# Annual Meeting of Members
June 20, 2016

## 2016 Resolutions

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) develop learning support materials that clarify and affirm the unique RN role contribution for two key audiences:

- For RNs: to help them better articulate the contribution and value of the RN role.
- For health-care leaders (employers): to help them better differentiate the contribution of the RN role from nursing roles with less depth and breadth of foundational knowledge.

Name of submitters:
Rosanne Beuthin, RN, CRNBC #663450 (Victoria, B.C.)
Megan Klammer, RN, CRNBC #866972 (Victoria, B.C.)

Rationale:
- A discourse of financial efficiencies combined with limited budgets has employers clamoring to replace RN roles with lesser educated and less costly nursing roles across all health-care settings.
- RNs individually know their value and depth of contribution yet often struggle to articulate this clearly or with impact that positively influences leadership decisions about nursing staff mix.
- Scope creep of lesser educated nursing roles has made it less clear for managers to distinguish why and when an RN role is necessitated and how to optimize having nurses with differing scopes of practice work together.
- The RN role continues to expand and evolve in scope and yet the impact and potential of this for health-care improvements is not fully understood or easily conveyed to others by practising RNs.
- Many acute care employers imagine the RN role best utilized in highly technical, specialty care units, and this thinking reduces opportunities for RNs’ contribution and influence across a patient’s broader care journey.
- Many studies illustrate that higher levels of educated nurse roles lead to improved care outcomes for patients.

Example scenario: A manager hints to RNs on a team that leadership is exploring replacing RNs with practical nurses. The manager believes practical nurses can perform all nursing tasks the RN does. The RNs are upset but silent, knowing their patients/clients have complex needs, but unsure how to make an effective argument. The RNs know that nursing care is much more than tasks alone, but they are often not able to put this into a sound argument that emphasizes critical decision-making and synthesis, and links to improved patient-care outcomes.

Relevance to CNA’s mission and goals: Giving RNs exact language that supports them to advocate for nursing’s continued contribution in our health-care system aligns with CNA’s goal to “promote and enhance the role of registered nurses to strengthen nursing and the Canadian health system,” and it also ensures that nurses have the words they need to advocate, which aligns with the goal to “broadly engage nurses in advancing nursing and health.”
Providing nurse leaders (employers) with clear information that supports them to see the value and continued need for RNs aligns with CNA’s goal of serving the public interest and aiming for best care outcomes.

**Key stakeholders:**
- RN Associations
- Educators

**Estimated resources required or expected outcomes:**
- A Learning Support Tool (1-2 pager) that lists talking points, e.g.:
  - It is dangerous to think about nursing being reduced to skills and tasks. This reductionist mindset undermines the complexity of the care provided.
  - Competencies include knowledge, skills, judgment and attributes. RNs may perform similar skills as practical nurses but have a greater depth of knowledge and advanced ability related to:
    - Critical thinking
    - Clinical expertise
    - Leadership
    - Decision-making
    - Synthesis
  - How RNs and practical nurses work together in new collaborative ways.

**References:**
Bloom’s taxonomy

Literature re: improved patient outcomes with RN care
Association of Registered Nurses of Prince Edward Island, Licensed Practical Nurses

RESOLUTION 2  
Nationally Defining the Role and Value of the Registered Nurse

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) works with federal, provincial and territorial governments to develop detail that would nationally define the unique role and value of the registered nurse (RN).

Submitted by: Saskatchewan Registered Nurses' Association (SRNA) Council

Rationale: SRNA has heard from its members that there is a need to have role clarity for RNs, as well as information to help communicate the value that RNs bring as leaders and members of collaborative health-care teams. SRNA strongly supports that RNs need to increase their visibility and ensure their unique role is sought and understood.

Such detail would assist RNs nationally as they describe their unique scope of practice in terms that are consistent, clear and easy to explain to other team members, employers, governments and the public. Presently, there is inconsistency and confusion on this matter across Canada.

SRNA identifies that the Framework for the Practice of Registered Nurses in Canada (2015) would be an ideal document to include such a definition and that CNA would be in the best position to manage this important dialogue and consultation across Canada and deliver important results.

Without this work, other care providers’ scope of practice continues to evolve, resulting in confusion and very little understanding of the difference between what is the unique role of the RN. This could result in the replacement of RNs and a risk to public safety.

Relevance to CNA’s mission and goals: SRNA believes that Saskatchewan is not the only province that is facing the issue of role clarity and value in the system. Like in other jurisdictions, expanding scope of practice of other care providers is occurring with the possible replacement of RN positions.

If there were a unified, national approach, it would unify the voice of the RN and make provincial efforts of role clarity much stronger. It would align with CNA’s mission and goals by:

- promoting and enhancing the role of RNs to strengthen nursing and the Canadian health system;
- shaping and advocating for healthy public policy provincially/territorially, nationally and internationally;
- advancing nursing leadership for nursing and for health;
- broadly engaging nursing in advancing nursing and health; and
- transforming CNA’s governance structure and processes.
Key stakeholders:
- All regulatory bodies
- Registered nurses
- Nurse practitioners
- Federal, provincial and regional decision-makers
- Educators
- Other health-care providers
- Unions
- General public
- Media
- Other relevant stakeholders

Estimated resources required or expected outcomes:
Costs would include development and administration of research, national dialogue forum.

References:

RESOLUTION 3
Need for a National Nursing Council to Shape Directions for the Next Generation of Nurses in Canada, Preparing Them to Care for Canadians in a Rapidly Evolving Health-Care System

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocates for the development of a national nursing council with membership drawn from key national and provincial/territorial nursing organizations representing professional associations, education, regulation and practice to collaborate together to collectively set directions and shape the preparation of the next generation of Canadian nurses.

Name of submitter:
Cynthia Baker, executive director of the Canadian Association of Schools of Nursing, CNA member from Ontario in the independent nurse category

Rationale: Canada’s health-care system is facing a perfect storm of pressures that will require excellence and optimal performance from all players in our health-care system. Governments are digitalizing health care and reorganizing the delivery of services to meet the growing health-care needs of an aging population while facing escalating costs and dwindling financial supports. New models, new approaches, new health-professional roles and new responsibilities are emerging rapidly,

It is essential that the nursing profession collaborate together in response to this rapidly evolving environment to collectively advance the profession. Our colleagues in health professions such as medicine, pharmacy and paramedics have been successfully redefining roles, responsibilities and competencies expected of their graduates in light of the changing Canadian health-care system. The competencies (knowledge, skills and attitudes) required for optimal performance of nursing roles must continuously evolve to meet new health-care demands and new models of health-care delivery. No one nursing sector can be responsible for shaping future directions of the profession. If we are to ensure that the next generations of nurses are prepared to truly meet the needs of the Canadian population, and if our profession is to remain a cornerstone of the Canadian health-care system, we must work together. Collaborative effort produces optimal results.

Similar to the Medical Council of Canada, a national nursing council of Canada, composed of representatives drawn from national and provincial/territorial professional associations, associations of schools of nursing and regulatory bodies, would rigorously protect Canadians, sustain public confidence in our nurses and advance the profession by ensuring the next generations of nurses are well prepared for the transformation in health-care delivery occurring in the Canadian context.

Relevance to CNA’s mission and goals: Adoption of this resolution will advance all elements of the CNA mission. A national nursing council, with representation from all key nursing stakeholder groups, will allow representative groups to work together, to determine the priorities and direction for nursing for tomorrow and into the future. It will enhance opportunities to build
strength in nursing leadership and promote nursing excellence, and the inclusion of all key stakeholder groups will provide opportunities for advocating for a quality health system that serves the public interest.

