



BUILDING ON OUR LEGACY



**NURSES
POWERING
THE FUTURE**

RNAO's 2026
Annual General Meeting

will be held May 28-29

Resolution Package

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2026 ANNUAL GENERAL MEETING Requirements & Procedures for Consultation Representatives

PLEASE READ THIS DOCUMENT THOROUGHLY to obtain complete information.

As directed in RNAO Policies – and specifically 2.04 ‘Consultation Representatives’ – each Provincial Interest Group, each Chapter / Region without Chapters, and the Nursing Students of Ontario Interest Group, shall submit to the RNAO Chief Executive Officer, a list of their elected [voting] Consultation Representative(s) and Alternates.

Representatives must hold a **valid, regular RNAO membership for 2026**. Notwithstanding this, the Nursing Students of Ontario Interest Group shall be entitled to elect **one** Representative. Retired Members can be Representatives. **At the Annual General Meeting, the Chief Scrutineer can accept votes only from those Representatives whose names appear on the certified list** thereby authorizing them to vote at the meeting. The certified list will be determined prior to the commencement of the Annual General Meeting.

The Annual General Meeting will be held **in-person at the Crowne Plaza Hotel**. Consultation Representatives play a vital role in the activities of the Association. Representatives are **required** to attend the one of the virtual Resolution Orientation Session held prior to the AGM on **Tuesday, May 19, 2026 or Wednesday, May 20, 2026**; and **must** be available to attend the full **AGM on Friday, May 29, 2026**, and will also actively participate in the afternoon consultation session where the Resolutions will be discussed and decided upon. The AGM is an exciting experience – but one that requires commitment and time. Consultation Representatives are on call during all of the business sessions.

Consultation Representative(s) are to attend the 2026 Annual General Meeting in-person, to be available to attend one of the following **mandatory** virtual sessions:

<p>Tuesday, May 19, 2026 (7:00pm- 9:30pm) or Wednesday, May 20, 2026 (5:30pm – 8:00pm)</p>	<p>Discussion with submitters of resolutions and RNAO Parliamentarian. ONLY those that attend this session will appear on the certified list of voters and receive a secure link to the AGM session for voting.</p>
<p>Friday, May 29, 2026</p>	<p>Consultation Representative must be sitting in their seats by 830am. If you are late, you will not be allowed to vote. The business of the Annual General Meeting is from 8:30am to 4:00pm.</p>



**Rules of Order
Annual General Meeting
May 2026**

1. Only accredited CONSULTATION REPRESENTATIVES (formerly called “voting delegates”) may vote on any question.
2. All questions will be decided by a majority of the votes cast, except on those questions requiring two-thirds majority, in which case, the chair shall so advise. In the case of a tie, the chair shall be entitled to vote but otherwise, she/he has no vote.
3. Voting will be by an online poll unless the chair in any particular case directs otherwise.
4. The chair reserves the right to limit the length of the discussion on any motion or amendment. At the start of the meeting, the chair will propose a timetable with an allotment of time for each motion or question.
 - (a) Each resolution will be discussed for a maximum of **eight (8) minutes** to ensure that all submitted resolutions are heard by Consultation Representatives.
5. A motion may be introduced **only** by an accredited Consultation Representative and shall be seconded by another Consultation Representative before being ruled upon by the chair, or discussed. This includes both main and subsidiary motions.
 - (a) The mover of a motion shall have **one (1) minute** to speak. A mover can defer the time to the submitter or an alternate.
6. Discussion will be for **four minutes (4) minutes** for a particular motion or question in order to permit 30 seconds for voting on it.
 - (a) Speakers shall have one **(1) minute each** (4 speakers maximum). No member shall speak more than once on a motion or amendment.
 - (b) The mover shall have **one (1) minute** further to close the discussion.
7. The chair shall call for a vote following discussion, and consultation representatives shall have **one (1) minute to vote**.
8. Amendments must be introduced by motion and will be voted on before the main motion is put to a vote. Any amendments discussed must be contained within the allotted discussion time. **Amendments made at the resolution session must be submitted to Chevonne Cordle at ccordle@rnao.ca by 12pm on May 28th, 2026.**

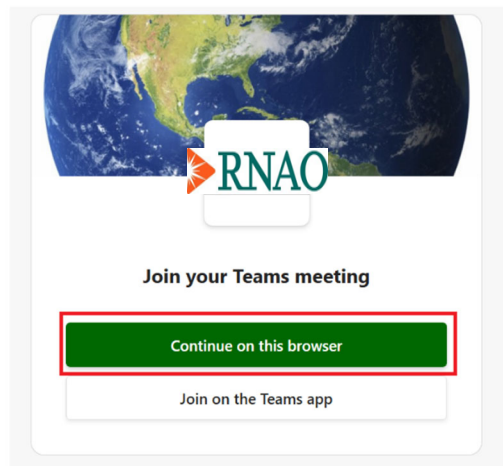
9. Any member of the Association may participate in discussion. However, the chair is prepared to entertain 'requests to speak' from others attending the annual meeting. The ruling on such requests will be based on consideration of:
 - (a) The amount of time available for debate;
 - (b) The fact that members have priority claim on opportunities to speak
10. Members, including Consultation Representatives, wishing to speak, are asked to identify themselves **clearly (name and chapter or region without chapters or interest group)**, before proceeding to speak.
11. 'New Business' items relating to proposed resolutions will not be entertained by the Chair, unless such proposed resolution(s) is/are brought forward by the **RNAO Board of Directors (BOD)**. They will be brought to the Secretary of the meeting (RNAO Chief Executive Officer), or her/his designate, not later than 8:00am on Friday, May 29, 2026 (RNAO Policy 6.07[5]). After this time, no other items of business will be considered.
12. The chair of the session will review the submission(s) and decide on the disposition of same.
13. The decision made on the disposition of the submission(s) will be reported to the assembled delegates by the chair, and may include:
 - a) presentation of a BOD resolution or motion to the annual meeting under 'New Business';
 - b) referral of a matter to RNAO Board of Directors;
 - c) ruling a matter out of order



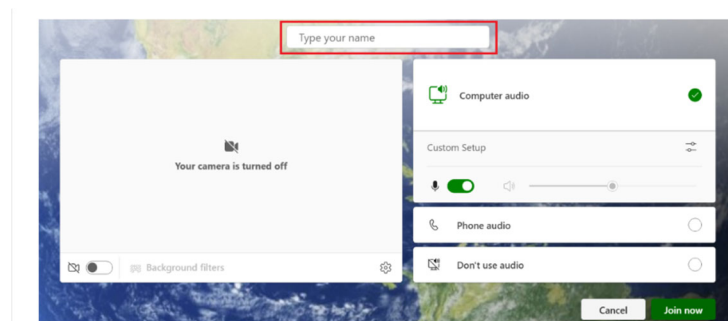
Microsoft Teams Instructions
RNAO Virtual Resolution Orientation Sessions
Tuesday, May 19, 2026 (7:00pm- 9:30pm) or
Wednesday, May 20, 2026 (5:30pm – 8:00pm)

Joining:

- We ask that all Consultation Representatives and Resolution Submitters log in 10 minutes before the scheduled start time to ensure the meeting begins on time.
- Consultation Reps and Resolution Submitters should join the meeting anonymously. Here are the steps:
 - **Open the Teams meeting link in a web browser.**
 - When prompted, select **“Continue on this browser”** instead of signing in or opening the Teams app.

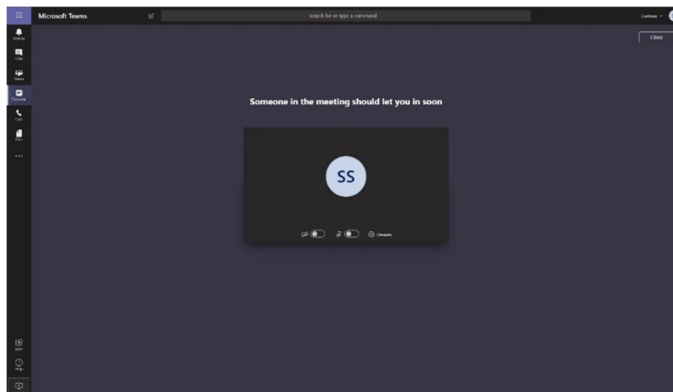


- On the pre-join screen, use the **‘naming convention’** found below to add your name:



Naming Convention:

- Please rename yourself in this format to be easily identified:
 - CRep_FirstName_IG/Chapter/Region w/o Chapter
 - Example: CRep_Chevonne_Region7
 - Add Submitter Naming Style ie. Sub#_FirstNameLastName
Example: Sub1_ChevonneCordle
- You'll be placed into a **Waiting Room** where the Credentialing Team will confirm your name on the **certified list** of consultation reps., before admitting you into the Microsoft Teams meeting.



- All lines will be muted and cameras will be turned off as you join the session. Please keep these off unless you have the floor.

