Resolution 1: A Call to Action for Governments and Healthcare Leaders to Promote Practices and Work Environments to Support Optimal Mental Health and Well-being, Resilience and Suicide Prevention

Submitted by: Debra Lefebvre, BA, RN, BN, MPA. In memory of all Health Care Workers who died by suicide

Conflict of Interest: No known conflict of interest

WHEREAS nurses working in stressful conditions (eg: high workloads, inadequate and unpredictable patient-staffing ratios, violent and abusive patients, insufficient personal protective equipment) is at an epic high and research suggests 80% of nurses reported critical incident stress, 63% reported burnout, one in three (36%) nurses reported depression, and more than one in four (26%) reported anxiety (Canadian Federation of Nurses Unions [CFNU], 2020), and an alarming 38% of nurses showed significant symptoms of post-traumatic stress disorder (PTSD) (Crowe et al., 2020); and

WHEREAS findings from a recent study with nearly 7,500 practicing nurses largely from hospitals across Canada show that one in three (33%) nurse professionals have suicidal thoughts (ideation), 17% have plans to die by suicide, and 8% attempted suicide (CFNU, 2020), and nurse suicide rates are now higher than the general population in the United States (Davidson et al., 2020); and

WHEREAS the current COVID-19 pandemic has further worsened the working environment, increased stress and workloads, and aggravated the poor mental health of nurses.

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) advocate for the government to direct more funding for mental health programs and resources for Ontario nurses and

THEREFORE BE IT FURTHER RESOLVED that RNAO advocate and urge government to include nurses in Bill 163, where it be recognized that nurses can suffer with PTSD due to workplace related stressors and exposure to trauma, and deserve a fair and balanced approach to make sure that nurses who are suffering from PTSD receive prompt diagnosis, treatment and support so that they can return to work and their lives as soon as possible.

Background

The prevalence of nurses' poor mental health and escalating mental illness is growing at an alarming rate particularly now during the pandemic. Findings from a recent study show that nurse suicide rates are now higher than the general population in the United States (Davidson et al., 2020). In a study conducted by Statistics Canada (2020) of 18,000 Canadian health care workers, one in three (37%) nurses reported poor mental health (Statistics Canada, 2020). Other research also suggests that nurses have experienced significant psychological distress related to the current COVID-19 pandemic where participants reported clinical concern for (23%), probable (13%) and significant (38%) symptoms of post-traumatic stress disorder, as well mild to severe depressions (57%), anxiety (67%) and stress (54%) (Crowe et al., 2020).

Poor mental health not only has a negative impact on the overall health and wellbeing of nurses, it can have a negative impact on patient outcomes, as well. Research shows that depression was the leading predictor of medical errors, and that emotional fatigue can reduce cognitive functioning including decision-making, memory and attention (Hume, 2018; Johnson et al., 2018; Melnyk et al., 2018). Studies show that evidence-based interventions, such as mental health training, self-care, and mindfulness and cognitive behavioral therapy/skills building, improve mental health, resiliency, and well-being (CFNU, 2020; CNO, 2020; Samson et al., 2019).

Creating and sustaining positive practice settings is essential to maximize the health, well-being and safety of nurse professionals, and evidence-based interventions are crucial to improve and support mental health, resiliency and well-being. When nurses take care of themselves, it not only benefits them with increased job and life satisfaction and overall well-being, it benefits patients, as well (Hume, 2018).

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Resolution 2: Integrated Strategy to Address Substance Use Disorder (SUD)

Submitted by: Kathy Moreland, RN, MScN and Christina Hughes RN, BScN on behalf of the Waterloo Chapter

Conflict of Interest: No known conflict of interest

WHEREAS substance use disorder (SUD) is a widespread and increasingly prevalent disease resulting in unacceptably high rates of hospitalization, death, individual and family suffering, healthcare worker and system burden costing Canadians billions of dollars/year.

WHEREAS in spite of calls to action and webinars provided by RNAO, registered nurses and other health professionals in all areas of care have knowledge gaps about SUD, treatment and trauma informed approaches resulting in inaccessible and inappropriate care, continued stigma toward this population and moral distress for those caring for them.

WHEREAS current stressors on our healthcare system continue to delay/minimize the Road to Wellness (2020) initiatives that were based on the recommendations of the 2010 Select Committee's report "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians" leaving this population vulnerable to suffering and/or death with few options for recovery or care and RN's and other healthcare workers with no accessible experts to support them or those with SUD and the community.

THEREFORE BE IT RESOLVED that RNAO and its membership call for the Ministry of Health and its allied partners (Associate Minister of Mental Health and Addictions, the Ontario Hospital Association, the Ministry of Social Services and Ontario Health) to accelerate and augment the Road to Wellness (2020) initiatives and implement a province wide, integrated strategy for SUD that will address prevention, reduction of opioid overdose deaths (legalized, safe drug supply, decriminalization, accessible consumption and treatment services in all regions of the province), timely, appropriate, affordable and accessible treatment for those with SUD as well as the creation and funding of regional, trauma informed SUD coordinators to support and educate those working with this population and those they serve.

Background

Substance use disorder (SUD) is a public health crisis that impacts us all affecting approximately 21.6% of Canadians (6 million people) during their lifetime (Statistics Canada, 2020). The estimated cost of substance use in Canada in 2014 was $38.4 billion (Canadian Substance Use Costs and Harms Scientific Working Group, 2018) including costs related to healthcare, criminal justice and lost productivity. In 2019, there were 10,471 cases reported ED visits due to opioid related issues in Ontario. Opioid related hospitalizations have reported to be as high as 15.1/100,000 (Public Health Ontario, 2020b). The increase in acute care hospital use has put great physical, mental and emotional strain on the healthcare system and its workers. In June 2020, a 25% increase in suspected drug-related deaths between March and May compared to 2019's monthly median was announced by Ontario's Chief Coroner. It was suggested that if this trend continued, there would be 2,271 opioid related deaths in the province by the end of 2020, a 50% increase from 2019 (Public Health Ontario, 2020).

SUD has been viewed by society as weakness, a moral failing or a lack of self-control of the affected individual. This attitude persists in spite of the recognition that SUD is a chronic disease driven by neurochemical changes in the brain. Nurses are susceptible to this way of thinking due to a lack of education about SUD and trauma informed approaches as well as negative role modelling (Farrell, 2020; Howard and Chung, 2000). This results in stigma and a negative impact on the care these patients receive (Velez et al., 2016).

In a 2010 report from the Select Committee on Mental Health and Addictions, strategic goals were developed to address the gaps in care of those with mental health issues and SUD in Ontario. Education of service providers to promote adequate care and reduce stigma were amongst the key goals. Little has been done to address the needs identified 11 years ago resulting in ineffective care, overdose and death for those affected, continued stigma, and progressive trauma for nurses, healthcare workers, affected individuals and their families. In early 2020, the Ontario government released its "Road to Wellness" strategy based on the recommendations of the 2010 Select Committee report. Competing healthcare priorities have stalled implementation. An augmented integrated strategy for the prevention, treatment and support for those with SUD and those that care for them is urgently needed.

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Resolution 3: Research and Advocacy to Support New Graduate Nurses

Submitted by: Lauren Rogers, RN
Conflict of Interest: No known conflict of interest

WHEREAS limited research demonstrates 30-57% of new graduate nurses will leave the profession by their second year of practice (Bowles & Candela, 2005), few studies have been conducted to examine the factors that lead to new graduate nurses leaving the profession in Ontario.

WHEREAS the high attrition rate of new graduate nurses contributes to the nursing shortage and has a lasting negative impact on staff morale, work productivity and patient outcomes while creating increasing financial burden on healthcare organizations and strain on the healthcare system (Beecroft, Dorey, & Wenten, 2008; Laschinger, 2012).

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) advocate for increased research on the current attrition rate of new graduate nurses in Ontario and their reasons for leaving the profession in order to facilitate investment in and implementation of evidence-based strategies to improve retention of new graduate nurses.

Background

Before the COVID-19 pandemic, the Canadian Nurses Association (CNA) predicted that the shortage of nurses would rise to 60,000 by 2022 (Canadian Nurses Association [CNA], 2009). Efforts were made to educate and recruit more nurses; however, retention of nurses, especially new graduate nurses, remains an issue (CNA, 2020). Despite the increase in the number of registered nurses eligible to practice, the percentage of practicing nurses continues to decrease, and new graduate nurses are the group with the highest attrition rate in the nursing workforce (CNA, 2020; Kramer, Brewer, & Maguire, 2013). When new graduate nurses leave the profession, there are financial and patient care implications, including increased patient mortality (Beecroft et al., 2008). Further, increased turnover of new graduate nurses can lead to turnover in tenured staff due to continual orientation and onboarding (Perreira, Berta, & Herbert, 2018). With increasing burnout and strain in the nursing profession, especially in the context of a global pandemic, it is more important than ever that we retain new graduate nurses and support them in their transition to practice in order to address the nursing shortage and prevent further burnout (Laschinger, 2012). Research regarding new graduate nurses' attrition rates and their

reasons for leaving the profession as well as advocating for increased initiatives to support new graduate nurses are actions required in order to address this issue (Chachula, Myrick, & Yonge, 2015).

Understanding the issue through research is critical to implementing evidence-based interventions to retain new graduate nurses (Laschinger, 2012). Lack of data on attrition rates of new graduate nurses in Canada and Ontario prevents implementation of strategies in the healthcare system as its urgency cannot be fully demonstrated (Chachula et al., 2015). There are multiple conflicting attrition rates and most studies are dated and limited in scope. The most commonly cited statistics that demonstrate large proportions of new graduate nurses leaving the profession that are used in Canadian literature are based on American research, for example that 57% of new graduate nurses will leave the profession within two years (Bowles & Candela, 2005). Further studies have been done in specific regions of Canada, such as in Western Canada, to gain additional insight into retention of new graduate nurses; however, data collection is limited in Ontario (Chachula et al., 2015). Studies are still unable to explain all the factors that contributed to new graduate nurses' intent to leave the profession in Canada and therefore, further research must be conducted (Beecroft et al., 2008). The impact of beginning a nursing career during a pandemic is one factor that has not yet been explored.

In contrast to the limited amount of research on new graduate nurses' attrition rates in Ontario, there is a vast amount of international literature exploring the known barriers to retention and strategies which reduce the number of new graduate nurses leaving the profession (Laschinger, Zhu, & Read, 2016). Inability to provide quality care and having a negative work environment results in job dissatisfaction and burnout, resulting in increased intention to leave the profession (Laschinger et al., 2016). Initiatives that improve retention and facilitate the transition between student and nurse include improving work environments, empowerment, mentorship, extended transition programs, fostering positive relationships, authentic leadership and supporting professional practice (Baumann, Hundsberger, Crea-Arsenio, & Akhtar-Danesh, 2018; Laschinger, Wong, & Grau, 2012; Laschinger et al., 2016). However, initiatives to support new graduate nurses require funding and prioritization within the healthcare field (Scott, Engelke, & Swanson, 2008). By implementing targeted strategies for new graduate nurse retention, institutions can retain their nursing workforce and therefore improve patient safety and decrease costs (Laschinger, 2012). With increasing patient acuity, a rapidly aging population and an evolving healthcare system, advocacy for new graduate nurse supports is even more critical in order to create a stable foundation for the future of the nursing workforce (Chachula et al., 2015; Laschinger, 2012).

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Resolution 4: Decriminalization of the possession of illegal drugs for personal use

Submitted by Louise Lemieux White RN, BScN, IBCLC
Conflict of Interest: No known conflict of interest

WHEREAS the opioid crisis has taken the lives of 17,602 Canadians between January 2016 to June 2020 and the current pandemic has increased the harm from this crisis, shown by the loss of 700 lives of Ontarians between mid-March and November 2020 (1, 2)

WHEREAS the criminalization of the possession of illegal drugs for personal use is a contributing cause of overdose deaths as persons requiring help for substance use disorder face many barriers in seeking medical treatment

WHEREAS the decriminalization of drugs has seen a reduction in problematic drug use, harms related to drug use and a reduction in criminalization (3)

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) hereby advocates that municipal, provincial, and federal governments take all actions within their power to decriminalize the possession of drugs for personal use to reduce the harms of the opioid crisis

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Background

A great amount of evidence exists to support decriminalization as an effective policy approach to reduce the harms of substance use (4). Presently in Canada, any individual caught with an illegal substance can be charged with possession and tried in a court of law. If found guilty they are burdened with a criminal record. Criminal records harm individuals with a substance use disorder by stigmatizing them and is a barrier to seeking medical treatment, to safe use and to recovery from a substance use disorder thus resulting in the progression of their illness at great expense to taxpayers and harm to the individual and their family and friends. Further, a criminal record can result in barriers to travel and employment. Substance use disorder is a health issue not a criminal justice issue.

Sadly, the pandemic has exacerbated the death toll from opioids due to a number of factors such as: an increasingly toxic unregulated supply, increasing barriers to access to harm reduction services and treatment, and the implementation of public health measures of physical distancing, which has subsequently led to more people using alone (2). In January

2021, the City of Toronto recorded the highest number of overdose deaths (38) in a month since it began to track these deaths in 2017. This is an increase of 36% from the month of November 2020 (5). In Ontario, there has been nearly a 40% spike in overdose deaths since the beginning of the pandemic (2).

Support for the decriminalization of possession of drugs for personal use, which can be defined as a three day supply, has been supported by The Toronto Board of Health in 2018, The Canadian Association of Chiefs of Police in 2020, The Canadian Mental Health Association in 2018, The BC Chief Medical Officer of Health in 2019 and the BC Chief Coroner in 2020 as well as the cities of Vancouver, Montreal and the Province of BC. In BC, requests have been made to the federal Minister of Health to grant under section 56 of the *Controlled Drugs and Substances Act*, an exemption from section 4(1) of that Act to decriminalize the possession of controlled substances for personal use (6).

It is time for Torontonians, Ontarians and all Canadians to rethink how to better support people who use drugs problematically to prevent the skyrocketing mortality rate. Addiction and mental illness are complex, but their complexity should not be a barrier to take the steps required to save the lives of someone's child, sibling, parent or friend. A public health approach and compassion are needed to address this issue. The current criminal justice approach is harmful to people who use drugs and their loved ones. Nurses are well positioned to advocate for people who use drugs who face the daily threat of death.

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1 Government of Canada Opioid and Stimulant-Related Harms in Canada

2 Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic

3 Policy Brief CSAM in Support of Decrim 2021

4 CCSA Decriminalization: Options and Evidence

5 The Toronto Star February 12 2021

6 CBC News January 28 2021

Resolution 5: Strategies to uphold the calls to action as proposed by the Truth and Reconciliation Commission

Submitted by: Chantal Byrnes Leadbeater on behalf of the Nursing Students of Ontario (NSO)
Conflict of Interest: No known conflict of interest

WHEREAS nursing students have identified that there is a lack of adequate teaching and knowledge around the Truth and Reconciliation Commission's Calls to Action refer to Appendix A.

WHEREAS The calls to action directly request that all medical and nursing schools in Canada should require that all students take a course in regards to Indigenous health issues to build a more culturally competent medical system (Truth and Reconciliation Commission of Canada, 2015).

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) to advocate for the inclusion of mandatory Indigenous Studies courses in the regular nursing school curriculum and to create a nursing practice standard to the College of Nurses of Ontario (CNO).

Background

Canada's history with Indigenous Peoples is long standing and tumultuous. Starting in the 1400s with the first settlers and the Doctrine of Discovery which provided a framework for the European Explorers to lay claim to land even if the land was inhabited by other peoples so long as they were not Christian (Assembly of First Nations, 2018). This rippled through history with The British North America Act where the government took responsibility for Indigenous peoples and lands, Indigenous who were considered "enfranchised" lost their status, and community (Government of Canada, 2015a). Another Act came into play shortly after named the Indian Act. The Indian Act further placed restrictions on the Indigenous community. This act introduced residential schools, created reserves, denied women status, enforced enfranchisement, forbade First Nations from forming political organization, forbade First Nations from speaking their native language, forbade First Nations from practicing their traditional religion, and denied First Nations the right to vote (Legislative Services, 2020). This Act led the way for Inuit relocation, the Sixties Scoop and the horror that was residential schools. Of the 139 officially recognized residential schools, a place that was a focused cultural genocide of the Indigenous peoples and are historic in their abuse, the last closed only in 1996 (Union of Ontario Indians, 2013). The Government of Canada only

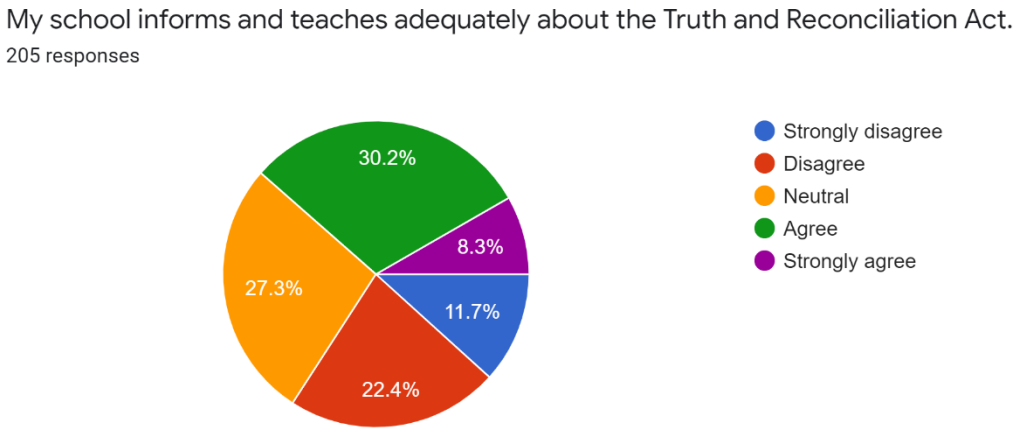
formally apologized for the residential schools in 2008 (Government of Canada, 2010b). The centuries of apathy toward the Indigenous people and Canada's poor record in protecting the rights of Indigenous peoples is abysmal (Carling & Mankani, 2020). This led to the creation of the Truth and Reconciliation Commission of Canada and their Calls to Action.