- Unifying the voices of RNs
- Strengthening nursing leadership
- Promoting nursing excellence and a vibrant profession
- Advocating for healthy public policy and a quality health system
- Serving the public interest

**Key stakeholder Groups:**
Canadian Nurses Association  
Principal Nurse Advisors Task Force  
Canadian Federation of Nurses Unions  
Canadian Association of Schools of Nursing  
Canadian Nursing Students’ Association  
Academy of Canadian Executive Nurses  
Nursing Education Council British Columbia  
Council of Ontario University Programs in Nursing  
Colleges of applied arts and technology (nursing)  
Quebec Region CASN  
Atlantic Region CASN  
Western-Northwestern Region CASN  
Canadian Network of Nursing Specialties

**Estimated resources required or expected outcomes:** Investigate sources of funding to support for a face-to-face meeting of key stakeholders to begin discussion of this opportunity to shape nursing for tomorrow.

**References:** N/A
WHEREIN Canada has a long history in developing, shaping and advancing its own registered nursing profession to meet the values and needs of Canadian society, the Canadian health system and the changing health needs of Canadians themselves;

AND WHEREIN Canada has the domestic skill set and intellectual capacity to continue leading the nursing profession to best serve Canadians and the Canadian health-care system in a way that is consistent with Canadian values;

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) support a “Canada first” approach to the education, regulation and advancement of the nursing profession;

BE IT FURTHER RESOLVED THAT CNA work in authentic partnership with Canadian nursing organizations at all levels to ensure that all aspects of the preparation and professional development of Canadian registered nurses be consistent with Canadian values and ideals.

Submitted by: CNA board of directors

Rationale:

Canada has a long history of developing and advancing our registered nurse (RN)/nurse practitioner (NP) profession to be responsive to the values and needs of Canadian society, the health system and the changing health needs of Canadians.¹ We are proud of the leadership we have demonstrated in shaping Canada’s publicly funded not-for-profit health system, one that is premised on the provision of health services based on need, not the ability to pay. Ours is a system based on social justice that embraces interprofessional collaboration, primary health care and the social determinants of health.

The stewardship of our highly valued and trusted profession is changing. Various components of the RN/NP profession are being outsourced to other countries whose RN/NP education, regulation and context of practice (health system) are markedly different than those in Canada.²³⁴ Registered nursing is the first profession in Canada to procure a number of foundational underpinnings of its profession from another country, including its entry-to-practice registration exam, nurse practitioner practice analysis, evaluation of internationally educated health professionals (against Canadian standards) and, potentially, education program approval. This trend is occurring despite Canada’s proven track record of developing and effectively providing high-quality, internationally respected services and programs related to the assessment, evaluation and credentialing of RNs/NPs and to nursing education. Registered nursing is the only health profession in Canada not to use a Canadian entry-to-practice exam.

Canada must reclaim sovereignty over the RN/NP profession in such areas as education, regulation, and advancement of the profession and all associated activities. Such sovereignty should include, but not be limited to, registration and workforce data management as well as assessment, evaluation, and credentialing of nurses and nursing education. Relinquishing our historical and “made-in-Canada-for-Canada” approach that has served us so well risks creating significant, far-reaching repercussions with regard to the following: trade agreements; costs to individual citizens and provincial/territorial/federal health services; human resources for health-care delivery; Indigenous people’s rights and treaties; charter rights (including access to care provided in both official languages); and the reputation of the RN/NP profession.
It is acknowledged that there may be instances when a particular service must be procured from other countries, either because they have qualifications or competencies that Canada does not or because developing them in Canada is not feasible. These are not the types of outsourcing of concern here.

International collaboration among nursing organizations and countries is also recognized as a strength of Canadian nursing and we have long history in which such work has contributed to the development of nursing across the world. Such collaboration is also not the subject of this resolution.

**Relevance to CNA’s mission and goals:** This resolution is particularly relevant to CNA’s mission to advance the practice and profession of nursing to improve health outcomes and strengthen Canada’s publicly funded, not-for-profit health system. Furthermore, it aligns with CNA’s objects, as defined in the Letters Patent (2013 revision), which is to promote profession-led self-regulation in the public interest.

The CNA board recognizes any actual or perceived conflict of interest over the fact that Assessment Strategies Inc., a wholly owned subsidiary of CNA, owned the previous RN entry-to-practice exam and could supply a future Canadian edition of the exam.

**Key stakeholders:** Canadian Association of Schools of Nursing, Canadian Federation of Nurses Unions, Consortium national de formation en santé, Canadian Nursing Students’ Association, Canadian Council of Registered Nurse Regulators, provincial/territorial governments, provincial/territorial nurse regulators, et al.

**References:**


RESOLUTION 5  Post-Traumatic Stress Disorder Policies and Legislation —  
Nurses Need to be Recognized

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) and its provincial and territorial members advocate that the federal and provincial governments recognize that RNs are at high risk for developing PTSD during their employment, so they should be entitled to benefits under the relevant legislation.

Name of submitters:
Gigi van den Hoef, B.Sc., RN, CCRP, MHS (in progress)
Riek van den Berg, RN, MScN
RNAO Region-10 executive members

Rationale: Post-traumatic stress disorder (PTSD) is classified as a trauma- and stress-related disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.).\(^1\) PTSD is characterized by symptoms that include “intrusive or distressing thoughts, nightmares, and flashbacks derived from past exposure to traumatic events.”\(^2\) PTSD is associated with an increased risk of cardiovascular disease and several other chronic illnesses.\(^3\) Women are more likely than men to develop PTSD after exposure to traumatic events.\(^4\) It is estimated that “the lifetime prevalence of PTSD is approximately 7%.”\(^8\) According to *Out of Sight, Not Out of Mind*, a report submitted to the Government of Canada in March 2012, “85% of Canadians dealing with mental health problems approach their family physician first. Unfortunately, many healthcare providers, including physicians, have stigmatizing attitudes towards patients presenting with possible mental health problems including PTSD.”\(^16\) The laws across Canada vary and most provinces have excluded nurses except Manitoba.\(^17\) We must act now.

On April 6, 2016, the Ontario legislature gave royal assent to Bill 163, *An Act to Amend the Workplace Safety and Insurance Act, 1997 and the Ministry of Labour Act with Respect to Posttraumatic Stress Disorder*.\(^5\) The amended section in the *Workplace Safety and Insurance Act, 1997*, states “that certain workers who are diagnosed with posttraumatic stress disorder are entitled to benefits under the Act for that disorder if certain conditions are met. The section creates a presumption that posttraumatic stress disorder in those workers arises out of and in the course of the workers’ employment, unless the contrary is shown.” Bill 163 also “amends the Ministry of Labour Act to allow the Minister to collect information relating to the prevention of posttraumatic stress disorder in certain workplaces.”\(^6\) Bill 163 includes, specifically, firefighters, fire investigators, police officers, paramedics, emergency medical attendants and workers in correctional institutions or secure custody but it does not include registered nurses or nurse practitioners.\(^5\) In Alberta, on December 12, 2012, first responders who suffer from PTSD are eligible for presumptive coverage through WCB Alberta. The first responders include police officers, firefighters, emergency medical technicians, and sheriffs. WCB Alberta’s list does not include nurses.\(^11\) On April 1, 2016, the New Brunswick legislative assembly approved the amendment of Bill 15, the *Workers’ Compensation Act for PTSD*, excluding nurses.\(^13\)
In British Columbia on February 23, 2016, Bill M 203-2016, Workers Compensation Amendment Act, 2016 was introduced and held its first reading the legislative assembly. The first responders post-traumatic stress disorder presumption in B.C. is currently excluding nurses.\textsuperscript{10}

In Manitoba, Bill 35 is the only province that recognizes nurses, ‘the government recognizes the leadership of several professions and their labour representatives for advocating for legislation that identifies PTSD as an occupational disease for presumptive worker’s compensation coverage, including nurses, firefighters, first responders and other front line workers.’\textsuperscript{12}