How to Join a Meeting Video Tutorial: https://www.youtube.com/watch?v=QVzZ_81yXME



AGM Orientation/Resolution Session Agenda

Tuesday, May 19, 2026 (7:00pm- 9:30pm) or
Wednesday, May 20, 2026 (5:30pm –8:00pm)

The order of the meeting will be as follows:

Welcome & Overview of Agenda <i>Marianne Cochrane, Parliamentarian</i>	2 minutes
Rules of Order & Voting Instructions <i>Marianne Cochrane, Parliamentarian</i> <i>Chevonne Cordle, RNAO Staff</i>	10 minutes
Question & Answer Period <i>Marianne Cochrane, Parliamentarian</i>	5 minutes
Breakout Resolution Discussion <i>Resolution Submitters</i>	15 minutes/resolution
Closing Remarks & Adjournment <i>Marianne Cochrane, Parliamentarian</i> <i>Chevonne Cordle, RNAO Staff</i>	3 minutes



Summary of Resolutions for Consideration at the 2026 Annual General Meeting

Resolution #	Title	Author(s)
Resolution 1	Ending Forced Birth Evacuation Through Indigenous-Led Community Birth and Nursing Advocacy	Andrea Oltsher
Resolution 2	The Need for Mental Health Supports in Long Term Care	Cheryl Forchuk PhD, Wajma Soroor and Lallu Sara John RN,BScN,MN, GNC(c), CPPS CPHQ,CHE, PhD(c) on behalf of the Brant Haldimand Norfolk Chapter
Resolution 3	Nursing Leadership in Antimicrobial Stewardship to Address Antimicrobial Resistance in Ontario	Dorothea Service, RN
Resolution 4	RNAO to Reduce Food Insecurity Among Nursing Students in Ontario	Pawel Chomicz, Dr. Allison Kern, Debra Lefebvre, Celia Piper, Dr. Andrea Rochon, Hugo Tam, Jessica Thomas, and Jennifer Waite
Resolution 5	Strengthening Employer and System Readiness to Support Registered Nurse Prescribing in Ontario	Ruby Amoncio, RN and Charlie Byer, RN, BScN, MS(N)
Resolution 6	Develop A Comprehensive RNAO Strategy To Help Nursing Educational Institutions Adopt Planetary Health Principles	Rachel Gonzales BScN, Hugo Tam, 4th-year nursing student, Nursing Students of Ontario, Rob Samulack RN, BScN, Beng, May Tao RN MSN and the ONE Executive Team on behalf of the Ontario Nurses for the Environment
Resolution 7	Preventing Discharge from Hospital to Homelessness	Brant-Haldimand-Norfolk Chapter (Patrick McCaffery and Cheryl Forchuk) and Mathew McGuigan (of Chatham-Kent)

Resolution #	Title	Author(s)
Resolution 8	Advocate to the Ministry of Education, Non-waged subsidies in clinical placements for undergraduate nursing students	Gurkirat Singh and Anthonia Chukwuyem, on behalf of the Nursing Students of Ontario Interest Group (NSO).
Resolution 9	Wounds As a Public Health Priority	Mathew McGuigan, RN, BScN and Rosemary Kohr, RN, BA (Arts Plastiques), BScN, MScN, PhD
Resolution 10	Advocate and Partner for Nursing Leadership Development Across Healthcare Organizations	Dr. Sue Bookey-Bassett and Heather Thomson on behalf of the NLN.ON Interest Group
Resolution 11	Supporting Mandated Comprehensive Palliative Care Education in Ontario Nursing Schools	Christina Oleynikov (RN) & Ana Constantin (RN) and the following nursing students: Carly Wong, Neveen Shnoudeh, Katie Browne, Cassie Wilson, and Aileen Gencturk.
Resolution 12	Continuing Advocacy & Efforts to Address Growing Rates of Intimate-Partner Violence (IPV)	Ama Arthur, Maria Tandoc, Sandrina Ntamwemezi, Selasie Ametorwo and Upneet Lohcham (on behalf of Brampton and Mississauga Chapters)
Resolution 13	Strengthening Indigenous Partnerships to Expand Rural Nursing Practicums and to Support the Decolonization of Ontario Nursing Pedagogy	Hugo Tam 4th year BScN student, Sierra Punchard 4th year BScN student, Esther Momanyi 3rd year BScN student, Lee Zhang 2nd year BScN student, Simran Virk 3rd year BScN student, on behalf of the Nursing Students of Ontario Interest Group
Resolution 14	Sickle Cell Resolution	Kaywana Malcolm on behalf of Black Nurses Leading Change Interest Group (BNLC)
Resolution 15	Expanding Eligibility Criteria for the Supervised Practice Experience Partnership (SPEP) Program for Internationally Educated Nurses (IENS)	Mark Anthony Gravoso, RN
Resolution 16	Advocate the Council of Ontario University Programs in Nursing (COUPN) and Colleges of Applied Arts and Technology (CAATS) for the standardization of clinical practicum opportunities to meet the College of Nurses of Ontario's (CNO) Entry-to-Practice (ETP) Competencies	Simran Virk 3rd-year BScN student, Gurkirat Singh 3rd-year BScN student, Hugo Tam, 4th-year BScN student, Sierra Punchard, 4th-year BScN student, on behalf of the Nursing Students of Ontario
Resolution 17	Strategy to Address Prescribed Drug Dependence, Withdrawal, and Harm	Joanna McCabe, RN



Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

Resolution: Ending Forced Birth Evacuation Through Indigenous-Led Community Birth and Nursing Advocacy

Submitted by: Andrea Oltsher

Conflict of Interest: No known conflict of interest

WHEREAS, Indigenous women in northern and remote communities in Ontario are routinely required under Health Canada's evacuation policy to leave their communities to give birth, a practice that has been shown to cause psychological distress, increased postpartum depression, cultural loss, and disrupted family and community bonds;

WHEREAS, Indigenous-led models of care including midwifery, doulas, and community-based birth programs have demonstrated outcomes equal to or better than evacuation-based care while preserving cultural safety, continuity, and maternal mental health.

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate to the Government of Canada, Health Canada, and Indigenous Services Canada for the phased elimination of routine obstetric evacuation and the funding and expansion of Indigenous-led community birthing services in northern and remote First Nations communities;

THEREFORE BE IT FURTHER RESOLVED, that RNAO develop a nursing-led policy and practice framework to support nurses working in evacuation-based maternity systems, including training in trauma-informed care, Indigenous cultural safety, and advocacy pathways to support women's right to birth close to home.

Background

Indigenous women from Northwestern Ontario, specifically focusing on the Sioux Lookout area First Nations, are routinely required under Health Canada's obstetric evacuation policy to leave their communities weeks before birth to deliver in distant urban hospitals (O'Driscoll et al., 2011). This practice separates women from family, land, language, and ceremony during a critical life event and is associated with increased psychological distress, postpartum depression, and trauma (O'Driscoll et al., 2011; Saleh, 2023). Evacuation is not a neutral safety measure; it is a colonial policy that continues to disrupt Indigenous maternal health and cultural continuity.

Quantitative evidence confirms this harm. Using the Canadian Maternity Experiences Survey, Daoud et al. (2019) found that 21.2% of Indigenous mothers scored ≥ 10 on the Edinburgh Postnatal Depression Scale (EPDS) and 11.1% scored ≥ 13 , nearly double the rates of non-Indigenous Canadian-born women. These disparities are compounded by forced relocation, loss of support networks, racism in urban hospitals, and lack of culturally safe care (Eggenberger et al., 2022; Kornelsen et al., 2013; Saleh, 2023).

Sioux Lookout serves as a regional hub for more than 30 remote First Nations across Northwestern Ontario. For decades, women have been evacuated from these communities to Sioux Lookout or Thunder Bay for birth, often without partners or family due to restrictive federal escort policies. Research from the Sioux Lookout First Nations Health Authority (SLFNHA) confirms that these policies continue to create distress, family separation, and mistrust in the health system (Hurlen & Edwards, 2025; O'Driscoll et al., 2011).

Local solutions already exist in other parts of Canada. The Maternal Infant Support Worker (MiSW) program, developed in collaboration with nurses, educators, and Elders, successfully trained Indigenous women to provide culturally and linguistically appropriate prenatal and postpartum support, thereby strengthening community capacity and continuity of care (Jumah et al., 2021). These community-based models demonstrate readiness and local leadership in restoring births closer to home.

International and Canadian evidence shows that Indigenous-led midwifery and community birth are safe and effective. In Nunavik, the Inuulitsivik midwifery program achieved an 86% local birth rate, a 97% spontaneous vaginal birth rate, and a cesarean rate of 2.1%, with perinatal outcomes comparable to those of southern hospitals (Van Wagner et al., 2012). These results directly challenge the assumption that evacuation is necessary for safety.

Indigenous doulas and midwives provide culturally safe, trauma-informed care that improves maternal mental health, strengthens trust, and protects women navigating racism and medical hierarchies (Cidro et al., 2018; Doenmez et al., 2022; Hayward et al., 2024). These relational models align with Indigenous concepts of birth as a ceremony, a family responsibility, and a community responsibility (O'Driscoll et al., 2011).

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Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

Resolution: The Need for Mental Health Supports in Long Term Care

Submitted by: Cheryl Forchuk PhD, Wajma Soroor and Lallu Sara John RN,BScN,MN, GNC(c), CPPS CPHQ,CHE, PhD(c) on behalf of the Brant Haldimand Norfolk Chapter

Conflict of Interest: No known conflict of interest

WHEREAS, Long Term Care Residents facing psychiatric illness require timely, specialized, integrated and coordinated care from the beginning of transition into long term care, to the end. Mental illnesses (i.e. depression, anxiety, substance use disorder, psychotic disorders, delirium) are compounded in those with mental illness *and* physical co-morbidities, which can lead to more vulnerability for aggressive behavior, sedation, restraints and isolation (Kehyayan et al., 2021). Therefore, existing staff need to be trained in psychogeriatric interventions so at risk patients with new or unresolved symptoms are assessed and identified early (Kehyayan et al., 2021).

WHEREAS, An integrated and coordinated approach to care must bring Psychiatrists, Geriatricians and Registered Nurses on board to monitor and review medications and lead ongoing management (Kehyayan et al., 2021). In LTC's with Registered Nurses, studies show there are lower rates of depression, aggression and restraint use, and families report satisfaction with their loved ones health status as well (Donald et al., 2013).

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate the provincial government to increase funding for psychiatric assessment and medication review such that people with psychiatric illness can be appropriately assessed within one month of admission or within one month of new unresolved symptoms.

THEREFORE BE IT FURTHER RESOLVED, that the RNAO advocate the provincial government for nursing consultations from Advanced Practice Nurses to address appropriate nursing plans for patients with ongoing mental health issues that are not responding to the current plan of care within one month of the need for consultation being identified.

Background

Residents of long-term care (LTC) facilities experience a disproportionately high burden of psychiatric disorders, with approximately 40% having a documented mental health need (Kirkham et al., 2024). Nearly half (44%) exhibit clinically significant depressive symptoms that negatively impact quality of life and functional status (Kirkham et al., 2024; Hoben et al., 2019). Accelerated cognitive and functional decline and higher rates of medical comorbidities (Kirkham et al., 2024) are frequently compounded by physical comorbidities, cognitive impairment, and dementia, which doubles the risk of depression (from 10% to 20%) compared with cognitively intact residents LTC (Hoben et al., 2019).

This complex clinical profile increases vulnerability and may lead to a cascade of adverse outcomes and correlating systemic issues such as:

- Behavioral disturbances (with corresponding shortage in staffing and skill) (Kehyanyan et al., 2021)
- Inappropriate use of medications (with limited access to specialized clinicians) (Kehyanyan et al., 2021). In LTC settings, 42% of residents are exposed to at least one potentially inappropriate medication (Vanker et al., 2024) leading to risk of adverse drug events and an increase in the complexity of medication management.
- Use of restraints (with inconsistent resident monitoring) (Kehyanyan et al., 2021)
- Social isolation (with potentially inappropriate or complex medications) (Vanker et al., 2024)

Despite national quality initiatives, inappropriate antipsychotic use in Ontario LTC homes rose from 20.2% in 2019 to 23.9% in 2021, underscoring the ongoing need for systematic, timely assessment and care planning (Vanker et al., 2024). Since prescribing patterns vary widely across LTC facilities, this suggests that use is driven more by modifiable facility-level factors such as staffing, skill mix, ownership, and access to specialized clinicians than by resident clinical need (Bibi et al., 2025). Facilities with limited registered nursing staff, minimal psychiatric or geriatric involvement, and for-profit ownership consistently show higher antipsychotic use, whereas homes with structured medication review and psychogeriatric expertise demonstrate more appropriate prescribing (Bibi et al., 2025). Notably, LTC facilities with Nurse Practitioners have demonstrated lower rates of depression, aggression, and restraint use, underscoring the critical role of Advanced Practice Nurses (Nurse Practitioners and Clinical Nurse Specialists) in improving mental health outcomes in this vulnerable population (Donald et al., 2013).

Therefore, the RNAO is urged to lobby the government for timely assessment, identification and consultation in unresolved and persistent mental health issues with appropriate escalation to, and intervention with, psychiatric services when required (Levenson & Desai, 2017). This aligns with the RNAO Clinical BPG's on the 3 D's and Alternative Approaches to Restraints and can mitigate the cascade of adverse mental health outcomes for LTC residents and simultaneously provides a framework of on-time assessment and monitoring of changing resident needs, with ongoing medication review under Geriatrician, Psychiatrist and Advanced Practice Nursing care.

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Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

Resolution: Nursing Leadership in Antimicrobial Stewardship to Address Antimicrobial Resistance in Ontario

Submitted by: Dorothea Service, RN

Conflict of Interest: No known conflict of interest

WHEREAS, antimicrobial resistance (AMR) is a growing public health threat that increases morbidity, mortality, health care costs, and threatens the effectiveness of life saving treatments. Antimicrobial resistance is significantly increasing in community, long-term care, acute care, and public health. In Ontario, it is estimated 6 lives are lost every day due to AMR infections (Public Health Ontario ((PHO), 2026). By 2050, AMR is projected to cost the Canadian healthcare system \$6 billion dollars (Diener, A. Wang H., et al., 2022).

WHEREAS, nurses are the largest regulated healthcare workforce and are uniquely positioned to positively impact AMR through antimicrobial resistance stewardship (AMS). Nurses have substantial influence over antimicrobial stewardship through comprehensive assessment, diagnosis, prescribing, patient education, and ongoing monitoring of therapeutic antimicrobial care. Nurses are essential leaders in antimicrobial stewardship across the continuum of care to improve patient outcomes and reduce inappropriate antimicrobial use.

THEREFORE BE IT RESOLVED, the Registered Nurses' Association of Ontario (RNAO) advocate to the Government of Ontario for the formal recognition of nursing as a core pillar of provincial antimicrobial resistance and antimicrobial stewardship strategies across all sectors of care; and

THEREFORE BE IT FURTHER RESOLVED, RNAO advocate for the integration of antimicrobial stewardship competencies into nursing education, province wide access to stewardship tools, and nursing AMS surveillance data.

Background

The World Health Organization (WHO) identifies antimicrobial resistance (AMR) as one of the top threats to global health, emphasizing the need for improving AMR Stewardship (WHO, 2025). In 2021, AMR was linked 4.71 million global deaths. It is projected annual mortality reaching 10 million by 2050 if current trends persist (WHO, 2025). AMR occurs when microorganisms evolve to withstand antimicrobials, leading to reduced treatment effectiveness, prolonged illness, increased mortality, and higher health care costs. Surveillance demonstrates rising resistance among common pathogens in Ontario, including a near doubling of carbapenem producing organisms and increasing resistance in urinary and bloodstream infections.

It is estimated 6 lives are lost every day due to AMR infections (Public Health Ontario (PHO), 2026). Additionally, with current infection rates, AMR is projected to cost the Canadian healthcare system \$6 billion dollars by 2050 (Diener, A., et al, 2022). Antimicrobial overuse remains a primary contributor to AMR.

Nursing practice is foundational to antimicrobial stewardship (AMS). Nurses assess patients, distinguish infection from colonization, obtain appropriate specimens, administer and monitor antimicrobials, identify adverse events, and educate patients and families. The Canadian Nurses Association (CNA) Antimicrobial Stewardship Competencies provide a pan Canadian framework outlining core, additional, and optional competencies across nursing roles and settings (CNA, 2023). Nurse-centred implementation resources also offer practical supports to advance diagnostic stewardship and appropriate antimicrobial use at point of care (Johns Hopkins Medicine, 2019). Using these tools, nurses act as essential stewards whose practice directly influences antimicrobial resistance (Momin, S., et al., 2025). Broad implementation of nursing AMS competencies across nursing care sectors has the potential to optimize patient care while reducing AMR and improving appropriate antimicrobial use.

The Canadian Antimicrobial Resistance Surveillance System provides the national surveillance for AMR and antimicrobial use (Public Health Agency of Canada, 2024), however, there remains a need for robust AMR population health surveillance dashboards that can include AMS nursing-specific surveillance. The development of AMS nurse specific indicators such as culture collection, treatment and duration adherence, antimicrobial nurse prescribing rates, patient education documentation, adverse event monitoring, case and contact management of AMR diseases of public health significance would support a clear understanding of the nursing impact on AMR and inform quality improvement efforts.

Nursing leadership plays a central role in ensuring access to AMR resources, adaptation to local context, and integration into orientation and competency programs. Leadership development for nurses should include stewardship governance, measurement, and change management, enabling workflow alignment, documentation, and audit-feedback (Bos, M. et al., 2024) with organizational and provincial AMS goals.

Nurse Practitioners (NP), and RNs with prescribing authority, are responsible for making informed decisions about antimicrobial use to ensure patients are prescribed the appropriate treatment paired with timely reassessment (CNO, 2025). Across care settings, nurses with prescribing authority play a critical role in preventing exposure to unnecessary antimicrobials, reducing adverse events, and slowing resistance to lifesaving medications. Embedding AMS competencies across undergraduate, postgraduate, and continuing education is essential to safe practice and to promote evidence-based prescribing practices.

AMR is a serious and escalating threat to global and provincial health. With millions of global deaths attributed to AMR, optimizing antimicrobial use through nursing stewardship is urgent. Nursing practice is central to this response. Strengthening nursing leadership, education, prescribing governance, surveillance, and access to point-of-care stewardship tools is essential to advancing evidence-based antimicrobial use and improving the health of patients.

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Registered Nurses' Association of Ontario
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Resolution: RNAO to Reduce Food Insecurity Among Nursing Students in Ontario

Submitted by: Pawel Chomicz, Dr. Allison Kern, Debra Lefebvre, Celia Piper, Dr. Andrea Rochon, Hugo Tam, Jessica Thomas, and Jennifer Waite

Conflict of Interest: No known conflict of interest

WHEREAS, food insecurity among Canadian post-secondary students is high, with reports showing increased usage of campus food banks as high as 400% in the past three years, and surveys of registered students at Canadian universities show that they experience moderate or severe food insecurity as high as 56.8% (Meal Exchange, 2021; Mohr, 2018; University of Ottawa, 2025); and

WHEREAS, food prices are forecasted to rise by 4 to 6% in 2026, and rising food costs will intensify the food insecurity burden for students (Agri-Food Analytics Lab, 2025; Statistics Canada, 2025; Wellington-Dufferin-Guelph Public Health, 2024); and

WHEREAS, nursing students face unique contributing factors, including unpaid clinical placements, travel costs, and other ancillary costs, in addition to academic obligations, resulting in restricted opportunities for paid employment; and the RNAO, as a leader in nursing advocacy with a long-standing commitment to supporting nursing students and advancing health equity, is well-positioned to champion policies that support equitable access to food for all nursing students, as well as directly support the ability of nursing students to access sufficient food to eat through the establishment of a food security fund.

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association (RNAO) collaborates with others in identifying the depth of food insecurity among nursing students in Ontario; and

THEREFORE BE IT FURTHER RESOLVED, that RNAO collaborates with others to propose solutions to address food insecurity among nursing students.

Background

Food insecurity is rising driven by increased food prices, high housing costs, and insufficient financial supports (Public Health Ontario, 2023). Studies identify food insecurity among registered students in post-secondary institutions as widespread at 60% (Cockerham et al., 2021).

Nursing students experience compounded risk factors, including unpaid clinical placements, program-related costs, limited capacity for paid work, and restrictive schedules, all of which have been linked to food access challenges (Bydalek et al., 2020; Cockerham et al., 2021). A mixed-methods study of nursing students documented food insecurity and hunger rates as high as 52% (Bydalek et al., 2020). Food insecurity threatens academic success, physical and mental health, increases perceived stress, and students' ability to complete clinical unpaid placements, all factors that directly affect Ontario's nursing workforce pipeline (Bydalek et al., 2020; Cockerham et al., 2021; Gamba et al., 2021; Rinaldi et al., 2025).

Ontario-specific cost pressures, including escalating housing prices, rising food costs, and increasing student reliance on food banks, contribute to a context in which students face significant financial strain (Wellington-Dufferin-Guelph Public Health, 2024)

Despite the availability of food insecurity research on Canadian post-secondary students, there is a lack of statistical data on nursing students specifically. During a third-year community BScN placement at St. Lawrence College in Kingston, a voluntary informal needs assessment of first-year BScN students identified food insecurity as a priority theme for student success and retention in nursing education. This underscores that food insecurity is not only a statistical concern but a lived, immediate experience for Ontario nursing students (Chomicz et al., 2025). This reality is compounded by the structure of nursing education, where unpaid clinical placements, travel expenses, and rigorous academic workloads limit students' capacity to maintain steady income to support nutritional requirements.

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Registered Nurses' Association of Ontario
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Resolution: Strengthening Employer and System Readiness to Support Registered Nurse Prescribing in Ontario

Submitted by: Ruby Amoncio, RN and Charlie Byer, RN, BScN, MS(N)

Conflict of Interest: No known conflict of interest

WHEREAS, Ontario has expanded the scope of practice for Registered Nurses to prescribe for select conditions and medications, with the potential to improve access to timely care, continuity of services, and health system efficiency; and

WHEREAS, RN Prescribing is being implemented inconsistently across practice settings due to gaps in employer and system readiness, including unclear role integration, limited availability of model policies and clinical governance processes, and inconsistent documentation and electronic medical record workflows, which can delay or limit the safe and effective use of RN Prescribing;

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) continue its advocacy and, in partnership with relevant collaborators, develop practical and adaptable RN Prescribing implementation resources, such as a toolkit, for employers and RN Prescribers that complement existing regulatory and legislative requirements. and RN Prescribers that complements existing regulatory and legislative requirements.

Background

Ontario's expansion of Registered Nurse (RN) prescribing authority represents a significant advancement in nursing practice and health system modernization. Effective November 2023, RNs who meet College of Nurses of Ontario (CNO) requirements may prescribe select medications and communicate diagnoses for the purpose of prescribing (College of Nurses of Ontario [CNO], 2023). This milestone reflects sustained advocacy by RNAO to enable nurses to practice to full scope in support of timely, equitable, and patient-centred care.

Despite this progress, implementation across Ontario remains inconsistent. RN Prescribers and employers report variability in organizational readiness, including gaps in governance structures, role clarity, clinical accountability, documentation standards, and electronic medical record (EMR) workflows (CNO, 2023). In some settings, RNs are authorized to prescribe but lack the organizational infrastructure required to do so safely, consistently, and sustainably. Evidence from nurse prescribing literature demonstrates that while prescribing authority improves access and continuity of care, successful integration depends on clear policies, clinical supports, and system-level implementation planning (Maier & Aiken, 2016; Weeks et al., 2021).

RNAO is well positioned to support this next phase of implementation. As a trusted professional association with expertise in developing evidence-informed guidance and advancing practice change, RNAO can complement regulatory requirements by supporting employer and system readiness through a range of strategies. These may include guidance, tools, knowledge exchange, and other supports that strengthen consistency in practice, reduce variation across settings, and enable safe, effective, and sustainable integration of RN prescribing across Ontario's health system.



RNAO

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Registered Nurses' Association of Ontario
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Resolution: To Develop A Comprehensive RNAO Strategy To Help Nursing Educational Institutions Adopt Planetary Health Principles

Submitted by: Rachel Gonzales BScN, Hugo Tam, 4th-year nursing student, Nursing Students of Ontario, Rob Samulack RN, BScN, Beng, May Tao RN MSN and the ONE Executive Team on behalf of the Ontario Nurses for the Environment

Conflict of Interest: No known conflict of interest

WHEREAS, the climate crisis is already having dramatic effects on human health globally, the world has already breached seven of the nine planetary boundaries [1], and healthcare is responsible for approximately 5% of global greenhouse gas emissions [2];

WHEREAS, the Planetary Health Framework [3], Roadmap for Planetary Health and Sustainable Health Systems for Canadian Medical Professionals [4], Green Hospital Scorecard [5] and Planetary Health Report Card program [6] offer an existing evidence-based models that have started to implement change and that teaching the next generation of nurses is crucial;

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) develop a comprehensive strategy to support nursing educational institutions to adopt planetary health principles throughout Ontario;

THEREFORE BE IT FURTHER RESOLVED, that RNAO collaborate with CASN, COUPN, and CAATS, and other relevant partners in developing the comprehensive strategy.

Background

The climate crisis is becoming one of the defining challenges to human health of our time, with growing evidence that human-caused environmental degradation is already having a profound deleterious effect worldwide. The *Planetary Health Check 2025* reports that seven of nine planetary boundaries have been transgressed, increasing risks to food security, water systems, population health (Potsdam Institute for Climate Impact Research, 2025) and leading to geopolitical instability. At the same time, healthcare systems contribute significantly to climate change, generating approximately 5% of global greenhouse gas emissions, largely through energy use, procurement, and clinical practices (Romanello et al., 2023). These intersecting realities place healthcare professionals, including nurses, at the forefront of both climate impacts and solutions.

Planetary health offers an integrated framework that links human health with the health of natural systems. The *Planetary Health Education Framework* identifies core competencies needed to equip health professionals to address ecological determinants of health, emphasizing systems thinking, equity, and prevention (Faerron Guzman & Potter, 2021). Complementing this, the *Roadmap for Planetary Health and Sustainable Health Systems for Canadian Medical Professionals* provides practical guidance for embedding sustainability into education, leadership, and healthcare delivery across Canada (Howard & Marks, 2024).

Existing tools demonstrate how planetary health principles can be operationalized and measured. The Green Hospital Scorecard supports healthcare organizations in tracking and improving environmental performance (Canadian Coalition for Green Health Care, 2026), while the Planetary Health Report Card engages learners in evaluating and advancing planetary health content within health professional education (Planetary Health Report Card, 2023). A comprehensive RNAO strategy would align nursing education and practice with these evidence-based models, enabling consistent adoption of planetary health principles across Ontario and strengthening the nursing profession's leadership in climate and health action.

The existence and health of humans and living beings are inextricable with not only our immediate environment but our planet as we interact with it (Carson, 1962, p.12). The chemicals used to increase agricultural production and protect our crops are passed down through the chain of living organisms that survive on one another (Carson, 1962, p.12). Planetary Health in comparison to environmental health widens the lens to encompass broad scopes in which we can view our own nursing praxis that empower nurses to contribute to global health goals in alignment with the United Nations 2030 Agenda for Sustainable Development (Meherali, 2025).

Although temperature increases are multifactorial, evidence suggests the main cause is human-related, such as burning fossil fuels which release greenhouse gases and raising global temperatures (Kalogirou et al., 2020). As nursing students and nurses, we perpetuate climate changes by contributing to our healthcare systems that generate significant amounts of greenhouse gases (Schenk et al., 2023). This is observed mostly in primary care settings where vast amounts of single-use resources are used but its waste is not diverted into proper streams (Schenk et al., 2023).

According to the CNO's ETP Competencies (2019), an Advocate as Registered Nurses are expected to "support environmentally responsible practice" (7.3) and as a Scholar, to "use knowledge about current and emerging community and global health care issues and trends to optimize client health outcomes" (9.6). To ensure nursing students and new graduate nurses understand, react, and implement these competencies into practice, it is essential to develop the foundational knowledge of Planetary Health (Aistle & Richard, 2024; Meherali et al., 2025).

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RNPAO

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Registered Nurses' Association of Ontario
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Resolution: Preventing Discharge from Hospital to Homelessness

Submitted by: Brant-Haldimand-Norfolk Chapter (Patrick McCaffery and Cheryl Forchuk) and Mathew McGuigan (of Chatham-Kent)

Conflict of Interest: No known conflict of interest

WHEREAS, at the current time, people experiencing homelessness or precarious housing are discharged from hospital to shelters or to the streets.

WHEREAS, this practice is harmful to patients' health and increases the chance of readmission.

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate the provincial government to require hospitals to have a plan to prevent discharge to homelessness using evidence-based strategies such as having on-site social supports that include housing and financial assistance and;

THEREFORE BE IT FURTHER RESOLVED, that RNAO advocate the provincial government for hospital-based, on-site social supports including housing advocates, identification card (ID) clinics, financial support assistance (Ontario Works and Ontario Disability Support Program) with wraparound transitional support provided in the community following discharge.

Background

Homelessness is a persistent public health issue in Canada, with some estimates suggesting there are **235,000 individuals experiencing homelessness annually** (Gaetz et al., 2016), which is likely an underestimate. Hospital discharge represents a critical yet underrecognized pathway into homelessness. In 2006, Forchuk and colleagues identified at least **194 individuals discharged directly from psychiatric inpatient units to shelters or no fixed address in a single year** in London, Ontario (Forchuk et al., 2006), a pattern reinforced by recent national data. In 2022-2023, approximately **30,000 people were identified as experiencing homelessness at hospital admission and/or discharge, with 93% of hospitalizations starting in the emergency department** (Canadian Institute for Health Information [CIHI], 2024). Discharge from hospital to homelessness undermines recovery, increases the risk of readmission and emergency department return visits, and perpetuates preventable use of costly healthcare services (Laliberté et al., 2019; Mikkonen & Raphael, 2010).

