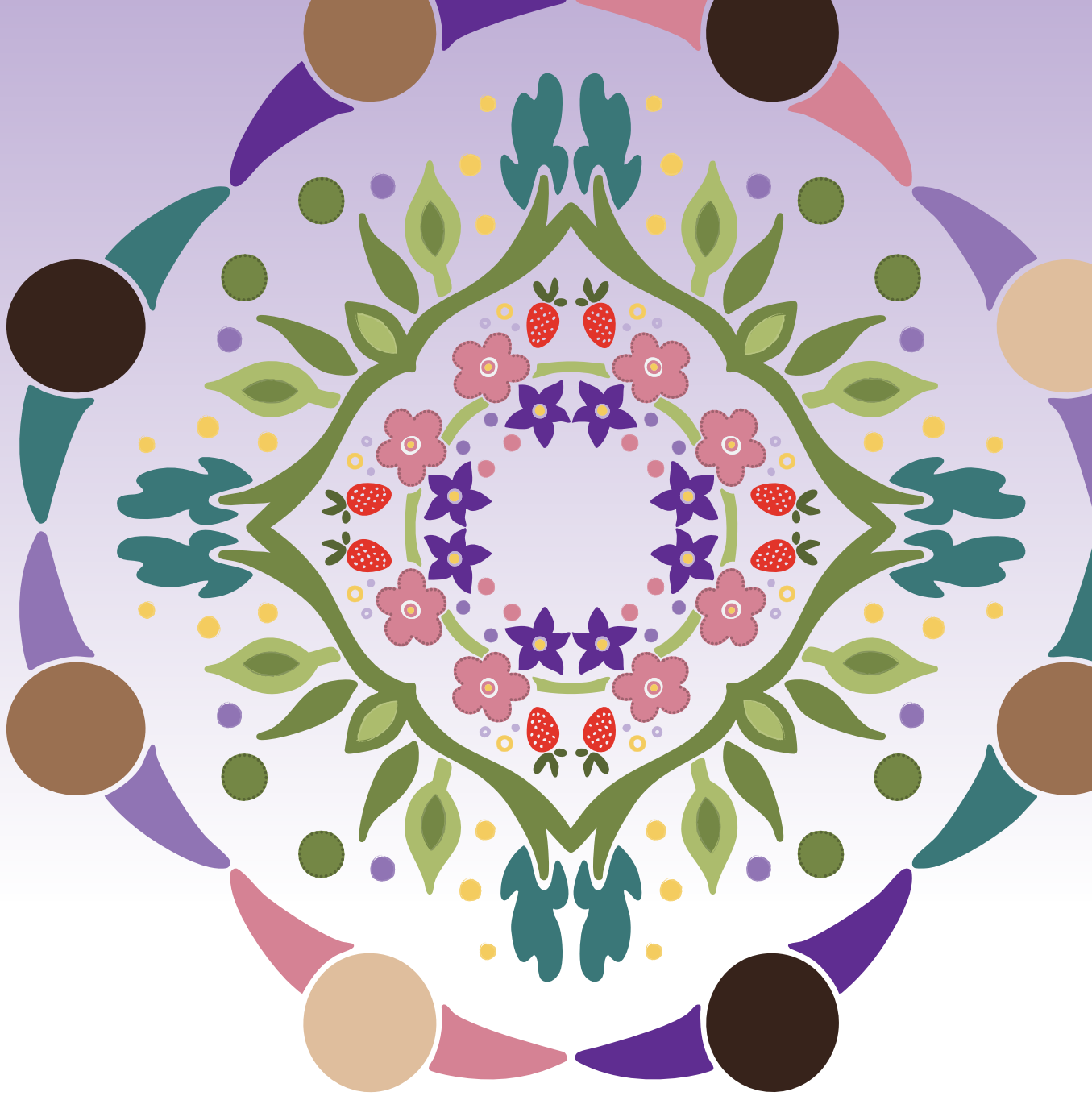

Cultural Humility and Cultural Safety Standards for Nursing Education

CANADIAN INDIGENOUS NURSES ASSOCIATION

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ACESI

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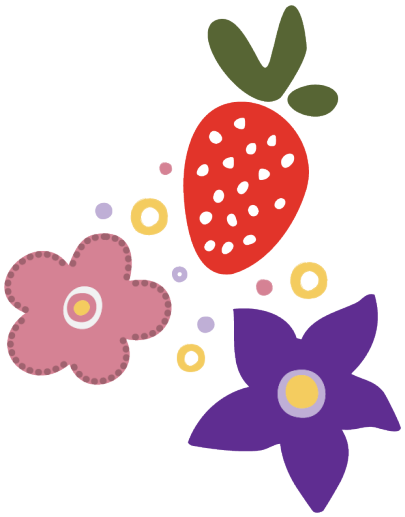

Inspired by the bond between community, Mother Earth, and our identity, a sacred circle takes form. This piece by Melaina Goos, at pipikwan pêhtâkwan, draws from the natural medicines and symbols of First Nations, Métis, and Inuit, illustrating the path toward healing through connection.

The ***outer circle*** embodies people of all nations coming together through community with hands joined as they look inward, toward healing, together. The ***middle circle*** reflects the interconnectedness between healing and our sacred connection to Mother Earth, deeply rooted in the knowledge and medicine passed down from generation to generation. The ***inner circle*** depicts the essence of First Nations, Métis, and Inuit. The strawberry, also known as the heart berry, represents First Nations and symbolizes community, relationships, and reconciliation. The prairie rose, valued both for its medicinal properties and its presence in traditional Métis beadwork, honours the Métis. The purple saxifrage, cherished as a healing medicine and one of the first flowers to bloom in the Arctic spring, represents Inuit.

A community flourishes when deeply rooted in its people, land, and medicines. Like flowers emerging through the changing seasons, we find strength when we nurture our connection to Mother Earth and her gifts. This circle is a reminder that through unity, connection to the land, and the wisdom of our ancestors, we find healing.

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Inclusion

CASN is committed to developing inclusive policies and statements that challenge discrimination, racism, heterosexism, and cisnormative behaviour. A guiding objective in developing the standards, therefore, is to ensure that they promote sensitivity, justice, inclusion, equity, and respect for all people, including but not limited to Indigenous Peoples, racialized people, migrants, 2S LGBTQIA+ people, and members of all marginalized communities.

Introduction

The *Cultural Humility and Cultural Safety Standards for Nursing Education*, developed by the Canadian Indigenous Nurses Association (CINA), the Canadian Association of Schools of Nursing (CASN), and the Cultural Humility and Cultural Safety Standards Project Advisory Committee, sets standards with accompanying specific learning outcomes that set clear knowledge and behavioural expectations for students completing a baccalaureate nursing education program in Canada.

While the standards are an important measurement and accountability tool for nursing students' learning, the document is aimed broadly at nursing education. To implement this document, nurse educators must consider the context and institutional environment in which nursing students are taught; the formal, informal, and hidden curricula (Hafferty, 1998); and the teaching-learning practices for both classroom and experiential learning.