In Quebec, Lavoie S., Talbot, L.R. & Mathieu, L (2011) stated, “emergency room nurses experience stress during traumatic events, for which they need support. It turns out that such support is insufficient, ineffective or non-existent”.\textsuperscript{6} Five-years later, Lavoie et al. (2016) state that traumatic events are “positively associated with peritraumatic distress (PD) in the days after the event”\textsuperscript{7} and that “PD is positively associated with PTSD symptoms.” In addition to nurses who work in the ER, nurses also respond to emergencies in air ambulances and as first responders. Palliative care professionals may also be at increased risk for PTSD symptoms.\textsuperscript{8} Palliative care professionals “support traumatized patients, routinely witness medical trauma and death, and take responsibility for difficult decisions at the end of life.”\textsuperscript{8} PTSD is not unique to Canada. Abu-El-Noor (2016) published a paper on PTSD among health-care providers following Israeli attacks against Gaza Strip in 2014. The findings showed that health-care professionals “suffered from severe posttraumatic symptoms after exposure to prolonged war stress” and “warrants intervention programs to reduce stress and trauma.”\textsuperscript{9}

According to the Guarding Minds @ Work (GM@W) workplace guide from the Canadian Centre for Occupational Health and Safety, there are 13 psychosocial factors (PF) that are relevant to Canadian organizations and employees.\textsuperscript{14} PF3 describes leadership as the foundation of the health pyramid.\textsuperscript{15} GM@W states that, “sound scientific evidence shows that when businesses adopt policies and programs to address psychological health and safety, they incur between 15% to 33% fewer costs related to psychological health issues.”\textsuperscript{14}

Not only do nurses need to be recognized within the legislation as people who can experience PTSD, nurse managers across Canada need to be supported to implement policies for PTSD. We need to work with provincial/territorial and federal governments to recognize nurses within their policy framework and legislation.

Relevance to CNA’s mission and goals: This resolution will advance CNA’s mission by unifying the voices of registered nurses and nurse practitioners and strengthening nursing leadership. Promoting nursing excellence, advocating for healthy public policy and serving the public interest.

This resolution will also shape and advocate for healthy public policy provincially/territorially, nationally and internationally, to advance nursing leadership for nursing and for health and to broadly engage nurses in advancing nursing and health, advancing policy and advocacy, and by building capacity through national research, policies and frameworks.

Key stakeholders: All RNs and NPs who work across Canada.
Estimated resources required or expected outcomes: The outcome of implementing this resolution will be advocacy resulting in universally recognized PTSD for nurses across Canada. CNA would be expected to maximize its current policy/political action resources, amend current legislation to include nurses and to add nurses to the current PTSD dialogue within each province/territory and to expand where necessary.

References:


RESOLUTION 6  CNA Member Fees

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) membership fee be increased by $2.75 for 2018, $2.90 for 2019 and $3.05 for 2020.

Submitted by: CNA board of directors

Background
The most recent fee increase, approved at the June 2008 annual meeting, was to cover membership fees for 2009, 2010 and 2011. The annual increase was to be equivalent to the cost of living based on the Bank of Canada’s consumer price index forecast, issued in April of the preceding year. The last fee increase of $1.16 took effect on January 1, 2011.


Information
The 2016 CNA membership fee is $54.95.
## RESOLUTION 7

**Establish a Canadian Taskforce to Address Registered Nurse (RN) Professionalism**

**BE IT RESOLVED THAT** the Canadian Nurses Association (CNA) spearhead the establishment of a Canadian taskforce to address public perception of registered nurse (RN) professionalism.

**Name of submitters:**
Caroline Porr, Madge Applin, Sharon Grantham and Candi Muise

**Rationale:** Do we project professionalism as members of the professional practice discipline of nursing? Some argue that, increasingly, our professional image is being threatened by non-conventional attire, body piercings and tattoos. Not so long ago the *National Post* made reference to RNs being dressed in pyjamas. *Pyjamas!* Have we come to expect a standardized professional uniform be worn by airline pilots, firefighters and police officers but not RNs? And just this month, an adult patient told a *National Post* reporter that she was “terrified” by the skull tattoo vividly displayed on an RN’s arm. Some argue that RNs have a right to self-expression be it through tattoos, piercings or attire, but what about the patient’s rights? What has happened to patient-centred care?

Everyone would agree that professionalism is much more than appearance. Definitions of professionalism refer to attributes, behaviours and adherence to a professional code of ethical conduct. Nevertheless, how an RN presents herself or himself to the patient is a critical element of professionalism for both the patient and the RN. RNs and nursing students alike claim that certain uniforms actually bolster their sense of professionalism, their personal feelings of being/becoming a professional. In fact, one nursing student stated, in reaction to having to wear the more contemporary casual, baggy, patterned smock, “I don’t feel very professional [in that kind of uniform]. I feel more like a cleaner” (Shaw & Timmons, 2010, p. 23). Presentation of self through dress is a form of communication that sends a message (nonverbally) to the patient about what can be expected from the RN (Kaser, Bugle, & Jackson, 2009). In today’s increasingly complex multi-disciplinary health-care environments it essential that patients and family members can identify the RN and also trust that the RN will provide high-quality care. Interactions with health-care providers are often short and infrequent, making first impressions of the RN critically important. Whether first impressions of the RN will instil patient comfort and reassurance, knowing that good care will be provided, are contingent on how the RN appears.

Non-conventional attire is not only making professional designation impossible but is possibly undermining patient perception of RN professionalism, according to American studies conducted over the last two decades (Albert, Wocial, Meyer, & Trochelman, 2008). Among the few Canadian studies, Porr, Dawe, Lewis, Meadus, Snow, and Didham (2013) report pilot study results of adult patients scoring certain uniforms higher than others for professional image traits including confidence, competence, attentiveness, efficiency, approachability, caring, reliability, cooperativeness and empathy.

Is RN professionalism being eroded in the eyes of the Canadian public? Are we losing our credibility? What are the issues across Canada? What can be done? RNs need to take ownership of the public image we portray. A Canadian taskforce needs to be established to identify issues, propose solutions and develop national RN professionalism standards.
Relevance to CNA’s mission and goals: The establishment of a Canadian taskforce on RN professionalism is consistent with CNA’s mission to “promote nursing excellence and a vibrant profession.” Including RNs from coast to coast on the taskforce would fulfill CNA’s mission to “unify the voices of RNs.” The taskforce would also include patients/health-care consumers and other key stakeholders, so that CNA would be serving the public interest and strengthening the Canadian health-care system.

Key stakeholders: Patients Canada, Canadian Nurses Association, Canadian Association of Schools of Nursing, Western and North-Western Region Canadian Association of Schools of Nursing, Atlantic Region Canadian Association of Schools of Nursing, Health Canada.

Estimated resources required or expected outcomes: The major outcome expected are national RN professionalism standards developed by RNs in collaboration with patients/health-care consumers and other key stakeholders. RN designates from across Canada who participate on the taskforce would not only contribute expertise, but enrich their understanding of the profession and discipline of nursing. They may gain leadership skills that may extend over into other initiatives, thereby the taskforce may promote and enhance the role of RNs in strengthening nursing and quality of health-care services delivery.

References:
BE IT RESOLVED THAT the Canadian Nurses Association (CNA) establish a position on the CNA board of directors for a representative from the Canadian Indigenous Nurses Association (CINA).

Submitted by: R. Lisa Bourque Bearskin, president of CINA

Rationale: CNA continues to work collaboratively in partnership with CINA (previously the Aboriginal Nurses Association of Canada), which is the longest-serving professional Indigenous health organization in Canada, with 40 years in existence as an Indigenous-governed, national organization guided by regional membership.

In February 2016, with the signing of the Partnership Accord between our two national organizations, the organizations identified a commonality of mutual goals to advance the interests related to Indigenous health and Indigenous nursing through “Indigenous-led and self-determining” process and principles.