The Truth and Reconciliation Commission of Canada (TRC) was created as a response to the horrific residential school legacy in order to facilitate healing and to provide an opportunity for Canada to do better (Truth and Reconciliation Commission of Canada, 2015). The Calls to Action were born from an 8 year expedition in which the TRC engaged the Canadian public, educated people about the history and legacy of the residential schools system and provided a place to share and honour the experiences of former students and their families (Truth and Reconciliation Commission of Canada, 2015). The 94 calls to Action were a summary of all the ways that further reconciliation could be provided between the Indigenous peoples and Canadians (Truth and Reconciliation Commission of Canada, 2015).

Unfortunately, while the RNAO does provide webinars, research papers and supports National Indigenous Peoples Day, there is little that is being enforced on a fundamental management level for instance there is no Indigenous seat on the Board of Directors. The recent changes within RNAO were spearheaded by student nurses who created the Indigenous Nurses and Allies Interest group and who advocated for approval of an Indigenous seat within the Nursing Students of Ontario. This is also reflective of what students are seeing in regards to their gaps in nursing education. Recent studies and surveys have found that approximately 45% of Canadians have never heard of residential schools and that escalates to nearly 60% in older demographics (Yoshida-Butryn, 2020). Actual Canadian history is simply not being taught or the importance of the Indigenous history is not a focus. It is time to do better, it is time to be better. Indigenous health care is not currently being explored in the depth and breadth that it both needs and deserves. In continuing to strive against institutional racism, we resolve that the RNAO advocates for nursing schools in Ontario to have at least one mandatory Indigenous Studies class and to create a nursing practice standard thereby upholding at least one of the 94 Calls to Action.

Appendix A

Results from the NSO student survey, 2020



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Resolution 6: Call to have placements and consolidations of nursing students be an essential service

Submitted by: Chantal Byrnes Leadbeater on behalf of the Nursing Students of Ontario (NSO)
Conflict of Interest: No known conflict of interest

WHEREAS during this pandemic nursing students have identified a significant gap in their learning regarding clinical experience as per Appendix A.

WHEREAS nursing programs require of their students to complete a certain number of hours in direct relation to how far along in their program they are. Due to this pandemic, schools have switched to subpar virtual simulations in the students' opinions.

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) advocates for nursing students to be deemed essential services in times of crisis, making it unable to be cancelled or delayed, to the College of Nurses of Ontario (CNO).

Background

For students in Ontario who are pursuing a career as a Registered Nurse (RN), the CNO requires the individual to complete "400 hours of clinical/practical/consolidation experience" (CNO, 2017) Since this pandemic, students are not receiving this as the CNO has been flexible on what a final consolidation looks like on a school-by-school basis. In some schools, final consolidation is only 300 hours, in others it is a mix of on-site learning and virtual simulation lab. However the virtual world does not adequately replace hands-on learning. The RNAO itself recognizes the importance of clinical placements by stating

"clinical learning experience in nursing education provides students the opportunity to consolidate theory and practice together. It is through clinical placements that nursing students develop and refine their skills in therapeutic relationship, person and family-centred nursing care, among other foundations learned in nursing school" (RNAO, 2017).

Many resources agree with what the RNAO places itself on this issue further stating ""There is no replacement for this type of learning. Learning in a clinical environment creates challenges that are missing in the classroom" (Concordia University, 2020). In November of 2020, the Nursing

Students of Ontario put forth a survey accessible to all Ontario Nursing students. While the concerns and complaints were many, there was one reoccurring theme. Many students took the extra time to write about their concerns with virtual placements replacing clinical experiences. Many spoke about feeling unprepared as nurses, expressing frustration at the lack of guidance and fears of stepping into health care after having the last year of placements frozen. A sample of concerns from the students are in Appendix B.

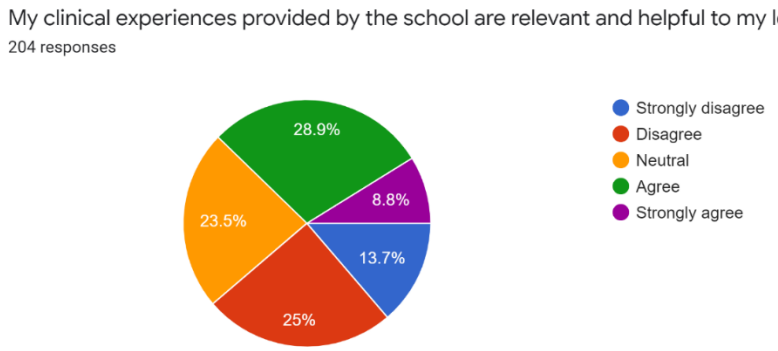
Instead of supporting nursing students during this time and advocating on their behalf, placements were cancelled, those with a few shifts left of consolidation were left hanging in the wind, and nursing students were provided with no identified plan, no resources and no communication for the weeks and months to come. This comes at a time when the CNO was calling for retired nurses to aid in the pandemic, but left a resource of thousands of students, with the most recent education and willing to do their civic duty, untapped. Resources have found that "many students have already disclosed that they would take on that risk if it means they could finish their Bachelor of Nursing degree" (Dewart et al., 2020).

This echoes the same issues that Canadian nursing students faced during the SARS pandemic. In the 2003 RNAO report *SARS Unmasked.* In this report it recognized that Ontario did not utilize their nursing students appropriately which led to workforce constraints (RNAO, 2003). It noted that similar to the COVID experience, clinical placements were cancelled leaving students who had critically important skill sets out of the picture left students feeling undervalued, especially knowing that students in other health professions were allowed to continue in some capacity (RNAO, 2003). Finally this led to a RNAO recommendation that appropriate guidelines for "health care organizations and nursing education programs to continue clinical placements during time of crisis" further stating that students possess both knowledge and expertise needed and even require the experience (RNAO, 2003)

This is not the first pandemic and it most certainly will not be the last. There needs to be legislation in place that allows nursing students, should they choose to work in those conditions, to be able to do so. The Nursing Students of Ontario urge the RNAO to advocate on behalf of nursing students to help make their clinical rotations an essential service by lobbying the CNO. We have already repeated history once, help to create a plan moving forward so that we do not make the same mistakes again.

Appendix A

Results from the NSO student survey, 2020



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Resolution 7: Sexual and Gender Minorities Content in the Nursing Standards

Submitted by:
Dr. Paul-André Gauthier, RN, CNS, PhD on behalf of the Rainbow Nursing Interest Group (RNIG)

Conflict of Interest: No known conflict of interest

WHEREAS given that sexual and gender minorities in Ontario experience prejudice, stereotyping, discrimination, harassment and barriers in accessing health services and experience higher rates of mental health concerns, lower rates of preventive screening for chronic health issues and cancer, higher rates of HIV and other sexually transmitted infections, higher rates of substance use (Health Equity Impact Assessment LGBT2SQ Populations, Sherbourne Health & Rainbow Health Ontario), and;

WHEREAS consistent with the recommendation in the Standing Committee on Health Report the Health of LGBTQIA2 Communities in Canada that "the Government of Canada work with the provinces, territories and provincial health professional and regulatory bodies to establish a working group to identify ways to promote training and education of health care professionals about the health needs of sexual and gender minorities," and;

WHEREAS RNAO is in the process of completing the development of a Best Practice Guideline (BPG) "Reconciling 2SLGBTQI+ Health: Best practices for advancing health equity in sexual orientation and gender identity minority communities (working title) Best Practice Guideline;" and; RNIG-Rainbow have reviewed the "Position statement: Respecting sexual and gender minorities" in February 2021.

THEREFORE BE IT RESOLVED that the Registered Nurses Association of Ontario advocates with the Ministry of Health of Ontario (MOH), the College of Nurses of Ontario (CNO), and the Canadian Association of Schools of Nursing (CASN) to include, the health needs of sexual and gender minorities into entry-to-practice competencies and a nursing practice standard.

THEREFORE BE IT FURTHER RESOLVED that the Registered Nurses Association of Ontario works with the Rainbow Nursing Interest Group (RNIG) in the lobbying in regard to the health needs of sexual and gender minorities, with other organizations, such as the Ministry of Health of Ontario (MOH), the College of Nurses of Ontario (CNO), and the Canadian Association of Schools of Nursing (CASN), in ensuring that our LGBTQ2S+ community is well represented in the process.

Background

As healthcare is historically heteronormative, many of the biases within the system against members of the LGBTQ2 community, may not be readily apparent (Enson, 2015). When there is a lack of discussion regarding gender identity and sexual practice with a health-care provider, for the majority, the assumption is that the client is cisgender and heterosexual (Baker & Beagan, 2014). This may induce fear and discomfort felt by some members of the LGBTQ2 community when accessing health services. Some of this discomfort is linked to a fear of discrimination from the health-care provider which can cause stress to the patient (Bidell & Stepleman, 2017; Von Doussa et al., 2016), and may lead to nondisclosure. Nondisclosure influences quality of care as those health-care issues prevalent in this population are neither discussed nor investigated (Baker & Beagan, 2014).

It has been known for some time that LGBTQ2 related health-care education for all health-care professionals is inadequate (Carabez et al., 2015; Charles et al., 2015; Greene et al., 2018; Lim & Hsu, 2016; Parameshwaran et al., 2017; Singer, 2015). There must be recognition of LGBTQ2 health in all aspects of normal human behaviour and health care provision. Time and emphasis in curricula for LGBTQ2 relevant health needs should be on par with the degree given of cisgender and heterosexual centric issues.

Although children in grades K-12 have little influence on current healthcare practice, early education influences student thoughts and behaviours and can impact future societal change (Westheimer, 2017). Despite the recognition that Canadian schools have been shown to be unsafe for LGBTQ2 youth (Taylor et al., 2011), encouraging teachers to integrate recognition of LGBTQ2 marginalization in the curriculum and to develop empathic concern has been associated with a reduction in homophobic behaviours in heterosexual youth (Baams, Dubas, Aken, 2017; Espelage et al., 2019). Proactive responses to harassment based on sexual and gender non-conformity can create a positive learning environment for LGBTQ2 youth and educators (Enson, 2015).

People who identify as LGBTQ2 experience high rates of discrimination in health care, including being refused health care, health-care providers refusing to touch them, use of harsh/abusive language, physical abuse, or blame for their health status (Lambda Legal, 2010).

In consideration of this, there should be an expectation that all who work in the system have received adequate education in respectful care of LGBTQ2 clients, through the use of formal, substantive education and training.

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Resolution 8: Support of a National Grief Strategy

Submitted by: Carolyn Wilson on behalf of the Palliative Care Nurses Interest Group
Conflict of Interest: No known conflict of interest

WHEREAS the pandemic has brought to the forefront the urgent need to respond to and support the healing of grieving Canadians as documented in the social, physical and psychological consequences of deaths and other losses (jobs, business failure, financial security) incurred during the unique circumstances of the pandemic for the public, healthcare workers, first responders and others delivering essential services.

WHEREAS in some cases, this can lead to increased instances of complicated and prolonged grief, depression, and the risk of suicide. As reported by the Canadian Grief Alliance (CGA), a group of leading grief specialists and more than 150 national and provincial organizations that are trying to advocate for the government's role in addressing the national gaps in grief services. These gaps in grief services are leaving Canadians feeling unsupported in their grief and thereby impacting every Canadians' health and wellbeing.

WHEREAS Registered Nurses of Ontario (RNAO) values health as a resource for everyday living and that health care is a universal human right. RNAO is committed to diversity, inclusivity, equity, social justice, and democracy, believing the leadership of every nurse advances individual and the collective health.

THEREFORE BE IT RESOLVED that RNAO formerly endorse and advocate to municipal, provincial and federal governments the implementation and funding of the 4 point plan by Canadian Grief Alliance, as a response to the COVID-related grief.

Background

"Canadians have been robbed of goodbyes with dying friends and family or people they care about and forced to grieve in isolation without funeral rites. They, and those working on the front lines of health care are at heightened risk for prolonged, complicated grief marked by depression, and the risk of suicide." (CGA, 2020) At present, the estimated count for Canadians affected by this 'pandemic of grief' is estimated at close to 3 million persons and that number only speaks to grief and loss as it relates to the death of individuals from COVID-19. At present, there has been very little to no research to capture the grieving of loss of jobs, relationships, milestones and many other societal norms. All of this in the midst of a society that struggles

with the acceptance and allowance that grief and grieving is a normal response to having lived and lost someone and tries to pathologize and categorize grieving responses as part of mental illness.

The Palliative Care Nurses Interest Group (PCNIG) of the Registered Nurses Association of Ontario (RNAO) is proposing that Registered Nurses and Nurse Practitioners are well positioned to advocate and power forward the agenda of a national grief strategy for the province of Ontario. In keeping with RNAO's values of health as an individual's right necessary for everyday living, and that the traumatic losses suffered as part of COVID 19 we believe that RNAO has a moral imperative to support this strategy provincially and nationally as part of our commitment to the health of all individuals.

The Canadian Grief Alliance (CGA), is a group of leading grief specialists and more than 150 national and provincial organizations that are encouraging the Government to adopt a proposal to address national gaps in grief. This includes the following 4-point plan: 1) a national investment to guide grief related services; 2) an invest in and expand existing services and resources to better support Canadians; 3) an awareness campaign and education for accessing services and resources and building resilience; and 4) fund research to guide response to the COVID-related grief.

The Alliance includes psychiatrists, psychologists, social workers and therapists, academics and organizations providing grief services. This group has found that this pandemic has not only increased the rate of deaths in Canada but also negatively impact the grief of those who lose family members to deaths of any kind during this time of physical distancing and social isolation. As a result they conservatively estimate that each death directly impacts 5 people – or 1,466,400 million Canadians. (CGA, 2020) This doesn't include impacts on extended families, friends, workplaces, schools, communities. It also does not account for people grieving other pandemic-related losses nor those grieving pre-pandemic deaths, whose grief has been prolonged by physical distancing and social isolation. Now is the time to act not only for the wellbeing of those family members , but all of those who have experienced and will continue to experience a cascade of losses and wellbeing , including our healthcare workforce, our RN, NP and nursing students who are part of experiencing and living through these traumatic losses.

Many patient advocacy groups, healthcare workforce colleges and professional groups, professional individuals have signed on to support, advocate and lead this change. The PCNIG believes that RNAO should also be one of those leaders, as they have always been powering forward to ensure, *"…. healthy public policy to positively impact the determinants of health, supporting Medicare and strengthening a publicly funded, not-for-profit health system"(RNAO website, 2020)* This resolution also continues the work as of PCNIG and RNAO in supporting the tenets of palliative care within the Ontario healthcare system, person and family centered care that strives to support those individuals across the continuum and trajectory of the lifespan and health system.

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Resolution 9: Support of Action on Compassionate Care Framework Now

Submitted by: Carolyn Wilson on behalf of the Palliative Care Nurses Interest Group
Conflict of Interest: No known conflict of interest

WHEREAS The Compassionate Care Act Bill 3 was proclaimed November 2020, to develop a framework to ensure that every Ontarian has access to quality palliative care.

WHEREAS The Act requires the Minister of Health to develop a provincial framework designed to support improved access to palliative care. When it comes to palliative care the health care system is only part of the equation. Compassionate Communities (CC) is the answer to provision of a public health approach to palliative care. The purpose of CC is to respond to local community needs and empower individuals to provide important physical, emotional, social, spiritual, and practical support to patients, families, and caregivers. At its core, a CC is about improving the quality of life for people with a life-limiting illness and their families by encouraging people to advocate and provide assistance and practical support within their community, a public health approach.

WHEREAS this is the fifth such report over the last 20 years urging the government to act on palliative care and address the inequities in access to " living well" until someone dies . Those at most risk to not "living well" are those who experience serious illnesses and structural vulnerabilities like homelessness, poverty and systemic racism. Those in most need of the Compassionate Care Act cannot wait for another report to be tabled they need action now.

THEREFORE BE IT RESOLVED that the Registered Nurses of Ontario (RNAO) power through advocacy, activism and action the Ministry of Health (MOH) not only a report but an established framework for compassionate care in Ontario for those who are at most risk from not “living well". This should be accomplished by working towards the RNAO achieving a Compassionate Community designation as their work with public health advocacy and with organizations like Ontario Palliative Care Network, Health Quality Ontario and Hospice Palliative Care Ontario to implement a palliative care framework to meet the needs of these most vulnerable populations.

Background

“To make palliative care more equitable and accessible we must scale up programs that support people who experience marginalization.” (Dosani,N., Toronto Star,2021) The intention of Bill 3, The Compassionate Care Act 2020 is good as it forwards a palliative care framework for all Ontarians, however it does not go far enough to action implementation, and rather it delays things for another 3 years asking only for another report. This is unacceptable when one considers that over the last 10 years there have been no less than 5 reports detailing what, who and how to implement palliative care reform in Ontario; 1) Palliative and End-Of-Life Care Provincial Roundtable Report A Report from Parliamentary Assistant John Fraser to the Minister of Health and Long-Term Care, 2016; 2) 2011 Declaration of Partnership, which established a common vision for the delivery of palliative-care services in this province and included over 90 commitments by various stakeholders to improve these services; 3) Health Quality Ontario had two reports, a) Palliative Care at End of Life 2016 and update 2019; 4) Access to Palliative Care In Canada, 2018.

While the details of what the report being requested should include are quite detailed:

(a) defines what palliative care is; (b) identifies the palliative care training and education needs of health care providers as well as other caregivers; (c) identifies measures to support palliative care providers; (d) identifies research and common data elements on palliative care; (e) identifies measures to facilitate equitable access to palliative care across Ontario, with a focus on underserved populations; (f) identifies measures to facilitate consistent access to palliative care across Ontario; (g) takes into consideration existing palliative care frameworks, strategies and best practices; (h) takes into consideration and supports the needs of specific patient populations, including peadiatric patients; and (i) leverages the expertise and capacities of other key partners in Ontario’s health system, such as the Ministry of Long-Term Care, Ontario Health, Ontario Health Teams, and other providers and organizations.

What is not noted is that all this has been previously identified in other reports and been reported to the Government in terms of how, when and who should be implementing this framework.

The RNAO has been at the forefront of enacting the actions of these reports and supporting the elements of the framework the Act is requesting. The RNAO through its advocacy, BPGs and collaborations with organizations across Ontario, has put forth a framework that should be taken up and pushed forward and not wait for up to 3 years for implementation. Examples of these are; Resolution on MAiD (RNAO); Resolution on ; Long-Term Care Best Practices Program(RNAO); Palliative Care for the Adult in the last 12 months of Life BPG (RNAO). There remains some work that could continue to support the strength of a fulsome framework that is truly reflective of all the needs of Ontarians these might include :BPG in Advance Care Planning, BPG in Compassionate Communities, BPG for Pediatric Palliative Care and the work that on a National Grief Strategy (CGA, 2020).

The RNAO is best positioned to ensure that this Act is not stalled and allowed to take up to 3 years to implement what already exists in the Ontario healthcare system a well supported and evidenced framework for palliative care and ensuring palliative care is available to all Ontarians equitably across the lifespan and in whatever setting they choose to live until they die. By working towards Compassionate Community (CC) designation the RNAO highlights its leadership in policy and political action. RNAO's work in healthy public health policy for those most vulnerable and at risk in society gives RNAO the best standing to achieve CC status and thereby improving the quality of life for people with a life-limiting illness and their families by encouraging people to advocate and provide assistance and practical support within their community.

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Resolution 10: Advocating for Protected Professional Development for Nurse Practitioners

Submitted by:
Petrina Barbas RN, BHSc, BScN, Tingna Xu RN, BScN, MN and Dr. Eric Staples, DNP

Conflict of Interest: No known conflict of interest

WHEREAS there is a lack of standardized expectations for employers of Nurse Practitioners (NPs) to include professional development days as protected time in employment contracts.

WHEREAS a growing number of NPs are spending time outside of working hours as a voluntary time commitment to participate in continuing education, professional development and mentoring of NPs, otherwise they will not be permitted as per their employer and/or contract to engage in these activities during working hours.

WHEREAS the advancement and continued growth of the NP profession rests on members being able to commit themselves towards professional development as a requirement of self-regulating health professionals, thereby necessitating employer support in securing protected time and space for NPs as per their terms of employment.

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO), in conjunction with the government, Ontario Health Teams (OHTs), organizations, academic institutions and placement partners, develop a plan informed by Recommendations 2.2, 4.1, 5, and 6 of the Nurse Practitioner Task Force's *Vision for Tomorrow Report* to support NPs in negotiating employment with any employer to exercise their professional right, as part of self-regulation, to include professional development and support for non-clinical activities, such as NP-led research, quality improvement, continuing education, and teaching, as part of their term of employment so if audited by the College of Nurses of Ontario (CNO), can demonstrate these competencies as part of personal and professional growth.

Background

The nursing profession has been self-regulating in Ontario since 1963 (College of Nurses of Ontario [CNO], 2020). Self-regulation recognizes that "Ontario's nurses have the knowledge and expertise to regulate themselves as individual practitioners and to regulate their profession through the College" (CNO, 2020). The *Regulation Health Professions Act, 1991* (RHPA) sets out the governing framework for regulation of health professions in Ontario (MOHLTC, 2018). To meet these requirements, the College establishes practice standards to "inform nurses of their accountabilities and the public of what to expect of nurses" (CNO, 2002, pg. 3). Continuing competence is one of seven broad professional standards outlined by the College and ensures that the nurse can "perform in a changing health care environment" (CNO, 2002, pg. 5).

The Nurse Practitioner Task Force's *Vision for Tomorrow Report* outlines in Recommendations 2.2, 4.1, 5 and 6 the need for protected professional development time for NPs. Systemic planning for development and implementation of new roles for NPs should include "the provision of protected time for non-clinical activities that support NPs to achieve all their competencies" and should be "established at the outset of role development to ensure successful implementation" (RNAO, 2021, p. 18). Moreover, to increase the number of NP preceptors for NP student placements as essential components of NP education, "academic institutions in collaboration with practice partners should assess current practices and develop and implement a plan to build and support a team of NP clinical preceptors across placement sites" (RNAO, 2021, p. 24). The report calls for NPs to be afforded time to teach, precept and mentor, as their physician counterparts do for residents and medical students, which must be incorporated into the NP role description and organizational contract (RNAO, 2021).

Participation in professional development activities to fulfill one's professional obligations as outlined by the College requires designated time, support, and resources. NPs are faced with multiple barriers limiting their participation in continuing education (CE), including a lack of time to leave the work setting, and family obligations (Baxter et al., 2013). Notably, a lack of employer support has been cited in restricting NPs' involvement in professional endeavours (Baxter et al., 2013). NPs value CE opportunities and show an interest in participating in them, yet are held back by time pressures, which are exacerbated by attempting to integrate into a system that continues to adapt to their emerging presence. A lack of time and financial support reflects a work environment that does not value these opportunities for NPs. Moreover, there are implications for patient and public safety when their primary care providers are restricted from meeting their educational needs as scopes of practice evolve and expand, and patient care becomes increasingly complex (Baxter et al., 2013).

To facilitate involvement in professional development, NPs must be supported by their employers by securing protected time for these activities within their employee contracts.

Individually, NPs may feel disenfranchised from negotiating these terms in their contracts without guidance from their professional associations. Additionally, NPs who are new to the profession and pressured to transition to the role may experience reluctance in advocating for protected time and financial support. Baxter et al. (2013) argue that "administrators in primary health care (PHC) settings must be responsible to provide release time for NPs to engage in continuing education activities" (pg. 357). Beyond individual NP and organizational efforts, Baxter et al. (2013) also point out the responsibility of policy makers to "ensure that relevant NP activities are readily available and that time is provided by organizations to those wishing to participate" (pg. 357). As the profession endures rapid role development, NPs are drawing upon the expertise of one another by way of knowledge sharing and communication. These horizontal exchanges of successes and challenges are largely informal yet are vital to NPs who are newly transitioning to their roles and the profession, and the need for such exchanges will only be greater as the number of NPs in each clinical context increases. As such, nurse administrators and managers are well positioned to formalize the time commitment and create meeting opportunities necessary to foster horizontal support (Chouinard et al., 2017).

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Resolution 11: Designated Mental Health Support for All Nursing Workplaces and Academic Institutions during Provincial Health Crisis

Submitted by: Kathryn Ewers on behalf of Nipissing Chapter, Algoma Chapter, Sudbury & District Chapter, Kirkland Lake Temiskaming Chapter, and Porcupine Chapter, and the Mental Health Nursing Interest Group

Conflict of Interest: No known conflict of interest

WHEREAS nurses, nurse practitioners, and nursing students are experiencing greater rates of depression, anxiety, and distress and have experienced sustained physical and psychological pressures associated with Covid-19, a crisis with impacts considered comparable to war (Son et al., 2020; Walton et al., 2020).

WHEREAS support for nurses' mental health has varied from "workplace to workplace and unit to unit" (Ralph et al., 2020), the availability of psychiatric support often scarce (Walton et al., 2020), and mitigation strategies have been deemed essential to ensure psychological wellness and a healthy, robust clinical workforce during crises (Wu et al., 2020).

WHEREAS the Canadian Armed Forces has emphasized principles of early intervention and frontline mental health supports (Russel & Figley, 2017), while organizational resources for the mental health of nurses have traditionally been put towards supporting nurses once they have developed a deterioration in their mental health (Walton, Murry, & Christian, 2020).

THEREFORE BE IT RESOLVED that the Registered Nurses' Association of Ontario (RNAO) advocate that the Ontario Ministry of Health and Long-Term Care develop and fund mental health services for provision of 24/7 on-line or on-site support as part of an emergency psychological intervention and public health response for all nurses and student nurses during the provincial pandemic crises.

Background

Nurses comprise the largest group within the healthcare workforce and are those whose mental health is most likely to be affected by the Covid pandemic and like crises (1). The morbidity and mortality worldwide, and impact of Covid-19, is considered comparable to war (2). Since March 2020, Ontario nurses have been working the front lines of COVID-19 in various practice environments. Although hospitals are most common, the workplace of nurses and nursing students extends to long-term care, residential care, community care, medical clinics, public health centres, research environments, and academia (3).

Challenges facing nurses during Covid have included frequently changing policies, discrepancies between governmental and workplace recommendations, inadequate staffing, long work hours, isolation, stigma of being Covid carriers, high acuity patient care, caring for colleagues, increased risk of contracting Covid, and inadequate personal protective equipment (PPE) (1, 2, 4-6).

Findings from Sampaio et al. (1) suggest that in the same country, nurses are presenting with higher depression, anxiety, and stress levels than the general population at the same moment during Covid-19. As evidenced from SARS, and from early research from China and Italy for Covid-19, nurses have reported higher rates of depression, anxiety, fatigue, sleep disturbances, unhealthy eating habits, use of sleeping aids, and long-term mental health effects (4, 5, 7).

A study in Windsor, Ontario (2020) identified that nurses "consistently reported increased mental health concerns, difficulties coping and substantial dissatisfaction with the level of support provided by their hospitals" (4). Similarly, within a study of 18,000 health care workers across Canada, of which most (41%) were nurses, 33% reported fair or poor mental health, while 70% indicated their mental health was somewhat worse or much worse than before March 2020 (8).

Nurses have not received support to maintain their own health and wellbeing (4). Support has varied from "workplace to workplace and unit to unit" (4), with the availability of psychiatric support often scarce (2). A study by WeRPN (9) in Ontario depicted that 67% of respondents felt they did not have adequate mental health support. Referrals to employee assistance plans were considered insufficient, as nurses are often reluctant to seek formal therapy and are more likely to seek support from coworkers or organization supports (4). Nurses also did not demonstrate positive attitudes towards therapy, despite that many organizations focused on tele-therapy options (4, 10). Also, organizational resources for nurses have traditionally focused on supporting staff once they have deteriorated mental health and not on preventing mental health concerns (2).

The psychological impacts of outbreaks may be more prevalent in settings without access to mental health services, indicating that short- and long-term outcomes among healthcare providers may be improved with ongoing evidence-informed, proactive and progressive interventions (5). Leaders need to provide opportunities to access formal support services and peer support systems among colleagues (5). Yet, during a crisis, nursing leaders themselves are 'living' in the crisis and equally impacted by it as much as those they lead (2). Thus, in addition to peer support, having a confidant outside of the healthcare team (e.g., relative stranger) to unload "fear, anger, and a reluctance to come to work at all" can be useful (2, p. 243). Drop-in sessions with psychologists or psychiatrists are an evidence-informed recommendation from previous outbreaks, especially when provided in comfortable settings (2).

As identified by Ralph et al. (4), efficient intervention and availability of supports are needed to address mental health symptoms and issues and reduce loss in the nursing workforce that has been observed after previous outbreaks (e.g., SARS). Practical and effective mental health supports are needed for the nursing profession, while addressing unsafe working conditions (e.g., secure adequate PPE, proper staffing, etc.) that are a primary source of distress and anxiety (1, 4). The prevalence of overtime and increased overtime hours worked by nurses, which has been deemed highest among nurses than other health professionals in 2020, combined with evidence highlighting associations between work conditions and impacts on nurses' wellbeing, prompts the need for more attention to manage the risks of health demands (11).

Concerning nursing students, a mixed method study of university students in the U.S. found that of the 195 students, 138 (71%) indicated increased stress and anxiety due to the COVID-19 outbreak (12). Multiple stressors were identified that contributed to the increased levels of stress, anxiety, and depressive thoughts among students, including fear and worry about their own health and of their loved ones (91%), difficulty in concentrating (89%), disruptions to sleeping patterns (86%), isolation (86%), and increased concerns on academic performance (82%). To cope with stress and anxiety, participants have sought support from others and helped themselves by adopting either negative or positive coping mechanisms (12). There was an "urgent need to develop interventions and preventive strategies to address the mental health of college students" (12).

The wellbeing of nurses and nursing students is a significant determinant of patient care, and workplaces need to support nurses as they work to support their communities (5, 6). Supporting the mental health of nurses and nursing students is a critical competent within the public health response to a crisis like the Covid-19 pandemic (2). Mitigation strategies are essential to ensure psychological wellness and a healthy, robust clinical workforce during crises in Canada (6).

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Resolution 12: Taking Action to Facilitate Access to Mental Health Supports for Ontario Children & Youth

Submitted by: Kierstin Kinlin, RN BScN MPH & Chantal Singh MScN BScN RN on behalf of the Pediatric Nurses Interest Group (PedNIG)

Conflict of Interest: No known conflict of interest

WHEREAS only 1 in 6 children and youth receive the mental health services they need, resulting in the majority of youth and families relying on acute care resources during crises6.

WHEREAS wait lists for child & youth mental health services in Ontario have more than doubled over 2 years, with over 28 000 Ontario children & youth waiting as long as 2.5 years for mental health treatment5.

WHEREAS Canada's paediatric hospitals report admissions related to suicide attempts have doubled since prior to the COVID-19 pandemic3.

THEREFORE BE IT RESOLVED that the RNAO lobby the government for designated funds to ensure access to mental health services within 30 days, so that children and youth do not suffer long term consequences related to delayed assessments, diagnoses, and interventions.

Background

70 percent of mental illness in adulthood stem from childhood, highlighting the value of early access and intervention for children and youth experiencing mental health challenges after initial presentation[8]. According to the World Health Organization[9], access to effective prevention and intervention during childhood and adolescence is essential to stemming the tide of chronic mental health disability into adulthood" (para 2). Addressing these concerns in childhood has the potential to reduce subsequent burden on not only health systems, but also to allow individuals to achieve their "potential to live fulfilling and productive lives"[9](para 4).

Healthcare wait times are a key public health issue. Children waiting too long for treatment results in a profound impact on schools, health systems, and families. Mental health concerns being addressed and treated in a timely manner results in better health outcomes, reduced emergency room visits & hospital admissions, and reduced economic burden[5]. Hallway healthcare currently costs the health system $260 million each year, partially attributed to almost

100, 000 youth seeking avoidable care in Emergency Departments due to mental health crises as there are not enough services to meet the growing needs of children and youth mental health[5].

While children and youth have demonstrated increased resilience to the impact of pandemics when compared to adults[1], their unique developmental considerations make them more vulnerable to the intermediate and long-term impacts of the pandemic[7]. Children and youth with pre-existing mental health diagnoses show greater deterioration in many mental health components compared with those without[1,3]. In addition, children from rural, remote, and northern communities as well as those who identify as a visible minority are more likely to report mental health challenges and experience gaps in accessibility of mental health services[3,5].

In addition to the systemic challenges of the current Canadian health system when it comes to mental health, children, youth, and families continue to face unprecedented stress and anxiety related to the COVID-19 pandemic and associated public health restrictions. Canadian parents are already witnessing the repercussions of the pandemic on children's mental health, development, and physical wellbeing, with 60 percent of parents reporting significant behavioural changes since COVID-19[4]. The United Nations[1] projects that during the pandemic the "vast majority (p.3) of mental health needs will remain unaddressed", despite innovative intervention strategies implemented by service providers.

Pervasive public health measures such as quarantine and lockdown restrictions are known to have adverse psychological effects[1]. Statistics Canada[2] reports youth are at higher risk of experiencing poor mental health (compared to other age groups) during the COVID-19 pandemic. Retrospective studies on mental health related to disaster or infectious diseases (such as the SARS-CoV-1 outbreak), found increased incidence of post-traumatic stress and depressive/anxiety disorders related to increased confinement period time or severity of crisis[1].

Moving forward, the mental health of children and youth in Ontario must be a central focus as Ontario transitions through various levels of pandemic-related restrictions, to ensure designated funds and resources are allocated to support the Mental Health of Ontario's children and youth.

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Resolution 13: Inclusion of the voice of knowledge keepers and elders of First Nation, Inuit, and Metis people when teaching nurses and providing nursing care

Submitted by: Archna Patel on behalf of the Mental Health Nursing Interest Group

Conflict of Interest: No known conflict of interest

WHEREAS Canadian nurses receive minimal training in cultural, spiritual, psychological, social, historical, political and community-specific aspects of Indigenous patients' needs. Healing specialists, Knowledge Keepers and Elders who are skilled in understanding and working within Indigenous cultural worldviews and determinants of health are increasingly needed in care partnerships, decision-making processes and patient care.5–8,11,12

WHEREAS although cultural interventions are frequently recommended in the literature, the nursing profession is under equipped to deliver these programs. Instead, discussions surrounding cultural healing practices should be welcomed and utilize the expertise of Knowledge Keepers and Elders (Baskins 2016, Dell, Dell, Dumont, Fornssler, Hall, and Hopkins, 2015)

WHEREAS emerging evidence suggests that Indigenous-led health service partnerships improve holistic (inclusive of mind, body, emotion, and spirit) health outcomes for Indigenous Peoples, as well as access to care, prevention uptake, and adherence to care plans. (Indigenous led health care partnerships)

THEREFORE BE IT RESOLVED the Registered Nurses Association of Ontario (RNAO) advocate for the Inclusion of the voice of knowledge keepers and elders of First Nation, Inuit, and Metis and Urban Indigenous people when teaching nurses and providing nursing to improve holistic health outcomes for Indigenous people and decolonize nursing education

THEREFORE BE IT FURTHER RESOLVED the Registered Nurses Association of Ontario (RNAO) advocate for the Inclusion of the voice of knowledge keepers and elders of First Nation, Inuit, and Metis and Urban Indigenous to establish and encourage indigenous-led health service partnerships to improve holistic health outcomes for Indigenous people.

Background

Indigenous-led healing movements reflect concrete steps in the efforts to advance health equity for Indigenous Peoples in Canada. Yet as the Truth and Reconciliation Commission of Canada reminds us, more work in these areas demand continued attention. As the recognition of

Indigenous knowledge and healing practices in Canada continues to grow, biomedical settler physicians will likewise benefit from increased consulting, engaging and collaborating.5,8 It is also important to note that Indigenous Peoples can embody culturally complicated, mixed and integrated identities with critical insight into what collaborative health and healing services partnerships can mean.1,2,4,5. Addressing health inequities requires a deeper understanding of the diversity within and across First Nations, Inuit and Métis communities, as well as how different models of Indigenous-led health partnerships can respond to context-specific service needs.5,8

If the swell of efforts of Elders, Knowledge Keepers and healers can be supported by the larger medical community, and if barriers to full health care rights for Indigenous Peoples can be lessened or removed, then systemic racism can be overpowered and health equity can more easily be approached.5,11,12,14. In the context of a global society, we view these Indigenous-led partnerships as opportunities for people from different cultures, health systems and worldviews to benefit from learning about and accepting each other. The challenge of Canadian medical practice and health care for the years to come will involve learning from Indigenous-led movements and building partnerships to improve health outcomes and equity for Indigenous Peoples, and for all

Key Points

Indigenous Peoples in Canada benefit from regaining access to and strengthening traditional cultural ways of life, including health and healing practices.

Many Indigenous communities are working to strengthen cultural healing practices that were marred through colonization and oppressive government policies.

Indigenous-led health care partnerships provide innovative models of interprofessional collaboration, be it in community based healing lodges, remote clinics or urban hospitals.

Emerging evidence suggests that Indigenous-led health service partnerships improve holistic (inclusive of mind, body, emotion and spirit) health outcomes for Indigenous Peoples, as well as access to care, prevention uptake and adherence to care plans.

Indeed, Call to Action 22 states, “We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.”

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Resolution 14: Annual Environmental Sustainability Reporting

Submitted by: Josalyn Radcliffe, Dominique Dominique Baillargeon, and Hilda Swirsky on behalf of the Ontario Nurses for the Environment Interest Group

Conflict of Interest: No known conflict of interest

WHEREAS the RNAO champions healthy and progressive public policies and practices that uphold the values of diversity, inclusivity, equity, and social justice;

WHEREAS the climate emergency and destruction of ecological systems are public health crises that disproportionately and negatively impact marginalized populations;

THEREFORE BE IT RESOLVED that the RNAO commits to ongoing ecological footprint reporting that incorporates environmental sustainability metrics into its publicly available annual report, including an assessment of the organization's waste, carbon footprint, and any applicable social and environmental impacts of its operations and investments.

Background

The climate emergency, the destruction of ecosystems, and increasing environmental pollution, such as plastics pollution, are converging crises that represent urgent health concerns (1-3). As stated by Horton and colleagues, "the harms we continue to inflict on our planetary systems are a threat to our very existence as a species" (4). Furthermore, those already most marginalized will suffer disproportionate health impacts as a result of these effects of these crises, including toxicity, extreme weather, wildfires, heat stress, and forced migration (3). Numerous nurses and nursing organizations have emphasized that our profession has an ethical and social responsibility to both respond to the current and predicted impacts and participate in the necessary steps to mitigate and transform both healthcare and society more broadly (1, 5-7).

RNAO's mission to protect and promote health aligns with the goals of the Paris climate agreement and United Nations' Sustainable Development Goals (8-9). Every member of RNAO has a responsibility to actively provide leadership to achieving these goals so that future generations will be able to thrive in a healthier, just, and sustainable world. Reporting on both social and environmental responsibility is increasingly becoming an expectation across many sectors (10-11) and a number of supports are available to assist with organizational ecological

footprint assessments (12-14). As a leader in health care, RNAO has a unique ethical and social responsibility to respond to our current ecological crises and their impacts in a transparent and public manner. Alongside its current reporting on social health impacts, the RNAO must now begin to evaluate and report its own ecological and climate footprint.

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Resolution 15: Strategy on Increasing Knowledge and Availability of Safer Opioid Supply

Submitted by: Mathew McGuigan, RN, and Shannon Kemp, BScN candidate on behalf of the Community Health Nurses' Initiatives Group (CHNIG) and the Chatham-Kent Chapter

Conflict of Interest: No known conflict of interest

WHEREAS the provision of safer supply has been shown to decrease adverse impacts to the social determinants of health among people who use drugs.

WHEREAS throughout the COVID-19 pandemic, there has been an unprecedented increase in illicit opioid use related overdoses and deaths in Ontario.

WHEREAS there is a growing body of peer reviewed evidence correlating safer supply to a decrease in adverse events related to illicit opioid use, including overdoses and deaths.

THEREFORE BE IT RESOLVED that the RNAO formally engage and collaborate with leaders and experts in advocating for the advancement of safer supply programs in Ontario.

Background

Over the past decade, Canada has been experiencing an ongoing and significant national public health crisis pertaining to opioid use. Opioid use disorder (OUD) is a complex substance use disorder and people with OUD face many challenges and barriers to their health and well-being. Some of these challenges include fatal overdose, endocarditis, sepsis, human immune deficiency virus (HIV), hepatitis C, emotional and physical violence, and stigmatization and discrimination (Canadian Research Initiative in Substance Misuse (CRISM), 2019).

Challenges faced by people with OUD have only further been exacerbated during the COVID-19 pandemic. According to Ontario Drug Policy Research Network (ODPRN, 2020), a 38% increase in opioid use related deaths was noted during the first 3.5 months of the pandemic, from 34 to 46 deaths weekly. If trends seen in the first quarter of 2020 continue, Ontario is projected to see 2,271 opioid-related deaths in 2020, in comparison to 1,512 in 2019 (ODPRN, 2020). These worsening trends may be due to decreased access to safe consumption services, increased isolation, using alone, decreased access to prescribed opioids, and an increased reliance on an unregulated, often adulterated, drug supply (PHO, 2020).

Opioid agonist treatments (OAT) such as methadone and buprenorphine-naloxone have traditionally been the front-line medications for people with OUD, however, some individuals do not benefit from these forms of OAT (CRISM, 2019). There is a growing body of evidence that supports the provision of regulated pharmaceutical grade opioids, also known as safer supply, as an effective way to reduce the harms and risks of illicit opioids. The Canadian Association of People who Use Drugs (2019) defines safer supply as the provision of "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market" (p. 4). While traditional models of OAT are on the continuum of safer supply, they tend to be oriented towards treating OUD, whereas safer supply models are aimed at reducing the harms and risk associated with use of an illicit drug market. Current safer supply models most often use a slow-release oral morphine (Kadian) as a baseline, alongside hydromorphone (tablets or injectable) or diacetylmorphine (Blanken et al., 2010). Safer supply has been shown to reduce use of illicit opioids; infection transmission; premature withdrawal of treatment; criminal activity; incarceration, and mortality, while improving treatment retention; medical and psychiatric status; employment status; and family and social status (CRISM, 2019; Penn, 2019).

Safer supply programs exist across a spectrum ranging from highly clinical models of injection OAT (iOAT) (e.g., witnessed daily doses, illegal drug abstinence) on one end, and low barrier, flexible models (e.g., harm reduction focused, low barrier, flexible eligibility, unobserved dosing) on the other (Penn, 2019). Take home injectable diacetylmorphine was available as a form of iOAT in the UK over a century ago (Hartnoll et al., 1980; Bansback et al., 2018; Strang et al., 2012) and supervised prescription diacetylmorphine is provided in Switzerland, Germany, Denmark, the Netherlands and increasingly (though still limited due to supply and costs issues) in Canada (Blanken et al., 2010; Oviedo-Joekes et al., 2010; Verthein et al., 2008).

Safer supply works in tandem with the RNAO Best Practice Guidelines on *Engaging Clients who use Substances* and *Implementing Supervised Injection services*, which outline the complexity of developing and implementing services for people who use drugs (PWUD) through a trauma informed lens. While the RNAO has called for increase access for safer supply through its Queens Park On the Road and Queens Park Day advocacy, more work needs to be done around educating RNs, NPs and prescribers, and policy makers on reducing stigma and increasing access to safer drug supply services.

We resolve that the RNAO create a collaborative task force consisting of RNs, NPs, and people with lived experience to develop a position statement and increase advocacy for safer drug supply in Ontario.

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Resolution 16: Evolution of Independent Practice for Support and Acknowledge Registered Nurses and Nurse Practitioners; the need to be recognized and remunerated directly

Submitted by: Colleen Scanlan, Olivia Brundia, Tracey Hotta, Kaitlin Brulotte, Ashley Manlow, and Piroska Bata on behalf of the Independent Practice Nursing Interest Group

Conflict of Interest: No known conflict of interest

WHEREAS Nursing is a practice discipline recognized as a profession that can self-regulate. Limitations for a number of RNs & NPs who provide nursing services independently exist. It is known that a shared vision for all nursing designations is an unfulfilled goal due to a lack of role clarity, power dynamics, and inconsistent regulations nationally. RNs and NPs face challenges when they offer independent nursing services to the public, as some agencies do not recognize that in Ontario RNs and NPs have the knowledge, skills, and judgment to practice independently and autonomously i.e., without a doctor's order.

WHEREAS there has been a steady number of RNs with a slight increase and a steady increase of NPs, that is reported from (CNO, 2015 - 2020) "self-employed" Registered Nurses and Nurse Practitioners in Ontario communities. I.e. primary health, alternative & complementary therapies. As well, there are a large number of full-time and part-time independent practitioners who provide services to Ontarians, and we need to support them as they manage health conditions and advance their physical, emotional, and spiritual health that are not captured by the CNO or by the RNAO. The College of Nurses of Ontario has developed a standard related to independent practice that acknowledges the evolution of these nursing services.

WHEREAS the Independent Practice Nursing Interest Group recognizes the need for resources to conduct independent practice excellence, and enhance remuneration strategies in order to address issues in self-employed settings; such as risk management, quality improvement, infection prevention & control, and health informatics, appropriate practice principles, and legal responsibilities. The IPNIG also recognizes the need to expand payment options to government sources and medical insurance programs.

THEREFORE BE IT RESOLVED RNAO recognizes the contributions of Registered Nurses in Independent Practice, aligning strategic initiatives with College of Nurses, Canadian Nurses Association, and WeRPN (Registered Nurses Association of Ontario) thereby enhancing access for Ontarians. In the current climate, this will support Registered Nurses who provide services outside of mainstream health care settings, promotes optimal health practices, and advances the role of nursing. Nurse Practitioner, Community Nursing, Footcare, Occupational health and Safety, Complementary Therapies including energy work, Cosmetic and Dermatological Care, RN

Psychotherapy, RN Coaching, Lactation Consulting, Patient Advocacy, Legal Nurse Consulting, Palliative Care, Parish Nursing, Health and Wellness Consulting, Nurse Consulting, etc.

Background

In the last five years 2020 had the largest number of RNs and NPs reporting to the College of Nurses of Ontario that they held one or more self-employed positions (CNO, 2021). There also have been an increased number of requests for assistance to the IPNIG as to how to set up a business or be self - employed as a Registered Nurse. In this metric those RNs and NPs who work full time and only practice independently part time may not be captured.

Despite this increase and the increased interest, there are limited educational resources available for independently practicing nurses to refer to. While there is a CNO Practice Guideline for Independent Practice, it is very broad in scope and provides limited direction on how to start the process and the full scope of legal and business requirements (CNO, 2019). On a search of the Canadian Association of Schools of Nursing resources and guidelines there are none that pertain specifically to independent nursing practice (CASN, 2021). Upon search of the RNAO policy library, no resources specific to independent practice were found (RNAO, 2021).

Nursing is a discipline that has its own theories, knowledge base, ethical guidelines and is recognized as a regulated profession. (RHPA, 1991). Within the scope and standards of practice laid out by the CNO, RNs can practice independently and autonomously. There is a large gap of knowledge to practice. This is evident from an educational and policy point of view. While within our provincial and national organizations there is support for the type nursing activity that can be practiced independently such as complementary therapies, RN psychotherapy, Nurse practitioner and so on. Yet no policy for support exists, there is no educational material available and struggle exists with remuneration strategies as some agencies do not recognize that RNs and NPs can practice independently and autonomously in Ontario. (Checked with insurance companies).

Access to the services of RNs and NPs in independent practice would enhance the health care of Ontarians as they provide important services from foot care to RN psychotherapy. The value of having access and a method of remuneration would bring peace of mind to clients, enhance nursing practice and expand nursing knowledge in the future.

It is vital that we create a strategy with respect to policy, education, access, and support remuneration of our hard working independently and autonomously working RNs, NPs, Complementary Therapists, Footcare, RN Psychotherapy, Legal Nurse Consulting, Occupational Health and Safety, Lactation Consultants, Patient Advocates, Parish Nursing, Palliative Care, RN

Coaching, Nurse Consulting, Health and Wellness Education and Consulting, Community Nursing and others that may arise on the horizon.

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Resolution 17: Fund a rapid response treatment team consisting of Nurse Practitioners and Registered Nurses and Physicians for seniors who live in their own homes and are 85 years of age and older.

Submitted by: Michelle Farah

Conflict of Interest: No known conflict of interest

WHEREAS emergency departments length of stay is increased related to the demand of the emergency services.

WHEREAS cost for the emergency department door to dispatch could be reduced if the geriatric population could be triaged with home care and other community services in their own dwelling. The pressures of the emergency department may be reduced, and the severity of the situation reduced if early intervention by a geriatric rapid response team could be available.

WHEREAS being taken to the hospital in an ambulance discombobulates and confuses this age group because they are not in their own surroundings. If rapid prevention of issues could be resolved at home then the number of geriatrics which require acute care beds in the hospital may be reduced and this also could reduce the number of people needing long-term care.

THEREFORE BE IT RESOLVED that the Registered Nurses' of Ontario (RNAO) advocate to municipal, provincial and federal governments for funding for public health, home care and community health services which could improve the quality of life of seniors, prevent illness and reduce hospital acquired infections or issues such as falling.

Background

The data demonstrates there an increase in number of admissions to the Emergency Department (ED) of patients over 85 years of age (Y.O.A).

In some cases, these admissions can be quickly resolved and the patient can return home if the community had the adequate resources of doctors, nurses and PSW and equipment to facilitate monitoring in the home.

The geriatric population of 85 years and older, often have co-morbidities that affect confusion and ability to navigate their surroundings while in the hospital setting. Confusion regarding surrounding could change how the individual will manage in a new environment that is

unfamiliar. For example, a person who has macular degeneration and cannot see well, are restricted to being in bed and not being allowed to be independent in daily activities of living and thereby decreasing their functioning level while in a hospital setting.

If the backlog cost in the ED versus the cost to mobilize out of the hospital quickly could be shown it may increase the prediction that community care for the geriatric population will produce better quality of care, decrease LOS, decrease confusion and disorientation, improve the ability to maintain activities of daily living in their own dwelling.

Case 1

The situation 85>years of age who rather not visit the ED ever.

Background or Behavior: This individual has chronic medical issues, however, they are short lived and require medical intervention for example diuretics, heart monitoring, and fluid.

Actions: If treatment with Lasix, metoprolol, and IV fluid for hydration been used in the home the patient emergency department visit may be avoided.

Recommendations: Knowledge of increased shortness of breath, accessory muscle, rapid heart rate and the end results of this were in the end the deciding factor to utilize EMS and the Emergency department. I ask you all, if access to acute care emergency services in the home were available, could this person be triaged in the confines of her own home? In my opinion, I would definitely say yes. It could have been resolved earlier in the day if a House call physician, or NP could of assessed this individual at home. This person became upset, agitated, and did not want to be in the hospital let alone go to the emergency department.

Although the restlessness and confusion subsided after treatment. It was still 16 hours in the ED.

If this person did not have an advocate and if this individual could not advocate for herself she would have been admitted for about 3 days in the hospital.

It is true that early recognition of signs and symptoms can prevent health deterioration (ACLS 2020).

Rapid in-home-intervention will reduce hospital costs and maintain independence, prevent infection and alleviate pressures in the emergency department.

Case 2

Redirecting a patient from primary care to specialist care in a Emergency Department in a different catchment area during a Pandemic does not make sense for two reasons 1)Infection Prevention and Control and 2)This person did not need to access Emergency Medical Services. What the individual needed was blood work and a urine sample. After urine sample was obtained the doctor discovered she just needed antibiotics instead of Emergency medical services in the ED. Cost of utilization of the ED was avoided. Long wait times in the ED was avoided and decreased exposure to infection was avoided.

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