In this document, we first define key terms found throughout this document to provide important context for the reader. We discuss the need for cultural humility and cultural safety standards specific to nursing education. Literature that provides context to the standards and learning outcomes is summarized, and the approach and methods used to develop the standards and learning outcomes are described. The standards and accompanying learning outcomes are presented under five domains. A detailed glossary of terms with additional definitions is provided.

Key Terms

The terms below are essential for providing context to the background literature, standards, and accompanying learning outcomes. By defining these terms, we aim to create shared understanding of these terms, particularly terms that have nuanced meanings. We recognize that our definitions explain our understanding of them at the time of writing and may also need to change in the future.

Anti-oppression – Anti-oppression is both a theory and practice. It involves examining how power and privilege work in society using various lenses (anti-racism, feminism, queer theory, colonialism, disability justice are some examples) in looking at a range of issues including poverty, gender-based discrimination and more. In practice, it involves planning interventions that account for various forms of societal oppression. Both theory and practice must continually adjust to address emerging issues and oppressive structures and systems (Aquil et al., 2021; Baines, 2007).

Anti-racism – Recognizes that racism occurs at all levels of society: individual, interpersonal, institutional, structural, and systemic and that "not being racist" will not address racial inequity in society. Anti-racism is an active stance that requires individuals to identify, challenge, and change individual behaviours, values, policies, and structures that uphold racism (Kendi, 2019;).

Colonialism – The ideologies, systems, policies, and actions that "seek to impose the will of one people on another and to use the resources of the imposed people for the benefit of the imposer" (Asante, 2006, p. ix). Unlike colonization, colonialism is an ongoing process that continues to the present.

Colonization – The process by which a group people arrives, settles, and takes control of a territory, defined as the "subjugation of a people or area especially as an extension of state power" (Merriam-Webster, n.d.). In this context, colonization describes the arrival and settlement of Europeans in what is now known as Canada and the forced displacement of Indigenous populations.

Cultural humility – A process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust" (First Nations Health Authority [FNHA], 2021b, p. 2).

Cultural safety – "An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care" (FNHA, 2021a, p. 5).

Intergenerational trauma – How trauma is transferred from one generation to subsequent generations. There are both socio-cultural and physiological models for how trauma affects the children of survivors (Menzies, 2024) and how trauma is passed from generation to generation. Intergenerational trauma is often used to describe the cumulative effects of the last 500-plus years of colonialism.

Trauma- and violence-informed care – A trauma- and violence-informed care (TVIC) approach assumes that all clients have experienced trauma and aims to create an environment where all clients feel safe and reducing the risk of re-traumatizing. TVIC accounts for intersecting impacts of individual trauma and interpersonal violence, structural violence and systemic inequity. It accounts for historical and ongoing violence on the client's health and wellbeing, and how they engage with health and social services (Browne et al., 2015).

White privilege – A term used to describe the unearned assets experienced by individuals with white skin that are largely invisible to white people (McIntosh, 1998).

White supremacy – Political, social, economic, and cultural systemics in which white people overwhelmingly maintain control over power and resources. There is continued subordination of racialized groups, and unconscious and conscious ideas of white dominance are present across institutions and social settings (Gillborn, 2006; Giroux & McLaren, 1994).

Need for the Standards

In 2009, CINA (then called the Aboriginal Nurses Association of Canada), the Canadian Nurses Association (CNA), and CASN collaborated to develop *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing*. This document included core competencies in six areas: 1) Postcolonial understanding; 2) Communication; 3) Inclusivity; 4) Respect; 5) Indigenous Knowledge; and 6) Mentoring and supporting success for nursing students. Since the publication of this framework, literature on addressing racism and creating culturally safe care environments has continued to evolve, and multiple critical junctures have implications for nursing education and practice.

In the 15 years since the framework was published, the discourse has shifted from *cultural competence*, in which health care provides respect and accounts for the diverse cultural values and practices of clients while providing care, towards *cultural safety*. Cultural safety requires health professionals to develop awareness of power dynamics between nurses and clients and act to dismantle these dynamics (Curtis et al., 2019). There is a need for a document that recognizes the ongoing impacts of colonialism and the need for nurses to develop skills in anti-oppression, anti-racism, cultural humility, and cultural safety.

In 2015, the Truth and Reconciliation Commission of Canada (TRC) published 94 Calls to Action to advance reconciliation in Canada. The TRC describes the framework for reconciliation as functioning of all systems and institutions, including educational institutions, in a manner that is consistent with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations, 2007). Calls to Action #15 to #24 (Health) and #62 to #65 (Education) have implications for Canadian nursing education. Call to Action #24 specifies required learning for all students in medicine and nursing on Indigenous health, the impact of the Residential School System, UNDRIP, Treaty Rights, and Indigenous teachings and practices, as well as "skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism" (TRC, 2015, p. 3). CASN's Accreditation Standards (2020) were updated to include a key element related to Call to Action #24. As well, CASN (2023) developed a series of free workshops in partnership with the Canadian Institutes of Health Research Chairs of Indigenous Health Research in Nursing to provide information, resources, and guidance on addressing and implementing changes in nursing education to address Call to Action #24.

However, in the near-decade since the release of the Calls to Action, progress towards health equity remains stagnant, incidents of discrimination continue, there is a lack of cultural safety and Indigenous-specific systemic racism remains entrenched in health care. In 2020, Atikamekw woman Joyce Echaquan died in the hospital after experiencing discriminatory treatment from nurses and other health care professionals (Principe de Joyce, 2020). In two separate instances at Canadian hospitals in late 2024, without either patient's consent, a Métis man's ponytail was cut and a Pasqua First Nation man's braids were cut and his eagle feather was thrown in the garbage (Farrell, 2024; O'Connor, 2024). These instances highlight the lack of cultural safety in health care and are symptomatic of a systemic and pervasive issue across health systems in Canada. The *In Plain Sight* report (Turpel-Lafond, 2020) detailed a comprehensive investigation of Indigenous-specific racism in the British Columbia health care system. The investigation found that Indigenous clients were subjected to stereotyping and discrimination by health care professionals, experienced more barriers to accessing care than non-Indigenous clients (e.g., longer wait times), and had worse health outcomes.

In recent years, standards, policies, and commitments have been implemented across Canada that aim to address Indigenous-specific racism, support health equity, and uphold Indigenous Rights:

- Governments, organizations, and associations in Canada have made formal commitments to address inequality and remove barriers to the rights of Indigenous Peoples to health care. The Government of Canada is a signatory to UNDRIP and officially adopted it November 12, 2017. It guarantees Indigenous individuals the right to the highest attainable standard of health and requires states to take steps to realize this right.