As CINA continues to strive to represent both the needs of its members and those who engage in its efforts on behalf of Indigenous communities in Canada, CINA believes that having representation at the CNA national board of directors’ table will improve communication and activities that represent both organizational members who are working to improve Indigenous health and support Indigenous nursing knowledge and experts who can offer their experience and dedication to support the work of CNA and CINA.

Relevance to CNA’s mission and goals: Including a dedicated seat for an Indigenous nurse representative to the CNA board of directors will be a positive step in forging our renewed relationship between our two sister organizations. A relationship based on the knowledge of our shared history, a respect for each other and a desire to move forward together with a renewed understanding that strong alliances in nursing will support the implementation of primary health care and nursing leadership that is inclusive of Indigenous nurses.

Key stakeholders: Canadian Nurses Association, Canadian Indigenous Nurses Association, regional nursing regulatory associations

Estimated resources required or expected outcomes: Cost to bring in additional board member to meetings. Expected outcome will be to strengthen the partnership between the two national nursing organizations.

References: N/A
WHEREIN Indigenous health and Indigenous nursing strategies are at various stages of development nationally, provincially/territorially and locally.

BE IT RESOLVED THAT the Canadian Nurses Association (CNA), in partnership with CINA and all jurisdictional members, call on the federal government to honour its obligations to Indigenous peoples and to support jurisdictional members to work with their provincial, territorial and local governments to achieve strengthened Indigenous health action. This includes addressing the historical, social, economic and environmental determinants of health; enhancing the retention, recruitment, education and utilization of nurses; and empowering the leadership of Indigenous peoples in the planning and delivery of primary health care.

BE IT FURTHER RESOLVED THAT CNA, in partnership with CINA, work with all jurisdictional members to advance a national framework from a nursing perspective and, consistent with the United Nations Declaration on the Rights of Indigenous Peoples, implement the seven health calls to action identified in the final report of the Truth and Reconciliation Commission.

Name of submitters:
Association of Registered Nurses of British Columbia (ARNBC)
Canadian Indigenous Nurses Association (CINA)
Registered Nurses’ Association of Ontario (RNAO)

Rationale: Access to health services continues to be a challenge in many First Nation, Inuit and Métis communities. Remote communities require nurses with an advanced scope of practice and cultural safety training. In some instances, nurses’ knowledge and skills are not fully utilized due to regulatory and organizational barriers. For example, most NPs do not have hospital admitting privileges and RNs cannot independently prescribe, which creates unnecessary limitations. Educational programs that prepare nurses for remote practice are not consistently accessible throughout Canada, and this affects prevention, assessment, diagnosis, treatment and holistic client care. The impact on nurses is burnout, low retention and job dissatisfaction. Compensation packages require enhancement to competitively recruit and retain nurses with advanced knowledge and skills (including in the area of mental health and addictions) to work with Indigenous peoples to address issues affecting their communities. The federal government must also improve health facilities to accommodate a wide range of health professions to assist nursing with health-service delivery. A great amount of study has already been completed and recommendations proposed to improve access to quality nursing services within Indigenous communities (RNAO, 2015; NINA, 2012). The time has come for action.

Nurses also maintain a strong awareness of the complex web of social, historical, economic and environmental factors, in addition to high-quality and accessible health services that influence the health of a population. Most recently, Canadians were stunned to learn of an apparent suicide pact by 13 young people in the remote First Nations community of Attawapiskat (Canadian Press, 2016). The unfortunate reality is that this is not a new or unique experience.
and is the result of “a long history of poverty, chronic unemployment and generations of sexual, physical and psychological abuse” (Nikolau, 2016). Other challenges include access to safe drinking water: “Between 2004 and 2014, 93 per cent of all First Nations in Saskatchewan and New Brunswick reported at least one water advisory in their communities. Alberta is close behind at 87 per cent. The lowest provincial rate is 51 per cent in Manitoba” (Levasseur & Marcoux, 2015). The Neskantaga First Nation in Ontario has been under a boil water advisory for 20 years. It is incomprehensible that the situation is being compared to the experience of a developing country (Nikolau, 2016).

Urgent, co-operative and sustainable federal, provincial/territorial and local action is needed to address this context. As a profession, we can uniquely leverage our knowledge, skill and expertise to impact meaningful change through leadership in practice, policy, research and education. Principles from the Truth and Reconciliation Commission identify the need for mutually respectful relationships, self-determination, joint leadership and trust building. Consistent with these principles, Indigenous peoples must identify and develop the solutions that are needed within their communities for comprehensive, multi-faceted and sustainable change. Moreover, adequate resources are needed to develop strategies that support meaningful change.

**Relevance to CNA’s mission and goals:** This resolution is directly connected to CNA’s and CINA’s mission. Supporting the health and well-being of Indigenous peoples represents healthy public policy and is an important demonstration of health equity. Nurses have a unique and pivotal opportunity to influence the discourse and promote strategic action. This resolution is timely because in February 2016 CNA signed a partnership accord with CINA to “collaborate on advancing Indigenous nursing and . . . address the gap between the health of Indigenous and non-Indigenous Canadians” (CNA, 2016b).

Over the last 40 years CINA has done extensive work to address these issues at a policy, educational, practice and research level. Other and more recent and related work includes: National Expert Commission; CNA 2015 Resolution 10 (submitted by A.N.A.C. to increase national collaboration to address Indigenous nursing issues); CNA 2014 resolution 1 (submitted by A.N.A.C. to identify strategies in all domains of nursing to reduce racism and structural discrimination in health care and to improve health equity for Aboriginal Peoples) (CNA, 2016a); CNA 2012 Resolution 10 (which resolved that CNA would work closely with ARNBC and has led to ARNBC selecting Indigenous health as a top policy priority, moving the Indigenous health policy work forward in British Columbia out of which information has and will be shared); CNA 2012 Resolution 12 (submitted by RNAO to support the treatment of opioid dependence within Indigenous communities); the development of a CNA Aboriginal Health Nursing Advisory Committee; the collaboration with the 2014 North American Indigenous Games; and the delivery of webinars on nursing interests in Indigenous health. However, many of the Indigenous nursing resolutions put forward at the 2014 AGM have yet to be realized, and a more widespread engagement process would bring together the Indigenous voice and provide CNA with a broader basis from which to move policy forward.
Key stakeholders:
- Canadian Indigenous Nurses Association (CINA)
- First Nation, Inuit and Métis leadership and communities
- CNA’s jurisdictional members and stakeholders
- Health Canada and other areas of the federal government
- Provincial and territorial governments

Estimated resources required or expected outcomes: The expected outcome is the demonstration of national nursing leadership that stimulates progress in advancing the health, well-being and self-determination of Indigenous peoples in Canada. Financial and human resources will be needed to establish or strengthen relationships and develop an effective and appropriate response to advance this work.

References:


RESOLUTION 10  Improve Health and Community Safety by Supporting Supervised Injection Services

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for the repeal of Bill C-2, An Act to amend the Controlled Drugs and Substances Act, so that health, health services and community safety may be improved by increasing access to supervised injection services.