Research by Forchuk and colleagues has sought to develop an evidence-based, best practice model for preventing discharge from hospital to homelessness. On-site housing, financial, and other social supports were strategically placed in medical and psychiatric inpatient hospital units in London, Ontario. Patients who identified as being at risk for homelessness upon discharge by nursing or other medical staff were connected to tailored supports prior to discharge. The **“Preventing Discharge to No Fixed Address (NFA) project** demonstrated the beneficial impact of integrated hospital-based interventions. Early phases resulted in only **3 of 256 patients** being discharged into homelessness (Forchuk et al., 2011, 2013), and a later iteration (2017–2020) found that **80% of people experiencing homelessness were housed and importantly, remained housed, 12 months post-discharge** (Forchuk et al., 2023). These findings underscore the critical role of coordinated, interdisciplinary discharge planning that integrates housing, financial, and community supports to reduce rehospitalization, improve long-term outcomes, and address homelessness at a systems level. An [Implementation Guide](#) for this evidence-based approach has been posted on the [Canada Mortgage and Housing Corporation \(CMHC\) Website](#) to encourage broader implementation.

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Resolution: RNAO to advocate to the Ministry of Education, Non-waged subsidies in clinical placements for undergraduate nursing students

Submitted by: Gurkirat Singh and Anthonia Chukwuyem, on behalf of the Nursing Students of Ontario Interest Group (NSO).

Conflict of Interest: No known conflict of interest

WHEREAS, undergraduate nursing students in Ontario are required to complete extensive unpaid clinical placements as a mandatory component of pre-licensure education, limiting their ability to engage in paid employment and contributing to financial strain, stress, and inequitable access to nursing education, particularly for students from low-income backgrounds, racialized communities, rural and remote areas, and those with caregiving responsibilities (Charron et al., 2025).

WHEREAS, peer-reviewed evidence demonstrates that paid undergraduate nurse, co-operative, and internship clinical placement models are associated with improved student confidence, clinical competence, transition to practice, and workforce retention, while also reducing orientation time and benefiting healthcare organizations and patient care outcomes (Gamroth et al., 2006; Charron et al., 2025).

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate to the Government of Ontario for the development and implementation of provincially funded and subsidized paid clinical placement models for undergraduate nursing students;

THEREFORE BE IT FURTHER RESOLVED, that RNAO collaborates with nursing schools, clinical placement partners, regulatory authorities, unions, and the government to provide standardized frameworks, suitable supervision systems, and long-term funding mechanisms that ensure safe and equitable care. For example, students undertaking their final practicum or consolidation placement should get remuneration in the form of alternative services, such as free or subsidized parking, transportation supports, meal subsidies, and access to hospital amenities including libraries, computers, and study spaces.

Background

Clinical education is an essential component of pre-licensure nursing programs; nevertheless, the current reliance on unpaid clinical placements places a significant financial strain on nursing students. Many students are obliged to juggle full-time clinical hours with outside jobs, which contributes to tiredness, stress, and unequal learning opportunities (Winchester et al., 2025). In fact, 28% of Canadian undergraduate nursing students have considered dropping out or changing their program due to financial difficulties (CFNU & CNSA, 2024). Evidence suggests that financial hurdles in clinical education disproportionately affect students from marginalized and rural populations, limiting fairness, access, and timely program completion. (Charron et al., 2025).

Paid clinical placement arrangements, such as undergraduate nurse positions and subsidized placements, provide significant advantages to students, healthcare organizations, and the larger health system. Students who participate in paid internships report increased confidence, competence, professional identity development, and preparation for autonomous practice (Gamroth et. al., 2006). Paid clinical placements reduce new graduate orientation time, improve recruitment and retention, and may save healthcare organizations money, all while supporting patient safety and workforce sustainability.

Although paid clinical placements may be difficult to implement due to regulatory and funding restrictions, non-wage subsidies are a practical and effective strategy to reduce the financial burden placed on undergraduate nursing students. Nursing students are calling for help which is why the majority of nursing students support being paid for their time in placement or for allowances or subsidies to lower the cost of attending clinical placements (CFNU & CNSA, 2024). As the cost of living continues to rise and impact nursing students, supports such as subsidized parking, meal vouchers or cafeteria discounts, and access to hospital amenities are cost-effective measures to decrease costs for nursing students. Implementing subsidies for clinical placements is an evidence-based method for strengthening Ontario's nursing workforce, promoting equality in nursing education, and improving the quality and sustainability of patient care.

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Registered Nurses' Association of Ontario
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Resolution: Wounds As a Public Health Priority

Submitted by: Mathew McGuigan, RN, BScN and Rosemary Kohr, RN, BA (Arts Plastiques), BScN, MScN, PhD

Conflict of Interest: No known conflict of interest

WHEREAS, chronic and complex wounds are a growing public health issue in Ontario, causing significant pain, disability, preventable complications and amputations, reduced quality of life, and increased pressure on the health system, with a disproportionate impact on people experiencing health inequities;

WHEREAS, Ontario Public Health Units have a mandate to promote health, prevent disease, reduce inequities, and deliver upstream, community-based interventions, and evidence shows that wound prevention and early intervention reduce harm and system costs

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) use its leadership and policy influence to collaborate with relevant partners and the Government of Ontario to coordinate the launch a virtual Wound Care Centre of Excellence, recognizing wound care as a universal right

Background

Chronic wounds are frequently framed as a downstream clinical problem. However, their causes and consequences are deeply tied to social determinants of health. Equity deserving individuals face increased barriers related to chronic disease, aging, mobility limitations, poverty, housing instability, and access to primary care which increase their risk for developing chronic wounds (Wound Care Canada, 2021). Further, people living or at risk of chronic wounds risk increased burdens related to the restriction's wounds place on their life (Klein et al., 2020).

A 2023 estimate placed national wound care spending at approximately \$12.1 billion (Laub, 2025). While in Ontario, wounds are estimated to account for 30% to 50% of all health care interactions, amounting to approximately \$4 billion in annual costs (Queen & Botros, 2025; Wounds Canada, 2025). Chronic wounds are frequently approached as a downstream clinical problem, but many are preventable through reduction, risk prevention, early identification and treatment, and community service coordination.

An infographic designed and distributed by Wounds Canada calls for the government to be part of the solutions in addressing the increasing burden of wounds on Ontario residents (Wound Care Canada, 2025). Ontario's Public Health Units (PHUs) are legislated under the *Health Protection and Promotion Act* to deliver population health assessment, health promotion, disease and injury prevention, and health equity-focused interventions through the Ontario Public Health Standards (OPHS) (Ontario, 2021). PHUs are uniquely positioned to address wounds upstream by integrating skin health and wound prevention into chronic disease prevention, healthy aging, injury prevention, and community-based outreach initiatives. Public health nurses possess expertise in health education, risk screening, surveillance, and interdisciplinary collaboration, all of which are essential to effective wound prevention strategies.

Currently, there is no explicit provincial direction or dedicated funding for PHU's to systematically address wound prevention or surveillance as a population health priority. The RNAO is uniquely positioned to coordinate with PHU's, special interest groups, and evidence-informed continuing education organizations, such as the Canadian Healthcare Education Network, to mobilize evidence and advocate for a provincial strategy aimed at reducing risks for chronic wounds in Ontario.



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Registered Nurses' Association of Ontario
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Resolution: Advocate and Partner for Nursing Leadership Development Across Healthcare Organizations

Submitted by: Dr. Sue Bookey-Bassett and Heather Thomson on behalf of the NLN.ON Interest Group.

Conflict of Interest: No known conflict of interest

WHEREAS, Evidence indicates strong nursing leadership is linked to improved patient safety, reduced adverse events, enhanced staff engagement, and higher levels of job satisfaction among nurses; and

WHEREAS, healthcare systems are experiencing rising complexity due to workforce shortages rising patient acuity, fiscal pressures, increasing demands on nurse leaders; and many nurses transition into leadership roles with limited formal preparation, mentorship, or ongoing leadership development, contributing to role strain, burnout, and leadership attrition; and

WHEREAS, leaders require different knowledge, skills and strategies to lead in the current healthcare environments; and evidence demonstrates that structured leadership development programs for nurses at all leadership levels, such as mentorship, coaching, succession planning, and formal education, strengthen leadership capacity to lead in complex healthcare systems (Bookey-Bassett et al. 2024; Shen et al., 2024).

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) in collaboration with the Nursing Leadership Network of Ontario (NLN.ON) explore opportunities to partner with academic institutions, the Canadian Association for Schools of Nursing (CASN) and the Canadian Nurses Association (CNA) to inform sustainable nursing leadership development programs.

Background

Rapidly evolving healthcare systems require strong nursing leadership at multiple levels in all healthcare settings [Lenssen et al., 2025]. Evidence from nursing literature demonstrates the importance of nursing leadership roles and their positive impact on nurse, patient, and organizational outcomes (Cummings et al., 2021).

As a result of nurse attrition, younger and less experienced nurses have been moved into leadership roles (Metersky & Fisher, 2025). Often these moves have been made without providing nurse leaders with the necessary education and preparation to confidently fulfill the demands of increasingly complex systems (Metersky & Fisher, 2025).

Nurses in leadership and managerial roles require ongoing opportunities to develop their leadership knowledge and skills. Effective nursing leadership contributes to team functioning and healthy work environments, as well as improved outcomes for staff and patients. (Bookey-Bassett et al. 2024). Further novice nurse leader-managers require support to develop and maintain leadership and managerial competencies, underscoring the importance of providing leadership development opportunities through programs offered by employers and professional associations. Healthcare organizations should consider how best to support ongoing nurse leader-manager development through leadership training and mentorship programs. (Bookey-Bassett et al., 2024; Metersky & Fisher, 2025). Without adequate training and preparation nurses may be reluctant to take on or stay in these leadership roles (Shen et al., 2024)

Despite existing barriers and challenges, leadership can be developed with adequate mentoring, resources, and a growth mindset. Formal leadership mentoring programs and educational interventions can help nurture and develop emerging and diverse leaders for the nursing profession. (Cummings et al., 2021; Metersky & Fisher, 2025; Shen et al., 2024).

Targeted approaches are needed to ensure both current nursing leaders and those of the future are well equipped to tackle the challenges of a burdened health-care system (Cummings et al., 2021; Metersky & Fisher, 2025). Strengthening nursing leadership at all levels is necessary to ensure that nurses have the knowledge and skills to actively engage in and influence health policy to support the overall effectiveness and lead change in healthcare services delivery in health and social care systems (WHO, 2020). Now is the time to invest in developing and inspiring a future generation of nurse leaders that represent the population we care for (Health Canada, 2024). Professional associations, academic institutions and healthcare organizations need to work together to inform leadership development curriculum and leader competencies for nurses in current leadership roles and those aspiring to become future nurse leaders.

Rationale Nursing leadership development is a strategic investment in patient safety, workforce stability, and system sustainability. As healthcare systems face unprecedented pressures, nurse leaders require structured preparation and ongoing support to effectively lead teams, manage change, and advocate for high-quality, equitable care. Without intentional leadership development, organizations risk increased turnover, diminished morale, and compromised care outcomes.

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Registered Nurses' Association of Ontario
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Resolution: Supporting Mandated Comprehensive Palliative Care Education in Ontario Nursing Schools

Submitted by: Christina Oleynikov (RN) & Ana Constantin (RN) and the following nursing students: Carly Wong, Neveen Shnoudeh, Katie Browne, Cassie Wilson, and Aileen Gencturk.

Conflict of Interest: No known conflict of interest

WHEREAS, comprehensive, compassionate, person-centred palliative care for people with life-limiting illness is a key nursing priority as it spans most clinical specialities and settings (Murray, 2025).

WHEREAS, there are no provincial policies or guidelines mandating standardized, comprehensive instruction or clinical palliative care exposure in Ontario nursing education to prepare future nurses in providing safe, compassionate palliative care (Cargill, 2020; Monette, 2012; Pereira et al., 2025).

WHEREAS, leaving palliative nursing education to individual prioritization and provision does not ensure that students adequately learn about palliative care and the soft skills necessary for providing compassionate, person-centred palliative care, such as relationship building, emotional support, and communication (Murray, 2025; Pesut & Greig, 2018).

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate to the provincial government, regulatory nursing bodies, and other educational partners for the development of a standardized, mandatory, competency-based palliative care nursing curriculum.

Background

The Registered Nurses Association of Ontario advocates for and prioritizes accessible, holistic, person-centred palliative care, having published Best Practice Guidelines (Registered Nurses' Association of Ontario, 2020) and facilitated panels on the topic. Despite the growing need for nurses to be prepared to handle care for people with life-limiting illness, palliative education in Ontario varies widely in content depth, placement, and quality (Pereira et al., 2025), largely because there are no provincial policies or guidelines mandating standardized instruction or clinical exposure in this area (Cargill, 2020; Monette, 2012).

Without consistent, standardized educational expectations, programs independently decide how, and whether to, integrate palliative care content, resulting in uneven nurse preparedness (Pereira et al., 2025; Pesut & Greig, 2018). The End-of-Life Nursing Education Consortium (ELNEC) model offers a compelling example of what sustained leadership, structured resources, and faculty development can achieve (Glover et al., 2025). Its success contrasts with Ontario's fragmented palliative education scene and highlights the need for system-level solutions, rather than relying on individual schools or faculty leaders' prioritization of palliative care education. While some organizations, such as Pallium Canada, the Canadian Hospice Palliative Care Association, and RNAO's Palliative Care Nurses' Interest Group have attempted to bridge the knowledge gap through training modules and educational tools, these initiatives remain optional and not systemically embedded within nursing curricula (Cano, 2018; Pesut & Greig, 2018). Research repeatedly demonstrates that integrating palliative care education early in undergraduate programs improves relationship-building, communication, and emotional support between nurses and those they care for (Murray, 2025; Pesut & Greig, 2018).

Given this evidence and the success of the ELNEC model, there is a clear imperative for Ontario's regulatory and educational stakeholders (Registered Nurses' Association of Ontario, 2016). The College of Nurses of Ontario, the Registered Nurses' Association of Ontario, nursing education boards, and academic leaders must advocate for the implementation of consistent, mandatory, competency-based palliative care education across all Ontario nursing institutions to ensure graduates are fully prepared to meet patient needs.

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Registered Nurses' Association of Ontario
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Resolution: Continuing Advocacy & Efforts to Address Growing Rates of Intimate-Partner Violence (IPV)

Submitted by: Ama Arthur, Maria Tandoc, Sandrina Ntamwemezi, Selasie Ametorwo and Upneet Lohcham (on behalf of Brampton and Mississauga Chapters)

Conflict of Interest: No known conflict of interest

WHEREAS, from 2012 to 2016, 10,935 ER visits were related to [Intimate Partner Violence (IPV)] in a study by Singhal, et al (2021), indicates that the burden of [IPV-related] visits are large enough to warrant timely public health interventions,

WHEREAS, the pandemic has highlighted the prevalence of this epidemic, especially in Peel Region whereby there was a 29.9% increase in IPV-related incidents between 2020 and 2023 (Peel Region, 2024),

WHEREAS, one of the pillars of the National Action Plan to End Gender-based Violence emphasizes primary prevention approaches to address the causes of gender-based violence, which includes addressing and changing attitudes and social norms that enable IPV to go unaddressed (Government of Canada, 2024a),

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate to municipal, provincial and federal governments for increased funding in order to promote public awareness and education about IPV, improve access to support services (e.g. safe and non-judgmental spaces where victims can go for help, legal support and crisis lines), expand affordable long-term housing and accessible infrastructure for individuals facing IPV (e.g. emergency shelters).

Background

The World Health Organization (WHO, 2024) defines intimate partner violence (IPV) as any behaviour by a current or former intimate partner “that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours”. Violence against women in the form of IPV has been identified by WHO as a major public health concern with far-reaching health and social consequences.

In Canada, rates of intimate partner violence continue to rise. Government of Canada (2024b) reported a 163% increase in intimate partner sexual assaults and a 14% increase in intimate partner physical assaults between 2014 and 2022. Women and girls account for approximately 78% of victims, with 117,093 individuals aged 12 years and older experiencing IPV in 2022 (Government of Canada, 2024b). Despite the severity of these trends, IPV remains significantly underreported; a 2019 survey found that 80% of individuals who experienced IPV did not report incidents to police, particularly in cases where abuse occurred infrequently (Government of Canada, 2024b). In Peel Region, intimate partner violence continues to escalate, with a 29.9% increase in family and IPV incidents (CBC, 2024; Peel Region, 2024).

The health and social consequences of IPV are well documented. Women who experience IPV face significantly poorer physical, psychological, and financial health outcomes (Nori et al., 2020; Singhal et al., 2021; Government of Canada, 2024b). Children are also deeply affected; investigations related to children’s exposure to IPV increased from 6.84 per 1,000 children in 2008 to 9.50 per 1,000 in 2019, underscoring the intergenerational impact of violence (Black et al., 2025).

Recent advocacy efforts reflect growing recognition of IPV as a systemic issue. Peel Regional Police have stressed the need for sustainable funding and safe, accessible locations for survivors as critical areas for system improvement (Peel Police Board, 2021). Despite these identified priorities, lives continue to be lost, underscoring the urgent need for coordinated action. In 2023, Rebecca Pacheco of Embrace Agency to End Violence and the Peel Committee Against Woman Abuse (PCAWA) called for legislative action and the declaration of IPV as an epidemic in Peel Region (Peel Region, 2023). Nationally, RNAO’s submission regarding Bill S-249 Recommendation 8 (2024), an Act respecting national action for the prevention of intimate partner violence, further demonstrates leadership in advancing coordinated responses following Canada’s declaration of IPV as an epidemic. Despite these efforts, the situation remains urgent across Ontario.

Research conducted specifically in Peel Region further highlights the barriers survivors face when seeking safety and support. Campbell and Nankoo (2025) identify gaps in legal protections, culturally appropriate services, and public awareness, emphasizing the need for multi-level policy reforms, expanded funding, stronger legal safeguards, and enhanced community-based support. Abdullah et al. (2025) found that racialized and diverse communities experience limited access to culturally responsive services, shortages of safe and affordable housing, barriers to mental health care, and fragmented service delivery. Together, these findings underscore the need for coordinated, survivor-informed, and adequately resourced approaches to address IPV in Peel Region and comparable communities.

Building on RNAO’s leadership and the National Action Plan to End Gender-Based Violence, this resolution calls for strengthened public education, expanded mental health supports, increased safe spaces, continued training of frontline professionals, and investment in income-based and dependent-based long-term housing (Government of Canada, 2024a; RNAO, 2024). With the collective voice of over 50,000 members, RNAO is uniquely positioned to advocate for the systemic change required to protect and save the lives of victims of IPV and their families.

