their experience of being bullied with a peer or a significant other, 49% did not report these incidents to their clinical instructor or supervisor (Joy, 2007). This demonstrates the need for a discussion on nurse-on-nurse bullying between educational institutions and their students prior to the beginning of each clinical placement. In addition, implementation of undergraduate course material that brings awareness to nurse-on-nurse bullying and empowers students to develop their own strategies to deal with it effectively is another way to break the cycle of horizontal violence in nursing. This will allow students to "be able to appropriately label what is occurring as 'horizontal violence' and place it

in a broader context than what is happening to them personally" (Curtis, Bowen & Reid, 2007, p. 162). Nurse educators must teach student nurses and new graduates that if the behavior encountered is offensive and undermines them or their job in any way, it is bullying and it should be addressed (Hinchberger, 2009).

Conclusion

The actions mentioned above will not only make everyone aware that bullying is an unacceptable behaviour but it will also create an open atmosphere in which students are willing to share their stories and seek counsel when the need arises. This empowering environment will allow students to see the power that lies within themselves to break the cycle of bullying which is predominant in the nursing profession.

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Position Statements 2013

Incorporating LGBTTIQQ2SA Education into Nursing Curriculum in Canada

Approved: January 2013
Approved by: CNSA National Assembly
Submitted By: Nicholas Alves, Centennial College
Emilie Hay, McMaster University

Background

The LGBTTIQQ2SA (Lesbian, Gay, Bisexual, Transsexual, Transgender, Intersex, Queer, Questioning, 2-Spirited and Allies) consists of a wide range of genders, sexes, races, ethnic groups and individuals, however, for the purposes of this position statement they will be referred to as the LGBT population. There are specific vocabulary, terms, facts and training related to LGBT people that are not taught in the nursing curriculum and therefore make it difficult for nursing students to provide compassionate, holistic, patient-centered care to members of this population.

While the LGBT population has been identified as a vulnerable population, minimal measures are being taken to specifically address their vulnerability (Daley & MacDonnell, 2011). The stigmatization, oppression, and discrimination experienced by this population contribute to a higher rate of substance use and abuse and other health issues (McKay, 2011). LGBT people may seem to represent a relatively low percentage of the population (5-10%), however, in Ontario alone it is estimated that up to 1.25 million may anticipate or face barriers to access health services (Daley & MacDonnell, 2011). LGBT youth are four times more likely to attempt suicide, and three times more likely to have experienced dating violence and rape then their perspective heterosexual peers (Pies, 2011). It is estimated that approximately 57% of transgender people are rejected by their families, 41% have attempted suicide, and 19% reported experiencing homelessness due to their gender identity (Pies, 2011).

The Canadian Nursing Students' Association (CNSA)'s Position

As the Canadian Nursing Students' Association (CNSA) is the national voice of student nurses in Canada, and one of its underlying principles is to influence and advance innovation in the nursing curriculum, the CNSA believes it is vital for education pertaining to the LGBT

population be integrated into the curriculum across the nation. As nursing students are responsible for providing appropriate nursing care to all clients, it is imperative that the specific needs of this population be met (CNSA, 2005). As future professionals in the healthcare setting, advocating for the nursing profession and ensuring quality healthcare for all Canadians is a fundamental part of caring for different minority groups seen within this country.

Although there are currently low numbers of homophobia among nursing students, there are a larger number of students who show ambivalent and heterosexist attitudes towards LGBT people (Lim & Bernstein, 2012). By proper education and training specific to this population, nursing students can be better equipped to create an environment in which the client feels safe to release any personal information pertaining to their healthcare needs, without feel of judgment. Proper education and training will promote sexual orientation and gender identity awareness and allow nursing students to provide culturally competent care by showing openness, using inclusive language, and normalizing disclosure of sexual orientation and gender identity. The large number of nurses present in the health care system, and by virtue of their scope of practice, put them in a position to bridge gaps in health inequalities and provide culturally sensitive care specific to the LGBT community (McKay, 2011). Educating nursing students of inclusive language and knowledge of the unique issues experienced by the LGBT population, will help correct the insensitive and uniformed cared they are currently experiencing (Lim & Bernstein, 2012).

Canadian Stakeholder Involvement

The Canadian Nursing Students' Association (CNSA) believes in actively engaging stakeholders, including but not limited to nursing schools and nursing organizations, in developing new areas of nursing curriculum and practice opportunities to prepare nursing students to provide safe, competent, ethical care for the LGBT community.

Nursing Curriculum

As nursing students are required in learning and caring for minority groups, CNSA accept this as their formal position on incorporating LGBTTIQQ2SA Education into Nursing Curriculum throughout Canada. Regional Directors will support nursing students in promoting this change in their nursing curriculum, and/or program. CNSA will suggest and coordinate educational activities to help promote awareness and bridge this gap in healthcare inequality.

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Changes to the Canadian Entry to Practice Examination

Approved: January 2013
Approved by: CNSA National Assembly
Submitted by: Ad Hoc Advocacy Committee of the CNSA Board of Directors 2012-13

Whereas the Canadian Registered Nurses Examination (CRNE) has been the standard examination to test entry to practice competencies in Canada for over forty years (CNA, 2012);

Whereas the CRNE has always been uniquely Canadian-developed, involving Registered Nurses, nursing leaders, employers, and other relevant Canadian stakeholders in all aspects of the design and development (CNA, 2012);

Whereas ten Canadian provincial regulatory bodies have formulated a contract with the National Council of State Boards of Nursing (NCSBN), the current administrator of the American NCLEX-RN Examination, to develop a North American Entry to Practice Exam;

The Position of the Canadian Nursing Students' Association (CNSA)

As the national voice of Nursing Students in Canada, the Canadian Nursing Students' Association (CNSA) is concerned for the best interests of all current and future Canadian nursing students. CNSA is committed to ensuring that the needs of nursing students are met, and that their best interests are at the forefront of future developments. As consumers of Entry to Practice (ETP) Examinations, nursing students must be considered a primary stakeholder in decisions related to ETP exam development. As the decision to forge a partnership with NCSBN to administer the NCLEX-RN examination as the licensing exam in Canada has been finalized, a major change will be occurring in Canadian nursing education and licensure over the coming years. CNSA believes that it is vital that the best interests of nursing students are considered with priority, and that CNSA, as the official representative of Canadian nursing students, is recognized as an active stakeholder in the development process of the revised NCLEX-RN examination.

CNSA believes that in order to meet the unique needs of Canadian nursing students, and ensure that this population is not disadvantaged in terms of obtaining licensure to become a Registered Nurse in Canada, the following priorities must be met.

Canadian Involvement

As the current exam is entirely developed by Canadian nurses and Canadian exam developers, CNSA supports the equal inclusion and active participation of Canadian Registered Nurses in all aspects of future exam planning, development, design, and evaluation.

Canadian Values

The Canadian health care system and practice environment is significantly different than it is in the United States. Areas such as the unique bilingual nature of the exam, the Canadian focus on Community and Primary Health Care, and the focus on preventative as opposed to reactive health care must be reflected within this examination. Most importantly, CNSA supports an exam that reflects the Canadian values of a publically funded and delivered healthcare system that allows for equal access for all Canadians.

Canadian Stakeholder Involvement

As nursing students are the primary consumers of ETP exams, CNSA must be seen as a key stakeholder. A vital aspect of exam development will be the engagement and consultation with stakeholders, including but not limited to, Canadian students, educators, and RNs

Canadian Resource Development and the Commitment to Success

As our current curriculums, examinations, and course work are presently designed to ensure success on the CRNE, students recognize the potential for decreased success due to incongruences between curriculums, resources, and the future ETP exam. CNSA believes that a key aspect of this change will include changes to curricula, available resources, and preparation for the ETP exam to ensure that future students are granted an equal opportunity to excel.

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Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites

Approved: January 2013
Approved by: CNSA National Assembly
Submitted by: Jodi Meacher

BE IT RESOLVED that the CNSA accepts this position statement promoting harm reduction and primary health care access through supervised injection sites.

BE IT RESOLVED that the CNSA, as the voice of the new generation of nurses, adopt this position statement and promote it within their chapter schools. Through education focused on the socioeconomic benefits of harm reduction and supervised injection sites, community organizations can be supported to make the changes necessary to implement more supervised injection sites in areas of need across Canada. Support must be garnered from professors, nurses, schools and students in order to prioritize this public health measure.

Background

Many individuals have difficulty accessing primary health care due to their use of intravenous drugs. Structural supports grounded in best evidence and a harm reduction philosophy, including needle exchange programs, supervised injection facilities, low barrier HIV and HCV testing, nurse-delivered safer injection education, street outreach, peer-led outreach,

and methadone maintenance therapy should be established by healthcare institutions to promote the health of those who use drugs (Fast et al., 2008).

Unsafe injection of illegal substances such as heroin and crack cocaine is associated with blood-borne pathogens such as HIV and hepatitis C (HCV), injection-related infections, endocarditis and death due to overdose. Those addicted to such drugs are vulnerable to poor health and will benefit from the health and social support that nurses provide. According to Small, D. (2012), it is not the controlled substances injected into the bloodstream that cause Hepatitis C or HIV/AIDS. Rather, the use of unsanitary equipment, techniques and procedures for injection permits the transmission of those infections, illnesses or diseases from one individual to another. This is the foundation of supervised injection as an intervention. The point of intervention focuses on reducing the harms associated with drug use without forcing abstinence as a precondition for receiving healthcare (Small, 2012).

Evidence

According to Lightfoot, B et al. (2009), Insite, a supervised injection facility in Vancouver, British Columbia, is an evidence-based response to the ongoing health and social crisis in the city's Downtown Eastside. It has been shown that Insite's services increase treatment referrals, mitigate the spread and impact of blood-borne diseases and prevent overdose deaths (Lightfoot, B et al., 2009). Insite offers a space for nurses to interact with intravenous drug users (IDUs) and establish therapeutic relationships with them while offering education around safer injection techniques and other health promotion topics. Insite has been studied since 2003 and the evidence is overwhelmingly positive.

According to Pauly (2008), the primary focus of Insite is to build trusting relationships with people who have experienced severe trauma and abuse and who are struggling to survive in horrendous living conditions. Nurses offer education around safer injection practices, provide wound care, administer STI testing and develop caring relationships with participants. Nurses provide a non-judgmental focus while treating participants with respect and understanding working towards assisting them with anything they may need. Attached to Insite, is Onsite, which offers a convenient location to detox, which is also an important part of the project as participants can start to take steps towards possible recovery or just respite from their lifestyle.

The Downtown Eastside had an epidemic of HIV and there are other areas across

Canada that are also beginning to see such epidemics. For example, the Public Health Agency of Canada (2009), found that Saskatchewan has experienced a substantial increase in new HIV diagnoses in the IDU category. Insite has been studied for ten years and all studies support supervised injection sites as best evidence of care not only for the participants using the site, but also as a public health measure. Nursing students must support the development of supervised injection sites across Canada particularly in areas that are experiencing a higher rate of IDU HIV rates.

Nursing students already support harm reduction efforts and therefore we must work to promote strong public health interventions to reduce harm in our communities. Supervised injection sites fit this mandate by strengthening the health of those most disadvantaged. They aim to meet participants where they are at and offer them choices in their own health care.

The Canadian Nurses Association (2008), states, "nurses do not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social or marital status, gender, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability or socio-economic status or any other attribute." It is our duty to provide accessible care to everyone in our society no matter what type of lifestyle they are living.

The Position of the Canadian Nursing Students' Association (CNSA)

The Canadian Nursing Students' Association strongly supports the need for more supervised injection sites across Canada as a public health measure and will promote this intervention in nursing venues across the country.

The Canadian Nursing Students' Association commits to supporting community groups who are working towards opening supervised injection sites.

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Changes to Health Care Coverage for Refugees

Approved: January 2013
Approved by: CNSA National Assembly
Submitted by: Barbara Harvey

Position Statement of the Canadian Nursing Students' Association

The Canadian Nursing Students' Association (CNSA) is united in stating its firm opposition to the recent federal cuts to the Interim Federal Health Program (IFHP). As current and future health professionals, we are deeply concerned that the cuts will adversely affect the health of some of the most vulnerable members of our society. By denying certain refugees access to medications and primary health care, the cuts will worsen already troubling health inequities, undermine public health objectives, and lead to increased public expenditures and unnecessary suffering as a result of untreated conditions. Together with members of the broader health care community, the CNSA calls on the federal government to immediately rescind the cuts and to restore equitable and humane health coverage for all those seeking refuge in our country.

Rationale

On April 25, 2012, federal Citizenship, Immigration and Multiculturalism Minister, Jason Kenney, announced sweeping cuts to the Interim Federal Health Program (IFHP). Since 1957, the IFHP has provided temporary health care coverage to refugees in Canada who do not qualify for territorial or provincial health care plans. Prior to the cuts, it offered basic coverage that was similar to what is available to Canadians under provincial and territorial plans. It also provided limited supplemental benefits such as vision care, dental care and prescription drugs, which the majority of Canadians have access to under either public or private insurance plans. Effective June 30, 2012, this coverage was drastically cut.