Name of submitter: Registered Nurses’ Association of Ontario (RNAO)

Rationale: The evidence for supervised injection services (SIS) as a means to improve health outcomes, increase access to health services and improve community safety¹ has only grown stronger since CNA released its 2011 discussion paper, Harm Reduction and Currently Illegal Drugs.² As part of a comprehensive continuum of health services for people who inject drugs, SIS provide a safe and hygienic environment where people can inject pre-obtained drugs under nursing supervision.³,⁴ Operating in over 90 sites in Australia, Europe and Canada (two sites), SIS save lives through prevention and treatment of overdoses, decreases transmission of blood borne diseases such as HIV and hepatitis, and facilitates access to addiction and detox services.⁵

RNs and NPs across Canada have been leading the way with harm reduction programs, including our colleagues in British Columbia who opened Insite in the Downtown Eastside of Vancouver in 2003. When Insite was under threat of closure by the previous federal government, the Association of Registered Nurses of British Columbia (ARNBC), CNA and RNAO were granted intervener status at the Supreme Court.⁶ Consistent with the findings of two British Columbia courts, the Supreme Court of Canada upheld Insite’s ability to operate: “Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation.”⁷

Instead of abiding by the public health evidence and in contradiction to the spirit of the 2011 Supreme Court ruling,⁸ in June 2015 the Conservative government passed Bill C-2, An Act to amend the Controlled Drugs and Substances Act.⁹ Although it would not be acceptable with any other health service, Bill C-2 created an inflexible and excessive application process that privileges opinions over evidence.¹⁰ The approval process creates opportunities for public opposition and further discrimination against an already marginalized population of people who use drugs.¹¹ Despite the risk of harm to this vulnerable population through this onerous process, Bill C-2 does not protect against arbitrariness or provide sufficient clarity on the level of information, research, opposition, or support needed for an application to be accepted or rejected.¹²

It is urgent that Bill C-2 be repealed as soon as possible. Based on strong public health evidence of need¹³ and cost-effectiveness,¹⁴ Toronto and Ottawa are starting the application process to incorporate SIS into health facilities that already serve people who use drugs.¹⁵,¹⁶ Montreal has applied to open SIS in three fixed locations and one mobile unit.¹⁷ Other
communities where SIS are under consideration include Edmonton, London, Thunder Bay and Victoria.\textsuperscript{18,19,20,21,22}

**Relevance to CNA's mission and goals:** Advancing this resolution will serve CNA's mission of advocating for healthy public policy and serving the public interest. It will assist with the goal of advancing nursing leadership to strengthen nursing and the Canadian health system. It will also serve to shape healthy public policy at all levels of government.

The repeal of Bill C-2 is consistent with ARNBC, CNA, and RNAO's position as interveners in the 2011 Supreme Court case. The Canadian Association of Nurses in HIV/AIDS Care is on record as being in opposition to Bill C-2.\textsuperscript{23}

**Key stakeholders:**
- CNA’s jurisdictional members and interest groups
- Coalition of Nurses and Nursing Students for Supervised Injection Services.\textsuperscript{24}
- A broad range of groups interested in public health and human rights, including people with lived experience.\textsuperscript{25}

**Expected outcomes:** The expected outcome is advocacy by CNA in collaboration with others to repeal Bill C-2. Staff time will be needed to establish or strengthen relationships and develop an effective advocacy campaign.

**References:**
\textsuperscript{5} Toronto Drug Strategy’s Supervised Injection Services Working Group. (2013). *Supervised injection services toolkit*.


23 Canadian Association of Nurses in HIV/AIDS Care. (2015). Bill C-2 legislation to amend the Controlled Drugs and Substances Act to allow exemptions for supervised injection sites (and services). Submission to the standing Senate committee on legal and constitutional affairs.

RESOLUTION 11 National Nursing Data Standards

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for the adoption of two standardized clinical reference terminologies, ICNP® and SNOMED-CT, and a standardized approach to nursing documentation in all clinical practice settings across Canada.

Name of submitter: Canadian Nursing Informatics Association

Rationale: While significant electronic health record (EHR) investments have been made within every Canadian jurisdiction, little effort has been made to unify approaches to online clinical documentation. Regardless of system vendor, the opportunity to adopt standardized models, tools and measures is being supplanted by every health-care organization adopting their own design. Ironically, while this is one of the greatest advantages to be derived from the use of EHRs, it has not yet been addressed within nursing. Canadian nurses are the largest contributor to EHRs; however, there is an overwhelming lack of standardization within nursing documentation. The adoption of a standardized terminology in EHRs for nursing, in all care settings, would advance our understanding of the contribution of nurses and the impact of nursing care on health outcomes for Canadians and the health system.

In Canada, the 1992 Nursing Minimum Data Set (NMDS) Conference, initiated by the Canadian Nurses Association (CNA), was the first step in developing a nursing minimum data set, now called Health Information: Nursing Components (HI:NC).1 The collection of the data elements comprising the standardized nursing minimum data set will allow for the collection, storage, retrieval, analysis and communication about nursing practice. The inclusion of standardized nursing data in health information systems will support nursing practice, health-system research and health policy decision-making.

In nursing, specific initiatives such as C-HOBIC2 and NNQR-C3 have begun to enable the standardized collection of nursing data within specific jurisdictions and health-care organizations. The C-HOBIC dataset is a Canada Approved Standard.4 In addition, the C-HOBIC data set has been mapped to both ICNP®5 and SNOMED-CT.6 Efforts are currently underway for inclusion of the C-HOBIC data set in the Discharge Abstract Database (DAD) at the Canadian Institute for Health Information (CIHI). However, a majority of nurse leaders have yet to appreciate the potential value to be garnered from the use of standardized terminologies, metrics, definitions and approaches within EHRs to documentation and reporting.

The International Classification for Nursing Practice® (ICNP) is the terminology endorsed by CNA for documenting professional nursing practice in Canada.7 In 2006, Canada Health Infoway approved and adopted the Systematized Nomenclature of Medicine – Clinical Terms (SNOMED-CT) as the clinical reference terminology to support the design of EHRs.8 In January 2014, the International Health Terminology Standards Development Organisation (IHTSDO) and the International Council of Nurses (ICN) announced the release of an equivalency table between ICNP® concepts and SNOMED-CT concepts.9 The adoption of these reference terminologies will support health-care organizations in Canada to consistently capture and
report standardized clinical nursing data and create the capacity for comparable, sharable clinical data across care settings.

An invitational National Nursing Data Symposium in Toronto held on April 9 and 10, 2016, included the participation of nurse leaders and key stakeholders from across Canada, representing all sectors of care and the areas of policy, clinical practice, clinical administration, research and education. Supported by CNA, CIHI, Canada Health Infoway and several members of the vendor community, the participants indicated strong support and a commitment to move forward with the adoption of nursing data standards within EHRs in Canada.

**Relevance to CNA’s mission and goals:** With an increased focus on primary care and management of chronic illness there is a need to collect standardized clinical information to support patient transitions and examine outcomes as people move across sectors of the health-care continuum. The strategic plan of CNA is focused on the role of nursing in primary health care. To build capacity and lead system change, nurses and nursing leaders require information to support administrative and clinical decision-making and inform health policy directions. The collection of standardized clinical data (such as C-HOBIC and NNQR-C) using standardized clinical reference terminologies, specifically ICNP® and SNOMED-CT, supports the sharing of information between and among health-care sectors and health-care providers for improved planning for appropriate care and resources.

**Key stakeholders:** Canadian Nurses Association, Canada Health Infoway, Canadian Institute for Health Information, Canadian Nursing Informatics Association, Information Technology Association of Canada, Canadian Association of Schools of Nursing, Academy of Canadian Executive Nurses, provincial/territorial nurses associations, Canadian Federation of Nurses Unions.

**Estimated resources required or expected outcomes:** Funding for working groups for the next five years:

- Development activities, e.g., standardized clinical documentation, consensus building
- Implementation support tool development, e.g., use of ICNP, SNOMED-CT
- Education, e.g., national awareness, communication and stakeholder engagement
- Evaluation activities, e.g., demonstration of value

**References:**


**RESOLUTION 12**

**Lobby for a Federally Funded National Nursing Research Strategy and Agency**

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) mobilize nurses across Canada to lobby for a federally funded national nursing research strategy and agency.