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Resolution: Strengthening Indigenous Partnerships to Expand Rural Nursing Practicums and to Support the Decolonization of Ontario Nursing Pedagogy

Submitted by: Hugo Tam 4th year BScN student, Sierra Punched 4th year BScN student, Esther Momanyi 3rd year BScN student, Lee Zhang 2nd year BScN student, Simran Virk 3rd year BScN student, on behalf of the Nursing Students of Ontario Interest Group

Conflict of Interest: No known conflict of interest

WHEREAS, Canadian nursing curricula accredited by CASN outline the inclusion of Indigenous Ways of Knowing to educate nursing students on anti-Indigenous racism, Indigenous values in health, care, and to understand their healing practices (3.2.9) (CASN, 2022), and;

WHEREAS, in Ontario there is a lack of nursing clinical practicum opportunities in rural Indigenous communities unlike other provinces like British Columbia that have rural nursing clinical practicum opportunities where available for nursing students to put education into practice.

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate and support COUPN, CAATS, Ministry of Education, and participating Indigenous communities in ethical, reciprocal, and community-informed partnerships in to expand clinical practicum opportunities for experiential learning to support social justice and in support of Truth and Reconciliation.

Background

The Truth and Reconciliation Commission of Canada (TRC) currently has 94 Calls to Action to spark action at all levels of government, organizations, and even individuals to affirm their commitment to create tangible change within our communities. Specifically, Calls #18-24 affirms the need for culturally sensitive, trauma-informed health education, and to implement measurable metrics to quantify progress (NCTR, 2013; Stein et al., 2023). It also affirms the recognition of Indigenous health practices and calls for Canadian institutions (Stein et al., 2023).

As nursing students, we develop our nursing competencies within our nursing programs in which one component of its education framework is to include Indigenous Ways of Knowing and to educate nursing students on anti-Indigenous racism, Indigenous values in health and care, and about their healing practices (CASN, 2022) to affirm their right to culturally sensitive and trauma-informed care.

Currently, Ontario nursing students do not have opportunities for Indigenous community care which maintains the status quo and limits our comprehension of Indigenous cultural safety (Kurtz et al, 2018). However, evidence supports that experiential and contextual learning supports the uptake and retention of knowledge regarding cultural safety and its power dynamics (Kennedy et al., 2021; Kutz et al, 2018).

Thus, we recommend that RNAO advocates on behalf of nursing students to stakeholders, regulatory bodies, and relevant ministries to create allied partnerships to allow Ontario nursing students to participate in Indigenous-focused clinical practicums.



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Resolution: Sickle Cell Resolution

Submitted by: Kaywana Malcolm on behalf of Black Nurses Leading Change Interest Group (BNLC)

Conflict of Interest: No known conflict of interest

WHEREAS, people living with SCD in Canada experience variability in access to early detection, standardized care pathways, and longitudinal follow-up due to jurisdictional differences and the absence of a coordinated national approach to SCD care; and

WHEREAS, disparities in access to care for people living with SCD contribute to inequities in outcomes and reflect longstanding gaps in health system planning and resourcing that align with RNAO's commitments to health equity, anti-racism, and evidence-informed policy;

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) adopt and publicly affirm a position statement in support of Bill S-201, An Act respecting a national framework on sickle cell disease, recognizing sickle cell disease as a significant health issue in Canada and affirming the need for coordinated national leadership to improve consistency, equity, and quality of care for people living with SCD; and

THEREFORE BE IT FURTHER RESOLVED, that the RNAO undertake sustained advocacy to advance a coordinated and equitable national approach to sickle cell disease care in Canada, including by:

- Advocating to local Members of Parliament to support the passage of Bill S-201 in the house of commons, to improve coordination, equity, and quality of care for people living with SCD;
- Advocating for the implementation of the Bill S-201 framework to reduce preventable complications associated with SCD, improve patient and family experiences, and address health disparities affecting communities disproportionately impacted by the disease.
- Supporting and promoting evidence-informed education and clinical practice guidance on sickle cell disease for nurses across the continuum of care, consistent with RNAO's role in professional practice leadership, and health system advocacy;
- Advocating for enhanced and culturally responsive blood donation strategies to ensure a diverse and sustainable blood supply, recognizing that individuals living with SCD require ethnically matched blood donors, in collaboration with the Ontario Ministry of Health and all relevant health-system partners.

Background

Sickle cell disease (SCD) is the most common human genetic disease worldwide that disproportionately affects Black People (CPS, 2022; Pendergrast et al., 2023; Srikanthan, 2024). It is a chronic condition characterized by multisystem involvement that requires comprehensive and coordinated lifelong care (CPS, 2022). In Canada, the full burden of SCD is unknown due to the absence of a comprehensive national registry (CPS, 2022). In Ontario alone, an estimated 3500 individuals live with SCD, with prevalence estimated at approximately 1 in 4200 (Pendergrast et al., 2023). Despite being more prevalent than several other genetic conditions, SCD historically receives less research and health system investment in Canada (Pendergrast et al., 2023).

Despite living across many health regions in Canada, people living with SCD experience variability in access to screening, specialized services, and standardized care, reflecting the absence of a coordinated national approach to SCD care (CPS, 2022; Pendergrast et al., 2023). In Canada, healthcare delivery is the responsibility of provinces and territories, resulting in variability in how sickle cell disease (SCD) care is organized and delivered across jurisdictions. While some provinces have implemented targeted initiatives, such as universal newborn screening programs or provincial quality standards for SCD, these approaches are not applied uniformly across the country (CPS, 2022, Ontario Health, 2023). In the absence of a coordinated national approach, people living with SCD experience inconsistent access to early detection, evidence-informed care pathways, and longitudinal follow-up, contributing to inequities in care and variable health outcomes across Canada (CPS, 2022; Pendergrast et al., 2023).

As a result of this variability, many individuals living with SCD experience preventable complications, avoidable emergency department visits, and disruptions in continuity of care across the lifespan. Evidence-based management of SCD, including early diagnosis, regular monitoring, pain management, infection prevention, and access to specialized multidisciplinary teams, is known to reduce morbidity and improve quality of life. However, inconsistent implementation of these practices across jurisdictions undermines their effectiveness (CPS, 2022). Gaps in coordinated, longitudinal care disproportionately affect individuals transitioning between pediatric and adult services and those living outside major urban centres, further compounding inequities in health outcomes for people living with SCD (Pendergrast et al., 2023).

The uneven delivery of SCD care must also be understood within a broader context of health equity and anti-Black racism in Canada's health system. As a condition that disproportionately affects Black communities, the historical underinvestment in SCD research, surveillance, and system planning reflects longstanding structural inequities that continue to influence access to timely, high-quality care (Pendergrast et al., 2023; Srikanthan, 2024). Addressing these gaps aligns with nursing values and RNAO's commitments to health equity, social justice, and culturally safe care. Nurses play a critical role across the continuum of SCD care, from screening and health education to acute and community-based management, and are uniquely positioned to advocate for system-level solutions that promote equitable access and improved outcomes for people living with SCD.

Bill S-201 represents an important opportunity to address these longstanding gaps by advancing a coordinated national approach to SCD in Canada. By supporting improved surveillance, data collection, and collaboration across jurisdictions, the bill would help lay the foundation for more consistent, equitable, and evidence-based



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care for people living with SCD, regardless of where they reside. National leadership in this area would complement provincial and territorial responsibilities while enabling shared learning, standard-setting, and accountability. Public support for Bill S-201 by the Registered Nurses' Association of Ontario would demonstrate nursing leadership in advancing health equity, strengthening coordinated care, and addressing systemic gaps that disproportionately affect Black communities and people living with SCD across Canada.

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Resolution: Expanding Eligibility Criteria for the Supervised Practice Experience Partnership (SPEP) Program for Internationally Educated Nurses (IENs)

Submitted by: Mark Anthony Gravoso, RN

Conflict of Interest: No known conflict of interest

WHEREAS, Internationally Educated Nurses (IENs) represent a significant and growing source of qualified nursing professionals who can help address ongoing nursing workforce shortages across the province when supported through effective integration pathways; and the Supervised Practice Experience Partnership (SPEP) program provides a structured, supportive, and evidence-informed pathway that enables nurses to demonstrate safe practice, to gain familiarity with Ontario's legislated nursing scope of practice, strengthen clinical competence and confidence, learn Canadian healthcare standards, and transition safely into the workforce while supporting patient safety.

WHEREAS, many IENs meet most of the registration requirements of the College of Nurses of Ontario (CNO) but are unable to meet the Evidence of Practice (EOP) requirement because current SPEP program eligibility criteria restrict participation to nurses who have been out of practice for more than five years, thereby limiting access to a key pathway that could support safe re-entry into nursing practice.

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) call on the Ontario Ministry of Health and the College of Nurses of Ontario (CNO) to expand eligibility for the Supervised Practice Experience Partnership (SPEP) program to include Internationally Educated Nurses (IENs) who have been out of nursing practice for more than five years but no more than eight years, and establish a standardized minimum of 240 hours of supervised practice across Ontario.



Background

Internationally Educated Nurses (IENs) are a vital and growing segment of Ontario's nursing workforce and play a critical role in addressing persistent nursing shortages across the province. As Ontario continues to face increasing healthcare demands, timely and safe integration of qualified IENs is essential to sustaining patient care, improving system capacity, and strengthening workforce resilience.

The Supervised Practice Experience Partnership (SPEP) is a collaborative initiative between the College of Nurses of Ontario (CNO), Ontario Health, and CNO-approved employers. SPEP allows applicants to demonstrate current nursing knowledge, skill, judgment, and, where applicable, language proficiency through a supervised practice placement in Ontario.

Since its launch in 2022, more than 5,500 internationally educated nurses have completed the program and obtained licensure in Ontario. With nearly 800 CNO-approved employers participating across the province, SPEP has demonstrated measurable impact at the patient level by strengthening nursing teams and supporting healthcare system sustainability (Ontario Health, 2023).

Under current criteria, SPEP is available to RN and RPN applicants, including nurses returning to practice, who have met all registration requirements except evidence of practice, or evidence of practice and language proficiency and/or transition to practice. However, eligibility is limited to applicants whose evidence of practice has expired no more than five years prior to application. Participants must complete a minimum of 140 hours of supervised practice, with additional hours assigned based on individual learning needs (CNO, 2024).

Problem Statement

Many IENs experience prolonged gaps in nursing practice due to systemic barriers beyond their control, including immigration and settlement processes, credential verification delays, licensure requirements, and limited access to bridging or re-entry opportunities. As a result, the current five-year cut-off for evidence of practice unintentionally excludes a significant number of otherwise qualified and experienced IENs who meet most CNO registration requirements but lack recent practice hours.

This exclusion delays workforce entry, exacerbates nursing shortages, and limits access to a proven, patient-safe re-entry mechanism that SPEP was designed to provide.

Evidence-Based

Evidence from the Journal of Nursing Regulation supports the effectiveness of supervised practice for nurses re-entering the workforce. Based on this exploratory investigation, Eaton and Henderson found that nurses with substantial prior professional experience --often more than five years --who had been away from practice for extended periods (5–10 years) were able to demonstrate safe and competent practice after approximately 120–216 hours of supervised practice. Importantly, the study emphasizes individualized assessment and supervision rather than rigid time-based exclusions, noting that appropriately placed and well-supported experienced nurses can reach required competency levels within 216–240 hours of supervised practice (Eaton & Henderson, 2025)

Expanding SPEP eligibility beyond the current five-year evidence-of-practice limitation would align policy with evidence, promote equity for IENs affected by systemic delays, and optimize the use of an established, regulated, and safe workforce integration model. Such an expansion would maintain patient safety while enabling Ontario to more effectively mobilize a qualified nursing workforce already committed to practicing in the province.



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Resolution: Advocate the Council of Ontario University Programs in Nursing (COUPN) and Colleges of Applied Arts and Technology (CAATS) for the standardization of clinical practicum opportunities to meet the College of Nurses of Ontario's (CNO) Entry-to-Practice (ETP) Competencies

Submitted by: Simran Virk 3rd-year BScN student, Gurkirat Singh 3rd-year BScN student, Hugo Tam, 4th-year BScN student, Sierra Punchard, 4th-year BScN student, on behalf of the Nursing Students of Ontario

Conflict of Interest: No known conflict of interest

WHEREAS, undergraduate nursing students across Ontario are enrolled in mandatory clinical courses with various foci, such as medical-surgical and mental health, yet variability in practicum settings result in a lack of opportunity to develop core practical nursing skills and clinical judgment (Hoe Harwood et al., 2009). This issue is exacerbated by varied levels of supervision and patient acuity, resulting in unequal opportunity to achieve CNO's ETP core competencies (Bisholt et al., 2014; CNO, 2019; Laugaland et al., 2021); and

WHEREAS, evidence from Canadian and international literature suggests that clinical experiences that meet the competencies in various clinical settings supports positive outcomes and an increased readiness to practice including increased confidence in clinical judgment, patient assessment, and medication administration. (Keeping-Burke et al., 2020); and

WHEREAS, according to Ontario and Canadian literature on new graduate nurses, when students are expected to learn core nursing skills, such as intravenous medication administration, but are placed in long-term care settings where opportunities to practice these skills are limited or unavailable, clinical preparation is inconsistent (Hallaran et al., 2023). The inconsistency contributes to a lower level of confidence, transfer shock, and perceived gaps in practice preparedness, which may adversely impact patient safety, workforce effectiveness, and nurse retention. (Regan et al., 2017; Hallaran et al., 2023).

THEREFORE BE IT RESOLVED, that the Registered Nurses' Association of Ontario (RNAO) advocate to the Council of Ontario University Programs in Nursing (COUPN) and Colleges of Applied Arts and Technology (CAATS) for the standardization of province-wide clinical practicum opportunities that, include but are not limited to:

- Defined minimum learning objectives and competency expectations for clinical placements designated under the same specialty or course title, regardless of care setting.

THEREFORE BE IT FURTHER RESOLVED, in the case the above meets are not met, the nursing program should provide - to a reasonable extent, supplemental simulation or practical experience to meet competency gaps.

Background

Clinical education is a critical component of undergraduate nursing programs and plays a foundational role in preparing students for safe professional practice. However, ongoing evidence indicates that nursing students' clinical learning experiences vary widely depending on placement setting, availability of Registered Nurse supervision, and organizational support structures (Bisholt et al., 2014; Laugaland et al., 2021). Students placed in environments with inadequate supervision and/or reduced exposure to acute care frequently report fewer opportunities to develop clinical judgment that may not meet CNO's ETP competencies (2019), proper and safe medication prioritization and administration, and confidence in managing active patient deterioration (Keeping-Burke et al., 2020).

Despite the variation in practical opportunities within diverse clinical placements, students are assessed using uniform evaluation tools and graduate under identical course designations, creating varied levels of educational preparation and masking systemic shortages of suitable clinical placement opportunities. Research involving new graduate nurses in Ontario and Canada further links inconsistent clinical preparation to transition shock, lower confidence, and significant challenges in new graduate and early career nurses, which have unfortunate implications for both patient safety and nurse retention (Regan et al., 2017; Hallaran et al., 2023). Establishing standardized clinical placements that offer opportunities to meet specific learning goals and CNO ETP competencies will promote transparency, accountability, and equitable nursing education, ensuring that graduates are adequately prepared to meet the demands of contemporary nursing practice across the province of Ontario.

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Resolution: Strategy to Address Prescribed Drug Dependence, Withdrawal, and Harm

Submitted by: Joanna McCabe, RN

Conflict of Interest: No known conflict of interest

WHEREAS, prescribed drug dependence, withdrawal, and associated harm represent a growing and under recognized public health concern in Canada, with approximately 22% of Canadians (over 6.5 million people) prescribed and taking psychotropic drugs, including antidepressants, benzodiazepines, stimulants, mood stabilizers, and antipsychotics, with prescriptions and duration of use continuing to increase globally (Davies & Read, 2019; Health Canada & Statistics Canada, 2019);
and

WHEREAS, long-term use and discontinuation of these drugs can cause tolerance, dependence, withdrawal syndromes, physical and psychological harm, functional impairment, and reduced quality of life significantly impacting individuals' physical, mental, emotional, social, and sexual health (Horowitz et al., 2022; Moncrieff et al., 2024; National Health Service England, 2023) and

WHEREAS, despite growing evidence of the risks associated with long-term use and discontinuation of psychotropic drugs, there remains a lack of awareness, education, and clinical guidance, leading to an underestimation of the risks of prescribed drug dependence, withdrawal, and associated harms. Current healthcare services cannot adequately support individuals to safely reduce or stop these drugs or address the associated physical, emotional, social, and functional impacts (Davies & Read, 2019; Moncrieff et al., 2024)

THEREFORE BE IT RESOLVED, that the Registered Nurses Association of Ontario (RNAO) advocate that the Ministry of Health develop and fund a national and provincial strategy addressing prescribed drug dependence, withdrawal, and harm that optimizes prescribing practices by considering safer non drug alternatives, reviewing long term use of psychotropic drugs, and requiring a high standard for informed consent; adequate education and training of healthcare professionals; and creation of clinical support services to assist individuals with deprescribing, management, and treatment of dependence, withdrawal, and adverse drug reactions.

THEREFORE BE IT FURTHER RESOLVED, that the RNAO advocate for inclusion of education on prescribed drug dependence, withdrawal, and associated harm in nursing and nurse practitioner school curriculum.

Background

There is considerable controversy and debate regarding the safety and effectiveness of psychotropic drugs. While psychotropic drugs can reduce symptoms in the short term, they can also cause iatrogenic harm, resulting in numerous negative outcomes, including premature mortality, neurological dysfunction and structural brain changes, suicidality, psychosis, cognitive impairment, poor long term recovery and functioning, post-SSRI sexual dysfunction, cardiovascular and metabolic disease, and withdrawal syndromes (Horowitz, 2025; Moncrieff et al., 2024). Psychotropic drugs cause adaptations in the brain, which can lead to dependence and withdrawal, making these drugs very difficult to stop, especially after long-term use. Withdrawal syndromes can be severe, debilitating, and lead to significant disability and distress (Moncrieff et al., 2024). Withdrawal symptoms can be categorized as physical or psychological, with the most clinically significant symptoms including akathisia and suicidality. Horowitz et al. (2023) report that the discontinuation period for antidepressants is “associated with a 60% relative increase in suicide attempts” (p. 148). Some individuals experience protracted withdrawal, with symptoms lasting months or years, which can have a devastating impact on people’s lives. Clinicians can mistake protracted withdrawal for a return of mental illness or a new mental or physical condition, triggering a prescribing cascade of additional psychotropic drugs (Jauca, 2025). Prevailing clinical guidance often frames psychotropic drug withdrawal as rare, mild, and self-limiting. The Canadian Network for Mood and Anxiety Treatments guideline for management of major depressive disorder, acknowledges withdrawal symptoms when stopping antidepressants, describing them as mild to moderate in severity and resolving in a few weeks (Lam et al., 2024). However, a systematic review by Davies and Read (2019) report that 56% of antidepressant users experience withdrawal, with 46% reporting severe withdrawal symptoms lasting several months to years. Lack of awareness and knowledge among healthcare providers has forced many individuals who are suffering to rely on guidance from internet and social media based supports to manage withdrawal and aid in recovery (Framer, 2021). The National Health Service (NHS, 2023) in England has developed a framework for caring for patients prescribed medicines associated with dependence and withdrawal and funds specialized clinics to assist with deprescribing, management, and treatment of dependence and withdrawal. The World Health Organization and United Nations (WHO & UN, 2023) call for all countries to adopt high standards of informed consent for psychotropic drugs due to their potential risks and associated harms. They recommend that individuals should have access to appropriate support to safely discontinue these drugs. In Canada, specialized clinics exist for safely stopping illicit drugs, but no such services exist for individuals discontinuing prescribed medications.

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