What has been cut?

Under the new IFHP regime, coverage eligibility and scope now depends on the status of an individual's refugee claim and country of origin. Some refugee claimants will be eligible for only "urgent" and "essential" care, and medications only if needed to treat a condition that threatens public health or safety. An individual in this category, for example, could be treated for an acute heart condition but be unable to obtain the necessary prescriptions for that condition upon leaving hospital. Other refugees will only be eligible for even more restrictive coverage, limited to only care and medications needed to care for conditions that threaten public health or safety. Those individuals who fall into this category of coverage will receive no care for matters such as chronic diseases, pregnancies, and even heart attacks. Physicians across the country have already documented numerous cases of patients negatively impacted by the cuts, including a man experiencing chest pain and displaying potential signs of tuberculosis who was not eligible to receive a diagnostic chest x-ray; young children with multiple prior hospitalizations for asthma who were denied access to their inhalers; a man diagnosed with cancer who was denied chemotherapy; and a woman in her third trimester of pregnancy who developed potentially lethal pre-eclampsia but had no coverage for her condition. An overall theme of the changes is a strong shift away from primary preventive care, which experts warn will lead to worsening health outcomes for an already vulnerable group of refugees and refugee claimants, as well as potential risks to public health as dangerous conditions go undiagnosed.

Are the cuts necessary?

Minister Kenney has suggested that the cuts are necessary to ensure that refugees do not receive "gold-plated health care benefits that are better than those Canadian taxpayers receive", to deter "bogus asylum seekers" from coming to Canada in order to abuse our health care system, and to reduce public expenditures. These suggestions are inaccurate, unfair, and only serve to perpetuate negative public perceptions of refugee claimants. First, as detailed above, the IFHP provided basic coverage prior to the cuts that was equivalent to what most Canadians have access to. Second, refugees escape to Canada to flee war, persecution, starvation, rape, and other atrocities, not to "abuse" health care. If anything, the challenge for health professionals has been to ensure that refugee and refugee claimant patients have access to health care services. Past experiences of trauma and violence, stigma, cultural and language barriers, and gaps in information can all act as obstacles to this access, and can prevent refugees and refugee claimants from obtaining the care that they may need. In fact, according to the Minister's own data, the health costs of a refugee claimant currently amount to only 10% of the average per capita cost for Canadians. And third and finally, public health experts have warned that the IFHP cuts will lead to an increase, not decrease, in costs as expensive complications and

hospitalizations result from an absence of primary care. As Dr. Mark Tyndall, head of infectious diseases at Ottawa Hospital, put it: "There is not a health economist in the world who would tell you that restricting primary and preventive care is a cost-saver."

How are health care professionals responding?

Given all of the foregoing, it is not surprising that health professionals across the country have been quick to voice their opposition to the IFHP cuts. Marches and demonstrations have been organized, government ministers have been questioned at press conferences and public events, petitions and newspaper articles have been written, and creative public information campaigns have been initiated. Numerous professional bodies have formally called on the federal government to reverse or rescind the cuts, including the Canadian Nurses Association, the Canadian Federation of Nurses Union, the Registered Nurses Association of Ontario, Doctors for Refugee Health Care, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the
Canadian Association of Optometrists, the Canadian Association of Social Workers, the Canadian Dental Association, the Canadian Medical Association, the Canadian Pharmacists Association, the Canadian Association of Community Health Centres, Canadian Doctors for Medicare, the Canadian Association of Midwives, the Canadian Psychiatric Association, the Canadian Paediatric Society, the Association of Medical Microbiology and Infectious Diseases Canada, Médecins du Monde, Public Physicians of Canada, Ontario's Medical Council of Medical Officers of Health, the Canadian Association of Occupational Therapists, the Canadian Association of Emergency Physicians, and others.

Relevance to the Canadian Nursing Students' Association

As current and future health care professionals, we as members of the Canadian Nursing Students' Association have an obligation to advocate for fair, equitable and just public health policies that best serve the public interest and to work to ensure that all members of our communities – particularly those who are the most vulnerable – have access to quality health care. An expression of firm opposition by the Canadian Nursing Students' Association to the IFHP cuts is an important step towards achieving both of these objectives.

About the Canadian Nursing Students' Association

The Canadian Nursing Students' Association (CNSA) is the national voice of Canadian nursing students. For over 40 years, it has represented the interests of nursing students to federal, provincial, and international governments and to other nursing and health care

organizations. The CNSA is dedicated to acting in the public interest for Canadian nursing students, nurses, and nursing. For further information, see http://www.cnsa.ca/english.

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Resolution Statements 2013

Peer Mentoring Support Programs for Nursing Students

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That CNSA encourage all official delegates and associate delegates to advocate for peer mentoring support programs in nursing education.

BE IT FURTHER RESOLVED That the CNSA advocate for their delegates and members to work with the student representatives of their school's decision making committees (e.g. Undergraduate Studies Committees) to advocate for peer mentoring support programs in all nursing programs across Canada.

Submitted by:
Olivia Brown
Elbonita Kozhani
Chantal Hurley

The Standardized, Transparent and Objective Evaluation of Psychomotor Skills

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That CNSA liaise with CASN to explore the use of objective structured clinical examinations as the standardized testing approach for teaching nursing psychomotor skills across Canada;

BE IT FURTHER RESOLVED That CNSA discuss this issue with delegates to explore the current state of psychomotor skill evaluation in nursing education programs across Canada.

Submitted by:
Deanne Drover

Kathryn Guy
Minji Kim
Stephanie Marshall
Donald Shepherd
Courtney Sparkes

Creating Student Awareness of the NCLEX-RN® Examination

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That the CNSA should be an informational resource for all official and associate delegates regarding the NCLEX-RN® exam so that delegates may in turn become resources for their respective student bodies;

BE IT FURTHER RESOLVED That the CNSA members create awareness among nursing students regarding conferences and educational sessions being held by external associations, such as the CCRNR and National Council of State Boards of Nursing, regarding the NCLEX-RN® exam;

BE IT FURTHER RESOLVED That the CNSA advocate for the presence of its delegates at external talks being held in relation to the adoption and implementation of the NCLEX-RN® exam with CASN, CNA, and CCRNR;

BE IT FURTHER RESOLVED That during the next national CNSA conference, an education session be held for the purpose of educating delegates about the NCLEX-RN® exam.

Submitted by:
Victoria Eveleigh
Sarah Marsden
Rebecca Puddester

A Resolution to Support Jordan's Principle

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That it is the concern of the Canadian Nursing Students' Association that all levels of government meet the health care and service needs of Canada's children equally.

BE IT FURTHER RESOLVED That the Canadian Nursing Students' Association sign on to support the federal, provincial and territorial adoption and implementation of Jordan's Principle.

Submitted by:
Lauren Guthro, CNSA Diversity Officer 2012-13

Political Activism Competency in Nursing Education

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That the CNSA National Assembly support this position statement on political activism competencies in nursing curriculum;

BE IT FURTHER RESOLVED That the CNSA advocate to nursing schools and other nursing education stakeholders regarding the importance of including political education in their curricula;

BE IT FURTHER RESOLVED that the CNSA support workshops that enhance political activism competencies amongst nursing students;

BE IT FURTHER RESOLVED that the CNSA promote opportunities for nursing students to increase their involvement in political action and policy development;

BE IT FURTHER RESOLVED that the CNSA support and encourage nursing students to adopt leadership roles as political and policy advocates in their local, regional, and national communities, and within their communities of practice.

Submitted by:
Karolina Gielarowiec BSc, Nursing Student
Robyn Micaela Hardy-Moffat BFA, Nursing Student
Erin Telegdi Hon.BA, Nursing Student

Lawrence S. Bloomberg Faculty of Nursing

Rise Up and Eliminate Barriers: Striving to Enhance Cultural Competence in Caring for the LGBTTIQQ2SA Community

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That the CNSA asserts the consistent use of gender-neutral language by nursing students in their health assessments and all other relevant communications with all clients and members of the health care team so as to be inclusive;

BE IT FURTHER RESOLVED That the CNSA encourage nursing students to reflect upon their own beliefs and attitudes towards the LGBTTIQQ2SA populations to ensure they are able to provide safe and culturally competent care;

BE IT FURTHER RESOLVED the CNSA upholds that nursing students strive to practice culturally competent care for the LGBTTIQQ2SA community through the active engagement of relevant activities such as taking initiative in seeking positive space training, identifying self as an ally, and participating in nursing interest groups.

Submitted by:
Vikky Leung, BSc University of Toronto, BScN (student) Ryerson University
Rebecca Sharmila Willis, BScN (student) York University

Mandatory End of Life Education for Nursing Students

Approved: January 2013
Approved by: CNSA National Assembly

BE IT RESOLVED That the Canadian Nursing Students' Association, through their involvement in curriculum decisions, planning and review, advocate for yearly education and training of end of life care, palliative care principles, and signs of active dying for nursing students across Canada.

Submitted by:
Benjamin Soer, Nursing Student
Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Resolution Statements 2011

Complementary Therapy

Approved: January, 2011
Approved by: National Assembly
Submitted by: Rod Simmons
Neeta Uppal
Mario Cotic
Leslie Hynes

Background

Complementary therapies (CT) can be defined as those therapies used in addition to conventional treatment, including deep breathing exercises, relaxation training, massage therapy, reflexology, biofeedback, and creative therapies, including art, music, or dance therapy (Fontaine, 2000; Pelletier, 2000).

WHEREAS researchers have clearly demonstrated that CT are an effective and cost efficient approach to nursing care for example, breathing relaxation exercises can reduce the need for opioids for pain management during chest tube removal (Friesner, Curry, and Modderman, 2006), massage therapy can reduce the use of analgesics and the need for antidepressant medicines (Leonie, 2005), relaxation training can significantly reduce blood pressure (Yung, French, and Leung, 2001) and CT nursing interventions are inexpensive, non-invasive, self-administered, and elicit little to no side effects, (Lai and Hsieh, 2003),

WHEREAS public interest in and use of CT has increased significantly in the past decade, and nursing is in a strategic position to be a leader in integrating these therapies into the Western biomedical health model and in conducting research on the use of CT (Snyder and Lindquist, 2001),

WHEREAS CT are already used in several Canadian acute care centers such as the Toronto East

General Hospital, the Hamilton Civic Hospital, the St. Joseph's Health Center, and the Tzu Chi Institute in Vancouver,

WHEREAS many CT are within the scope of nursing practice as defined by Canadian nursing practice legislation, e.g. therapeutic touch, and massage therapy,

WHEREAS researchers have suggested that nurses are underutilizing CT including music therapy, biofeedback, therapeutic touch, and counseling (Tracy et al, 2005),

WHEREAS the CNSA as a member of the Canadian Nurses Association (CNA), expects nurses to facilitate and respect the client's right to informed choice for treatment, and to incorporate the client's personal strengths and resources in meeting self-care needs,

WHEREAS research supports incorporating education regarding CT into nursing education programs to prepare nursing students for professional practice (Groft and Kolischuck, 2005)

BE IT RESOLVED that CNSA recognize that CT are effective and cost efficient approaches to nursing care across the life span, and

BE IT FURTHER RESOLVED that the CNSA advocates for nursing education programs that prepare nursing students to implement CT, advocate for CT in practice, and enable nursing students to educate their clients about complementary therapy options.

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Interprofessional Nursing Education

Approved: January, 2011
Approved by: National Assembly
Submitted by: Catherine Burt
Megan Fagner
Ashley Goobie
Rebekah King
Traci Trimm
Robyn Wrice

WHEREAS The CNSA is the official "voice" for nursing students in Canada and are actively dedicated to increasing the professional and educational aspects of the nursing profession,

WHEREAS The CNSA's Strategic Plan (2006-2010) identifies the need to take a leadership role in the promotion and development of Interprofessional Education (IPE) with an identified outcome of advocating for nursing students to become involved in promoting and incorporating nursing into inter-professional education,

WHEREAS The accrediting body for nursing education, the Canadian Association of Schools of Nursing (CASN) has recently formed an IPE task force with the mandate of providing advice and recommendations on how CASN can create a role for nursing education within the context of IPE,

WHEREAS IPE is supported by the World Health Organization (WHO) who believes interprofessional education is an essential step in developing a collaborative practice-ready health workforce that is better qualified to respond to the needs of the public, the Canadian Nurses Association (CNA) partners with nurses, other health care providers, health system stakeholders and the public to acquire and sustain optimal practice environments and enhance client outcomes, and the National Health Science Students Association (NaHSSA) Advocacy Task Force whose objective is to focus on advocating for interprofessional education in current curriculum and practice settings,

WHEREAS Participation in IPE can enhance awareness of professional roles and develop mutual role respect, (Derbyshire & Machin, 2010), decrease anxiety during interprofessional rounds, and improve participation in care planning and interprofessional collaboration (Miller et al, 2008),

BE IT RESOLVED that the CNSA recognize and emphasize the importance of IPE within nursing education programs.

BE IT FURTHER RESOLVED that CNSA will advocate for nursing schools across Canada to

include IPE in nursing education programs.

BE IT FURTHER RESOLVED that the CNSA will work collaboratively with CASN to develop standards and policies to implement IPE as mandatory accreditation criteria.

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Promoting Health Through Harm Reduction Strategies

Approved: January, 2011

Approved by: National Assembly
Submitted by: Meghan Cleary
Danielle Drummond
Kimberly Goodyear
Katrina MacFarlane
Jillian Strickland

Background

Harm reduction is a non-judgmental, non-confrontational approach to health care. It encourages a healthier life and reduces the consequences of negative behaviours by promoting strategies that lead to achievable goals. This philosophy recognizes that some people will engage in higher risk behaviours and focuses on reducing the harm associated with those behaviours. The harm reduction philosophy includes strategies that are used to decrease the risks associated with behaviours such as drug use, smoking, driving, and sexual activity. Harm reduction is a philosophy that incorporates the principles of social justice and equal access to health care.

WHEREAS the CNSA (Canadian Nursing Students' Association) as the official voice of nursing students, provides a medium through which members can express their opinion, encourages participation in professional and liberal education, and has the responsibility to educate and inform government, health care professionals, and the public,

WHEREAS harm reduction strategies in nursing practice have been shown to be effective in reducing health, social, and economic consequences in individuals who engage in high risk behavior,

WHEREAS CNSA as a member of the International Council of Nurses (ICN), supports equal access to health care as evident in their theme for the 2011 International Nurses Day 'Closing the Gap: Increasing Access and Equity',

WHEREAS the Canadian Nurses Association (CNA) as a member of ICN, believes that everyone has a right to make informed decisions and choices about how to manage their own health,

WHEREAS CNSA as a member of CNA values promoting and respecting informed decision making where nurses provide patients with the information they need to make informed decisions related to their health and well-being,

WHEREAS CNSA as a member of CNA values promoting health and well-being where nurses enable patients to attain their optimum level of health,

WHEREAS the World Health Organization (WHO) recognizes the benefits of implementing harm reduction strategies and found no convincing evidence of any negative consequences,

WHEREAS provincial organizations across Canada have developed policies on the value of harm reduction strategies,

WHEREAS CNSA as a member of CNA pursues social justice as a goal in its policy-making process and supports equal access to health care and health resources,

BE IT RESOLVED that CNSA supports and become involved in promoting health through harm reduction strategies in nursing practice and education.

BE IT FURTHER RESOLVED that CNSA actively advocate for the Canadian Association Schools of Nursing and nursing schools and education organizations to promote health equity through education on harm reduction strategies in nursing education programs.

BE IT FURTHER RESOLVED that CNSA encourage official delegates and associate delegates to inform their regions of this CNSA resolution on promoting harm reduction strategies in nursing practice.

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Resolution Statements 2010

Facilitating New Graduate Transition

Approved: January 2010
Approved by: National Assembly
Submitted by: Erin Lindsay Croal (McMaster University - Conestoga College Campus)

WHEREAS, the first 3-4 months of professional nursing practice is a critical transition period.

WHEREAS, new nurses require support in order to effectively and safely navigate through this transition period.

BE IT RESOLVED that the Canadian Nursing Students' Association raise awareness among its members surrounding the transition experience and disseminate tools and resources aimed at aiding students in preparing for and navigating through this transition.

BE IT FURTHER RESOLVED that the Canadian Nursing Students' Association lobby for mentored, supernumerary, and full-time employment following Graduation.

BE IT FURTHER RESOLVED that the Canadian Nursing Students' Association promote healthy workplace environments conducive to recruitment and retention of all nurses, and above all, patient safety.

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Global Relief Efforts in Natural Disasters

Approved: January, 2010
Approved by: National Assembly
Submitted by: Jessica Drover
Krista Howell
Megan Hudson
Jessica Hunt
Katelyn Hynes

Whereas CNSA believes in fostering the growth of competent and concerned nurses and in doing so, encourages learning opportunities that allow students to develop values such as advocacy, empathy, leadership skills, and active participation which are fundamental characteristics for the nursing profession and these values reflect and support the nursing profession's commitment to global relief efforts

Whereas CNSA advocates for nursing student leadership development and encourages nurses and nursing students to develop leadership skills and promote leaders in nursing,

Whereas CNSA, as a member of CNA, values interprofessional collaboration to facilitate the development and maintenance of relationships among professionals and believes that professional relationships that support emergency response must be developed and nurtured before emergencies occur,

Whereas CNSA as a member of ICN, recognizes the importance of government and relief organizations in establishing support for relief workers and direct disaster victims,

Whereas the principles of social justice and equal availability of essential health and social services guides CNSA activities, therefore by supporting nurses and nursing student being involved in supporting global relief efforts,

Whereas CNSA is the official voice for nursing students, provides a medium through which members can express opinions on nursing issues, and has the responsibility to educate and advocate all levels of government, health care professionals and the public about issues relevant to the nursing profession,

Be it resolved that CNSA endorse, support and become involved in global relief efforts and acknowledge the impact of natural disasters on both national and international levels.

Be it further resolved that CNSA promote and support strategies that prevent the spread of disease through education about diseases and social behaviours associated with disasters that may be exacerbated by deteriorated living conditions.

Be it further resolved that CNSA advocates for global equality and availability of essential resources such clean and safe water to all people by developing global partnerships to gain insight and knowledge, as well as aid in relief efforts. These partnerships should include networks with other nursing student associations, professional disciplines, governmental and nongovernmental agencies at local, regional, national, and international levels.

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Position Statements 2009

Self-Care Practices Among Nursing Students

Approved: January, 2009
Approved by: CNSA
Submitted by: Jennifer Jackson, St. Francis Xavier
Sarah Gaudet, ARD, St.

Nursing students have a responsibility to protect their own health, as well as the health of others. However, nursing students often put self-care in last place of their other responsibilities. Self-care practices are the activities that maturing and mature persons initiate and perform, within time frames, on their own behalf in the interests of maintaining life, healthful functioning, continuing personal development and well-being, through meeting known requisites for functional and developmental regulations (Orem, 2001). Simply put, self-care practices can be used to maintain and promote one's own health.

Students traditionally have low levels of self-care, which is evident in many specific dimensions. Self-care can be effectively assessed using Orem's Universal Self-Care Requisites (a full description of which is beyond the scope of this work) (2001). Areas included in this framework include: air, food, fluid, elimination, activity and rest, social interaction, normalcy, and prevention of hazards. All of these areas contribute to a holistic health portrait of the individual.

Research into university student health paints a bleak picture. Riordan and Washburn (1997) assessed health behaviour in nursing students (N=82). Rates of physical activity dropped significantly between first year students to fourth year students. They also found no difference in new nursing students' and graduates' abilities to cope with stress. Chow and Kalischuk (2008) sampled nursing students to assess their nutritional practices. They found that 23% reported that they rarely ate well. Nursing students also indicated that on non-clinical practice days they consumed an average of six glasses of juice and water. However, on clinical days, 69% of students indicated that they drink two glasses of water. Vaez et al. (2006) established that university students drink more alcohol than their working peers and more often. Shriver and Scott-Stiles (2000) examined safe sex practices among Nursing and English students. Nursing students' rates of condom use decreased during their time at university. Hours of sleep each night for nursing students was also found to be significantly lower than the general population

(Clement, 2002).

When all of these factors are considered, the state of nursing student health is nothing short of alarming. As future health care professionals, it is important that nursing students look after their own health, role model healthy behaviour, advocate for health promotion, and effectively protect personal wellbeing. As a self-regulating profession, it is essential that nurses look after themselves as well as their clients.

CNSA believes that nursing students should be supported in looking after their own health. Nursing practice is optimized when nurses can care for others at their full capacity. CNSA has the responsibility to raise awareness about student health to key stakeholders, promote educational conditions that support student health, and empower nursing students to achieve their full health potential.

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Resolution Statements 2009

Patient Safety

Approved: January, 2009
Approved by: CNSA
Submitted by: Angela Espejo and Harmeet Minhas, University of Alberta

WHEREAS the CNSA acts as the official voice of nursing students and encourages participation in professional and liberal education. The CNSA's vision embraces the goals of professionalism, leadership, visibility, education and advocacy.

WHEREAS poorly managed health care that results in negative health consequences for patients continues to capture the interest of the public, the media, and individuals and groups that provide health care (Wong & Beglaryan, 2004). With the current staff shortages and the increasing strain on RNs there has been a significant rise in medical errors (Canadian Nurses Association, 2005). An estimated 5,000-10,000 lives are claimed in Canada each year due to adverse events (Wong & Beglaryan, 2004).

WHEREAS studies suggest that actions taken toward patient safety must be initiated by learning organizations in order to prepare undergraduates with an education grounded in a culture of safety (Callahan & Ruchlin, 2003; Gregory, Guse, Dick, & Russell, 2007). Evaluation of nursing students' errors is primarily perceived as the individual student's responsibility rather than considering the systematic factors that contribute to adverse events (Gregory, Guse, Dick, & Russell, 2007). Errors are contributed to by flaws in equipment, miscommunication, short-staffed units and nursing burn-out, the complexity of health systems, and disciplinary culture that deters the reporting of adverse events and learning (Wong & Beglaryan, 2004; CNA, 2005). A multi-faceted approach to address patient safety requires participation from different stakeholders: policy makers, educators, governments, professional associations and the public (Wong & Beglaryan, 2004).

WHEREAS "preventing individual and system errors and enhancing patient safety are shared responsibilities among schools of nursing, students, and clinical units." (Gregory, Guse, Dick, & Russell, 2007, p. 81) The importance of educating new nurses and students on patient safety is paramount to ensuring that clients receive quality care. Patient safety initiatives may include:

- Encouraging schools to include safety in evaluation of student nursing practice
- Faculty Administration and clinical instructors adopting the perspective that mistakes are an opportunity to learn and improve rather than a "culture of blame"
- Universities including the prevention of adverse events in curricula, developing policy on disclosure and benchmarks, and facilitating discussion of patient safety in clinical courses
- Universities maintaining records and creating statistics on student errors so as to provide educational interventions in collaboration with clinical units
- Supplementing clinical experiences with the replication of real-life crises using simulation technology to educate students on patient safety
- Clinical placement settings clearly communicating patient-safety standards and enforcing those requirements
- Professional associations disseminating knowledge on best practice

THEREFORE, BE IT RESOLVED that the Canadian Nursing Students' Association endorses the Safety Competencies of the Canadian Patient Safety Institute (2008) that are integrated into daily health care practice and contribute to the provision of safe care.

BE IT FURTHER RESOLVED that the CNSA actively engage stakeholders, including but not limited to nursing schools and nursing organizations, in developing curricula and practice opportunities to prepare nursing students to provide safe, competent, ethical care.

BE IT FURTHER RESOLVED that the Vice-President/ Director of Inter/Intra-professional Education & Research, in conjunction with the Regional Directors, shall suggest and coordinate educational activities related to the promotion of patient safety initiatives in undergraduate education.

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Mental Health Education

Approved: January, 2009
Approved by: National Assembly
Submitted by: Colleen Wright-Loree, Bachelor of Science in Nursing, 2009 McMaster University - Conestoga College Campus. Director of Communications 2009-2010, Canadian Nursing Students' Association

Meghan Kresky, Bachelor of Science in Nursing, 2010. McMaster University Conestoga College Campus

WHEREAS a dose-dependent association between cannabis use and risk of developing psychotic symptoms has been confirmed (Stefanis et al., 2004; van Os et al., 2002; Zammit et al., 2002)

WHEREAS cannabis use may precipitate psychosis in vulnerable persons and may worsen symptoms among those who already have a psychotic disorder (Degenhardt et al., 2003)

WHEREAS psychosis-free adolescents who begin cannabis use comprise a vulnerable group and exposure to cannabis early in adolescence (i.e. before 16 years of age) increases the risk for developing subclinical psychotic symptoms (Ferdinand et al., 2005; Ferguson et al., 2003; Henquet et al., 2004)

BE IT RESOLVED that the Canadian Nursing Students' Association promote national efforts to raise awareness regarding the potential effects of cannabis use and promotion of overall mental health, among youth.

BE IT FURTHER RESOLVED that the Canadian Nursing Students' Association supports ongoing research to further elucidate the causes of and treatments for psychosis.

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Leadership Development

Approved: January, 2009
Approved by: CNSA
Submitted by: Danielle Radchenko GN, BScN
Gail Denschuk, RN, BScN
Alanna Carty, SN

BE IT RESOLVED that CNSA accepts this position statement on Leadership Development.

BE IT RESOLVED that the CNSA BODs and CNSA chapters endorse this position statement by lobbying key stakeholders and their individual schools to: a) recognize CNSA leadership activities within the undergraduate curriculum and b) encourage students to become involved in nursing leadership at the local, provincial, national and international level whether through CNSA or another nursing organization.

Introduction

The Canadian Nursing Students Association (CNSA) is the national voice for Nursing students. One major goal of the Association is to create opportunities for students to develop their leadership skills within the nursing profession. It is well known and documented that there is a nursing shortage not only in Canada but also at an International level. Initiatives and plans have been developed to educate, recruit and retain front-line nurses across Canada, however the fostering of future nurse leaders at the undergraduate level is often overlooked. In the past succession planning in regards to the development of future nursing leaders was neglected as nurses faced budget cuts, layoffs and downsizing. Gregory (2003) affirms, "As is the case with practice, administration and research, nursing education is experiencing a 'leadership crisis within' whereby our most seasoned colleagues are retiring in greater numbers." (p. 40). This has resulted in an increased need for upcoming nursing students to be both educated and supported in the area of leadership and career development as their predecessors look to pass the leadership torch on to new hands.

Because CNSA is privy to attend meetings with key stakeholders such as CASN, CNA, ACEN, CFNU etc and in a position to speak on behalf of all Canadian Nursing Students, it is imperative that we vocalize the need for formalized recognition and encouragement of student nurse leaders as well as the development of course credit for this work within the students'

education.

The development of Canada's future nurse leaders should not be left to chance. It is imperative that key stakeholders and students' themselves advocate for leadership opportunities and skill development to become a recognized part of nursing school curriculum (French, 2004). The majority of nursing schools identify leadership development as one of their overall objectives but lack the ability to look beyond the clinical and classroom schoolwork necessities. Nursing educators need to become more aware of the opportunities their students are taking and may be involved in as a method to enhance their educational experience.

The Canadian Nurses Association's code of ethics also calls upon nurse educators and leaders to advocate for nursing schools that recognize and support professional development at a student nurse level (2008). Ethically, nursing educators need to play a key role in encouraging student leadership as well as working towards incorporating leadership volunteer work into curriculum as well as making leadership development a priority in the curriculum.

Nursing students across Canada dedicate many hours as local, regional, national and international leaders. When nursing students are asked if their leadership development needs are met the majority answer "no" (CNSA leadership survey, 2008) CNSA is committed to support these students by speaking on their behalf to both improve the leadership development and mentoring provided by CNSA and nursing schools and to advocate for students to receive recognition in the form of class credits as already done in other countries such as in the United States for work with the NSNA (Leadership U website, 2004).

We know that nursing leadership is needed more now than ever as health care continues to evolve, patient acuity continues to rise and workplace issues steadily become more demanding. Nursing schools, organizations and leaders need to recognize the opportunity of leadership development at the undergraduate level by recognizing student leadership activities as course credit, introducing formalized methods of integrating students into student leadership, becoming a CNSA chapter and supporting versus discouraging their students involvement in nursing leadership activities.

Position Statement

The Canadian Nursing Students Association strongly support the need for both formalized curriculum credit and support by educators that recognizes the nursing leadership initiatives taken on by their students within the Canadian Nursing Students' Association.
The Canadian Nursing Students Association commits to supporting and providing leadership

development opportunities to its members.

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Primary Health Care Nurse Practitioner

Approved: January, 2009
Approved by: CNSA
Submitted by: Kayla Drouillard, OD, University of Windsor
Mathew Wilson, AD, SaultCollege
Tyler Kuhk, ORD, Lakehead University/Confederation College

WHEREAS we the student nurses of the CNSA Ontario Regional Executive feel that is of utmost importance that Nurse Practitioners of all types, including the Primary Health Care Nurse Practitioner (PHCNP) are trained at the master's level to set a measurable and attainable standard that must be met in order to ensure that patients are provided with the appropriate care and safety.

Rationale: "Our concern is for the safety of the public, if nurses are extending their role into areas historically considered to be within the boundaries of medicine and beyond, then we consider that a formal preparation at the Master's level is a minimum requirement for safe practice" (Gibbon, Luker. 1995). The masters program should be a minimum standard to begin practicing as a Nurse Practitioner in any discipline; the School of Nursing at John Hopkins University in Baltimore, MD has developed their Masters program based off of four objectives. The second objective outlined in an article written by Vessey & Morrison (1997) is to standardize the educational requirements. Meaning that no matter where you are trained whether it be Prince Edward Island, Quebec, Ontario, or British Columbia all NP should be Masters level trained.

WHEREAS the availability of training to the average individual will depend upon government funding and support to ensure that programs can run, and fees are reasonable for all interested.

Rationale: Without government support and funding, programs will not be able to run, nor will people be able to afford them. Some students in the United States wishing to pursue a Master's level NP cannot due to lack of funding and/or support.

WHEREAS the current crises in Canada with regards to Primary Health Care is a large issue that PHCNPs can be utilized to help fix.

Rationale: Currently the Nurse Practitioner Lead Clinic in Sudbury has provided primary care to approximately 5 000 people in the Sudbury area with another clinic set to open which will provide even more help. The Algoma Health Unit estimates that there are currently 14 000 people in Sault Ste Marie without primary health care. Having more NPs come through a masters program and trained at that level will help alleviate the primary care provider shortage that not only Sault Ste Marie is experiencing but the province as well. CNA projects a shortfall of 118 000 nurses by 2016.

WHEREAS, should Ontario set a precedence such as this, that it is quite possible that other provinces will follow through with the same actions.

THEREFORE, BE IT RESOLVED that the CNSA take a National standpoint on this issue and support master's level education of all advanced practice nurses in Canada, including the PHCNP

BE IT FURTHER RESOLVED that the CNSA recognize the Primary Health Care issues we are facing in this country, and the support that can be contributed by PHCNPs to help address the current state of our Primary Health Care.

BE IT FURTHER RESOLVED that in the event that the topic becomes public knowledge and that governments begin to cut funding and stop supporting these programs that the CNSA will institute appropriate measures to ensure the voice of students nationwide are heard with regards to their support for these advanced practice roles.

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Position Statements 2006

POSITION STATEMENT: HEALTH AND HOMELESSNESS

Homelessness is a growing problem in Canada that affects not only large urban populations but also rural areas alike.[1] Approximately 17 million people in Canada are homeless and/or experience great difficulty coping with the lack of affordable housing,[2] both of which are found to have a direct impact on health.[3] Further, the determinants of health are broadly affected when the access to proper shelter is deficient.[4] Overall, it has an impact on individuals, families, and communities, further emphasizing the need for healthcare providers, including nurses, to embrace a leadership role that addresses and advocates for programs that promote affordable housing and strive to assure health of all.

Though there is no concrete definition for homelessness, certain classifications have been established. According to the Registered Nurses Association of Ontario (2004), « There are different ways in which homelessness occurs:

Absolute Homelessness: Individuals sleeping outside or using public or private shelters

Concealed Homelessness: Individuals who are provisionally lodging with friends or family

Risk of Homelessness: Individuals struggling to meet core housing needs of which affordability, suitability and adequacy norms are all elements. »

Homelessness exists in many different faces which include families, individuals, and youth.[5] This fact is further supported by an Ottawa-based longitudinal study which found that in 2002 and 2003 « 17% of those interviewed identified themselves as being of Aboriginal descent, compared to their 1% representation in the general Ottawa population » (www.unitedwayottawa.ca). The issue of homelessness has a multiplicity of causes including: eviction, loss of employment, inability to afford the cost of rent, conflicts, as well as mental and physical health problems.[6] Thus, comprehensive assessment may serve as an effective tool to complement the faculty of nursing skills and resources.

Homelessness has a direct correlation to health outcomes and the accessibility of health services. Also, individuals who are homeless are found to be at an increased risk for several chronic and/or fatal diseases such as the growing concern of Tuberculosis (TB). Individuals who are homeless are 20-300 times more likely to contract TB.[7]

Over the years, housing programs have been decreased or cancelled. From 19841993, the federal government cut approximately two billion dollars from the national housing program, and subsequently delivered the biggest hit with the cancellation of the national housing program in 1993.[8] Financial cuts to any programs often cause great losses. In 2000, the federal government held an inter-provincial and inter-territorial housing summit that proclaimed the plan to create affordable housing.[9] However, a concrete national housing strategy has not yet been realized. Rather, announcements regarding new housing were delivered but the materialization of which accounts to fractions.[10] Governments and individuals must act on promises and develop strategies to eliminate homelessness and poverty.

There are many initiatives occurring at the activist level. Two such initiatives include the «Make Poverty History Campaign» and the «1% Solution». « The Make Poverty History» campaign wants to improve aid, trade-justice, eliminate the deficit, and end child poverty in Canada» (www.makepovertyhistory.ca). «The Toronto Disaster Relief Committee (TDRC) initiated the 1% Solution to call on all levels of government to double their commitment to housing programs by restoring and renewing house spending» (www.tdrc.net).

CNSA believes that nurses as well as nursing students, have many roles and responsibilities in assisting with the abolishment of homelessness. Nursing practice will be impacted by homelessness and by the lack of affordable housing due to the emotional, mental, physical, and physiological toll that it has on the health of individuals who are battling housing issues. We have the responsibility to educate and advocate all levels of government, health care professionals, and the public. We must endorse, support and become involved in initiatives that call on all levels of government and policy to acknowledge and respond to the crisis of homelessness and the lack of affordable housing in Canada.

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Resolution Statements 2006

ENDORSEMENT OF THE REGISTERED NURSES ASSOCIATION OF ONTARIO (RNAO)

BEST PRACTICE GUIDELINES (BPGs):

Submitted by: James Chu and Colleen Ferris

BE IT RESOLVED that the Canadian Nursing Students' Association endorse the Best Practice Guidelines of the Registered Nurses Association of Ontario that are evidence-based and used in clinical and educational practice.

Background

- The BPGs were initiated in 1999 with funding from the Ontario Provincial Government.
- BPGs focus on one of the five identified clinical areas: Primary Health Care, Home Health Care, Mental Health Care, Gerontology, and Emergency Care.
- Each guideline that is being developed goes through five phases: planning, development, pilot implementation, evaluation and dissemination/intake.
- Currently 29 guidelines have been developed and another is in the development phase.
- 8 of the guidelines have been translated into French.
- Fact sheets have been developed that correspond to the guidelines. These are available for patients and families.
- RNAO hosts the International Best Practice Guideline Conference.
- Educational tools have been developed to assist educators to incorporate BPGs into their teaching
- RNAO and in collaboration with the Canadian Nurses Foundation (CNF) have chosen two research proposals that will examine the role of BPGs in improving nursing care.
  o Montreal's McGill University Health Centre (MUHC) will examine the introduction of RNAO's BPGs at five sites of MUHC.
    - The second one will be co-funded by the Victorian Order of Nurses and will examine the role of the BPGs in bereavement. This study will occur in Nova Scotia.

- Another BPG study that is occurring in Ontario is looking at the long-term impact of BPGs on nursing care.

Rationale

One of the objectives of CNSA is to increase the awareness of both the existence of and the need for nursing research. The BPGs support this objective and provide tools that can incorporate evidence-based practice into our education. It is important to work in collaboration with our provincial/territorial jurisdictions to support each other's initiatives.
Source www.rnao.org

Resources

[1] (Stamler & Yui, 2005)
[2] (TDRC, National Housing Report Card, 2005)
[3] (Stamler, Yui, 2005)
[4] (RNAO, 2004)
[5] (United Way, 2005)
[6] (United Way, 2005)
[7] (Tuberculosis Action Group, 2003)
[8] (TDRC, 2000)
[9] (TDRC, National Housing Report Card, 2005)
[10] (TDRC, National Housing Report Card, 2005)

Position Statements 2005

POSITION STATEMENT ON JOB ACTION

The Canadian Nursing Student's Association (CNSA) is the official voice of nursing students across the country, representing more than 11,000 students nationally. We feel that the rights of students are of utmost importance and we strive to uphold this principle.

CNSA appreciates how difficult a time this is for your membership. CNSA feels that although this is a time of change in many organizations and governments, nursing students remain the future of Canadian Health Care. We therefore would like to take this opportunity to remind you to consider the effect your actions may have on nursing student activities.

POSITION STATEMENT REGARDING THE CANADIAN REGISTERED NURSES' EXAMINATION (CRNE)

The CNSA supports the CRNE as a means to measure the competencies of future registered nurses and therefore to protect the public by ensuring that entry-level registered nurses possess the competencies required to practice safely and effectively. The CNSA is however in opposition to the planned changes to the cost of writing the CRNE. The CNSA proposes the following for further consideration by the CNA: The CNSA feels that changes such as these are necessary to ensure the feasibility of current nursing students and nursing graduates to write the CRNE.

The CNSA supports four incremental increases to the cost of writing the CRNE versus the proposed one time increase, with the final cost determined by the provincial governing body. These incremental increases in price will allow nursing students to prepare financially for the cost difference, versus the proposed change.

The CNSA supports the provision of a complimentary CRNE study guide for each nursing student enrolled in, or graduate of, a Canadian nursing degree program. Evidence of enrolment, or graduation, along with a receipt for the study guide would allow the CRNE to be written for the cost of the exam minus the cost of the study guide.

The CNSA supports the provision of a free online study guide to current nursing students enrolled in Canadian nursing degree programs. Access to the guide could be controlled through passwords provided or sold to educational institutions.

The CNSA supports collaboration between the professional organizations and the nursing students. The provision of funding from the CNA to future nurses in the form of funds that would go directly towards supplementing the cost of writing the CRNE.

The CNSA supports the provision of the LeaRN CRNE Readiness Test, currently $42.70 per use, free of charge to nursing students preparing to write the CRNE.

Finally, the CNSA is concerned with the March 2005 publication date for the new CRNE study guide. The CNSA supports changes such as those above. These changes will demonstrate accountability and professionalism with respect to the launch of the new CRNE.

Resolution Statements 2005

PERMANENT ADDITION OF A TRANSLATION AND BILINGUALISM DIRECTOR TO THE BOARD OF DIRECTORS

Whereas, it is stated on CNSA website:
"CNSA/AEIC is committed to bilingualism and makes every effort to ensure documents and the proceedings are available in both English and French.

Currently there is a national standing Translation Committee that works with the BOD to develop a strategic plan to make CNSA/AEIC more bilingual in a way that is economically feasible. If you would like to participate in this committee or would like to volunteer your time and expertise translating documents please contact us."

Whereas, the following are CNSA objectives:
Provide a communication link among nursing students across Canada, recognizing the specific language needs of our bilingual country. Act as the official voice of nursing students.

Whereas, Translation has been an ongoing concern within the CNSA for many years.

Whereas, the responsibility of translation has traditionally fallen on any French/bilingual member on the board.

Whereas, the translation budget required an increase from 3500$ to 6500$ for the 2004-2005 year.

Whereas, in January 2003 and 2004, the National Assembly approved a temporary, one-year addition of a Translation and Bilingualism chair to the board, to be reviewed at the 2005 National Assembly.

Be it resolved that the position titled "Director of Translation and Bilingualism" be added to the Board of Directors pending approval from the Minister of Industry for a change to the Bylaws to include this new board position.

Be it further resolved that, the following description of the duties of this title be added to the rules and regulations:
The Director of Translation and Bilingualism shall:

- Advise the Board of Directors on matters concerning the translation of documents and the accessibility of French and English translations to the board members and regional executives, when necessary and financially possible;
- Advise the Board on how to uphold the association's commitment to been bilingual association;
- Manage the CNSA resources allocated to bilingualism;
- Ensure that all CNSA documents be written and published in both Canadian official languages, when financially possible;
- Research funding opportunities for Bilingualism;
- Be responsible of recruiting a interpretation company for the National Conference, according to resources allocated by the NCD;
- Surrender to the incoming Director of Translation and Bilingualism all records and files with a oral and written explanation by April 1.

ADDITION OF NATIONAL CONFERENCE BOD MEETING AGENDA TO THE RULES AND REGULATIONS

Whereas, the Rules and Regulations of the CNSA presently outline inclusions of the agenda for the Spring and Fall meetings of the BOD.

Whereas, the BOD meets for a final meeting prior to the National Conference.

Whereas, an agenda must be set for all meetings, according to Robert's Rules of Order.

Be it resolved, an addition be made under Part VI (Meetings of the Association) of the Rules and Regulations as follows: National Conference BOD Meeting

- Evaluation of Resource Officer Position
- National Assembly package;
- Changes to Rules & Regulations/Bylaws to be presented to the National Assembly;
- Resolutions and position statements to be presented to the National Assembly.

ADDITION OF CHANGEOVER MEETING AGENDA TO THE RULES AND REGULATIONS

Whereas, the incoming and outgoing Board of Directors meets prior to the adjournment of the National Conference Board Meeting.

Whereas, the Rules and Regulations of the CNSA presently outline inclusions of the agenda for the Spring and Fall meetings of the BOD.

Whereas, an agenda must be set for all meetings, according to Robert's Rules of Order.

Be it resolved, an addition be made under Part VI (Meetings of the Association) of the Rules and Regulations as follows: BOD Changeover Meeting

- Oaths of Office
- National and Regional Conference Directors' contracts
- Contracts
- Transfer of Information to incoming BOD.

PROCEDURE TO FILL VACANT BOARD OF DIRECTOR POSITIONS

Whereas, the Rules and Regulations lack a procedure in regards to filling vacant Board of Director positions.

Be it resolved, a new section be added in the Rules and Regulations under Part V: Power and Duties of the Board of Directors. This section will be added after Individual Position Budgets and be titled Vacancies.

Be it further resolved, The Vacancies section will state the following: "If an Officer of the Board position becomes vacant, a present Board Member must be voted into the position by a 2/3 vote from the Board of Directors. Upon receiving the Officer of the Board position, that individual must immediately verbally resign from his/her previous position.

If a non-Officer of the Board position becomes vacant the present Board of Directors will determine a suitable replacement. The individual must be voted in with a 2/3 vote of the Board of Directors. The vote will be overseen by the Resource Officer via telephone and/or email"

TO CHANGE THE DESCRIPTION OF THE DIRECTOR OF COMMUNICATIONS POSITION

Whereas, the current job description of the Director of Communications states that "Ensure that the web page is up to date by maintaining regular communication with the appointed manager of the web site."

Be it Resolved that, the description of the responsibilities of the Director of Communications be extended to include primary communication with the appointed manager of the web site

Be it further resolved that, all members of the BOD and CNSA be responsible for submitting information that they would like placed on the website to the Director of Communications who will then forward it to the appointed manager of the website

BOD COMMUNICATION

Whereas, one of the CNSA's objectives is to provide a communication link to nursing students across Canada.

Whereas, it is the Board of Directors' responsibility to communicate with each other.

Be it resolved that defined guidelines for communication among the Board of Directors be created.

Be it further resolved, the addition of a section titled "BOD Communication" be added to the Rules and Regulations under Part V, which will state the following:

1. "By the first week of each month, from April to March, each board member will submit a monthly memo that must:
    a. Consist of activities undertaken in the previous month
    b. Be posted on the BOD bulletin board on the CNSA website
2. Fourteen days prior to BOD meetings, each board member will submit, via email to the BOD, a detailed BOD meeting report consisting of:
    a. Personal objectives and duties of the Board position as stated in Part V (Power and Duties of the Board of Directors) in the Rules and Regulations

b. Activities undertaken over the past months to meet these objectives
c. Plans for upcoming months.

3. Thirty days prior to the National Assembly, each Board member will submit, via e-mail to the Resource Officer and the President, a detailed National Assembly report consisting of:
    a. Objectives of the CNSA
    b. Activities undertaken to meet each objective throughout their Board term
    c. Recommendations for the incoming Board member
4. The Board communication will be maximized in the following manner: The president and the vice-president will each divide up the contact list of the BOD members and will make telephone calls every three to four weeks in order to enhance information exchange regarding BOD positions and regional issues.

INCLUSION OF BOD COMMUNICATION GUIDELINES

Whereas, there is no defined structure regarding the communication and information transfer process among board members.

Whereas, this may lead to incomplete and disorganized information sharing during BOD turnover and throughout the term.

Be it resolved that structured and defined guidelines for communication among BOD be implemented.

Be it further resolved that the guidelines for communication among BOD be stated in the Rules and Regulations as such:

1. By the first week of each month, each board member will submit a monthly memo that must:
    a. Be sent via email to all board members
    b. Consist of activities undertaken in the previous month
    c. Be posted on the national discussion bulletin board on the CNSA website
    d. Be done from and including April to and including March of the subsequent year.
2. Fourteen days (two weeks) prior to BOD meetings, each board member will submit (via email) a detailed BOD meeting report consisting of:
    a. Personal Objectives and duties of the board position as stated in Part V (Power and Duties of the Board of Directors) in the Rules and Regulation

   b. Activities undertaken over the past months to meet these objectives
   c. Plans for upcoming months
3. Thirty-days prior to the National Assembly, each board member will submit (via email) a detailed National Assembly report consisting of:
   a. Constitutional Objectives
   b. Activities undertaken to meet each objective throughout their term as board director
   c. Recommendations for the incoming board director
4. The intraboard communication will be maximized via the following procedure:
   a. The president and the vice-president will each divide up the contact list of the BOD and will make follow-up calls every three to four weeks in order to enhance information exchange regarding BOD positions and regional issues.
   b. Following each calling session, the two officers will exchange lists in order to ensure the raised issues are being addressed. The officers will also provide all board members with a report (included in their monthly memo) in the following format:

Board of Directors Member	Issue/Topic of Discussion	Recommendations/Actions to be taken

   c. The president and the vice-president will maintain contact with each other via monthly follow-up phone calls in order to address the issues raised during monthly discussions with other board members.

Resolution Statements 2004

CHAIR OF TRANSLATION AND BILINGUALISM

Be it resolved that the title of chair of translation and bilingualism be added to the Board of Directors.

CHANGE THE MEMBERSHIP GUIDELINES

Whereas, the 2003/2004 September Package official membership form states "In order to assist new chapters, if your school is a new member (has not been a member for greater than four years) or is in the second year of membership, you are responsible for only remitting 50% of the fees."

Whereas, the description as stated can lead to confusion.

Be it resolved that the September package official membership form states, "a new member school in its first and second year of membership will receive a 50% discount for the membership fees.

Be it resolved that a new member school be defined as follows:

1. A school that has not previously been a member of the CNSA
2. A school that previously was a member but has not been a member for four or more consecutive years.

ONTARIO NURSING BOOK

Whereas, the Ontario Nursing book organized by Peter Carle is advertised to hospitals and associations that every nursing student in Ontario will receive a copy.

Whereas, at CNSA - McMaster chapter, there are approximately 700 students and 100 Ontario Nursing books.

Whereas, it is very expensive to place an ad in the Ontario Nursing book. Hospitals and Associations would rather place an ad in the Ontario Nursing book than in chatbooks, conference books, etc. organized by nursing students in the region.

Whereas, we feel the advertising of the books deters fundraising by individual chapters.

Whereas, the CNSA, more specifically the Ontario Region has concerns about the potential fundraising money lost because of the Ontario Nursing books and the advertising they promote.

Whereas, it would be of increased benefit for hospitals, students and CNSA if information was disseminated and resources not only promoted by nursing students but also distributed by nursing students. By advertising in nursing students organized publications not only are hospitals and associations directly funding nursing students but guaranteeing the information is properly distributed within the nursing student sector.

Be it resolved that, the CNSA will no longer financially support &/or promote the Ontario Nursing book within the regions of the CNSA.

DISTRIBUTION OF SEPTEMBER PACKAGE

Whereas, the September package was not distributed in due time to OD's and AD's of the Ontario Region.

Whereas, the concern was brought forth by the Ontario Regional Director to the Board of Directors after the Regional Conference as the packages were still not received.

Whereas, it is now online and schools are expected to print a copy off the webpage at their own cost.

Whereas, the September package was previously provided free for all changes.

Be it resolved that the Regional Directors distribute the September Package to their delegates.

Be it further resolved that the September Package be distributed by a specific date across each region.

Be it further resolved that the Chapters are not responsible for the cost of the initial September Package.

Resolution Statements 2003

AUTHORITY ON PROJECTS

Whereas, CNSA members or individuals wish to seek business services outside the CNSA.

Whereas, one individual alone cannot solely act on the behalf of the CNSA with regard to business interactions.

Whereas, only the CNSA Board of Directors has control over financial and contractual obligations.

Be it resolved that: No individual shall be given sole authority over any project that affects the CNSA as a whole.

Be it further resolved that: Any non-CNSA member responsible for a project for the CNSA valuing over $100.00 must enter into a contractual relationship with the CNSA.

Be it further resolved that: Particular chapters, regions, regional conferences, and national conferences, when undertaking any project or event clearly represent themselves as a particular member chapter, region, regional conference, or national conference as appropriate

MEN IN NURSING

Whereas: Men were not allowed into all nursing schools in Canada until 1969.

Whereas: The shortage that the nursing profession is facing will eventually drain the present pool of applicants.

Whereas: The CNSA has a long history of men holding positions in the organization.

Whereas: Men holding leadership positions in nursing organizations provide positive role models to encourage the recruitment of men into nursing.

Be it resolved that: The Canadian Nursing Students' Association create a position statement that demonstrates the intentions and actions we are willing to take to endorse the active recruitment and retention of men into nursing.

Be it further resolved, that: The Canadian Nursing Students' Association maintain the gender-neutral promotions material (e.g. video project, Posters, etc.), and the availability of all positions within the organizations regardless of gender.

The Men in Nursing Position Statement reads:
During the 1960's, nursing schools across Canada opened their doors to men. Although this was a huge step for the nursing community the number of male applicants and graduates has risen at a painfully slow pace. With the most devastating nursing shortage on the horizon the need to recruit potential nurses is greater than ever. The Canadian Nursing Students' Association fully supports the active recruitment and retention of men into the nursing profession. As with our actions in the past the Canadian Nursing Students' Association will continue to create gender -neutral publications and promotions material. More importantly the Canadian Nursing Students' Association will continue to set the standards for a non-bias availability of all positions within the organization.

NURSING SCHOOLS WITH MORE THAN ONE PHYSICAL CAMPUS

Be it resolved that, the following be added to the Rules and Regulations, Part III: membership stating that "Schools of Nursing with more than one physical site or campus, in which students attend only one physical site or campus at one time, should apply to the Board of Directors as separate chapters. Schools of Nursing with more than one physical site or campus in which students attend more than one physical site or campus concurrently should apply to the Board of Directors as one chapter".

Resolution Statements 2002

FRENCH SPEAKING SCHOOLS OUTSIDE OF THE QUEBEC REGION

Whereas, An object of CNSA is "To provide a communication link among nursing students across Canada, recognizing the specific language needs of our bilingual country."

Whereas, most regional conferences and meetings outside of Quebec are conducted in English.

Whereas, the highest concentration of French Schools are in Quebec

Whereas, there are French speaking schools outside of the Quebec region

Whereas, CNSA cannot afford to provide simultaneous translation at regional meetings

Be it resolved that French speaking schools may choose to become part of the Quebec region instead of the region where they are geographically located in order to recognize the language needs of French speaking schools and to promote more effective communication, both regionally and nationally.

Be it further resolved that, Section 4.08 of the by-laws be modified to read:

> 4.08 Regions of Membership: Membership shall be divided into regions based upon location and/ or language; for chapter, individual and distance members the location shall be the location of their school of nursing and for all other members location shall be the location of their principal residence. The Atlantic region shall include all members in the provinces of Newfoundland, Nova Scotia, New Brunswick, and Prince Edward Island. The Quebec region shall include all members in the province of Quebec. The Ontario region shall include all members in the Province of Ontario. The Prairie region shall include members in the provinces of Manitoba, Saskatchewan, and Alberta. The Western region shall include all members in the province of British Columbia, Nunavut, the NorthWest Territory, and the Yukon Territory. Nursing programs may choose to become part of the region where their specific language needs are met" instead of "the region where they are geographically located.

CNSA FINANCIAL PROCEDURES

Whereas, CNSA must be financially responsible

Whereas, CNSA must be able to be financially flexible throughout the year

Be it resolved that the following section be added to the rules and regulations:

13. Financial: This section may only be modified by the national assembly.
    13.1 Budget
        13.1.1 A detailed yearly budget must be planned at the first meeting of the board of directors and reviewed at each subsequent meeting. 13.1.2 The board of directors may not budget yearly expenses in excess of 90% of the prior year's revenue.
    13.2 Funds Dispensing
        13.2.1 No funds may be dispensed without first obtaining a receipt or invoice of the expense. Distribution of awards funds shall be the sole exception to this rule.
        13.2.2 No funds shall be distributed outside of the budgeted amounts without prior authorization of the officers or the board of directors.

REGIONAL COMMUNICATION

Whereas: An object of CNSA is to "To provide a communication link among nursing students across Canada, recognizing the specific language needs of our bilingual country."

Whereas: CNSA is dependant on and relies on the Official and Associate delegates to act as liaisons between the general membership and the board of directors.

Whereas: There have been problems in the past maintaining adequate and effective communication with the Official and Associate Delegates.

Be it resolved, that the following guidelines for regional communication be established and added to the rules and regulations of CNSA:

4.3 Regional Communication:
    4.3.1 It is expected that the OD/AD of each member school will:

4.3.1.1 develop and/or maintain an email account for the CNSA/AEIC chapter at their school;

4.3.1.2 inform their Regional Director and the OD/ADs of other schools in their district of this email address, as well as a mailing address and telephone number;

4.3.1.3 check their email on, at a minimum, a weekly basis, preferably more frequently;

4.3.1.4 respond to queries from all sources as soon as possible, preferably the same day;

4.3.1.5 write monthly memos via email to their Regional Director and other OD/ADs in their region. These may be informal in nature, and are meant to be used to keep others informed of what is happening at your school;

4.3.1.6 both have access to the email account and that they communicate all information or messages from this and all other sources to each other.

4.3.2 A problem or breakdown in communication is defined as:

4.3.2.1 not having an email account set up at the beginning of September of the school year;

4.3.2.2 not passing the email address, mailing address or telephone number on to others;

4.3.2.3 not writing a monthly memo;

4.3.2.4 not responding to direct queries from your Regional Director or other OD/ADs.

4.3.3 The Board of Directors has determined that the following actions may be taken by the Regional Directors if a communication problem exists:

4.3.3.1 if no response from the individual has been received within one week, the Regional Director will send another email;

4.3.3.2 if, following a week after this email, the Regional Director will telephone the individual;

4.3.3.3 if there is still no contact or response after this, the Regional Director will send an official letter to the individual stating that they assume the person wishes to resign from their position. A copy of this letter will also be mailed to the Officers of CNSA. Included in this letter will be contact information of the Officers if the individual wishes to contact them. The individual will have two weeks to respond to this letter. This gives a non-responsive individual a total of 4 weeks of

attempted communication from the Regional Director. The Officers will make the final decision on the status of the individual.

4.3.4 Extenuating circumstances which may excuse the individual from the above scenario include:

4.3.4.1 illness or death of the individual or their family member

4.3.4.2 periods during which the individual is absent or busy and will not be able to access email. For the above two scenarios, it is mandatory for the individual to notify their Regional Director and others in their region of this situation;

4.3.4.3 during times of academic recess when students are not in school, it is assumed that email will not be accessed as frequently. However, it must be checked at least every two weeks.

4.3.5 In the absence of an established process for filling the OD position at a school, it is assumed that the AD will take on the role of the OD if this position becomes vacant.

PROOF OF ENROLMENT

Whereas, the membership fees for a school are based on the number of students at a member school.

Whereas, there are inconsistencies between member schools in the proof provided of the number of students.

Be it resolved, that the enrollment of a school for purposes of fees collection shall be determined by a signed letter from the registrar or other appropriate official.

Be it further resolved, that the following statement be included in the 3.1 Membership fees portion of the rules and regulations, and that the section be renumbered appropriately.
The number of students at a school for the purposes of fees collection shall be determined by a signed official letter from the chapter school's registrar or other appropriate official. A chapter member shall not be considered a member in good standing until this letter is received, along with the appropriate fees.

POST-RN MEMBERSHIP IN CNSA

Whereas, membership of post-RN students has been inconsistently applied by member schools for the purpose of determination of fees.

Whereas, it is often difficult to obtain membership fees from post-RN students because they feel they do not have to be members of CNSA/AEIC due to other professional memberships.

Be it resolved, that post-RN students are considered to be CNSA/AEIC members if they are integrated into their educational institutions' undergraduate nursing program.

Be if further resolved, that the following statement be added to the 3.1 Membership Fees section of the rules and regulations: "In chapter schools where post-RN students are integrated into the regular undergraduate classes, the post-RN students shall be included in the total number of students for the purposes of fee payment;" and that the section be renumbered appropriately.

NATIONAL CONFERENCE TIME EQUIVALENT TO CLINICAL TIME

Submitted by: Paul Terpstra, National Conference Director
Lisbet Rygnestad, Western Regional Director

Whereas, the CNSA promotes, encourages, and provides opportunities for students to gain experience in professional activities. The CNSA believes these activities are integral to developing as a professional.

Whereas, professionalism is important to nursing, and active participation in the process, at the student level, is crucial to advancing the practice. When looking at the excellence of care "professionalism constituted an all encompassing theme subsuming [holistic care, practice, and humanism] all others" (Coulon, Mok, Krause & Anderson, 1996). Effusing from professionalism's importance to nursing, are the benefits of being involved.

Whereas, numerous studies on the "Socialization into nursing" suggest that being actively involved gives the student a solid self-concept of their roles (William, 1995; Greenawalt 1996) that will consequently help to combat low self-esteem and low self-confidence (Bright 1992). Helping to garner this solid self-concept has a positive impact on recruitment and retention (Cohen, 1992) in that it decreases job dissatisfaction, (Krichbaum, 1997) instills a level of comfort and belonging, (A basic human need Maslow's hierarchy) and fosters a more solid commitment

to nursing. (Lu & Chiou, 1998) Furthermore, it simply provides another opportunity of experience that will undoubtedly improve the quality of the nursing graduate. (Ruetter, Field, Campbell & Day, 1997)

Whereas, correlating with involvement is the ability of new graduates to show a greater capacity to adapt to changing, and extremely demanding, work environments. (Bedard & Dupette, 1998) In addition to adaptation, professionally developed students are better able to see issues affecting their practice (Krichbaum, 1997), enhance collaboration and affect change in the system. (Richardson, Valentine, Wood, & Godkin, 1994) Active participation allows one to learn the process of activism, which will foster and ensure nursing has a strong, articulate voice to enhance the image of nursing. (Cohen, 1992) As students, even without the refined voice, participation will allow for input to be made in nursing education that will change the way we are educated. The student perspective is integral to the education process. (Thornton & Chapman, 2000).

Be it resolved, that the CNSA believes that Professional time should have academic credit.

Be it further resolved, that CNSA actively lobby nursing schools and nursing education organizations promoting this policy.

Be it further resolved, that conference directors will provide a list of attendants to the regional director. The regional directors will be responsible for writing a letter following national and regional conferences to the dean or director of each school with a description of the conference and a list of the students from the school who attended.

References

Bedard, D. & Dupette, A. (1998) Nurses' professional self-concept. Canadian Nurse, 9 4, (6) p. 43-45.

Bright, K. (1992) The professional self-concepts of nursing undergraduates and their perception of influential forces. Journal of Nursing Education, 3 1, (3) p. 121125.

Cohen, L. (1992). Power and change in Health Care: Challenge for nursing. Journal of Nursing Education.(31) 3. Pp. 113-116.

Coulon, L., Mok, M., Krause, K. & Anderson, M. (1996) The pursuit of excellence in nursing care: what does it mean? Journal of Advanced Nursing, 24, (4) p. 817-826.

Greenawalt, W. (1996) Professional socialization of baccalaureate nursing students: a study of the meaning of selected concepts related to professionalism. Doctoral Dissertation: Kent State University. Krichbaum, K. (1997). Focuses on the teaching of leadership to student nurses. Creative Nursing, 3, (2). p. 12-16.

Lu, K. & Chiou, S. (1998) Professional commitment of nursing students. Nursing Research, 6, (2) p. 109-20.

Maslow, A. (1954). Motivation and personality . New York: Harper & Row.

Reutter, L., Field, P., Campbell, I. & Day, R. (1997) Socialization into nursing: Nursing students as learners. Journal of Nursing Education, 3 6, (4) p. 149-155.

Richardson, S., Valentine, P., Wood, M. & Godkin, D. (1994) Leadership: A nursing perspective. Canadian Journal of Nursing Research, 2 6, (4) p. 82-95.

Thornton, R. & Chapman, H. (2000) Student voice in curriculum making. Journal of Nursing Education,39, (3) 124-131.

CERTIFICATE OF EXCELLENCE IN THE ROLE OF PRECEPTOR / MENTOR

Whereas, the CNSA/AEIC is committed to recognizing those nurses who have assumed the role(s) of preceptor and/or mentor and have made outstanding contributions to the overall growth, development, education of nursing students.

Be it resolved that, the CNSA/AEIC will award certificates of excellence for their dedication and commitment in the role of preceptor and/or mentor.

BACCALAUREATE AS ENTRY TO PRACTICE

Whereas, the nursing profession is faced with increasingly complex health care needs of clients.

Whereas, Registered Nurses must possess the educational background to understand and keep abreast of the challenges and changes they will face across a lifetime of practice.

Whereas, Health Care practices are expected to be based on evidence and research requiring Registered Nurses to have the ability to understand, conduct, and utilize these findings.

Whereas, the evolution of the nursing profession is contingent upon an educational system which allows one to learn leadership, teamwork, and communication skills with the time to integrate this learning with the practice.

Be it resolved, that CNSA/AEIC, as the official voice of nursing students, maintains the position that entry level competencies for future nurses are most effectively and economically achieved through baccalaureate nursing education.

Be it further resolved that CNSA/AEIC actively lobby this position where appropriate.

Position Statement 2001

POSITION STATEMENT ON PRIVATIZATION

Be it resolved that CNSA accepts the position statement on privatization.

Introduction

The Canadian Nursing Students Association (CNSA) is the National voice for nursing students. One major goal is to allow students to express their opinions on current nursing issues at the National as well as at the provincial level. For the past few years, privatization of our health care system has been a subject of great debate amongst governments, for example with bill 11 in Alberta, and the reaction of many Nursing Association, for example, The Canadian Nurses Association (CNA), The Canadian Federation of Nurses Unions (CFNU) and many others. Because CNSA has been represented at many important meetings such as the National Nursing Forum and was asked to speak in the name of all Canadian Nursing Students, it is time for us to have an official position on the issue of Privatization.

We have consulted two papers: Towards a Sustainability, Universally Accessible Health-Care System written by Alberta Association of Registered Nurses, Canadian Nurses Association, Ontario Nurses' Association, Registered Nurses Association of Ontario and United Nurses Alberta, and Women Privatization and the Health Care Reform: The Ontario Case' paper by Patricia Armstrong.

We know that privatization would compromise access to Health Care for all Canadians. According to Pat Armstrong, health care must be understood as a public good rather than a market commodity. She points out two important differences between health care delivery and goods production. First, care providers assume and demand autonomy in making decision based on their assessment of the individual need, in contrast, strategies in the for-profit sector assume and demand managerial control over processes and decision-making. Secondly, in for-profit sector, selling is critical to maintaining profit growth whereas in our health care reform the stated purpose is to spend and use less.

Position Statement

The Canadian Nursing Students Association supports a totally public health care system in accordance with the Canadian Health Act, including Medicare, Pharmacare and Primary Care.

References

Armstrong, P. (1999) Women, Privatization and Health Care Reform. National Network on Environments and Women's Health. (Dec.)

Alberta Association of Registered Nurses, Canadian Nurses Association, Ontario Nurses' Association, Registered Nurses Association of Ontario and United Nurses Alberta (2000). Towards a Sustainable Universally Accessible Health-Care System. (May).

Resolution Statements 2001

NEW MEMBER SCHOOL FEES

Whereas, CNSA/AEIC is always striving to recruit non-member schools.

Whereas, It is important to make becoming a member school as easy and attractive as possible.

Whereas, Fees/fee collection inhibits interested non-member nursing students from getting their schools involved.

Whereas, It is a complicated and long process to have CNSA/AEIC fees included in the tuition.

Resolved that CNSA/AEIC make the fees for new member schools ½ the normal amount for the first two years of membership.

DISTANT CNSA MEMBERS

Whereas, The CNSA wants to expand their membership to non-member schools

Whereas, distant membership have been applying for membership and paying the same fees as individuals of member schools

Whereas a fee increase for distant members would be an incentive to encourage their entire school to become a member.

Resolved, that CNSA membership fee for distant members of non-member schools pay $15.

CREATION OF A NEW AWARD

- Be it resolved that CNSA accept the resolution to create an award.

TRANSLATION COMMITTEE

- Be it resolved that an amendment be made to the resolution that $3000 of the CNSA's annual budget be allotted to the translation committee such that $3000 be allotted in this manner for the upcoming year only and that during this year,

- Funding for the translation of CNSA documentation be lobbied for, and that the original resolution be revisited at the 2002 National Conference.

Resolution Statements 2000

BOD NATIONAL CONFERENCE REPORTS

- Be it resolved that the resolution be adopted with the deletion of the third whereas;
- Discussion: The resolution means that the Board of Directors must submit their reports earlier than when they arrive at the National Conference.

(No archives found for 1996, 1997, 1998, 1999)

Resolution Statements 1995

AD HOC COMMITTEE ON STRATEGIES FOR COMMUNICATION LINKS

- Be it resolved that an Ad Hoc Committee be created to plan strategic political action for a new communication link; further be it
- Resolved that the committee look at the different types of communication links and report all their findings to the Promotional Director

STRATEGIC PLAN

- Be it resolved that future BOD members work with the Resource Person developing implementation strategies for set goals and objectives; further be it
- Resolved that an evaluation of the strategic plan should be done each year to see what has been accomplished and what needs change; further be it
- Resolved that any member of the CNSA/AEIC is allowed to submit suggestions, proposals, etc. to the BOD in furthering the development of the strategic plan

PROPOSAL FOR MEDIA WATCH

- Be it resolved that the CNSA/AEIC OD's and AD's report negative nursing portrayals in the media to their Regional Director, further be it,
- Resolved that Regional Directors report to all other BOD to alert the membership to action, and further be it,

- Resolved that the Regional Director inform Provincial and National Professional Nursing Associations of the actions being taken by the CNSA/AEIC membership

INFORMATION PACKAGE ON MEDIA WATCH

- Be it resolved that University of Lethbridge compile a media monitoring information package and further be it
- Resolved that this compilation be distributed to Regional Directors by April 30th, 1995, and further be it
- Resolved that his package be included in the OD?AD 1995 CNSA/AEIC information package

STUDENT REPRESENTATIVE FOR ICN ENTERTAINMENT COMMITTEE

- Be it resolved that UBC be responsible for the recruitment of one student to sit on the ICN Entertainment Committee; further be it
- Resolved that should UBC be unable to find one student by February 1st, 1995, the Western Regional Director recruit one student to sit on the ICN Entertainment Committee by February 15th, 1995.

ICN STUDENT ASSEMBLY AGENDA

- Be it resolved that an Ad Hoc Committee containing at least one member from each of the four regions be formed to create the agenda for the ICN student assembly in collaboration with the Promotional Director.

AUDIO TAPING

- Be it resolved that all regional, national, and BOD business meetings be recorded audibly; further be it
- Resolved that the cassette tapes be clearly labelled and be placed in the Archives along with the written minutes.

FEE INCLUSION TO SCHOOL'S REGISTRATION

- Be it resolved that each Official Delegate and Associate Delegate lobby their school's administration to include CNSA/AEIC fees into the school's registration costs.

STANDARD PORTFOLIO PROPOSAL

- Be it resolved that the CNSA/AEIC incoming BOD compile a standard portfolio containing information pertinent to BOD member, and further be it
- Resolved that this standard portfolio be kept at CAUSN, under the Administrative Assistant.

Resolution Statements 1994

INTERNATIONAL NURSING STUDENT SUPPORT COMMITTEE

- Be it resolved that the resolution regarding International Nursing Student Support Committee be accepted.
- The resolution stated that the CNSA/AEIC participate on the International Nursing Student Support Committee, to support fellow nursing students in their efforts to organize within their countries.

INTERNATIONAL COUNCIL OF NURSES MEETING 1997

- Be it resolved that we adopt the resolution regarding the International Council of Nurses Meeting 1997.
- The resolution stated that CNSA/AEIC begin searching for funding sources and budget planning so that a significant number of the board will be able to attend/represent Canada's issues a concerns in 1997.

PD Planning Student Assembly

- Be it resolved that we amend resolution 9.1.2 (b) to read that "CNSA/AEIC promotion director work".
- Be it resolved that CNSA/AEIC PD work with CNA and ICN Secretariat in the planning of student related events for ICN 1997.

CONNECTION FUNDING

- Be it resolved that we adopt resolution 3b as presented re: "Connection Funding".
- It was discussed and approved that the Association allot $2000.00/annum to finance the publication of the Connection. Barbara Sybol of CNA stated that her services are free and will continue to do so.

GROUP B STREPTOCOCCUS

- Be it resolved that we adopt the resolution of GBS as read.
- Discussion: that the CNSA/AEIC nationally support the creation of an Ad Hoc committee which would implement and coordinate the activities to educate fellow nurses and nursing students of the nature of GBS infection in prenatal, intra-natal, and postnatal women.

First Aid Requirement

- Be it resolved that the CNSA/AEIC support the elimination of First Aid Certification as a requirement for nursing students, in nursing programs across Canada.
- Be it resolved that motion No. 20 be amended to include "request that the First Aid information be included in Nursing programs' curriculums".
- Be it resolved that each Official Delegate present this motion to their respective faculties before the end of this academic year (April 1994), request that the First Aid information be included in the curriculum, and report the faculty response and/or action taken, with respect to this matter, to the ad-hoc committee prior to the 1995 National Conference.

Resolution Statements 1993

NATIONAL ACCOUNT

- Be it resolved that the CNSA/AEIC National Account remain indefinitely at the CIBC branch located at 112 Street and 82 Avenue in Edmonton, Alberta.

BOD Food Allowance

- Be it resolved that each member of the Board of Directors receive $15.00 per day for food allowance at each board of directors' meeting and National Conference effective in the 1993-1994 year.

WORKER'S COMPENSATION BOARD (WCB)

- Be it resolved that the official delegates within the CNSA/AEIC determine the status of Worker's Compensation coverage, as it relates to students in Nursing, in their community and report to their respective Regional Director by April 30, 1993.

PERMANENT ADDRESS

- Be it resolved that the head office of the Association shall remain in the City of Edmonton, Alberta;
- Be it further resolved that a permanent post-office box be acquired by the Resource Person by April 1, 1993.

DISTANCE STUDENTS

- Be it resolved that CNSA/AEIC membership for nursing student in a distance program be on a voluntary and individual basis; and
- Be it further resolved that the following amendments be made to Bylaw 6 Section C;
- Be it further resolved that Bylaw 43 Sections A, B, & C be added to the constitution as amended.

NURSING SCIENCE REFERENCE

- Be it resolved that CNSA/AEIC formally refer to R.N. programs as "Nursing Science" programs i.e. Faculty of Nursing Science.

SECRETARY AND TREASURER POSITIONS

- Be it resolved that the number of positions on the board of director be increased to include both a secretary and a treasurer effective in 1994-1995.

Resolution Statements 1992

CUNSA/AEIUC ARCHIVES

- Be it resolved that the National Assembly ratify the decision of the Board of Directors to have the CUNSA/AEIUC Archives at the AARN offices in Edmonton.
- Action: Archives is now presently located at the AARN office in Edmonton.

DISSOLUTION OF HISTORICAL REVIEW COMMITTEE

- Be it resolved that the Historical Review Committee be deleted from the CUNSA/AEIUC Constitution.
- Action: Implemented by the 1992 BOD.

LOCATION OF HEAD OFFICE

- Be it resolved that the head office of the Association shall be in the city of Edmonton, Province of Alberta; further,
- Be it resolved that the permanent address of CUNSA/AEIUC be: 8510, 111th Street, #1411, Edmonton, Alberta, T6G 1H7 403 433 1170 - Action: 1992 BOD implemented this.

CUNSA/AEIUC LEADERSHIP AWARD

- Be it resolved that 30% of the profits from the Charity Auction at the National Conference be designated for scholarship activities and deposited in to a fund annually.
- Be it further resolved that a plan for a CUNSA/AEICU Leadership Award be revised be the 1992-1993 Board of Directors and presented to the 1993 National Assembly

JOB DIRECTORY DISTRIBUTION

- Be it resolved that the Communication Director compile and distribute the National Job Directory before December of each year accordingly to the Job Directory Distribution Plan.
- Action: 1992-93 Communication Director was unable to implement this due to late submissions from OD's. It was available for the National Conference.

Job Directory Distribution Plan
The "Accordion Plan"

September: Each Official Delegate shall collect and compile job directories from their respective University.

October: Each Official Delegate shall bring their job directory to the Regional Assembly (Regional Business Meeting), Regional Directors shall compile a regional job directory.

November: Regional Directors shall bring their job directory to the November Board of Director's meeting. The Communication Director shall compile a National Job Directory and distribute a copy to each regional directory by the end of the November Board of Director's meeting.

Regional Directors shall distribute copies of the National Job Directory to each University within their region before December. The Communication Director will keep a copy of the National Job Directory for further references.

TRANSLATION COMMITTEE

- Be it resolved that the National Assembly support the change of the present role of the translation committee to one of: assessing the resources available for translation and implementing a plan for translation of the documents deemed by the BOD as being most necessary to translate.
- Action: There was no translation committee in 1992-93.

DISTANCE STUDENTS

- Be it resolved that CUNSA/AEIUC membership for nursing students in distance programs be on a voluntary and individual basis.
- Action: Referred to the 1992-1993 BOD. They were given permission to suspend or modify the provisions of section 6 of the constitution (for one year) at their discretion. A new resolution was presented at the 1993 National Assembly for consideration.

DIPLOMA AND COLLABORATIVE STUDENTS

- Be it resolved that the Canadian University Nursing Students' Association expand membership to include diploma and collaborative nursing students.
- Action: Implemented by the 1992-1993 BOD. George Brown College in Toronto was the first diploma school to have membership in CNSA/AEIC. George Brown, Humber and Fanshaw Colleges attended the 1993 National Conference in Edmonton.

PROPOSAL FOR THE NAME: CANADIAN NURSING STUDENTS' ASSOCIATION

1. Name - The name of the corporation is the Canadian Nursing Students Association/ L'Association des etudiant(e)s infirmiers(ieres) du Canada.

4. Purpose - The purpose of the Association shall be to promote professionalism among nursing students.

5. Objectives - The objectives of the Association are:
   A. To provide a communication link among nursing students across Canada.
   B. To act as the official voice of nursing students.
   C. To provide a medium through which members can express their opinions on nursing issues.
   D. To encourage participation in professional and liberal education.

E. To provide a liaison with other organizations concerned with nursing.
F. To increase the awareness of and the need for nursing research.

6. Eligibility for Membership

Membership in the Association, with the exception of special and affiliate members, shall be made up of students:

A. Who are duly registered in a baccalaureate-nursing program whose Faculty, College, or School of Nursing is eligible to be a member of the Canadian Association of University Schools of Nursing (CAUSN);

B. Who are duly registered in a diploma program leading to eligibility to write the CNATS exam;

C. Who are registered as full or part time students in nursing programs, and;D. Whose fees have been paid on their behalf by their chapter in accordance with Bylaw VII.

Action: the 1992 BOD made these changes.

LOCATION OF THE HEAD OFFICE

- Be it resolved that: Article 3 be amended as follows:
- 3. Head of office
- The head office of the Association shall be in the City of Edmonton, Province of Alberta.
- Action: Changes made by the 1992 Constitution Committee.

FEE INCREASE

- Be in resolved that membership fees for CUNSA/AEIUC be increased to $4.00 per full-time student and $2.00 per part-time students starting the year 1992-1993.
- Action: Referred to the BOD to be implemented in Sept. 1993.

CURRICULUM ON LOBBYING

- Be it resolved that CUNSA/AEIUC support the inclusion of effective lobbying activities and techniques into the mandatory curriculum; and further,
- Be it resolved that all official Delegates and Associate Delegates work with the Dean/Director of their respective nursing Faculty/School to include effective lobbying activities and techniques into the mandatory curriculum; and further,

- Be it resolved that the vice-president write to CAUSN to inform them of the position of CUNSA/AEIUC on lobbying and to offer CAUSN assistance in introducing these changes to the curriculum.
- Action: Letter written by vice-president to CAUSN in 1992. CNSA supports inclusion of lobbying into curriculums. Most OD's approached their Deans/Directors with concerns re: lobbying inclusion into curriculums.

ACADEMIC EQUIVALENCE FOR ATTENDING NATIONAL CONFERENCE

- Be it resolved that the official Delegate submit a written proposal to the Dean/Director of their respective Faculty/School of Nursing to obtain academic equivalence for the students who attend the CUNSA/AEIUC National Conference.
- Action: Equivalence was reworded to state: Recognition. OD's encouraged by Regional Directors. Uncertain of action taken by OD's.

PROMOTION COMMITTEE

- Be it resolved that CUNSA/AEIUC strike up an ad hoc committee at McMaster University to develop a promotional package for CUNSA/AEIUC.
- Action: Ad Hoc Committee formed and headed by Steve Cairns Excellent promotional package produced for CNSA.

PROMOTIONAL STRATEGIES

- Be it resolved that the Official Delegate or the Associate Delegates of each University submit to the Promotion Committee by March 9, 1992, strategies for promoting CUNSA/AEIUC that have been successful as well as strategies that have failed and ideas for future and ongoing promotions.

Resolution Statements 1989

BOARD OF DIRECTORS LEDGERS

- Be it resolved that expenses incurred from December 31 until the National Conference be recovered with presentation of receipts to the Secretary/Treasurer at the National Conference.
- Action: Implemented by the incoming board of directors.

National Account Closure

- Be it resolved that any CUNSA/AEIUC cheques not cashed by March 1, be cancelled and reissued by the incoming Secretary/Treasurer so that the National Account can be closed and funds be transferred to the new Secretary/Treasurer by March 31.
- Action: Implemented by the 1989-90 BOD.

CHANGE IN ELIGIBILITY FOR VICE-PRESIDENT

- Be it resolved that a change in the Bylaws be made such that Section XII, Item A2 should read: "Vice-President, hereby referred to as VP, shall be elected from the BOD, excluding the President, at the first meeting of the BOD".
- Action: Implemented by the 1989-90 BOD.

HOST OF THE 1992 NATIONAL CONFERENCE

- Be it resolved that Queen's University host the National Conference in 1992 in conjunction with the 150th anniversary of Queen's University and the 50th anniversary of the Queen's School of Nursing.
- Be it further resolved that the Western Region be designated to host the 1993 National Conference after which time the schedule will return to normal.

CPR

- Be it resolved that where no mechanisms for CPR certification exist within the Faculty, CUNSA/AEIUC recommend that the Official Delegate arrange for a CPR course by a qualified instructor to be given at a time and place convenient for the student body, and communicate these arrangements to the students.

Resolution Statements 1988

BILL OF RIGHTS

- Be it resolved that the Board of Directors appoint an Ad Hoc Committee to formulate a CUNSA bill of rights.
- Action: University of Alberta Ad Hoc Committee looking onto several issues re: rights of nursing students
- University of Alberta/University of Lethbridge moved that the students' Bill of Rights of 1988 be rescinded at the 1989 National Assembly. This was based on the University of Alberta Ad Hoc Committee Report on student's rights.

UP-TO DATE "GRADUATE BOOKLET"

- Be it resolved that an appointed university produce an updated Graduate Education Booklet which contains information about certificate program, Master's programs as well as Doctorate programs for nurses, and
- be it further resolved that this updated bilingual Graduate Education Booklet be ready for sale in the 1988-89 CUNSA term.
- Action: McMaster Committee chaired by J. Grogan
    - Graduate booklet was not available to be sold during the 1988-90 CUNSA term
    - The 1989-90 Board of Directors was made aware that the company that had been chosen to solicit advertising and print the booklet (MTA Communications) has allegedly misrepresented CUNSA as well as the advertisers that they (MTA) had solicited
    - CUNSA is currently looking for a new company to perform the duties that MTA was originally contracted to do
    - S. Lappan, Fundraising Director (1989-90) has been in contact with legal authorities regarding MTA Communications.

CREATION OF COMMITTEES

- Be it resolved that the policy and procedure committee be located at the President's member university, and
- further be it resolved that committees be created at the universities where the following board members are found: Education/Research Director, Fundraising Director, Conference Director, Communication Director, and that these committees will function as a resource to the Board of Directors member to help the member achieve his/her mandate; and
- be it further resolved that these committees be designated standing committees under section XXXVI of the bylaws and that they be added to the bylaws as such.
- Action: Being done to a varying degree.

NATIONAL CONFERENCE SURPLUS

- Be it resolved that the Board of Directors recognize the efforts of the host university by giving that university (?) and
- further be it resolved that any surplus funds from the National Conference go into national accounts and remain designated for future National Conference deficits.

- Action: Unclear what will be given (if anything) to host university -1988 surplus from University of Manitoba put into National Account.

LOBBYING ENTRY INTO PRACTICE

- Be it resolved that CUNSA establish written guidelines for local CUNSA chapters to lobby government officials on the Entry to Practice issue with the support of the CUNSA organization nationally.
- Action: Committee formed at University of Saskatchewan to establish guidelines
- University of Saskatchewan presented these guidelines at the National Assembly (1989).

EXPENSES FOR BOARD OF DIRECTORS

- Be it resolved that Directors shall claim expenses only for travel, rooming accommodations and $10.00 per day for meals at each of the Board of Director's meetings and the National Conference, and
- further be it Resolved that the RD's claim these same expenses for their respective regional conferences.
- Action: Being used without difficulty
- Purpose - to eliminate the possibility of submission of receipts for extras and clearly define allowable expenses.

FIRST AID

- Be it resolved that CUNSA support the inclusion of First Aid training and certification in the first and subsequent years of generic nursing programs at no cost to the student, and
- further be it resolved that the President of CUNSA write letters to the Deans of each member university supporting the inclusion of First Aid training in their curricula, and
- further be it resolved that each OD present to their respective nursing undergraduate societies this issue for further action at each university and to report back to the RD before the May Board of Director's meeting.
- Action: Uncertain as to action undertaken at member universities.

Resolution Statements 1987

NATIONAL STUDENT INFORMATION SERVICE

- Be it resolved that CUNSA establish an Ad Hoc Committee to explore the formation and exaction of a national information/answer service for Canadian university nursing students. The service will involve the participation of each CUNSA university chapter.
- Action: Ad Hoc Committee formed at UNB - status unknown.

RESOURCE PERSON

- Be it resolved that the development of a resource person position be evaluated by the Board of Directors in their spring meeting 1987, and
- further be it resolved that this investigation include review of information obtained in correspondence with CAUSN, CNA and provincial associations currently on file with the ORD.
- Action: position ratified at 1988 National Conference
    - Luc Therrien instated as first Resource Person for 1988-90
    - Remains very active in the position to date.

MAIL SECRETARIAT POSITION

- Be it resolved that CUNSA Board of Directors approve the appointment of a CUNSA member by the OD of University of Ottawa, to the position of Mail Secretariat for the purpose of redistributing mail to CUNSA members which is received at CAUSN'S head office, 151 Slater Street, Ottawa, Ontario.
- Action: Carried out by Ottawa University in past
    - University of Ottawa has relinquished membership this year (89-90) and has not been fulfilling mail secretariat duties.

FEE CHANGES

- Be it resolved that CUNSA membership fees be as follows:
    - Full-time/Part-time o 1987-88 $2.50/ $1.25 o 1988-89 $3.00 /$1.50 o 1989-90 $3.50 /$1.75
    - Paid in two equal installments per year with the first due at the fall regional conference and the second due at the national conference.

- Action: Being undertaken o To be reassessed at the 1990 Board of Directors meeting prior to National Assembly.

ZUCCHINI PLAN

- Be it resolved that an Ad Hoc Committee from one University be appointed to explore the ramifications of a horizontal organization model and
- further be it resolved that the Ad Hoc Committee plan the steps to establish this organizational model and
- further be it resolved that the Ad Hoc Committee submit interim reports to the Board of Directors for their Spring and Fall meeting, before the National Conference and a final report to the next National Assembly.
- Action: Final report submitted by Dalhousie University February 1988 (Jeff Baines Chair)
- Plan being implemented with 4 Ad Hoc Committees active and communication operating effectively (i.e., BOD -> RD's -> OD's-> universities) according to plan.

Resolution Statements 1986

CPR

- Be it resolved that CUNSA support the inclusion of CPR instruction certification and recertification into the first and subsequent years of curricula of baccalaureate program across Canada, i.e., included in tuition fees.
- Action: uncertain if letters were written to Deans and Directors.

SMOKING

- Be it resolved that CUNSA urge individuals to take responsibility for their health care by encouraging them to refrain from smoking.
- Action: Individual responsibility.

PROFESSIONAL IMAGE

- Be it resolved that CUNSA urge each member to promote a professional image by refraining from purchasing, wearing or displaying articles of slogans demeaning to professional nursing and nursing students.
- Action: motion tabled, individual responsibility.

Resolution Statements 1985

INCORPORATION

- Be it resolved that: CUNSA incorporate under part II of the Canada Corporations Act, June 7, 1979.
- Action: Board of Directors formed
- Corporate seal received
- CUNSA inc. initiated by M.L. Hesson.

CHARITY STATUS

- Be it resolved that: CUNSA seek registered charity status and tax exempt number from Revenue Canada.
- Action: annual endeavor o Attempts in 1988-89 by S. Ross, Fundraising Director, to create foundation
    - Attempts in 1989-90 by S. Lappan, Fundraising Director, and A. Lesperance, Communications Director, have yielded documents for application for charitable status.

FISCAL YEAR

- Be it resolved that: the fiscal year of CUNSA coincide with the dates of the terms of office of the national executive.
- Action: Carried out.

BOARD OF DIRECTORS

- Be it resolved that CUNSA's Board of Directors consist of the following members: President, Secretary/Treasurer, Conference Director, Communications Director, Education/Research Director, Fundraising Director, Atlantic Regional Director, Quebec Regional Director, Ontario Regional Director and Western Regional Director.
- Action: Carried out.

Resolution Statements 1984

CANADA HEALTH ACT

- Be it resolved that CUNSA support the new Canada Health Act and

- be it further Resolved that CUNSA support the CNA'S recommendations to the new Canada Health Act and the CNA's efforts to incorporate the said recommendations into active legislation.
- Action: the National Chairperson, on behalf of CUNSA, submit a letter of support to the new CHA and the CNA's recommendations to the new CHA to the following persons:
    - Monique Begin Provincial Ministers of Health
    - MP's - Helen Glass (CNA Pres)
    - Dr. Josephine Flaherty.

NUCLEAR WEAPONS

- Be it resolved that CUNSA take a stand to oppose both the production and testing of any or all nuclear weapons in the province of Alberta or in the country of Canada and other nations of the world.
- And that the National Chairperson will send telegrams to Mr. Lougheed, the Premier of Alberta and Mr. P.E. Trudeau, Prime Minister of Canada, presidents of ICN, CNA and the embassies of USSR, USA, China, France, UK, and India opposing the production, testing and development of nuclear weapons.
- Action: Letters - uncertain whether sent - attempt by R. Stollery (UBC) to sue CUNSA over inactivity.