**Name of submitter:** Canadian Association for Nursing Research (CANR)

**Rationale:** The profession and discipline of nursing is in dire need of research funding. Fellows of the Canadian Academy of Health Sciences voiced grave concerns in their *Canadian Nurse* commentary entitled, “Does Nursing Research have a Future?” (Bottorff et al., 2011), and questioned how, without research, can our profession ensure that nurses are providing the highest quality care? Something has to be done! Nursing scholarship encompasses research, education, leadership, policy development and improvements in practice (Stockhausen & Turale, 2011). It is research that informs and guides practice. However, research opportunities have been scarce since 2009, when the federal government discontinued health-care research funding to the Social Sciences and Humanities Research Council and ended the Nursing Care Partnership Fund (two agencies that provided funds for nurse researchers in Canada). Canadian Institutes for Health Research (CIHR) is the major funding source for all health-care professionals (experienced and novice nurse researchers). The number of research applicants to CIHR has increased by 31% between 2005-06 and 2010-11 (CIHR, 2013). Research funding is highly competitive, and only the best and most experienced researchers receive a research grant. In 2013, only 400 (18.87%) of all research with a rating of 3.5 or greater received funding per competition. In 2014-2015, CIHR reformed its Open Operating Grant programs to Foundation Scheme grants, which are designed to contribute and sustain health research leaders by providing long-term support for the pursuit of innovative, high-impact programs of research (CIHR, 2014).

**Relevance to CNA’s mission and goals:** CNA is best positioned to mobilize nurses and sound the national professional voice calling for a federally funded national research strategy and agency to increase opportunities for nurses to pursue evidence-informed practice through research.

**Key stakeholders:** Canadian Nurses Association (CNA), Canadian Association for Nursing Research (CANR), Canadian Association of Schools of Nursing (CASN), Canadian Nurses Foundation (CNF), Health Canada (HC), Public Health Agency of Canada (PHAC).

**Estimated resources required or expected outcomes:** Albeit CNA lobbying is part of its mandate, we anticipate extra lobbying will be required; however, our network group, CANR, will take an active role in lobbying and supporting CNA in all its efforts. Evidence-informed nursing practice through research will promote nursing excellence and enhance service to the public and, ultimately, strengthen our profession and discipline. Engagement in research also fosters nursing leadership for sustained advancement of nursing and the health-care system.
References:


BE IT RESOLVED THAT the Canadian Nurses Association (CNA) assume a national nursing leadership role to influence the development of a new multi-year federal-provincial/territorial health accord that focuses on: enforcing the Canada Health Act, increasing health transfers, advancing interprofessional primary care with RNs and NPs working to full scope, reinstating the Health Council of Canada and establishing a pharmacare program.

Name of submitter: Registered Nurses’ Association of Ontario (RNAO)

Rationale: In January 2016, provincial and territorial health ministers met with federal Health Minister Jane Philpott. Now is the time to ensure that Ottawa follows through on election commitments to restore its leadership role in health and health care.

Enforcing the Canada Health Act
The 2004 health accord was an agreement between the federal government and the provinces and territories that provided health-care funding in return for agreed upon national standards. It expired in 2014 and the federal government of the day refused to renew it. Negotiating a new one represents a commitment to the Canada Health Act by ensuring stable funding and setting national standards. Without it, there is no cohesive strategy to create equity and improve social progress. It is important that a new agreement provides the necessary funding and oversight to ensure the health system is publicly administered, universally accessible, comprehensively covered, accessible (without extra charges or discrimination) and portable across Canada. The absence of a health accord risks eroding medicare and increasing privatization.

Increasing Health Transfers
On December 19, 2011, the former federal government announced it was changing the way it would transfer funds to the provinces.

- The Canada Health Transfer (CHT) growth would continue at six per cent per year for three years (2014-15 to 2016-17) and then be cut to the rate of growth of GDP.
- The Canada Social Transfer (CST) would continue to grow at three per cent per year.
- Equalization transfers would grow at the rate of growth of GDP.

Without urgent intervention, far less money will be provided to provinces and territories than in the past. Roy Romanow, a former premier of Saskatchewan, has described Ottawa’s plan for health-care transfers as a deliberate strategy to abandon health care to the provinces and foster the development of more private, for-profit medical enterprises.

Advancing Interprofessional Primary Care With RNs and NPs Working to Full Scope
An ample supply, distribution and utilization of health professionals working together in teams are essential to sustain and expand medicare. Canadians receive the best care when it is provided through an interprofessional team where all members are enabled to practise to the full extent of their knowledge, skills and competencies. The previous health accord made interprofessional primary care a staple, and this resulted in substantial progress throughout the
country. In Ontario, it led to the expansion of community health centres and the creation of NP-led clinics and family health teams.

Reinstatement of the Health Council of Canada
Also under the previous accord, the Health Council of Canada (HCC) — an independent national agency that monitored and assessed Canada’s health system — was established. Sadly, it was dismantled under the previous federal government. The HCC disseminated innovative practices across the country for 10 years, and its elimination represents a significant gap by reducing federal oversight on national health-care standards.

Pharmacare
Canada is currently the only country with universal health care that does not include a national pharmacare program. A comprehensive universal pharmacare program would save Canadians billions of dollars through reduced drug prices and would deliver access to many whose health suffers because they cannot afford to pay for prescription drugs.

The federal Liberals campaigned on a promise to improve access to necessary prescription drugs and join with the provinces and territories to buy drugs in bulk. The concern is the federal government may confine itself to bulk drug purchases and provide catastrophic drug coverage, defined as “the provision of a general level of coverage that protects individuals from drug expenses that threaten their financial security or cause ‘undue financial hardship.’ ” This would still leave Canadians with out-of-pocket expenses that deter the proper use of drugs. What we need is a pharmacare program that is universally accessible to all Canadians and covers all medically necessary medications.

Relevance to CNA’s mission and goals: This resolution is directly connected to CNA’s mission. Advancing a new health accord will improve health outcomes in a publicly funded and not-for-profit health system. Moreover, doing so will uniquely position nursing in a leadership role to strengthen Canada’s health system by advocating for healthy public policy. This resolution serves the public interest by ensuring that a universally accessible and high-quality health system is available for all Canadians for generations to come.

Key stakeholders:
- CNA’s jurisdictional members and interest groups
- Health Canada
- Federal government
- System stakeholders (e.g., Canadian Federation of Nurses Unions, Canadian Health Coalition, Canadian Doctors for Medicare, and Canadian Association of Community Health Centres)

Estimated resources required or expected outcomes: The expected outcome is the demonstration of national nursing leadership that leads to the development of a new multi-year federal-provincial/territorial health accord. Staff time will be needed to establish or strengthen relationships and develop an effective advocacy campaign.
References:


RESOLUTION 14

National Leadership to Secure Access to RNs and NPs for Canadians

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) work with its jurisdictional partners and interest groups to develop a national framework to stop the replacement of RNs and NPs with lesser qualified providers and halt organizational models of nursing care delivery that disrupt continuity and fragment care.

Name of submitter: The Registered Nurses’ Association of Ontario (RNAO)

Rationale:

Nursing Skill Mix

RNAO supports evidence-based staffing and skill-mix decisions that ensure care is delivered by the appropriate provider to the appropriate patient. This means aligning knowledge, skills and competencies with patient/client needs. Throughout Canada, RN positions are at risk of being replaced with less qualified providers as a short-sighted cost-saving measure. A former CEO of Alberta Health Services is quoted as saying “In some places it is not possible to recruit RNs so an employed LPN is seen as being better for everyone than getting existing RNs to work overtime. . . . LPNs are generally paid less and they can perform many RN functions at equivalent quality” (Born, Dhalla, and Ferguson-Pare, 2013). In Ontario, RNAO has long advocated against this short sighted and misinformed thinking. The evidence clearly demonstrates that higher RN staffing results in improved patient, organizational and cost outcomes. Most recently RNAO has been vocal against dangerous skill-mix decisions in Ontario, such as the proposed replacement of RNs with practical nurses in a neonatal ICU (Frketich, 2016).