- Jordan's Principle, named in memory of Jordan River Anderson, is a child-first principle and commitment by the federal government to ensure First Nations children have access to health and social service supports when needed (Government of Canada, 2024). Similarly, the Inuit Child First Initiative supports Jordan's Principle and is a commitment from the federal government to work with provinces, territories, and Inuit partners to ensure Inuit children have access to health and social services without barriers (Inuit Tapiriit Kanatami, n.d.-b).
- Joyce's Principle, named in memory of Joyce Echaquan, reaffirms the right of Indigenous Peoples to access health carefree from discrimination. The federal government committed to co-developing legislation to uphold this principle, and many institutions have publicly declared their commitment to abide by it.
- The Nursing Declaration Against Anti-Indigenous Racism in Nursing and Health Care (CNA, 2021) identified seven actions aimed at combatting Indigenous-specific racism, responding to Call to Action #20, and advocating for greater government action.
- The CNA Code of Ethics for Registered Nurses (2017) requires nurses to provide safe care and report instances of unsafe care, recognize the worth of each person and honour dignity, and safeguard human rights and promote equity and justice.
- Cultural humility, cultural safety, and cultural competence are practice requirements detailed in the practice standards and entry-level competencies of registered nurses and nurse practitioners across jurisdictions. The British Columbia College of Nurses and Midwives (2022) practice standard for Indigenous Cultural Safety, Cultural Humility, and Anti-Racism provides detailed expectations and guidance to nurses in practice.

At the outset of developing the standards, CINA and CASN conducted a focus group with 13 nursing students at the Canadian Nursing Students' Association Conference in January 2024. The participants indicated significant variability between schools in relation to content on Indigenous health, colonial harms, and Indigenous teachings and practices. These nursing students indicated a need for more information in bringing knowledge to action in addressing Indigenous-specific racism.

Schools of nursing have a pivotal role in addressing Indigenous-specific racism—they influence how future members of the profession interact with individuals, families, and communities when they join the profession (National Commission to Address Racism in Nursing, 2022). The detailed guidance and expectations set out in this document provide current, evidence-informed standards with learning outcomes that aim to support the development of these critical skills in nursing students and to influence the learning environment and all dimensions of curricula.

Background

Historical Impacts of Colonization, Colonialism, and Genocide

When considering the impact of colonization and colonialism on Indigenous Peoples in Canada, it is conceivable that all legislation, policies, institutions, and actions have affected and continue to affect Indigenous health and well-being. To provide context for the cultural humility and cultural safety standards for nursing education, we describe how European settlers disrupted Indigenous societies, and the historical and ongoing impacts of colonial legislation, policies and institutions on Indigenous health. We then discuss how nursing education plays a critical role by preparing future nurses to provide culturally safe care and to influence transformation in institutions and at the systems level by challenging discriminatory practices and policies. This background section is limited. Readers are encouraged to learn more about Canada's colonial history,

> **"While much is made of the fact that Canada offers universal health care to all of its citizens, Indigenous people are all too aware that this universality does not equate to efficient and expedient medical services for all" (Starblanket & Hunt, 2020, p. 5).**

Prior to the arrival of Europeans, Indigenous communities had well-developed practices to support health and healing, including the use of plants for medicinal purposes (FNHA, n.d.). Health was also considered broadly, beyond simply the presence or absence of disease, and included overall wellness physically, mentally, and spiritually in connection with one's environment (Craft & Lebihan, 2021).

The arrival of Europeans in North America immediately disrupted Indigenous societies. The spread of new diseases, exacerbated by immune-system suppression resulting from interrupted food harvesting, led to the collapse of Indigenous populations across North America (FNHA, n.d.). In this context of destabilization, Europeans began settling in what is now known as Canada. As First Nations communities were removed from their lands, they lost access to plants, animals, and minerals used for medicines and in healing practices (Starblanket & Hunt, 2020).

The process of colonialization is deeply intertwined with white supremacy and the belief of European cultural superiority. The Doctrine of Discovery, a legal principle maintaining that European powers could lay claim to territories not occupied by Christians, justified European colonization across the globe. The belief that racialized people were inferior led to systems of racial hierarchy (Canadian Human Rights Commission, 2023). The structures and systems derived from these colonial ideologies created a health disparity between Indigenous and non-Indigenous people in Canada.

The Royal Proclamation of 1763 recognized Indigenous land rights and set protocols for the cessation of lands through formal treaties. The Numbered Treaties, which were negotiated to secure land and its natural resources for settlers west of Quebec, were more comprehensive. Crown representatives made verbal commitments to the provision of health care and medicine; however, the written treaties either lacked any reference to health or contained only implied commitments. Only Treaty 6 contains a written commitment to the provision of health care—the medicine chest clause—which specified that basic medical supplies and medicines would be available by the Indian agent representing the Crown (Craft & Lebihan, 2021). The clause places decision-making and access in the control of the federal government (Starblanket & Hunt, 2020).

First Nations had a long history of treaty-making prior to European arrival; with this experience, they entered into agreements with the government with the aim of placing limits on settlers, affirming Indigenous Rights, and delineating shared responsibilities in shared spaces (Starblanket & Hunt, 2020). This approach included a wholistic view of health in relation to the environment, the continued use of healers and medicines, and access to European medicines and vaccines to counteract new illnesses. This view that First Nations and European

settlers would coexist and learn from each other, and that Indigenous ways of life would not be interfered with, drastically contradicts how European settlers viewed and implemented the Treaties in relation to health (Craft & Lebihan, 2021; Starblanket & Hunt, 2020).

Following confederation, the *Indian Act* was passed in 1876 to codify laws, policies, and regulations to govern the lives of First Nations living on-reserve, referred to in the Act as Status Indians. The Act facilitated the expropriation of lands for settlement and resource exploitation and established a framework for controlling many aspects of the lives of Status Indians (Henderson et al., 2018).

The *Indian Act* gave the federal government authority over education, leading to the establishment of the Indian Residential School System and Indian Day Schools. Although Métis people, Inuit, and some First Nations were excluded from the provisions of the *Indian Act*, their children were still sent to these institutions (TRC, 2015). The physical, sexual, and mental abuse that children were subjected to within these facilities caused significant physical and psychological harms among survivors (National Centre for Truth and Reconciliation [NCTR], 2022). The inadequate and overcrowded facilities led to uncontrolled spread of tuberculosis (TB) and other communicable illnesses, and the neglect by staff and lack of medical interventions led to the preventable deaths of many children (Hay et al., 2020). Students were not allowed to participate in any cultural practices or speak their own language (Hanson et al., 2020). In 2022, the House of Commons adopted a motion recognizing the Indian Residential School System as genocide (Lavery, 2022).

The federal government formally segregated health care in the 1930s by establishing Indian Hospitals because of fears surrounding the prevalence of TB among Indigenous populations, a direct result of colonialism, including the Residential School System and substandard and crowded housing on reserves (NCTR, 2022). The medical and nursing care provided in Indian Hospitals was inadequate. Moreover, they also served as a venue for medical experiments on Indigenous patients (Craft & Lebihan, 2021).

The *Indian Act* underwent a series of reforms in 1951, one of which gave authority over child welfare to the provinces. Apprehension of Indigenous children was so frequent over the next 30 years, particularly in the 1960s, that the term *Sixties Scoop* was coined by social worker Patrick Johnston (Sinclair, 2007). Indigenous children were placed with non-Indigenous families, and their family members were not informed of their whereabouts. The Sixties Scoop affected the mental health and well-being of survivors and their families, with some experiencing mental illness or substance use problems (Kodeeswaran et al., 2022).

The effects of the Indian Residential School System, Indian Hospitals, and other harmful institutions, policies, and actions are still felt today by both survivors and their descendants in the form of intergenerational trauma. For example, Residential School attendance has been linked to current health and social outcomes, with the descendants of survivors experiencing higher levels of psychological distress. Research has shown that the effects are cumulative (Bombay et al., 2014).

Colonialism aimed to extinguish Indigenous cultures, including languages, spiritual beliefs, ceremonies, traditions, and practices. The efforts to eliminate the use of Indigenous languages also halted the transmission of Traditional Knowledge, including that of medicines (Burnham, 2018). Cultural practices contribute to overall well-being, a sense of community, and social connectedness. Hill (2009) describes the revitalization of cultural practices and Indigenous languages as a part of wholistic wellness of communities.

Contemporary, Ongoing Colonialism and Nursing Practice

Colonialism is an ongoing force embedded in individual and collective mindsets, institutions, and systems. To describe the continued impact of colonialism on Indigenous health, Loppie and Wren (2022) use a tree metaphor for Indigenous determinants of health: root (structural determinants), core (systems and infrastructure), and stem (direct impacts). Colonial ideologies and governance as well as Indigenous self-determination are described as root determinants of Indigenous health. These root determinants are "deeply embedded ideological and political foundations, which shape all other determinants" (Loppie & Wren, 2022, p. 12). Colonial governance and structures remain in place in Canada and continue to limit Indigenous self-determination and affect Indigenous health and well-being. Economic marginalization, environmental racism, food insecurity, lack of access to clean water, and government control of health care, education, and child welfare are clear evidence of continued colonialism. Indigenous women, girls, and 2S LGBTQIA+ individuals are targets of violence, murder, and disappearances. Indigenous women and girls are over-represented in domestic human trafficking cases (Roudometkina & Wakeford, 2018), and concerns regarding the forced and coerced sterilization of Indigenous women are ongoing (Leason, 2021). Gender-based discrimination and patriarchal systems have placed Indigenous women and girls in precarious social and economic situations and are the root causes of this ongoing human rights crisis. Nurses were directly involved in historical harms against Indigenous Peoples and continue to uphold and perpetuate systemic racism in health care. This fact is a direct tension with nursing discourse, which upholds the ideas of neutrality, efficiency, equality, and multiculturalism (Blanchet Garneau et al., 2019), and the Code of Ethics for Registered Nurses, in which social justice is a central tenet of the profession. According to Symenuk et al. (2020), "the image of nurses and nursing being good and caring … provides a complex and compounding barrier to undertaking the first steps in uncovering the profession's complicity in colonial harms and assimilative policies" (p. 90). For this discourse to change, each nurse must take responsibility for examining how they and their institutions continue to uphold colonial ways of thinking and doing.

Anti-Racism, Cultural Humility, and Cultural Safety

Nursing education must not perpetuate a nursing discourse that upholds colonialism and racism. Despite many years of nursing education focusing on cultural competence and cultural safety, Indigenous-specific racism remains embedded in the health care system and acts of discrimination by health professionals continue to occur. As Kelly and Chakanyuka (2021) have emphasized, we must "explore how our educational and academic hierarchies dampen down antiracist or decolonizing approaches through soft language that sidesteps core issues of entrenched bias" (p. 2). Future nurses must move past the notion of "not being racist" into an active role of challenging racism in themselves, others, and the health care system, being anti-racist (Kendi, 2019).

To address and challenge biases and stereotypes within themselves, nurses are encouraged to practise cultural humility. Rather than focusing on knowledge and understanding of cultures, nurses are called on to address power imbalances in health care settings. Nurses must work towards creating environments in which all individuals feel safe and respected and are treated with dignity, regardless of their cultural background (Brascoupé & Waters, 2009; Ramsden, 2015). According to Curtis et al. (2019), "healthcare organisations and authorities need to be held accountable for providing culturally safe care, as defined by patients and their communities" (p. 15).

The education of health professionals on anti-racism and on cultural safety requires improvement and greater standardization across the country (Turpel-Lafond, 2020). A 2022 study of nursing students in clinical practice found that while students had confidence in their knowledge and understanding of anti-racism, cultural humility, and cultural safety, they did not feel comfortable in situations in which they needed to implement these practices (Braithwaite et al., 2022). Education in these areas must also give nursing students the support and tools they need to translate these skills into action.

Nurses must understand how the historical and current harms inflicted on Indigenous Peoples in Canada may affect health-seeking behaviour and health care interactions, and work from a trauma- and violence-informed lens. Among the many foundations of trauma- and violence-informed care is the recognition of the prevalence of trauma and violence at interpersonal and structural levels and their impacts on lives and behaviours (EQUIP Health Care, n.d.).

Indigenization

TRC Call to Action #24 calls on schools of nursing to integrate Indigenous health teachings and practices. Indigenous Knowledge strengthens nursing practice and the ability of nurses to provide culturally safe care. Respectful engagement with Indigenous Knowledge is also foundational to equity within nursing education (Kennedy et al., 2020). The goal is not to extract this knowledge and apply it but to shift the lens. As described by Askew et al. (2020), "within health, we typically learn 'about' Indigenous peoples and therefore miss out on the opportunity to become with—to be in relationship with and thereby learn with and from—acquiring in the process a different disposition" (p. 105). This decolonizing process should create opportunities not only for non-Indigenous students to learn from Indigenous health professionals, Elders, and Knowledge Holders, but also for Indigenous nursing students to be supported in using their Indigenous Knowledge if and when they feel comfortable doing so (Kennedy et al., 2020).

Collaboration With First Nations, Inuit, and Métis Peoples

Kirkness and Barnhardt (1991) put forward a framework of principles to guide post-secondary institutions on meaningful engagement with Indigenous students: respect, reciprocity, relevance, and responsibility. More recently, two additional principles, relationship and representation, have been added to create the Six Rs framework (Tsosie et al., 2022). The Six Rs framework provides guidance in developing meaningful collaborations with First Nations, Inuit, and Métis communities that can be used to guide Indigenization of nursing education, research and collaboration in practice.

Nurses must also be aware of and act in accordance with the principles of Indigenous data sovereignty. Indigenous Peoples have the inherent right to control data about their communities. Several frameworks guide data management and sovereignty, such as the First Nations principles of ownership, control, access, and possession (OCAP) (First Nations Information Governance Centre, n.d.) and the Manitoba Métis Federations framework of ownership, control, access, and stewardship (OCAS) (University of Manitoba, 2021). Research and data management must be defined at the community level, with researchers respecting the overall principle of Indigenous data sovereignty.

UNDRIP and Indigenous Self-Determination

UNDRIP affirms the right of Indigenous Peoples to the highest attainable standard of health, access to health care, and the right to develop health care policies and programs. Indigenous Peoples have long advocated for the autonomy and self-determination to achieve health equity through Indigenous-led culturally safe and culturally relevant services (Halseth & Murdock, 2020). While the impacts on health outcomes are just emerging, the lower death rates from COVID-19 in Indigenous communities in Alaska who have health care sovereignty show the potential future effects of self-determination (Tiwari et al., 2023).

In Canada, Indigenous health care sovereignty varies significantly between provinces, territories, and regions. To date, only British Columbia has established an Indigenous health authority, the First Nations Health Authority (FNHA). In 2013, First Nations communities, the federal government and British Columbia provincial government signed an agreement to transfer health programs and services from Health Canada to FNHA

(NCCIH, 2020). The British Columbia Declaration on the Rights of Indigenous Peoples has mandated that provincial legislation align with UNDRIP and FNHA provides an example of how UNDRIP can be implemented and of Indigenous self-determination in health care.

The federal government has put forward a vision of distinctions-based Indigenous health legislation, which calls on all levels of government to work with First Nations, Inuit, and Métis Peoples and communities in ways that acknowledge specific relationships with government and unique priorities, uphold UNDRIP, and respect Indigenous sovereignty (Indigenous Services Canada, 2023). Distinctions-based approaches have been criticized for their potential to leave Indigenous groups or individuals behind. For example, urban Indigenous people may experience gaps in both provincial and federal health care due to jurisdictional wrangling. The National Association of Friendship Centres (2022) has called for focusing "on the needs and realities of Indigenous people first and foremost, many of whom may not fit within the current policy and practice approaches" (p. 5). Nurses are well-positioned to work in collaboration with Indigenous-led efforts at community levels and in all levels of government.

Guidance for Using These Standards

While the document delineates learning outcomes for nursing students, to be effectively implemented nurse educators must consider the learning environment as a whole and all dimension of curricula.

Nurse educators must remove the deficit lens through which Indigenous health is often presented. Teaching materials and textbooks used in nursing education frequently convey a construction of difference in which whiteness is normalized, and disease causality implies deficit thinking about racialized groups (Bell, 2021). Nurse educators must be prepared to effectively use an anti-racist pedagogy, deconstruct white normativity in nursing, while shifting towards strengths-based a (Bell, 2021).

While discussing Canada's colonial history and the current state of colonialism and racism in nursing is crucial, these discussions may traumatize or retraumatize Indigenous nursing students in the classroom. A trauma- and violence-informed approach to nursing education should be implemented (Goddard et al., 2021; Browne et al., 2015). Educators are encouraged to engage with learning materials and consider how they might affect learners and provide context for the materials in advance. Educators should ensure they are prepared to meaningfully engage with students in courageous conversations. Educators are also encouraged to share options for on-campus mental health supports and provide alternative learning options for Indigenous nursing students who may be traumatized or retraumatized by engaging in these discussions.

Nurse educators must be prepared to address racism in the classroom and in clinical settings. Dr. Holly Graham's (2024) CPR-RACISM guide provides information and steps to address racism in real time, calling on nurses to actively address these situations as required by nursing practice standards and the Code of Ethics for Registered Nurses (CNA, 2017). In nursing programs, students may witness or be subjected to racism in classroom or experiential learning from educators, clinical instructors, staff, fellow students, patients, etc. Educators need to model how to respond effectively to stereotyping and discriminatory comments or actions, and provide immediate support to students who have been subjected to racism.

Approaches to Indigenization that are not grounded in an authentic relationship continues the cycle of appropriating Indigenous Knowledge and tokenizing (Bourque Bearskin et al., 2022). These processes of Indigenizing schools of nursing, the curriculum, and teaching practices must be done with guidance and presence from the local Nation or community, Elders, Knowledge Holders, and local Indigenous organizations in a manner that benefits all involved. Critical discussions are needed to differentiate between cultural appreciation and cultural appropriation, and to create an understanding that there is no pan-Indigenous worldview.

Methods

An Advisory Committee of Indigenous nursing leaders and several non-Indigenous collaborators were struck to provide expertise and guidance in the development of these standards.

The standards development was informed by an environmental scan of peer-reviewed and grey literature on Indigenous-specific racism in health care and anti-racism, cultural humility, and cultural safety in nursing practice. Policies, principles, standards, and frameworks related to First Nations, Inuit, and Métis health were reviewed, as were jurisdictional nursing practice standards. A small focus group with 13 nursing students was conducted to gain insights on how the Calls to Action were being addressed in nursing education and to understand feelings of preparedness to address Indigenous-specific racism.

A consensus-building approach was used to develop the *Cultural Humility and Cultural Safety Standards for Nursing Education*. The Advisory Committee developed an initial draft of the standards. The next step was to hold a virtual consultation forum with additional Indigenous nurses in various practice roles (education, clinical, and policy) as well as non-Indigenous collaborators from across Canada. The purpose of the consultation forum was for each standard and learning outcome to be further reviewed in a World Café format. Following the forum, the feedback was collated and presented to the Advisory Committee for review. Once the Advisory Committee reached a consensus on the next iteration of the standards and learning outcomes, the standards were reviewed by a focus group of nurse educators and nursing students at the 2024 CASN Biennial Canadian Nursing Education Conference with the aim of gaining insights from educators or students not previously involved in the development of the document. The focus group feedback was used to revise the standards.

As a final step in building consensus, the standards were put into an online validation survey. Respondents were asked to rate each standard statement and learning outcome according to whether it was important for undergraduate nursing education, with a response of *Yes, No, or Unsure*. Respondents were also given the opportunity to provide comments throughout the survey.

The survey received 29 responses. Almost all standard and learning outcome statements received a ranking of over 89% as *Yes*; any outliers were reviewed by the Advisory Committee.

Standards and Learning Outcomes

This document defines nursing education standards[1] in cultural humility and cultural safety. These **standards** set clear knowledge and behavioural expectations for students completing a baccalaureate nursing education program. They are grounded in the values and ethics of the nursing profession across jurisdictions which requires all nurses, including those entering practice, to provide respectful care that is free from discrimination.

The standards, organized into five domains, are accompanied by a set of learning outcomes. **Learning outcomes** "express the lasting changes that must arise in the learner during or following an educational experience" [translation] (Legendre, 2005, as cited in Richard, 2016, p. 4). The learning outcomes serve as guidance for curriculum and course development as well as indicators for assessment and the manifestation of learning.

[1] At time of publication, these standards are not included in the CASN Accreditation Standards and Framework (2020). Inclusion in the Accreditation Standards requires approval by the CASN Advisory Committee on Accreditation Policy and CASN Council. These standards will be submitted for consideration in the next scheduled major revision to the accreditation standards.

DOMAIN 1.

Colonization, colonialism, and genocide

Education Standard 1.1

The graduating nursing student understands the need for nurses to address the historical impacts of colonization, colonialism, and genocide on First Nations, Inuit, and Métis Peoples.

Learning Outcomes

On completion of their nursing education, the nursing graduate:

1.1.1. Defines, acknowledges, and recognizes colonization and describes the immediate and continued effects of colonization on First Nations, Inuit, and Métis Peoples.

1.1.2. Describes how Western cultural superiority and white supremacy were used and continue to justify colonization.

1.1.3. Recognizes that the loss of self-determination and sovereignty resulting from colonization negatively affects the health and well-being of First Nations, Inuit, and Métis Peoples.

1.1.4. Describes how forced relocation interrupted Indigenous social systems and cultural practices that support health and well-being and prevented access to health practices and traditional medicines.

1.1.5. Articulates the failure of colonial governments to honour Treaty commitments to provide health services to First Nations, Inuit, and Métis Peoples.

1.1.6. Explains the impact of genocidal colonial policies and actions, including but not limited to Indian Hospitals, Indian Day Schools, the Indian Residential School System, and the Sixties Scoop, on the mortality and morbidity of First Nations, Inuit, and Métis Peoples.

Education Standard 1.2

The graduating nursing student addresses the continuing and contemporary impacts of colonialism on the health and well-being of First Nations, Inuit, and Métis Peoples.

Learning Outcomes

On completion of their education program, the nursing graduate:

1.2.1. Recognizes that all nurses have a professional responsibility and are accountable to respond to the Truth and Reconciliation Commission Calls to Action to close the gap in health and social outcomes between Indigenous and non-Indigenous communities.

1.2.2. Describes how colonial perspectives on health and illness continue to oppress First Nations, Inuit, and Métis Peoples and negatively affect their health and well-being.

1.2.3. Describes the social determinants of Indigenous health and recognizes colonial ideologies, structures, and systems as the root causes affecting other social determinants of health.

1.2.4. Describes the application of key policy documents that mandate health equity for Indigenous individuals, including Jordan's Principle, the Inuit Child First Principle, and Joyce's Principle.

1.2.5. Understands the responsibility to recognize that the societal factors, economic conditions, and systemic racism that underpin the current crisis of Missing and Murdered Indigenous Women and Girls and 2S LGBTQIA+ individuals were created and continue to be influenced by colonialism.

1.2.6. Recognizes and respects the enduring strengths and resilience of First Nations, Inuit, and Métis Peoples in preserving their distinct cultural identities, knowledges, and practices in the face of genocide and colonial harms.

1.2.7. Understands that the intergenerational trauma experienced by First Nations, Inuit, and Métis Peoples is a result of historical and continuing colonial harms.

DOMAIN 2.

Indigenous-specific racism in nursing practice and health care

Education Standard 2.1

The graduating nursing student acknowledges that widespread discrimination and systemic Indigenous-specific racism is present in Canadian health care, including in nursing practice.

Learning Outcomes

On completion of their nursing education, the nursing graduate:

2.1.1. Demonstrates the capacity to challenge and dismantle Indigenous-specific racism in health care services.

2.1.2. Articulates and demonstrates through course work and practice the nurse's professional responsibility to address Indigenous-specific racism and health service inequities, as required by the Canadian Nurses Association Code of Ethics and provincial and territorial standards of nursing practice.

2.1.3. Understands that Indigenous-specific racism in health care is a barrier to accessing care for First Nation, Inuit, and Métis Peoples and negatively affects health outcomes.

2.1.4. Recognizes and responds effectively to interpersonal racism towards Indigenous clients and colleagues.

2.1.5. Takes action against institutional racism by questioning prejudiced policies and procedures, actively working to create equitable and supportive environments, and advocating for accountability measures.

2.1.6. Critically examines the contemporary structural and systemic racism affecting the delivery of care to First Nations, Inuit, and Métis Peoples and actively models the change that they envision in every interaction, for system changes at all levels.

2.1.7. Approaches conversations regarding bias, prejudice, stereotyping, and racism about or towards Indigenous Peoples with a willingness to listen and learn and an openness to constructive feedback.

DOMAIN 3.

Cultural humility and cultural safety

Education Standard 3.1

The graduating nursing student engages in continuous reflective practice and demonstrates cultural humility.

Learning Outcomes

On completion of their education program, the nursing graduate:

3.1.1. Defines cultural humility and articulates why cultural humility is an essential component of developing a therapeutic relationship with First Nations, Inuit, and Métis clients.

3.1.2. Engages in a continuous process of deep self-examination to identify one's personal assumptions and beliefs and develops an awareness of how these affect interactions and relationships.

3.1.3. Respectfully listens to and values the unique perspectives and lived experiences of First Nations, Inuit, and Métis clients.

3.1.4. Recognizes the interconnectedness of culture, spirituality, health, and social determinants of health in understanding that cultural awareness and cultural sensitivity are part of providing wholistic care.

Education Standard 3.2

The graduating nursing student is aware of their positionality and any privileges they may hold, understands the impact of power imbalances on the nurse–client relationship, and strives to provide culturally safe care.

Learning Outcomes

On completion of their education program, the nursing graduate:

3.2.1. Recognizes how their identities and social location influences their approach to nursing practice and their relationships with clients.

3.2.2. Understands how white privilege and white fragility, other forms of privilege, and Indigenous-specific racism affect health care services provided to First Nations, Inuit, and Métis Peoples.

3.2.3. Recognizes the complexity and intersectionality of identities in relationships with First Nations, Inuit, and Métis Peoples.

3.2.4. Recognizes the individual responsibility that each nurse holds to create a culturally safe environment for addressing the power imbalances inherent in therapeutic relationships and the health care system as a structure.

3.2.5. Recognizes that the safety of spaces and experiences in health care is determined by the client.

Education Standard 3.3

The graduating nursing student demonstrates respectful engagement and the capacity to develop a care plan in partnership with First Nations, Inuit, and Métis clients.

Learning Outcomes

On completion of their education program, the nursing graduate:

3.3.1. Listens actively to understand the needs and concerns of First Nations, Inuit, and Métis individuals and their families, recognizing that the concept of family is defined by the client and may include community members, Knowledge Holders, and Elders.

3.3.2. Respects the rights of Indigenous Peoples to the highest standard of physical and mental health as specified in the United Nations Declaration on the Rights of Indigenous Peoples.

3.3.3. Respects the rights of First Nations, Inuit, and Métis Peoples to make decisions about their health care and receive the care that is aligned with their cultural values, beliefs, and/or spirituality, including traditional healing practices.

3.3.4. Applies the principles of trauma- and violence-informed care when caring for First Nations, Inuit, and Métis clients, recognizing the potential for mistrust of the health care system due to colonial harms and Indigenous-specific racism.

3.3.5. Employs a strengths- and distinctions-based approach in creating an evolving care plan with First Nations, Inuit, and Métis clients that mobilizes their strengths and is inclusive of the client's values and approaches for healing.

DOMAIN 4.

Indigenous Knowledge and practices for health

Educational Standard 4.1

The graduating nursing student honours, respects, and upholds Indigenous Knowledges, cultures, and practices for health and healing.

Learning Outcomes

On completion of their education program, the nursing graduate:

4.1.1. Recognizes that Indigenous Knowledge represents the cumulative and unique understandings of each distinct Indigenous society, built on its historical experiences and ancestral relationships with its environment.

4.1.2. Seeks to learn about the diverse and distinct cultures of First Nations, Inuit, and Métis Peoples across Canada, with the understanding that there is no pan-Indigenous worldview.

4.1.3. Strengthens the nurse–client relationship by engaging in relational inquiry with First Nations, Inuit, and Métis clients to learn about their knowledge, values, and preferences in areas such as birth, child health, and end-of-life practices.

4.1.4. Supports the integration of Indigenous Knowledge and practices when providing care to First Nations, Inuit, and Métis Peoples, without appropriating or exploiting this knowledge.

DOMAIN 5.

Collaborations with First Nations, Inuit, and Métis communities and organizations

Educational Standard 5.1

The graduating nursing student articulates how to respectfully build collaborations and partnerships with First Nations, Inuit, and Métis groups, communities, and organizations.

Learning Outcomes

On completion of their education program, the nursing graduate:

5.1.1. Adheres to the principles of respect, reciprocity, relevance, responsibility, representation, and relationship[2] when engaging with First Nations, Inuit, and Métis Peoples in nursing practice or research.

5.1.2. Respects the autonomy and self-determination of First Nations, Inuit, and Métis Peoples in health and healing and in advocating for the development of Indigenous health programs and systems.

5.1.3. Describes approaches for engagement and collaboration with First Nations, Inuit, and Métis individuals, families, and communities to advocate for and implement upstream approaches that address the structural and social determinants of health.

5.1.4. Recognizes the unique factors affecting health equity in urban, Northern, rural, and remote Indigenous communities and advocates with communities based on identified needs.

5.1.5. Collaborates with First Nations, Inuit, and Métis Peoples to advocate for integrating Indigenous Knowledge, languages, and cultural practices in health care organizations and programs.

5.1.6. Describes and adheres to the principles of Indigenous data sovereignty, such as ownership, control, access, and possession (OCAP) and ownership, control, access, and stewardship (OCAS).

5.1.7. Defines a distinctions-based approach and describes nursing's role in upholding distinctions-based processes when invited to participate in the co-development of health programming and policies with First Nations, Inuit, and Métis Peoples.

[2] The principles of respect, relevance, reciprocity, and responsibility (the Four Rs) were developed to guide post-secondary institutions in creating respectful environments that engage Indigenous learners (Kirkness & Barnhardt, 1991) and have guided research and collaborations between Indigenous and non-Indigenous individuals and communities. Scholars have built on this work and proposed adding the principles of relationship and representation, creating a framework known as the Six Rs (Tsosie et al., 2022).

Glossary

Bias – "The action of supporting or opposing a particular person or thing in an unfair way, because of allowing personal opinions to influence your judgment" (Cambridge Dictionary, n.d.). Conscious bias refers to the biased attitudes we are aware of and that can be accessed, unconscious bias is the attitudes operating outside our awareness and control, they influence our actions more than conscious biases (John M. Flaxman Library, 2024).

Cultural awareness – The understanding of "one's own culturally shaped values, beliefs, perceptions, and biases." It involves "observing one's reactions to people whose cultures differ from one's own and reflecting upon these responses" (Georgetown University Center for Child and Human Development, n.d., para. 5).

Cultural sensitivity – "Recognizing the need to respect cultural differences" and "acting with respect towards people of other cultures" (Okanagan Nation Alliance, n.d., para. 2).

Cultural supremacy – A tool used "by the dominant culture to disparage, expropriate, and erase other cultures; force acculturation; and set itself as the standard." It "constantly perpetuates itself within the structures and institutions that sustain its limited picture of reality" (Genia, 2020, para. 1).

Discrimination – "Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" (United Nations [UN], 1965, p. 2)

First Nations – One of three groups of Indigenous Peoples in Canada. First Nations were the original habitants of land south of the Arctic region in what is now known as Canada.

Genocide – Certain acts as defined in Article II of the Genocide Convention that are "committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group" (United Nations, n.d.-a, para. 4).

Indian Day Schools – These schools were similar to Indian Residential Schools, however students attended these institutions in their community and returned to their families at the end of each day. 150,000 Indigenous children attended these institutions (Canadian Encyclopedia, 2023).

Indian Hospitals – Although the "initial purpose of these hospitals was to reduce the prevalence and spread of tuberculosis," these hospitals were opened "to assuage fears" of a "perceived threat … that Indigenous people posed" to the non-Indigenous population (IRSHDC, n.d.-b, paras. 1–2).

Indian Residential Schools – These schools were in operation for over 150 years, with the first school opening in 1831. The Indian Residential School System was funded by the federal government in the 1880s. Schools were a tool of assimilation whereby First Nations, Inuit, and Métis children were removed from their families and sent to schools where cultural practices and Indigenous languages were forbidden. The schools were under-funded and over-crowded, and rife with disease and abuse. (IRSHDC, n.d.).

Indigenization – "The addition or redoing of Indigenous elements. Indigenization moves beyond tokenistic gestures of recognition or inclusion to meaningfully change practices and structures. Power, dominance and control are rebalanced and returned to Indigenous peoples, and Indigenous ways of knowing and doing are perceived, presented, and practised as equal to Western ways of knowing and doing" (Coulthard, 2014).

Indigenous Knowledge – Indigenous Knowledges are Traditional Knowledges or knowledge that derive from a community and are collected by generations of Indigenous Peoples. They are expressed in many formats, such as orally, through ceremony, and as artistic creations, and do not exist only in the past; "there is continued growth, innovation and change in practices" (University of Alberta, 2024, para. 2).

Indigenous Peoples – While there is significant diversity among Indigenous Peoples globally, there are some common characteristics: Indigenous Peoples have distinct social, economic, and political systems, as well as languages, cultures, and beliefs. They are non-dominant groups and have continuity with pre-colonial or pre-settler societies and strong connections to lands and natural resources (United Nations, n.d.-b). In Canada, there are three groups of Indigenous Peoples: First Nations, Inuit, and Métis Peoples.

Indigenous-specific racism – Prejudice, stereotyping, and racism experienced specifically by Indigenous people.

Inuit – One of three groups of Indigenous Peoples in Canada. The majority of Inuit live in the four Inuit regions, "collectively known as Inuit Nunangat. The term 'Inuit Nunangat' includes land, water, and ice" (Inuit Tapiriit Kanatami, n.d.-a, "Inuit Regions of Canada"). The four regions that constitute Inuit Nunangat are the Inuvialuit Settlement Region (Northwest Territories), Nunatsiavut (Labrador), Nunavik (Quebec), and Nunavut.

Inuit Qaujimajatuqangit – The term used to describe Inuit epistemology or the Indigenous Knowledge of Inuit. The term translates directly as "that which Inuit have always known to be true" (Tagalik, 2009–2010, p. 1).

Interpersonal racism – When a person's racial bias or beliefs influence their interactions with others.

Intersectionality – Coined by Kimberlé Crenshaw, this term is a lens for looking at how different forms of inequality, based on gender, class, sexuality, race, etc., "often operate together and exacerbate one another" (Steinmetz, 2020, para. 3).

Institutional racism – Racism is reproduced through the policies, procedures, and practices of an organization that consistently produce inequitable outcomes for racialized people or groups. These practices are enacted by individuals and distill racism into routine practices (Beagan et al., 2023, p. 196).

Intergenerational trauma – How trauma is transferred from one generation to subsequent generations. There are both socio-cultural and physiological models for how trauma affects the children of survivors (Menzies, 2024) and how trauma is passed from generation to generation. Intergenerational trauma is often used to describe the cumulative effects of the last 500-plus years of colonialism.

Jordan's Principle – Named in memory of Jordan River Anderson of Norway House Cree Nation, this child-first principle prevents First Nations children from being denied or experiencing delays in accessing health or social services where there is a jurisdictional dispute regarding the provision of services between provincial, territorial, and federal governments (Government of Canada, 2024).

Joyce's Principle – Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health. Joyce's Principle is named in memory of Joyce Echaquan, an Atikamekw woman who was subjected to racism by nurses and other health care staff while at the Joliette Hospital Centre in Lanaudière, Quebec. Joyce's Principle is a call to action to uphold the government's commitment to the United Nations Declaration on the Rights of Indigenous Peoples (Principe de Joyce, 2020).

Métis – One of three groups of Indigenous Peoples in Canada. Métis Peoples are of both European and Indigenous ancestry and originated largely from the Great Lakes and Red River Valley Settlement. Relationships between Scottish and French fur traders with Indigenous women, usually Cree, Saulteaux, and other Plains nations, in the 18th century led to the emergence of the Métis Nation. There are current controversies on what characterizes Métis identity, with some arguing it is not simply a result of dual heritage, but a matter of possessing cultural heritage that can be traced back to the Red River community and Great Lakes trades (Gaudry, 2023).

Missing and Murdered Indigenous Women and Girls – An ongoing human rights crisis of systemic violence against Indigenous women and girls in Canada. A National Inquiry was launched in 2016 and the findings were published in 2019. The inquiry found "significant, persistent, and deliberate" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 174) human rights violations and abuses as the root causes of the crisis and issued 231 Calls for Justice to governments, institutions, and the public.

OCAP – The First Nations principles of ownership, control, access, and possession assert that First Nations have control over data collection processes and that they own and control how this information can be used (First Nations Information Governance Centre, n.d.).

OCAS – The Manitoba Métis Federation subscribes to the principles of ownership, control, access, and stewardship of their data (University of Manitoba, 2021, p. 14).

Prejudice – A preconceived judgement, opinion, or attitude towards an individual or group based on a characteristic such as skin colour or ethnicity.

Race – A social construct used to characterize people into hierarchical groups based on physical characteristics such as skin colour.

Relational inquiry – An approach to nursing practice in which nurses reflexively consider the relationship between interpersonal, intrapersonal, and contextual factors of the person or people receiving care (Younas, 2020).

Royal Proclamation of 1763 – Issued by King George III, it set the constitutional structure for the negotiation of treaties with Indigenous Peoples in Canada. It explicitly stated that all land was considered Indigenous land until ceded by treaty and forbade settlers from claiming land from Indigenous Peoples (Indigenous Foundations, 2009).

Sixties Scoop – Coined by Patrick Johnston, this term refers to the mass removal of Indigenous children from families and placement into the child welfare system, in many cases without the consent of the family. This practice existed before the 1960s but grew drastically during that decade (Hanson, 2009).

Social location – This term describes how elements of a person's identities (e.g., race, class, gender) intersect within that person and affects their position in relation to others. Understanding one's own social location helps one to understand how these elements affect perceptions, relationality, and actions (Rumble, n.d.).

Stereotyping – Preconceived ideas and oversimplified beliefs that are untrue or unjustifiable about a person based on characteristics such as their skin colour, ethnicity, religion, or place of origin.

Strengths-based approach – A nursing approach guided by eight key values that focuses on the strengths of clients and their capabilities and assets in order to deal with health challenges, rather than any deficits. Nurses develop relationships focused on collaborative, empowering relationships with clients and their families. This approach centres on promoting health, healing, and alleviating suffering. The values are health and healing; uniqueness; holism and embodiment; subjective reality and creative meaning; person and environment are integral; self-determination; learning, timing, and readiness; and collaborative partnership (Gottlieb, 2014).

Structural racism – The interconnected social structures in society (e.g., education, health care, politics) and how they operate in a manner that reproduces racialized hierarchies (Beagan et al., 2023).

Systemic racism – Racism that exists within and across institutions and structures that are interconnected and reinforced over time (Osta & Vasquez, n.d.).

Truth and Reconciliation Commission Calls to Action – The Truth and Reconciliation Commission (TRC) was "created through a legal settlement between Residential Schools Survivors, the Assembly of First Nations, Inuit representatives and the parties responsible for creation and operation of the schools: the federal government and the church bodies. The TRC's mandate was to inform all Canadians about what happened in residential schools. The TRC documented the truth of Survivors, their families, communities and anyone personally affected by the residential school experience. This included First Nations, Inuit and Métis former residential school students, their families, communities, the churches, former school employees, government officials and other Canadians" (NCTR, n.d., paras. 1–2). The TRC created 94 Calls to Action to further reconciliation between governments, settlers, and Indigenous Peoples. Call to Action #24 is now required for accreditation in all schools of nursing in Canada. CASN's Accreditation Standards (2020) were updated to include a key element related to Call to Action #24.

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) – This declaration "establishes a universal framework of minimum standards for the survival, dignity and well-being of the Indigenous Peoples of the world and it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of Indigenous Peoples" (United Nations, 2007).

Wholistic care – Caring for the whole health of a person, including the physical, spiritual, emotional, and mental elements, that reflects Indigenous Ways of Knowing, understanding, being, and doing (Miles et al., 2023).

World Café method – "An approach to creating a safe, welcoming environment in which to intentionally connect multiple ideas and perspectives on a topic by engaging participants in several rounds of small-group conversation" (Parkhurst et al., 2016, p. 1).

2S LGBTQIA+ – Two-Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, and asexual people, where the "+" is inclusive of diverse sexual orientations (e.g., pansexual, greysexual) and gender identities and gender expressions (e.g., nonbinary, gender-diverse, agender) that are not explicitly named in the acronym (Registered Nurses' Association of Ontario, 2021).

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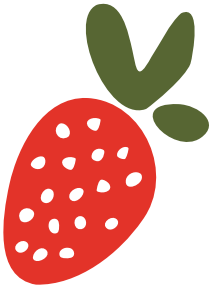

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