Given the evolving health needs of the population and the needs of health systems, NPs represent a viable and effective solution. There is evidence to show that NPs contribute to safe, high quality and cost-effective care, thereby meeting both patient and health system needs (DiCenso & Bryant-Lukosius, 2010; RNAO, 2009). NPs are autonomous health professionals that increase patient access to care, and have demonstrated effectiveness in various models of hospital care: NPs can be added to existing interprofessional models of care, where the goal is to improve quality of care, remedy gaps in care, and can also function as the Most Responsible Provider (Acorn, 2015; Donald et al., 2014; Newhouse et al., 2011; Stanik-Hutt et al., 2013).

RNAO is concerned about growth of the physician assistant (PA) role in Canada. PAs are unregulated care providers in Ontario and are not accountable to a regulatory college (Health Force Ontario, 2015; RNAO, 2010) Given their lack of autonomy and accountability, RNAO believes that continuing to invest in PAs has the potential to fragment patient care and increase costs of care (Health Professions Regulatory Advisory Council, 2011; RNAO, 2010). RNAO believes that NPs present a safer, more cost-effective alternative with a demonstrated history. RNAO is gravely concerned about funding structures that incentivize the hiring of PA’s over NPs.
in hospitals and urges CNA to act to promote the role of NPs in order to ensure that patients have access to the highest quality of care.

**Organizational Models of Nursing Care Delivery**

Since the early 1900s organizational models of nursing care delivery have evolved from patient-allocation models, functional models and team-based models to primary nursing, where one nurse takes responsibility for all of a patient’s care needs on a continuous basis throughout the patients’ journey (Rudisill et al., 2014). Primary nursing increases continuity of care (Duffield et al., 2010), enables understanding of patients’ non-verbal cues, facilitates early intervention when signs of disease progression appear (Mefford & Alligood, 2011), and decreases adverse events (Glance et al., 2012; Kane et al., 2007; Patrician et al, 2011). These decreased adverse outcomes also reduce organizational costs (Needleman et al., 2006).

In the past year there has been a resurgence of functional models of care in Ontario hospitals. These models fragment patient care into tasks which are then delegated to the least costly provider. It is unconscionable that short-sighted solutions to balance budgets are taking precedence over the safety and effectiveness of the Canadian health system.

RNAO does not feel that Ontario is alone in needing to protect the role of the RN and NP for the health and safety of the public. Nor do we feel that we are alone in striving to maintain continuity of care and continuity of caregiver. Urgent national leadership is needed to strengthen the RN/NP role and organizational models of nursing care that emphasize continuity and consistency.

**Relevance to CNA’s mission and goals:** This resolution is directly related to CNA’s position as the national professional association for RNs and advancing the profession to improve health outcomes. As RNs and NPs are replaced with lesser qualified providers, care is fragmented, Canadians suffer and the national RN/NP workforce will be depleted.

**Key stakeholders:**

- CNA’s jurisdictional members and interest groups
- All levels of government
- Regional health authorities and/or funding/planning bodies
- Health organizations
- Health administrators

**Estimated resources required or expected outcomes:** The expected outcome is an end to the replacement of RNs/NPs with less qualified providers and a halt to organizational models of nursing care delivery that fragment care. CNA would be expected to use its policy and political action resources to promote advocacy.

**References:**


BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for thorough public consultations on the ratification of the Trans-Pacific Partnership (TPP) and fully participate in those consultations, with the goal of identifying and remedying the health implications of this far-reaching agreement.

Name of submitter: Registered Nurses’ Association of Ontario

Rationale: The Trans-Pacific Partnership (TPP) is an agreement that would cover 40 per cent of the world’s economy, with 12 participants: Canada, the U.S., Australia, Brunei, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore and Vietnam. Other interested countries include South Korea, Taiwan, the Philippines, Colombia, Thailand, Laos, Indonesia, Cambodia, Bangladesh and India. The TPP is nominally about free trade, but few of the 30 chapters in the massive TPP agreement are strictly about traditional trade. They include chapters on investment, intellectual property, competition policy and state-owned enterprises. The devil is in the rest of the details. The Council of Canadians has justifiably characterized it as a free trade and corporate rights deal. The deal as written would be a threat to Canada’s ability to protect the health of its citizens and its environment.

Unsettlingly, Canada has already signed the deal with no public consultations. The government has promised consultations prior to ratifying the deal. It would have been much better to have had those consultations before signing, and that makes it urgent to have thorough consultations so that the government can understand what is at stake for Canadians.

As noted above, the potential impact on health comes from the constraints the TPP would impose on government's ability to legislate, regulate, implement policies and implement programs. In particular, the investor-state dispute settlement (ISDS) mechanism would give foreign investors the right to take the Canadian government to a tribunal to claim damages if any of the normal actions of government could be construed as unfairly interfering with current or anticipated profits. The TPP is very far-reaching: the Canadian government would be liable for investor damage claims not only as a result of its own actions, but also the actions of lower levels of government.

Canada should have learned from its past experience. As of 2014 alone, it had been the target of 35 claims under the NAFTA ISDS and had paid out damages of over $172 million, along with having spent over $65 million defending itself against these claims. Many claims are still pending, with some involving huge sums of money. Over half of the claims were for environmental protection, including the notorious ruling against Canada for banning the importation of the gasoline additive and suspected neurotoxin, MMT; this in spite of the fact that automakers also wanted MMT banned because of its effect on vehicle diagnostics systems. Quebec's ban on fracking triggered a $250 million claim against Canada. Eli Lilly has filed a $500 million claim against Canada because the Federal Court invalidated its Zyprexa drug
patent extension — invalidated because the drug had not delivered on promised utility. TPP will create more opportunities for corporations to sue Canadian governments. Canadian companies have also availed themselves of the ISDS under NAFTA to challenge environmental protection. For example, Methanex sued unsuccessfully for $970 million over California’s ban on the gasoline additive MTBE. The ISDS mechanism does not stop governments from acting on behalf of the public, but it makes it so potentially costly that governments may be deterred from doing so. The smaller the country, the more vulnerable it is. The deeper the pockets, the greater the chance of success.

There are minor reactive improvements in the TPP over the standard NAFTA model. For example, an exemption has been included for tobacco control, after tobacco giant Philip Morris used investment provisions of a trade deal to take action against Australia over plain packaging requirements. Philip Morris also used ISDS to challenge Uruguay’s move to increase the size of warnings on cigarette packages. It is an unequal struggle when the plaintiff (Philip Morris in this case) has more revenue than the respondent (Uruguay) has GDP. However, as corporate investor advisors note, the TPP investment protection provision remain broadly consistent with past U.S. investment protections, save for exceptions for tobacco control. Canada can expect further litigation if it ratifies the TPP. Canadians should not be lulled into a false sense of security by seeming protections in TPP for health and the environment, as they are little different than those in NAFTA, and we know the result there.

The implications of any government action — legislation, regulation, program or policy — being under threat are far-reaching. Not only are protective measures at risk, so are programs like medicare. Even if there is an exemption for medicare, it will not protect natural expansions to areas like pharmacare, as the results will certainly be seen as a threat to the profits of international pharmaceutical companies, who would be sure to avail themselves of any protection that TPP can afford them. Furthermore, the TPP is being used to protect the already overly strong patent protection that results in unconscionably high prices for drugs: “The upshot is that pharmaceutical companies would effectively be allowed to extend — sometimes almost indefinitely — their monopolies on patented medicines, keep cheaper generics off the market, and block ‘biosimilar’ competitors from introducing new medicines for years.” And of course, those higher drug prices will also hit Canadians who pay out-of-pocket and employers who pay for employees’ drug insurance.

Under the circumstances, the Canadian government owes its people a full public consultation, and it is in the interest of registered nurses, nurse practitioners and nursing students to demand and participate in this consultation.

Relevance to CNA’s mission and goals: The implications of the TPP on health and nursing are significant. This resolution fits with CNA’s mission of unifying RN voices through an active role in the consultation, strengthening nursing leadership, advocating at the national level for healthy public policy and a quality health system and serving the public interest by engaging Canadians.
Key stakeholders:
- CNA’s jurisdictional members and interest groups
- Federal Government
- Other health professions

Estimated resources required or expected outcomes: The expected outcome of this resolution will be advocacy in favour of public consultations on the TPP and full public participation in those consultations. CNA would be expected to use its policy and political action resources to promote advocacy.

References:


5 North American Free Trade Agreement


RESOLUTION 16  Expanding Oral Health Programs for Low-Income Adults

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) take steps to nationally advocate for the expansion of public dental programs to include prevention and treatment services to low-income adults, and those who have limited dental coverage through existing social assistance programs, before the year 2020.

Name of submitters:
Poonam Sharma, member, Registered Nurses’ Association of Ontario
Ioana Gheorghiu, member, Registered Nurses’ Association of Ontario

Rationale: A significant portion of the adult population in Canada experiences economic and other forms of marginalization, making it difficult to access dental care. It is important that Canadians, and Canadian public, private and professional policy-makers, become informed of the extent and severity of oral health conditions in Canada. In the 2007-2009 Canadian Health Measures Survey, 17%, or six million, Canadians reported that they did not make an appointment to see a dental professional due to the cost, and 16% reported that they avoided getting all their recommended treatments, also due to cost. The cost of dental problems is extensive when considering that a significant amount of time is lost due to dental checkups or problems with teeth: 40.4 million hours are lost from school or work or normal activities in one year.

Research shows that Canadian adults experience income-related inequalities in oral health and inequity in the access to oral health services. In 2012, it was reported that approximately 58,000 adults visited an Ontario hospital emergency room (ER) for a dental problem resulting in an estimated minimum cost of $513 per visit or 30 million health-care dollars annually. Unfortunately, acute care intervention in the hospital provides a band-aid solution with prescription medication.

Compared to the rest of the population, vulnerable groups in Canada are:
- less likely to have dental insurance
- more likely to avoid the dentist due to cost
- more likely to consult dentists only in emergencies
- more likely to have untreated dental decay, gum disease, missing teeth and dental pain
- more likely to avoid eating healthy foods such as fruits and vegetables due to oral health problems

Oral diseases are widespread but their societal distribution is uneven, being particularly high in disadvantaged groups, with the gap between advantaged and disadvantaged getting worse. The main contributors to inequity in oral health-care use are income and dental insurance coverage, where low income and a lack of insurance play a dominant role in limiting people’s ability to access oral health care.
At present, the majority of dental care in Canada is provided in the private sector. Although dentistry in this sector provides good quality oral health care for a majority of the population, it serves as a poor model of health care for vulnerable groups. In Canada, 32 per cent of the population has no dental insurance. Research indicates a connection between poor oral health and systemic diseases such as diabetes, respiratory disease, heart disease and premature low birth weight babies. The World Health Organization states that “oral health is essential to general health and quality of life.” Furthermore, the Canadian Dental Association defines oral health as “a state of the oral and related tissues and structures that contribute positively to physical, mental and social well-being and the enjoyment of life’s possibilities, by allowing the individual to speak, eat and socialize unhindered by pain, discomfort or embarrassment.”

Canadian households are spending an ever-increasing percentage of their total household income on health care, with the greatest increase in households in the lowest income group (63.2% increase between 1998-2009). Poverty is one of the main social determinants of poor overall health, including oral health. In order to address the oral health problems for vulnerable Canadians, there needs to be an upstream approach that focuses on preventive strategies. Government investment in public dental programs for low-income adults would provide increased access to dental treatment and engage in an ongoing preventive program to reduce future oral health issues and costly ER visits.

In the early 1980s, approximately 20 per cent of all oral health care was publicly funded in Canada, with a significant infrastructure for oral health-care delivery present; however with the economic recession in the 1980s, and another in the 1990s, the government imposed severe cutbacks and public financing for oral health care began its decline. Right now, when ranked by the amount of public funds allocated to oral health care in 10 OECD (Organisation for Economic Co-operation and Development) countries, Canada is close to last. Organizations such as the Association of Ontario Health Centres, the Canadian Academy of Health Sciences, the Ontario Association of Public Health Dentistry and the Ontario Oral Health Alliance all agree that a dental program for low-income adults is needed. Action to extend public dental programs is needed now.

Relevance to CNA’s mission and goals: This resolution enhances CNA’s mission to unify the voices of RNs in advocating for healthy public policy and a quality health system as well as the mission to serve the public interest.

This resolution is also in line with CNA’s goals to shape and advocate for healthy public policy provincially/territorially, nationally and internationally as well as broadly engaging nurses in advancing for nursing and health.

Key stakeholders:

- Provincial and federal governments
- The Canadian Association of Public Health Dentistry
- The Canadian public
- Health and human services providers and their organizations
- Civil society groups and movements
- Canadian RNs, including CNA’s jurisdictional members and their interest groups

Estimated resources required or expected outcomes: CNA would be expected to maximize its current policy/political action resources and to expand, where necessary.
**Expected outcomes**: Increased access to dental care for low-income adults, better overall health for vulnerable populations and a decrease on cost expenditures related to oral health problems in the health-care system.

**References:**


RESOLUTION 17 Acceptance of the Proposed Practice Standards and Guidelines for Aesthetic Nurse Injectors

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) adopt the Practice Standards and Guidelines for Aesthetic Nurse Injectors, which will ensure that non-surgical, aesthetic injection treatments are performed in a professional and ethical manner, with an emphasis on client safety.

Name of submitters:
Canadian Society of Aesthetic Specialty Nurses (CSASN) executive committee:
Deborah Elias — Ontario
Catherine Gobeil — Quebec
Kathryn Woodcock — British Columbia
Angela Haff — British Columbia
Tracey Hotta — Ontario

Rationale: With the support of CNA, the Practice Standards and Guidelines for Aesthetic Nurse Injectors will have greater credibility and unity with all provincial colleges of nursing and provincial colleges of physicians and surgeons. This will assist in establishing clear and comprehensive guidelines that will ultimately result in exemplary patient care and safety and public trust.

Relevance to CNA’s mission and goals:

Unifying the voices of registered nurses: The Practice Standards and Guidelines for Aesthetic Nurse Injectors is a comprehensive document available to all nurses from across the country. CSASN unifies the largest number of aesthetic nurses under a common society and is an invaluable resource for all nurses who practise medical aesthetic injectable treatments.

Strengthening nursing leadership: The Practice Standards and Guidelines for Aesthetic Nurse Injectors can be used as a tool to foster nursing leaders through mentorship. CSASN supports the philosophy of mentorship in medical aesthetic settings by offering continuing education workshops, local and national conferences and/or video calls. CSASN recognizes the responsibility of all RNs to mentor, guide, educate and support novice nurses injectors.

Promoting nursing excellence and a vibrant profession: The Practice Standards and Guidelines for Aesthetic Nurse Injectors encourage all members to take ownership of their expertise and excellence. The nurses are educated, skilled and valuable members of an interprofessional team including physicians and other health professionals. “Excellence involves caring in action and is fundamental to the achievement of optimal health outcomes for the patient, registered nurse, and system” (RNAO, 2004).

Advocating for healthy public policy and a quality health system: The Practice Standards and Guidelines for Aesthetic Nurse Injectors include facility recommendations for medical clinics where the aesthetic treatments are performed. This ensures that proper infection controls practices, confidentiality and emergency equipment are readily available.
Serving the public interest: CSASN advocates, through The Practice Standards and Guidelines for Aesthetic Nurse Injectors, that all members take ownership of their expertise and excellence, and that continuing competence is a mandatory component of practice. Public interest is best served when nurses constantly improve their application of knowledge, skill and judgment.

Key stakeholders: Aesthetic nurse injectors, physician collaborators, medical directors, educational training companies, manufacturers, distributors, and the public.

Estimated resources required or expected outcomes: We would request the assistance of CNA for a professional and public awareness campaign on client safety when undergoing an aesthetic injection procedure.

References:


