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## An Exploration of the Nursing Leaders' Experiences Addressing Indigenous Health in University Undergraduate Nursing Programs in Ontario

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Nursing

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## Abstract

**Introduction.** Although there are serious health inequities experienced by Indigenous people compared to non-Indigenous people in Canada and racism and discrimination continues to be rife in health care environments, there remains a general lack of attention to Indigenous health (IH) in health professional education programs. In response, the Truth and Reconciliation Commission (TRC) has recommended this be addressed within health profession education, including nursing (Truth and Reconciliation Canada, 2015). However, there is a paucity of evidence describing the challenges and facilitators to incorporating IH into nursing education.

**Methodology and Methods.** This qualitative descriptive study employs post-colonial theoretical perspectives to explore the experiences of eight academic nurse leaders in incorporating IH and addressing the TRC's recommendations in their respective schools of nursing, using interpretive descriptive analytic tools. Data were collected using in-depth semi-structured interviews over video conference and an interpretive analysis was employed.

**Results.** An inductive iterative analysis produced five high-level analytic themes: (a) Doing the Right Thing, the Right Way; (b) Building Program Capacity; (c) Addressing Institutional Inequity; (d) Disrupting the Status Quo: Challenges and Facilitators; and (e) Journey Toward a Vision. Within these themes, findings are further divided into subthemes that reflect the challenges, facilitators, and opportunities experienced by nursing leaders in incorporating IH and the TRC recommendations into their schools.

**Recommendations.** Findings indicate that doing this work in a genuine way means avoiding tokenism, engaging in critical self-reflection, threading Indigenous content thoroughly throughout curricula, and building meaningful partnerships. In addition, cultural safety training for nursing faculty and staff, future research to address the efficacy of that training, and a

genuinely collaborative approach across Indigenous and non-Indigenous people to inform strategies designed to address the TRC recommendations in a meaningful way are recommended.

*Keywords:* Indigenous health; nursing education; Truth and Reconciliation Commission; nursing academic leaders; cultural safety

## **Co-Authorship Statement**

Contributions to this paper were made by the thesis committee: Dr. Victoria Smye and Dr. Kim Jackson, Western University.

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To my sister Hillary and father Dave, thank you so much for stepping up and being the kind of family that routinely asks me what you could do to make my life just a little easier. The dog is truly grateful for the walks you took, and I am truly grateful for the ears you lent.

To my dear friend Erin—you know what you did. I am forever grateful.

Finally, I would like to express my deepest love and gratitude to my partner Nate. Although the past two years has been anything but easy (especially that time you literally almost died), you were endlessly supportive and encouraging, always helping me see the silver lining. Thank you so much for the ways in which you cared for me while I was caring for others so much that I had trouble caring for myself.

## **Dedication**

This research is dedicated to my mother Lisa. If it weren't for her bossiness, I would likely be a hairdresser instead of a nurse.

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## Chapter One: Introduction, Background, and Significance

Poor health status among Indigenous<sup>1</sup> people has been studied extensively across the peer-reviewed literature, but a recent report summarizing select health indicators from 2015-2016 Statistics Canada data effectively summarizes a myriad of disparities in physical and mental health between Indigenous and non-Indigenous Canadians, which ultimately result in lower life expectancy and lower perceived health and wellness (Public Health Agency of Canada, 2016). These health inequities result from colonial and neocolonial processes such as severing of historical and cultural values, physical dispossession of land, manipulation of economic resources, forced assimilation, and unequal access to the social determinants of health (Adelson, 2005; Browne, 2017). In addition, colonial ideologies underpinned by racism flourish in our health care and health professional educational institutions. To be clear, racism in the health care system can be fatal (Leyland et al., 2016). For example, Mr. Brian Sinclair, an Ojibwa man living in Manitoba, who sat in a wheelchair for 34 hours in an emergency room without treatment, died of sepsis associated with an untreated urinary tract infection (UTI). His family formed a movement entitled, 'Ignored to Death' in which they describe Mr. Sinclair's death as homicide (Sinclair Working Group, 2017). Health care professionals, including nurses, are implicated in the death of Mr. Sinclair. The transcripts of the inquest trial related to this very tragic death point to the 'why' we in nursing need to shed light on our profession to examine how we prepare nurses to stand against racism and discrimination and structural violence like that enacted on Mr. Sinclair. This story, among many others found recently in the literature, points to the urgent need to expand and explore knowledge and attitudes about

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<sup>1</sup>The term 'Indigenous' is used in this study as a term inclusive of people of First Nations, Inuit, and Métis ancestry.

societal, systemic and institutionalized racism and the effects on health and how the nursing, medical and legal systems perform. Health equity cannot be achieved without drawing attention to societal and structural violence, including poverty, stigma and discrimination.

Given nursing's social mandate to support health equity (Canadian Nurses Association [CNA], 2017; Duncan, Thorne, & Rodney, 2015; International Council of Nurses [ICN], 2012), the profession is well-suited to lead social justice efforts to reduce inequities, thus advancing health for populations marginalized by social and structural inequity, such as Indigenous people in Canada (Smith, 2007; Willis, Perry, LaCoursiere-Zuccherro, & Grace, 2014). Although there are some exceptions, the nursing profession has been slow to take up this mantle, and nursing education is no exception. Dominant discourses influenced by colonial and neocolonial ideologies and associated practices continue to permeate nursing, including nursing education (McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014).

In response to the colonial and neocolonial history in Canada and the burden of illness and other disparities associated with it, the Truth and Reconciliation Commission (TRC) of Canada Calls to Action document (2015) has made 94 recommendations, many specific to education in the health professions, including nursing.

### **The Truth and Reconciliation Commission of Canada**

In the early 1990s, survivors of Indian residential schools (IRS) began to come forward and publicly describe the experiences of abuse they experienced after being forcefully removed from their families and communities to attend IRS (Indigenous and Northern Affairs Canada, 2018; Nagy, 2014). During this time, the Royal Commission on Aboriginal Peoples was formed and began an inquiry into IRS, facilitating 'exploratory dialogues' to find peaceful resolution as an alternative to litigation between over 400 Indigenous leaders, IRS survivors, and healers, as

well as church leaders, legal counsel, and government officials (Nagy, 2014). Litigation continued during this process, however, reaching class action status and justifying the need for the largest out-of-court settlement in Canadian history, known as the Indian Residential Schools Settlement Agreement (IRSSA) on September 19, 2007 (Daly, 2014). The IRSSA was entered into by the Canadian government, representatives for the survivors, church organizations, Inuit representatives, and the Assembly of First Nations, for the purpose of bringing multiple forms of restitution for survivors of the Indian residential schools and their families (Daly, 2014; Nagy, 2014). Throughout this settlement process, various stakeholders assembled to create an informal round table to implement further public inquiry into the IRS, but the group's mandate eventually shifted from inquiry to "a people's commission for truth, hope, and reconciliation" as a way to better organize the sharing, healing and reconciliation process using a community-based approach (Nagy, 2014, p. 210). Thus, the TRC was formed on June 1, 2008, as one of the collective measures included within the IRSSA to address the legacy of the Indian residential school system (Truth and Reconciliation Commission of Canada [TRC], n.d.). With new recognition of the profound impact of the IRS on Indigenous families, culture, and language, former Prime Minister Stephen Harper extended a formal apology on behalf of all Canadians to survivors of the Indian residential schools on June 11, 2008 (Indigenous and Northern Affairs Canada, 2010). The TRC then adopted a 5-year mandate to gather statements from survivors and their families in a culturally safe and holistic manner, and, in 2015, issued their final report that acknowledged the truths of those families (TRC, n.d.). Within this report, the TRC called for action to redress the legacy of the residential schools and enact change to move toward reconciliation (TRC, 2015). Ninety-four specific recommendations were made to all levels of government pertaining to child welfare, education, language and culture, health and justice.

Multiple points of reconciliation, including rights and equity for Indigenous people, programs and services to foster respectful relationships with Indigenous people, and commemoration of Canadian heritage were included among these recommendations (TRC, 2015), some of which can be directly addressed by the nursing profession at multiple levels.

I have highlighted TRC recommendations pertaining to Canadian Schools of Nursing below:

We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practises and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and elders where requested by Aboriginal patients. (Truth and Reconciliation Canada [TRC], 2015, p. 322, #22)

We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the healthcare field.
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- iii. Provide cultural competency training for all health care professionals. (TRC, 2015, p. 322, #23)

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require



skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (TRC, 2015, p. 323, #24)

We call upon the federal, provincial, and territorial governments, in consultation and collaboration with Survivors, Aboriginal peoples, and educators, to: [...] provide the necessary funding to post-secondary institutions to educate teachers on how to integrate Indigenous knowledge and teaching methods into classrooms. (TRC, 2015, p. 331, #62, ii)

While the TRC recommendations are clear, there is a dearth of knowledge related to how to best address the recommendations of the TRC, and more fundamentally, the colonial ideologies embedded within nursing education. For example, the dominance of western cultural norms embedded within health texts, theorizing, language, health models and research methodologies, has displaced other ways of knowing, including Indigenous epistemologies, to inform leadership, policies, nursing practice, research methods, education and training (Mulaudzi, 2016).

### **Statement of Purpose**

To address this central problem, the overall purpose of my research is to explore nursing leaders' experiences of addressing Indigenous health in nursing programs, including how they address the TRC recommendations. The objectives of my study are to: i) describe how nursing leaders are addressing Indigenous health in their nursing programs; ii) describe the challenges, facilitators and opportunities related to engaging with this work; and iii) based on my findings, propose recommendations to inform how nursing leaders/educators might take up and/or continue this journey/work. To do this I employed a qualitative descriptive methodology using

interpretive descriptive analytic tools, and critical approaches informed by postcolonial theoretical perspectives.

### **Research Question**

The research question guiding this study was: “*What is the experience of university nursing leaders in addressing Indigenous health and the TRC recommendations within their undergraduate programs?*”

### **Declaration of Self**

I am a white settler woman currently residing in the traditional territory of Anishinaabeg, Haudenosaunee, Attawandaron, and Wendat. I am a novice researcher with 6 years of nursing experience on a clinical neurosciences unit, and 4 years of experience teaching nursing students in a variety of clinical and classroom settings. I have been studying Indigenous health as a response to the troubling history and colonial legacy that is still experienced by Indigenous people today and have further informed my nursing and teaching practice through the San’yas Indigenous Cultural Safety training programme. I am positioning myself in this way because, as a resident on these lands by virtue of my colonial ancestors, and a product of early settler-colonizer socialization, I feel a responsibility and duty to respect local Indigenous protocols and epistemologies and foster deeper understanding of Indigenous knowledge within myself. Further, I am writing in the first person because as a researcher working within an interpretive paradigm (as discussed in the methodology section), I will take an active role in the direction of the research, and a reflexive stance from which I will discuss the influences and choices I make throughout this project (Webb, 1992). My hope is that I can in some way contribute to promoting the health of Indigenous people among my profession. I am writing this study for a nurse educator audience, with the aim of raising awareness of the factors and processes involved

in current efforts to decolonize Ontario SON. Ideally, this contribution will propagate further change in terms of decolonizing nursing education, thus contributing to improving Indigenous health in Ontario, and hopefully, beyond.

### **Overview of the Thesis**

In Chapter One, I have provided a brief overview of the central problem and outlined the purpose of my research and the research objectives. In Chapter Two, I present the methodology and theoretical perspectives guiding my work, a comprehensive review of the literature associated with the research question, my findings in narrative form, and discussion of these findings. Then, in Chapter Three, I provide implications and recommendations of these findings in terms of nursing research, education, and practice.

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## **Chapter Two: Toward Decolonizing Nursing Education**

In this Chapter, I begin with a literature review to provide the background to my research focus; to explore nursing leaders' experiences addressing Indigenous health and the recommendations put forward by the TRC in university undergraduate nursing programs in Ontario—referred to as Schools of Nursing (SON) in this text. Firstly, I provide a brief overview of my approach to the literature review. Then I provide an overview of the selected theoretical lens. I then go on to provide an overview of Western and Indigenous epistemologies, including Indigenous history and ways of knowing to provide a context for this work. After this, I employ a postcolonial lens to critically analyse the literature related to current nursing education epistemology. I highlight the current state of work being done to support Indigenous health and the TRC recommendations among SON in Canada, and discuss gaps found within these bodies of literature. Finally, I describe my research study, for which I employed a qualitative descriptive design informed by postcolonial theoretical (PCT) perspectives, critical ethnographic methods, and an interpretive descriptive analysis to explore current processes and practices taking place in SON in Ontario. I have focussed this study on challenges, facilitators, and opportunities found in engaging in this work.

### **Review of the Literature**

Review of scholarly literature was conducted using general search engines (Google Scholar), and healthcare-related databases (PubMed, Scopus, Medline, Nursing and Allied

Health Database [CINAHL]). Search terms began with Indigenous OR Aboriginal AND Canada to focus the review on the Canadian context. To focus on nursing education, keywords included but were not limited to nursing education, nursing educators, nursing curriculum, nursing curricula, nursing student(s), nurse(s), nursing faculty, truth and reconciliation, Ontario, cultural competence, cultural safety, cultural self-efficacy, cultural awareness, and postcolonial. Grey literature was reviewed using general search engines and focused news databases. Keyword searches were then performed within the results found. Searches were initially constrained to the past 5 years, and yielded over one hundred unique results, but after eliminating articles that were not relevant to the Canadian context, to nursing academia in any sense including staff, students, and curricula, or to Indigenous health, 13 scholarly articles remained. Upon reviewing references found within these articles, additional earlier works were deemed relevant and reviewed, and further searches were performed ad hoc using additional keywords, yielding 39 additional results that included qualitative, quantitative, and theoretical scholarly works. In addition, documents within professional nursing bodies' websites were reviewed, and for the purpose of focusing on the schools of nursing within Ontario, websites for all schools recognized by the College of Nursing of Ontario were thoroughly searched for indications of Indigenous topics and interests found within their programs. Searches were performed both ad hoc and systematically.

### **Postcolonial Theory**

Postcolonial theoretical perspectives arise from multidisciplinary concerns about the persistent effect of the legacy of colonialism on people's lives (Browne, Smye, & Varcoe, 2005). The aim of postcolonial research is typically to critically analyze the dominant culture and enable previously marginalized perspectives to become agents of change. While relatively new to



nursing, postcolonial theory (PCT) within the discipline provides a lens through which to critique contemporary discourses of culture, how those discourses contribute to exclusion or inclusion in health care, and power relations that have resulted from colonial history and neocolonial practices (Browne, Smye, & Varcoe, 2005). PCT is thus a critical discourse that aims to disrupt race-thinking and essentialist constructions of culture, and draw attention to structural and social inequities that affect access to quality healthcare (Browne, Smye, & Varcoe, 2007; Gandhi, 1998). In the context of nursing education, postcolonial perspectives can be used to explain how historical construction has normalized social and power imbalances into the foundational epistemologies used to guide nursing pedagogy. PCT can thus provide avenues to challenge these ideologies, deconstruct culturalist and essentialist views of culture, and provide an ethical and critical space in which reconstruction and agency become possible (Chulach & Gagnon, 2016). This theoretical lens is appropriate to apply to nursing education due to its alignment with the concepts of emancipatory intent and social justice commonly taught in nursing curricula (Bickford, 2014). As such, PCT will be the theoretical lens providing context to my review of the literature, informing my methodology, and guiding my analysis.

### **Western and Indigenous Epistemologies of Health**

Western definitions of health traditionally have been underpinned by a dominant biomedical perspective and a curative model (Pender, Murdaugh, & Parsons, 2015). This model has been critiqued for a lack of holistic dimensions and failure to take into consideration the psychological and social effects of health (Engel, 1977). Thus, a biopsychosocial model of health emerged, encouraging health practitioners to examine all factors contributing to health and illness, rather than simply the biological, and this model continues to shape Western medicine today (Farre & Rapley, 2017). Although the biopsychosocial model of care is commonly known

as a holistic model that guides nursing practice, it is largely individualistic and continues to have biomedical principles at its core (Hatala, 2012; Santos, Bashaw, Mattcham, Cutcliffe, & Giacchero Vedana, 2018).

By contrast, traditional Indigenous epistemologies (or ways of knowing) of health do not distinguish between physical and spiritual health. An individual's health is seen in the context of that individual's family and community—when traditional healing modalities are employed, they reach beyond individual illness into maintaining communal health (Douglas, 2013, p. 29).

Although Indigenous belief systems vary between groups and may not include common views of health and healing, a widely acknowledged example found at the centre of Indigenous health is the Medicine Wheel, which reflects an Indigenous worldview that recognizes the interconnectedness of all things (Sasakamoose, Scerbe, Wenaus, & Scandrett, 2016). The Medicine Wheel is made of four quadrants, each representing a different but interconnected aspect of human life: spiritual, emotional, intellectual, and physical, which must all be in harmony to foster holistic health, healing, and well-being (Douglas, 2013; Graham & Stamler, 2010). Great value is placed on the dimension of spiritual health, facets of which include peace, balance, faith, awareness, and living well (Brant Castellano, 2015). Spiritual healing is considered an integral part of communal health, and as such, can be undermined by anything that threatens the community, and has thus been largely suppressed throughout colonizing processes such as disrupted access to land and disconnected families (Hunter, Logan, Barton, & Goulet, 2004; Robbins & Dewar, 2011). However, Indigenous ways of knowing, healing traditions, and traditional medicine teachings are still occurring among Indigenous peoples as they continue to heal from the consequences of colonial and neocolonial processes and practices, including intergenerational trauma (Robbins & Dewar, 2011). Despite the historical and continuing

penetration of Western health epistemologies into traditional Indigenous ways of knowing, Douglas (2013) argues that Indigenous people still benefit from Western science, and challenges health practitioners to provide culturally appropriate care without the prejudices that often accompany biomedical perspectives. Studies show, however, that this is not consistently done in practice, and, as noted in Chapter One, Indigenous people seeking mainstream health care are often met with racism, barriers to access, structural violence, and systematic oppression (Cameron et al., 2014; Marchildon et al., 2015; Tang, Browne, Mussell, Smye, & Rodney, 2015; Van Herk, Smith, & Gold, 2012). This poses a challenge to health profession educators; how to prepare a cadre of health professionals, including nurses, who become part of the solution, rather than a part of the problem.

### **Toward Decolonizing Nursing Education: A Critical Perspective**

For the purposes of this project, I will use the term *decolonizing* or *decolonization* as an umbrella term referring to intent or action taken by SON that include but are not limited to: addressing Indigenous health in any format within the program; engaging in strategies to recruit and retain Indigenous nursing students; strategic planning to address the TRC's recommendations; or supporting faculty to engage in reconciliation between a Western epistemology of rationality and reason, and an Indigenous pedagogy of respect, reciprocity, relevance, and responsibility. Decolonization consists of long-term processes involving "bureaucratic, cultural, linguistic, and psychological divesting of colonial power" (Tuhiwai Smith, 2012, p. 101). These processes value Indigenous individuals as the crux of Indigenous epistemologies, supporting them as the source of a collective raising of consciousness in society (Greenwood & Jones, 2015). Some authors state that to decolonize requires vacating previously colonized physical land, arguing that use of the word for other purposes is simply a metaphor

without true meaning (Tuck & Yang, 2012). Others see decolonization as an agenda that aims to increase community skills and self-esteem, and foster revitalization of Indigenous healing traditions (Richmond, 2015). Despite these and other varying opinions found within the literature, decolonization in the context of this research can be described as “the process of undoing the impact of a colonial state” (Bourque Bearskin & Jakubec, 2017, p. 391), although it is important to note that the concept does embody multiple complex and critical lenses.

To understand the meaning of decolonizing SON, we must first examine how nursing education became a colonial entity. PCT provides a helpful framework through which to analyze the current Canadian nursing pedagogy—it supports historical, structural, and social inequities as the context for discourse, allowing us to examine how the dominant culture of the profession has imposed the meanings and social structures found within it (Browne & Smye, 2002; McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014). The purpose of PCT as a lens through which to critique nursing education herein is thus to examine knowledge that is considered foundational, identifying neo-colonial power structures that maintain those foundations to the near-exclusion of the perspectives of those who were colonized. A PCT framework opposes this view of race and culture as “other,” and redefines racialization as socially constructed through political and socioeconomic processes of colonialism (Anderson & McCann, 2002).

The breadth of current topics within undergraduate nursing pedagogical literature was too vast to be reviewed for the purposes of this literature review, so foundational theories known to be taught within nursing undergraduate courses will be described below, in a PCT context.

### **Theory in Nursing Education: A Case in Point**

Theory has been an underpinning of nursing science since the inception of the profession, regarded as useful for shedding light on clinical practice situations and critical in undergraduate

education to foster understanding of the connection between nurse and patient (Karnick, 2013, 2014). Barbara Carper, a foundational nursing theorist, states that “it is the general conception of any field of inquiry that ultimately determines the kind of knowledge that field aims to develop, as well as the manner in which that knowledge is to be organized, tested, and applied” (Carper, 1978, p. 13). Conception of grand and mid-range nursing theories currently taught at the undergraduate level were inherently colonial, given that they were largely developed by white, middle- to upper-class nurse leaders who aimed to secure a dignified and respectful position of the profession within a male-dominated system driven by medicine and business (McGibbon et al., 2014).

The overarching metaparadigm of nursing, within which all other nursing theories are encapsulated, consists of the central concepts of *person, environment, health, and nursing* (Masters, 2014). Largely absent from within these concepts are determinants of Indigenous health such as racism, land, and colonialism, as well as guidance on how to address the oppressive politics and power that maintain colonial and neocolonial processes. While abstract at this level, the four guiding principles found within this metaparadigm are interwoven throughout the traditional theory-based and practical models that directly guide nursing practice and are taught in undergraduate nursing education. Without acknowledgment of the aforementioned determinants or colonialism, however, all models stemming from the metaparadigm can be critiqued for their inadequacy of preparing nurses for practicing safely with Indigenous clients.

Although his list is not exhaustive, Goetl (2011) has drawn attention to shortcomings in multiple traditional nursing theories currently being taught in the lower years of undergraduate nursing education. For example, *Orem's Self-Care Deficit Theory* guides nursing interventions

based on identified deficiencies in defined self-care requisites such as safe environment, proper nutrition, chronic illness, and aging, under the assumption that all people are able to learn and perform tasks that maintain health in these areas (Masters, 2014). These basic tenets alone provide opportunity for postcolonial critique in terms of socioeconomic barriers preventing not only Indigenous people, but any person who is marginalized by social and structural inequity, from achieving health in the sense defined by this theory. Goettl (2011) argues that although this model acknowledges that health behaviours are learned within a sociocultural context, it does not offer guidance on how nurses can identify sociocultural conditions or political injustices shaping a person's ill-health that are beyond that person's control, nor does it provide tools for that nurse to address those issues. Goettl (2011) found this major limitation was mirrored in other theories such as *Roy's Adaptation Model*, in which nurses provide intervention based on a person's response to symptoms of ill-health, and *Neuman's Systems Model*, which offers nursing interventions that aim to reduce, treat, or prevent recurrence of disease. These aforementioned models are mainly based on biomedical framework, but Goettl also found that interpersonal and relationship-based models fell short in fundamental ways, such as neglecting the nurse's beliefs and biases, and how these can affect quality of care (2011). Examples of this include *Watson's Theory of Transpersonal Caring*, and *Leininger's Cultural Care and Diversity Theory*, which focus on fostering trusting relationships between nurse and client, and providing culturally sensitive care, but don't attend to reasons behind health disparities among non-dominant cultures (Goettl, 2011; Masters, 2014).

Even Carper's own theory, *Fundamental Patterns of Knowing*, which includes empirical, aesthetic, ethical, and personal knowledge (1978) can be critiqued for its lack of inclusivity of knowledge systems relevant to Indigenous health and Indigenous nursing. These concepts are

assumed to drive the nurse-client relationship by expanding perceptions of oneself and the world, thus impacting nursing care in a system valuing empirics and evidence-based practice (Terry, Carr, & Curzio, 2017). The theory has already been critiqued for its hierarchal approach favouring empirics over the other three, more holistic ways of knowing (Porter, 2010), but Indigenous knowledge systems are not acknowledged anywhere within these concepts.

### **Practical Application of Nursing Education**

From a more practical perspective, I continue to critique additional practices within nursing education through a postcolonial lens, particularly in light of Carper's emphasis on empiricism. The *NANDA Nursing Diagnosis*, for example, is an evidence-based statement built from comprehensive nursing assessments of medical conditions, meant to guide intervention and care plans (NANDA International [formerly the North American Nursing Diagnosis Association], 2017). The nursing diagnosis has been long-critiqued for its ethnocentric and Western diagnostic categories, limited language translatability, and its highly biomedical focus (Leininger, 1990). In the context of Indigenous health, the nursing diagnosis can therefore be problematic, potentially further oppressing marginalized populations and supporting a dominant Western view of health that may not be relevant or appropriate for Indigenous people (McGibbon et al., 2014; Powers, 2002). Further, the emphasis on empirically grounded "evidence-based" practice in nursing education is questionable through a postcolonial lens, begging the questions, from whose voice and from which worldview does the "evidence" derive (McGibbon et al., 2014), thereby challenging inclusivity in evidence-based practice. Some researchers go so far as to say that evidence-based practice has been defined by and evolved from strictly white knowledge and preferences (Nielsen, Stuart, & Gorman, 2014). Finally, the primary focus on nursing skill acquisition, also grounded in empirics and evidence-based

practice, does little to foster students' awareness of cultural and societal impacts affecting Indigenous peoples' health (Green, 2016). Despite these obvious shortcomings, the nursing diagnosis and evidence-based practice remain at the forefront of recommended undergraduate nursing pedagogy (Fiset, Graham, & Davies, 2017; Smith & Craft-Rosenberg, 2010).

In summary, many grand theories taught in undergraduate curricula are apolitical, involve analyses that are primarily individually-focussed, and exclude historical and neocolonial antecedents of Indigenous health. In addition, the practical foundations on which nursing education is built are problematic when looking through a postcolonial lens.

### **Culture in Nursing Education through a Postcolonial Lens**

Equity and anti-racism programming are fairly recent among nursing curricula (Hagey & MacKay, 2000; McGibbon et al., 2014), with literature searches demonstrating emerging evidence in the late 1990s and early 2000s. Within the context of undergraduate nursing education, these topics simply serve to support the traditional and arguably inadequate multiculturalism framework typically used to accommodate cultural differences and foster “tolerance” and “sensitivity” in nursing (Goettl, 2011). Culture is typically taught and practiced in nursing using the concepts of *cultural sensitivity* and *cultural competence*, meaning that nurses see culture as various worldviews, sets of shared beliefs, knowledges, symbols and meanings within distinct groups, passed down through generations (Aboriginal Nurses Association of Canada [ANAC], 2009). To this end, thinking about multicultural diversity seems to take precedence over examining colonial contexts of power and privilege within nursing curricula (McGibbon et al., 2014). However, when narrowly defined in these ways, the notion of culture can lead to essentialist understandings—that is, perspectives of culture as static and unchanging (Garneau & Pepin, 2015). These essentialist understandings manifest in culturalist nursing care



practices, whereby the stereotypical representations and social organization of a culture are used to explain differences between that culture and the “other” (Browne et al., 2009). When culture is taken up uncritically and narrowly defined as a set of attributes, characteristics, behaviours and traditions attached to particular groups of people, we run the risk of providing biased care, and seeing health problems as arising from cultural behaviours rather than oppressive conditions (Garneau & Pepin, 2015, p. 10). Simply put, the essentialist views of culture currently at the forefront of nursing education can put Indigenous clients at risk for unsafe care at the hands of nurses who justify the etiology of disease or illness by the client’s own Indigeneity (Rahaman, Holmes, & Chartrand, 2016). ANAC suggests shifting from this essentialist approach to a constructivist approach, whereby culture is viewed as a complex relational process involving history, gender, class, sociopolitical constructs, and underlying power relationships (2009). Many authors agree that although the essentialist approach provides nursing students with cross-cultural knowledge and skills, they remain unprepared to work with Indigenous people in healthcare settings (Hart, Cavanagh, & Douglas, 2015; Walker, 2017). Therefore, the Canadian Association of Schools of Nursing (CASN) recommends *cultural safety* (CS) training as part of nursing curricula.

Cultural safety was initially conceptualized as an alternative model to address the social, cultural, economic, and health inequities experienced by the New Zealand Maori people that resulted from colonial processes not unlike those experienced by Indigenous people in Canada (Nursing Council of New Zealand, 2011; Papps & Ramsden, 1996; Smye, Josewski, & Kendall, 2010). The concept was first proposed by Maori midwifery students in response to feeling unsafe within the predominantly Anglo (*Pakeha* in Maori) educational setting in which they were trained (Smye et al., 2010). It was then further developed by Maori nurse educator and

Indigenous scholar Irihapedi Ramsden to provide an explanation for the poor uptake of health services by Maori in general (Smye et al., 2010). The writings of Ramsden have been especially important to the formation of this concept—the implementation of principles of cultural safety (*Kawa Whakaruruhau* in Maori) was considered a way of redressing Indigenous health inequities in New Zealand (Smye et al., 2010).

Originally, CS was conceptualized as an acknowledgement that culturally dyadic health care encounters have an implicit power differential that could result in further deterioration in health of those who feel unsafe accessing care (Papps & Ramsden, 1996). CS ultimately became a requirement for nursing and midwifery education in New Zealand, with a focus on the practitioner examining their own biases, being open-minded to those different from themselves, and shifting blame from the individual to the historical and social reasons behind their health challenges (Papps & Ramsden, 1996). Today's conceptualizations of CS have not strayed far from its initial foci and have in fact been developed to reflect upstream approaches. The process continues to shift blame from the cultural 'other' to the systemic processes that oppress them, and has the potential to transform the structural policies, processes, and practices found within health care, using social justice as a goal (Browne et al., 2016). Ultimately, CS is an anti-racism, anti-oppression stance that is intended to be both a process and outcome. It also puts the onus on the health care provider to actively examine inequitable power relations within the health care encounter and acknowledge ongoing historical impacts on health, thus ensuring safe care and promoting equity (Canadian Nurses Association [CNA], 2010; Varcoe et al., 2017).

However, the notion of 'culture' underpinning the concept of cultural safety in practice differs from the essentialist ways in which culture is often taken up in nursing education in Canada, as discussed above. In practice, CS includes the commonly taught concepts of cultural

competence and sensitivity, but also fosters awareness of the practitioner's historical and social location; creates relationships based on respect, trust, caring, and empathy; and emphasizes mutual goal setting and client autonomy (Shah & Reeves, 2015). While cultural competence and sensitivity are woven throughout the professional best practice nursing literature, cultural safety adds a social justice lens, with attention to systematic injustice, to the provision of care. This enables both client and practitioner to examine power imbalances and social inequities at play in health, thus empowering Indigenous clients and communities to address the sociopolitical issues they deem most important in supporting their definition of good health (Shah & Reeves, 2015). In light of this obvious benefit, professional nursing bodies are beginning to emphasize cultural safety within their documents and standards: the Canadian Nurses Association (CNA) has provided a position statement that cultural safety holds value in nursing practice and could be useful in assisting to operationalize equity and social justice (CNA, 2010); culturally safe client care is considered a core competency for entry-level nurses by the College of Nurses of Ontario (College of Nurses of Ontario [CNO], 2014); and CASN includes cultural safety as part of its accreditation process (Canadian Association of Schools of Nursing [CASN], 2014a). The CNA, and CASN, in partnership with ANAC (now the Canadian Indigenous Nurses Association [CINA]), have developed a set of core competencies to assist SON educators foster cultural safety among nursing students (Hart-Wasekeesikaw, 2009), and CASN has since built upon those competencies and developed a framework illustrating specific points nursing students need to know about the colonial legacy of Indigenous peoples (CASN, 2013). Further, the Canadian Nursing Students Association (CNSA), the organization representing the interests of nursing students nationally, has taken a strong position advocating for the inclusion of Indigenous ways of knowing, Indigenous health, and cultural safety in the Indigenous context into nursing

curricula (Canadian Nursing Student Association, 2015). Given that the original intent of cultural safety was to increase recruitment and retention of Maori nursing students in New Zealand (Papps & Ramsden, 1996), this could pave the way for similar processes in Canada, as it is well known that Indigenous nursing students experience a variety of challenges in completing a baccalaureate nursing degree (Etowa, Jesty, & Vukic, 2011; Green, 2016; Johansen, 2010).

### **The Notion of ‘Culture’ and Challenges for Nursing Faculty**

While cultural safety offers rich opportunity to advance nursing education from a postcolonial perspective, the concept is significantly more developed among nursing programs in Australia and New Zealand than Canada (Isaacs et al., 2016; Penn, 2014). One study was found that examined ways in which cultural safety and competence were integrated into 38 Canadian SON; findings suggested that most schools used Indigenous health as the focus of these topics, the most common modality being isolated case studies (Rowan et al., 2013). However, challenges such as limited prep time, lack of education to effectively deliver cultural safety education, and no additional funding to further develop cultural concepts hindered full integration (Rowan et al., 2013). A recent review of nurse educators who also teach Indigenous students revealed that there are no studies that measure the cultural competence of educators; leading one to infer that nurse educators are not provided with supports necessary to safely teach Indigenous content or Indigenous students (Lane & Petrovic, 2018). Lane and Petrovic (2018) found additional gaps that corroborate with my own, namely that measurements of nurse educators’ own cultural safety and competency in relation to teaching Indigenous content is largely absent among the literature, and that there is little exploration of how Indigenous students and non-Indigenous nurse educators relate to one another and perceive the others’ messages.

However, there were some recommendations on how nursing faculty could improve their classroom strategies to provide better support to Indigenous students (Beavis et al., 2015; Lane & Petrovic, 2018; Pijl-Zieber & Hagen, 2011), and multiple calls for increasing the number of Indigenous instructors and faculty within nursing programs (Beavis et al., 2015; Jamieson et al., 2017; Rowan et al., 2013; Stansfield & Browne, 2013). Generally, however, nursing faculty were largely underrepresented within this body of literature; I did not find any studies focussed on the recruitment of Indigenous nursing faculty exclusively, nor studies assessing challenges and facilitators to addressing the TRC recommendations within curricula.

### **Current Decolonization Efforts within Canadian Schools of Nursing**

Although many universities in Canada offer Indigenous programming, mandated requirements of Indigenous education for graduation, Indigenous spaces, student support, and alternate admission procedures for prospective Indigenous students, few faculties of nursing within Ontario universities boast Indigenous content and support on their websites at the undergraduate level. Websites of schools of nursing recognized by the Council of University Programs in Nursing (COUPN) were searched for multiple indicators of the TRC's recommendations being addressed, such as purposeful inclusion of Indigenous content in curricula, support for Indigenous students, and active recruitment of Indigenous students into their programs. Grey literature indicating purposeful moves toward institutional inclusivity and accessibility for Indigenous students was also reviewed. Only schools with four-year undergraduate nursing degrees were included. Overall, evidence of active recruitment and purposeful retention of Indigenous students is limited among Ontario schools of nursing, but there are promising efforts.

Lakehead University proactively addresses the issue of Indigenous students being unprepared for postsecondary education with a formal bridging program that provides necessary skills and preparation to complete a Bachelor of Science in Nursing (BScN), and guarantees admission to the program (Lakehead University, 2017a). Lakehead also boasts an emphasis on Indigenous health and wellness, exemplified by an aesthetic project that has been incorporated into a course in the first year, wherein students participate in storytelling, talking circles, and mask-making to support relational inquiry (Spadoni, Doane, Sevean, & Poole, 2015). Immersive clinical placements in Indigenous communities are also offered, beginning in the first year of the program (Lakehead University, 2017a, 2017b). Trent-Fleming's collaborative nursing program has incorporated Indigenous health into their strategic plan. They focus their students on social justice, providing opportunities for students to choose a specialization in Indigenous health among other foci within their degree. The strategic plan also includes adding 'Indigenous ways of knowing' into course content, and strategies to increase recruitment of Indigenous nursing students, and immersion of students into Indigenous communities for clinical placements (Trent-Fleming School of Nursing, 2014). Schools of nursing at McMaster and Western Universities have both recently begun faculty-led initiatives to engage their staff and students in discussions of Indigenous health and develop culturally responsive curricula, thus beginning their focus on decolonizing their programs (McMaster University, 2017; V. Smye, personal communication, November 27, 2017). Overall, among the 14 universities in Ontario offering BScN degrees recognized by COUPN, only three schools of nursing include Indigenous content on their websites. While I acknowledge that websites are not always an accurate representation of formal processes in place, they are a readily available source of information for potential students, which could have implications for recruitment.

By contrast, mainstream schools of nursing in other parts of the country are making strides toward decolonizing nursing education. Dalhousie University's Arctic Nursing program is academically similar to that of other SON across the country, but is taught almost entirely from a *Inuit Qaujisarvingat* (Inuit knowledge) perspective, concepts and values of which are congruent with those of nursing (Edgecombe & Robertson, 2016). The University of New Brunswick offers a comprehensive "Aboriginal Nursing Initiative" which provides a bridging program for those who do not meet entry qualifications, access to an Elder, a laptop lending service, social projects such as a Medicine Wheel garden, and boasts cultural competency, social justice, and Indigenous Health perspectives as central to the curriculum (University of New Brunswick, 2017). The University of Manitoba has developed an Aboriginal nursing cohort initiative with two potential pathways for students: a transition year in which students are prepared for nursing education with science and English courses, as well as a course called "Introduction to University" to help them adjust to academic life; or entry directly into the initiative, which includes smaller class sizes, reduced number of courses, and availability of tutors and counsellors (Martin & Seguire, 2013). This particular nursing program has a large number of students wishing to practice in Indigenous communities, so curricula heavily emphasizes understanding of colonialism and residential schools (Martin & Seguire, 2013). The University of Manitoba also has provided an additional nursing program at their University College of the North, which supports Indigenous nursing students in rural Northern Manitoba, in response to the necessity for accessible, culturally competent, and safe learning spaces for those living in remote areas (Zeran, 2016). Thompson Rivers University (TRU) in British Columbia has modelled their curriculum to address each of the core competencies recommended in the Aboriginal Nurses Association of Canada's (2009) framework for cultural safety, and provide

learning activities promoting Indigenous health in all four years of the program (Mahara, Duncan, Whyte, & Brown, 2011; Thompson Rivers University, 2017).

In the Northwest Territories, Aurora College has made purposeful moves toward a decolonizing pedagogy and epistemology through the use of a concept-based curriculum that is taught from a critical post-colonial perspective; this institution continually evaluates and reshapes their curriculum based on a campus-wide Indigenous Education Protocol (Moffitt, 2016). The University of Alberta has an Indigenous nursing initiative (led by an Indigenous nursing advisory committee), with goals of increasing enrolment of Indigenous nursing students, acknowledging Indigenous knowledge to inform the curriculum, and building knowledge capacity among staff and students regarding the history of Canada's relationship with Indigenous people, colonization, and reconciliation (University of Alberta, 2017). Although these initiatives all hold promise in terms of decolonizing curricula, I also noted within the literature that some schools extend their efforts outside the walls of their institutions. For example, the University of Saskatchewan has addressed issues of access by extending their program to smaller communities in the northern parts of the province in a "learn where you live" format, using creative technology that is more interactive than traditional distance learning models, with an aim to recruit Indigenous students into the workforce who would not be able to attend due to distance (Butler, Bullin, Bally, Tomtene, & Neuls, 2016). At the University of Northern British Columbia (UNBC), nurse educators are moving beyond the practical and pushing for new theoretical underpinnings for northern nursing education, directing research in specific areas: northern population health, education for rural, remote, and northern Canadian nursing practice, and experience of nursing in these locations (Zimmer, Banner, & MacLeod, 2016). Throughout this body of literature, it would seem as though nursing educators and scholars in northern and



western areas of the country are leading efforts to decolonize nursing education. Nurse educators from schools of nursing in the Northwest Territories, Yukon, and Nunavut have recently come together to create an online educational module focusing on community development for health nurses and social workers, using a pan-territorial approach to support them to reflect and act upon the colonial tensions in the North (Bradbury, Starks, Durnford, & Moffi, 2016).

For many potential Indigenous nursing students who do not live in these areas, attending University out of province presents a significant financial barrier. Given Ontario has the highest population of Indigenous people of all provinces and territories, yet the lowest proportion of Indigenous nurses in the workforce, we might expect Ontario schools of nursing to be more active in recruiting and retaining Indigenous nursing students. Anishanawbe Health Ontario's survey assessing inclusion of Indigenous cultural safety into health sciences curricula in Ontario colleges and universities corroborates this finding: many universities include some material related to Indigenous history, but colonization and its implications for health are largely neglected across curricula, leaving nursing students with little to no training in cultural safety (Shah & Reeves, 2012). Instead, nursing theory and evidence-based practice are the preferred epistemologies, critiqued in previous sections as outdated ideals of white healthcare discourse.

### **Research Purpose and Significance**

Despite the shortcomings discussed above in terms of current nursing pedagogy, it is clear that many SONs in Canada are engaging in the work required to respond to the TRC's (2015) Calls to Action. However, there is a vast difference regarding apparent Indigenous health foci across nursing programs, a lack of knowledge regarding nursing leaders' experiences of doing this work, and an absence of evidence pointing to challenges and facilitators of and

opportunities for addressing Indigenous health and the TRC recommendations in nursing programs. This not only serves to foster speculation that Ontario SON may not visibly be making as great a stride as those in other provinces, but it also may indicate that barriers to decolonizing Ontario SONs are more substantial or different from other provinces in Canada and/or that facilitators and opportunities are insufficient to fully engage in this work.

Given the literature review and the current gaps found in relation to this topic, my research question, methodology and methods are as follows here.

### **Research Question**

The research question guiding this study is: “*What is the experience of university nursing leaders in addressing Indigenous health and the TRC recommendations within their undergraduate programs?*” Therefore, the purpose of this study is to explore the experience of nursing leaders in addressing Indigenous health and the TRC recommendations in undergraduate nursing education programs in Ontario. The objectives of the study are to, i) describe how nursing leaders are addressing Indigenous health in their respective nursing programs; ii) explore the challenges and facilitators of, and opportunities for, engaging with this work; and iii) based on my findings, propose recommendations to inform processes and practices in doing this work in Ontario Schools of Nursing.

### **Methodology**

To address the research question, I have employed a qualitative descriptive design informed by postcolonial theoretical perspectives, methods that were informed by critical ethnography, and an analytic process grounded in interpretive description. Interpretive description was conceptualized by nurse scholar Dr. Sally Thorne, who sought to facilitate departure from traditional qualitative research approaches that prescribe methods not necessarily

in keeping with the unique epistemology of nursing inquiry (Thorne, Kirkham, & MacDonald-Emes, 1997). It is not a prescriptive methodology, rather it is a means by which a researcher can draw from a variety of theoretical lenses and methodologies to inform a foundational and organizing analysis that benefits applied disciplines (Thorne, 2016). This type of research is well-suited to nursing, given the interdisciplinary underpinnings of nursing science, and the necessity to stray from the theoretical confines of traditional methodological approaches to suit research questions that seek to advance nursing knowledge (Thorne et al., 1997). Within this descriptive study, I have thus used interpretive description as an analytic tool to produce what Sandelowski (2010) refers to as a “thematic survey” (p. 78). This design allowed me to use critical approaches to interpretation, but without transforming the findings into critical views that may not have been reflected by my participants (Sandelowski, 2010).

Approaches typically found within critical ethnography (CE) were used to inform my process. CE is informed by critical perspectives; functions under the assumption that existing systems require exposure of the dominant forces driving knowledge within them; and fosters critical reflection on those forces with the goal of discovering starting points for emancipatory transformation (Munhall, 2012; O’Leary, 2017). Given that PCT aligns with the foundational principles of critical perspectives and emancipatory knowledge (Bickford, 2014), aspects of Carspecken’s (1996) five-stage approach to critical ethnographic qualitative research were therefore drawn upon to guide inquiry. This is discussed further in the methods section. Carspecken’s process also requires that the researcher explore their own values and identify what they expect to find prior to beginning the study, thus creating self-awareness and acknowledgment of their perspectives (Carspecken, 1996; Smyth & Holmes, 2005). This is consistent within the underpinnings of this study: critical scholarship (including PCT) involves a

self-reflective aspect, demanding accountability of researchers for their assumptions, perspectives, and their own transformative effect; ethnographic inquiry requires self-interrogation of one's own positionality in relation to the work; and Thorne herself recommends disclosing any thoughts, perspectives, or experiences that may shape the researcher's angle or agenda (Davis & Craven, 2016; Polit & Beck, 2012; Thorne, 2016).

PCT and CE approaches add independent yet complementary lenses that have informed the interpretive descriptive analysis of this study and have contributed to comprehensive understandings of the experience of academic nursing leaders in addressing Indigenous health and the TRC's recommendations within their programs. The ability of these perspectives to address power structures was suitable for this study, as it could be inferred that current nursing pedagogy holds power over the worldviews of nursing students, who then engage in relationships with Indigenous patients.

## **Methods**

### **Sample**

The study was based in London, Ontario, although participants resided and worked in all areas of the province. Participant recruitment took place via electronic (email) letters of invitation to participate in a one-on-one video conference call, lasting approximately 60 minutes. Participants were required to meet the following criteria. They 1) were leaders within a baccalaureate nursing program recognized by the Council of University Programs in Nursing (COUPN); 2) had current or recent experience as lecturers, professors, or instructors in the classroom or clinical settings; and 3) were in a position to oversee the potential work of addressing the TRC recommendations and bringing Indigenous health into their curriculum. Invitations were therefore sent out to my entire sample frame, searching for participants within

each of the 14 University Program Schools of Nursing recognized by COUPN. There were no explicit exclusion criteria—anyone who met the inclusion criteria was invited to participate.

Although I have used the term ‘decolonizing’ as an umbrella term as defined in previous sections, Tuck & Yang (2012) argue that the word has been superficially imposed into educational strategies, replacing social justice and other critical methodologies. The authors also state that use of the term is misappropriated, is consistent with a lack of recognition of the struggles for sovereignty of Indigenous people, and simply serves to alleviate settler guilt (Tuck & Yang, 2012). I defend that this is not the case in this context. The social mandate of nursing can allow us to use this term in a fashion that contributes to reconciliation, not prematurely as the authors state is often the case, but at an appropriate moment in the history of nursing. It has become clear that the profession is in a unique position to positively contribute to improving the health of Indigenous people in Canada. As such, I did not use this language during the recruitment process. I had intended on doing so during data collection only if the participants themselves referred to their work in this manner, as it is important to this study to understand how the participants themselves define this work.

### **Sampling Strategy**

For this study, I employed purposive sampling to access participants who met the specific criteria needed to address my research question. Specifically, I recruited nursing directors, coordinators, deans, and/or chairs/co-chairs, chosen for their authority and ability to answer the research question. In addition, I sought opportunities for snowball sampling. I invited my participants to forward my contact information and letter of information to additional individuals within their Schools who were actively engaging in this work and could speak practically about the challenges and facilitators involved. Those individuals were invited to contact me if they

were interested in participating. In addition, given the diversity of Ontario's geography in the context of Indigenous populations, participants were situated in different areas of the province to reflect that some schools may be in closer proximity to Indigenous communities, or affiliations with health care institutions that serve a greater population of Indigenous clients, than others. Therefore, I also hand-picked participants from my sample, which would allow me to explore potential differences in approaches that are grounded in geographical situation (O'Leary, 2017). This was in line with the principles guiding the study, as postcolonial theoretical perspectives involve "critical analyses that are inclusive of multiple voices across diverse socio-historical locations" (Browne, Smye, & Varcoe, 2007, p. 127). To recruit participants, my thesis supervisor sent a letter of information and consent to administrators of all the COUPN schools by way of electronic mail as a COUPN delegate.

### **Data Collection**

Data collection was guided by Carspecken's five-stage process (1996). This method was appropriate due to the critical focus of this study, and as Smyth and Holmes (2005) note, its ability to lead to change and personal growth within both participants and researcher. The study did not include the traditional ethnographic strategy of participant observation in the field, which Carspecken describes as the first stage of critical ethnography (1996). However, Carspecken supports standalone use of individual stages in cases where the researcher is conducting an interview-only study, and this piece-work is in keeping with the tenets of interpretive description (Carspecken, 1996; Polit & Beck, 2012; Thorne, 2016). Therefore, stages three through five guided the process of data collection. Stage three, *dialogical data generation*, took place using the traditional ethnographic method of in-depth interviews. As participants were located throughout the province, travel for in-person interviews was not possible. Interviews therefore

took place via video conference, using *Zoom*, a video conferencing software that is accessible online through a personalized link I provided to each participant. I chose this over telephone interviews not only due to the benefit of having both audio and visual cues during the interview process (Polit & Beck, 2012), but also due to the opportunity to facilitate a rapport between researcher and participant when face-to-face meetings were not geographically convenient. In addition, telephone-only interviews are subject to methodological skepticism as they are often kept short, reducing opportunities for in-depth discussion, and invite potential distractions for the participants in their environment (Novick, 2008).

To maximize flexibility during the discussion (Carspecken, 1996), interviews were semi-structured, with sixteen concrete, open-ended stem questions used in each interview. See Appendix A for the full interview guide. Using open ended questions allowed for further probing, and provided participants the freedom to respond as they wished (Morse, 2012).

Stage four, *conceptualizing the social system*, involves ascertaining system integration by discovering and describing relations between social sites (Carspecken, 1996; Smyth & Holmes, 2005). This involved assessing the geography surrounding each participant's location for accessibility to Indigenous communities, as well as examining affiliations between the SON and facilities that may serve a high number of Indigenous clients. Rationale for this became apparent during stage five, *using system relations to explain findings*. Carspecken advises researchers to note relationships between cultural reconstructions and the environments in which the participants live, learn and work, and question the economic and political explanations for these conditions (1996). For example, the former Kamloops Indian Residential School is visible from the TRU campus, and has become a key resource for faculty and students (Mahara et al., 2011). Some Ontario SONs may have a stronger system of access to Indigenous clients than other

Schools, thus influencing their efforts to address the TRC's recommendations or include Indigenous health more prominently in their curricula.

### **Data Analysis**

Interpretive description was used as an analytic tool throughout my process. As is typical of ethnographic research and interpretive description, data analysis began and was concurrent with data collection, and rudimentary concepts were identified in early interviews that guided subsequent lines of questioning in later interviews (Thorne, 2016). For example, upon Participant A discussing the challenges of integrating new concepts into an already overflowing curriculum, I was compelled to ask that participant, and the subsequent participants interviewed, if they felt there was anything in their curricula that could be removed in favour of IH. During each interview, I made reflexive fieldnotes by hand to assist in later processing concepts I deemed significant at the time.

Interviews were conducted and immediately sent for transcription. Upon receiving each transcript, I began my inductive analysis using a process that reflected Thorne's (1997) approach via repeated immersion into the data. Firstly, I read through the transcripts and cross-referenced them with the field notes I had generated during the interviews to refresh my initial thoughts. Secondly, with the guidance of my supervisor, I read through the transcripts a second time alongside the conference call recording. During this second exposure, I checked for accuracy of transcription and made trackable corrections as needed. I also hand coded each line of the interviews during this second review using track changes and comment bubbles within the transcription document, identifying common patterns among all interviews as well as prevalent patterns within each interview. These initial coded transcripts were sent to my supervisor for review, at which point I also began a third reading of each transcript in the absence of the audio-



visual file. From this third reading, I created two additional documents: a spreadsheet that classified my initial coded concepts under broader concepts including the location of each within the interview transcripts (see appendix B); and another document summarizing the main points of each interview. By creating these alternative organizational documents, I was able to inductively engage with the data while slowing my analytic process to avoid, as Thorne (2016) cautions, coming to higher level themes prematurely. My research advisory committee contributed to my analysis throughout all phases using a highly iterative process of discussion and drafting—their guidance enabled me to use my coded broad and sub-concepts to arrive at five high-level analytic themes. Each theme is comprised of subthemes that reflect the participants' perspectives of their own experiences in leading or participating in efforts to incorporate IH into the curricula of their respective SON and will be discussed below.

### **Approaches for Creating Authenticity and Rigour**

Strategies for creating authenticity within my study were based largely on the concept of reflexivity, that is, an awareness of the background and values I brought to the construction of this knowledge, and the way I attended to data collection, analysis, and interpretation (Polit & Beck, 2012).

Firstly, the literature review as described above had created assumptions that efforts to employ processes and practices to address Indigenous health and the TRC recommendations have been minimal in Ontario. To address this, I regularly engaged in critical conversation with my supervisor about these assumptions, as she herself has experiential insight into processes and practices that are currently unpublished. Secondly, as a registered nurse, a 5-year graduate of an Ontario baccalaureate nursing program, and a current part-time faculty member of an Ontario University SON, I have experiential knowledge of the manner in which Indigenous health has

been included in curricula at particular Schools within the province. Therefore, when interviewing leaders from my alma mater, I had to carefully bracket my own experience. Bracketing is a self-reflective approach in qualitative research wherein the researcher becomes aware of and suspends their a priori knowledge to mitigate skewed interpretations (Tufford & Newman, 2012). Thirdly, Ramsden's work on cultural safety was based on the premise that increasing numbers of Indigenous nurses would, by and large, improve Indigenous health (Papps & Ramsden, 1996). Nurse researchers focussed on Indigenous health worldwide have corroborated this assumption, often making a distinct statement that more Indigenous nurses in the field would close the gap in health inequities experienced by Indigenous people (Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014; Etowa et al., 2011; Vukic, Etowa, & Perley-Dutcher, 2014; West, Usher, & Foster, 2010). This left me with an impression that nurse Indigeneity guarantees culturally safe care, despite Indigenous nurses having experienced the same colonial legacy as the Indigenous patients for whom they care. In keeping with qualitative and interpretive descriptive process, I addressed these issues by maintaining a reflexive journal to assist with limiting my own subjectivity and creating a safe space in which I can try out and analyze my own conceptualizations of the data (Thorne, 2016). In addition, to ensure trustworthiness, I presented my results to my participants at the COUPN quarterly meeting, including the recommendations that arose from the research prior to submitting this thesis. The presentation included time for discussion, during which I received feedback from my participants, and other individuals involved with COUPN. I took this feedback to heart and adjusted the recommendations and limitations of the study. I also contacted my participants by electronic mail to ask them if the presentation was logical and useful, and if they had any additional concerns or suggestions as a form of member checking. An Indigenous leader who

attended the COUPN meeting suggested that I present my findings to elders for their input on the recommendations within my community of practice. I plan to do this after I defend the thesis as part of knowledge mobilization practices.

To ensure credibility and rigour, Thorne (2016) recommends moving beyond evaluative standards into a subtler critique of the research. Thus, I have employed Thorne's (2016) perspectives of critique typically addressed within interpretive description: *moral defensibility*, *disciplinary relevance*, *pragmatic obligation*, *contextual awareness*, and *probable truth*.

In this study, *moral defensibility* addresses why the findings are necessary for the explicit purpose of decolonizing Schools of Nursing, and the potential benefit they hold for participants. The findings and recommendations within this study could be helpful in guiding participants through the initiation of this work. For example, promotion of critical reflection among staff and faculty, and collaboration with Indigenous stakeholders.

*Disciplinary relevance* refers to how the findings contribute to advancement of nursing science. The findings within this study have implications for how current nursing theories are taken up in nursing education and could initiate critical inquiry into the adequacy of these theories in addressing Indigenous health.

*Pragmatic obligation* involves an interpretation of how the multiple coexisting perspectives that contribute to the knowledge create a prerequisite for action. This study is not necessarily generalizable due to the varying stages of this work in which participants find themselves. These stages are influenced by multiple variables such as geographic location, available Indigenous input, and a plethora of competing demands. However, the social mandate of the nursing profession combined with the findings and recommendations within this study can be applied to incorporation of the TRC's Calls to Action (2015).

*Contextual awareness* involves an acknowledgment that my own perspectives on this study are centrally located within my own historical context and disciplinary perspective, and that these may be mirrored by participants that share those social constructions (Thorne, 2016). While I have addressed my own positionality and reflexivity within this thesis, it is important to articulate that the findings represent different social contexts and realities, and therefore may not be applicable across multiple settings.

Finally, *probable truth* acknowledges that while the findings within this study may not be absolute truths, they are valid until additional knowledge providing reason to abandon those truths is generated (Thorne, 2016). Thus, until further research on this topic is developed, perhaps guided by the recommendations or limitations within this study such as an exploration of the learners' perspective of this topic, the findings within this thesis should be considered.

### **Ethical Considerations**

Ethical approval to conduct this study was obtained from Western University's Human Research Ethics Board (HSREB). Participation was voluntary, and participants were informed that they were free to withdraw from the study at any time. There were no anticipated risks associated with participating in this study, but given the narrow sample frame, it was discussed with participants that they may be identifiable. To ensure utmost privacy, all data files were stored on a password-protected computer. Transcript files were in digital format and stored in a separate folder from their according audio-visual files. Audio-visual files were deleted once data analysis was complete. All data was accessible to only me. Transcript files will be kept on a password-protected external hard drive for five years, in accordance with policy per Western University's HSREB, electronic files will be destroyed.

## **Limitations**

Limitations of this study are visible in terms of the nature of my participants; my research purpose was to address the experiences of a very specific sample, specifically academic nursing leaders. Therefore, my sampling strategy targeted only nursing leaders of a particular rank within their SONs, as they alone could answer my research question. As such, my study does not have an Indigenous voice, as no Indigenous academic nursing leaders were available to participate.

In addition, I feel as though learner input would be valuable to this topic. Had this been a longer study, I would like to have recruited nursing students and perhaps a broader sample of nurse educators to provide their experience of receiving or delivering IH or CS education, respectively, to ensure multiple perspectives were examined and described.

## **Findings**

### **Participants**

In total, eight academic nursing leaders holding various titles within their Schools were interviewed. All participants were directing or participating in efforts to incorporate Indigenous health or knowledge into their programs at some level. One participant was a lecturer, two were deans as well as associate professors, two were directors with one being a full professor and the other being an associate professor, one was an associate dean and associate professor, and two were associate professors. All were female. Participants were interviewed 2.5 years after the summary of the final report of the Truth and Reconciliation Commission containing 94 calls to action was released, and during a political climate in which the Government of Canada was gaining momentum in their affirmation and implementation of Indigenous rights.

## Themes

With the guidance of my research supervisor, I was able to use my hand-coded data to arrive at five high-level analytic themes among the data: (a) *The Moral Compass and Nursing's Social Mandate: Doing the Right Thing, the Right Way*; (b) *Building Program Capacity*; (c) *Addressing Institutional Racism and Inequity*; (d) *Disrupting the Status Quo: Challenges and Facilitators*; and (e) *The Journey Toward the Vision*. Each of these themes are comprised of subthemes that reflect the participants' perspectives of their own experiences in leading or participating in efforts to incorporate IH into the curricula of their respective Schools, and will be discussed below.

## Themes

### **Theme 1. The moral compass and nursing's social mandate: doing the right thing, the right way.**

When asked what precipitated their engagement in this work, participants often referred to the social mandate of nursing, and overwhelmingly responded that engaging in this work was "the right thing to do" and that it needed to be "done right." Four subthemes were identified under this theme: (a) obligation and personal duty; (b) steering the ship; (c) genuineness versus tokenism; and (d) personal growth. These subthemes were found to intersect strongly at multiple locations within the data.

#### ***Subtheme 1a. Obligation and personal duty.***

The TRC was the formal signal for all participants to begin engaging in this work within their respective nursing programs, however, the influence of the document itself was discussed to varying degrees. One participant speaks to this in the following;

I think for all of us, the TRC and the strong recommendation for Schools of Nursing to really understand ... the antecedents to the health of Aboriginal people in Canada, we were tasked with it by the TRC strongly and it isn't just our duty to follow the recommendations. I see this as a moral obligation, but I also see it as ensuring that nursing education for Canada is inclusive of everyone and all of what students need to learn and not dependent on where they've come from; with no assumptions that because they're Canadians that they would know this information. I see it is both we are obliged to do it, but we shouldn't be doing it because we're obliged. We should be doing it because it's the right thing to do. (PB4)<sup>2</sup>

The simple existence of the TRC document was a prompt for many of the participants to begin this work, and some participants took direction from the specific recommendations of the TRC as guidance, for example stating that moving forward recommendations #23 and #24 was the priority (e.g., PG24) or they verbalized the importance of increasing access to post-secondary education and health professions for Indigenous people (e.g., PE5/24). However, doing the “right thing” was a central theme;

These people are the original people of the country we occupy. Our ancestors, thinking they were doing right, did wrong. There's some wrong we can't make up, but I do think we have to be very conscious. I certainly agree with the recommendations of the TRC. I think that, as Canadians, we have an obligation to look at them and say, ‘How do we move forward on them?’ (PG139)

This participant, as well as others, reflected on the colonial past and the misdirection of their ancestors, acknowledging how reading the TRC fostered a moral obligation but also serious

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<sup>2</sup> Quotes are coded by confidential participant identifier and the line number within the transcript at which the quote is located. Here, the participant is PB, and the according location of the quote is line 4 within that transcript.

reflection on what it means to engage in this work in the right way. The “right way” for several people had a strong connection to the notion of time and authenticity;

I think there's a danger in just not being advised and not doing it in the right way. I've noticed that there is some backlash to the Truth and Reconciliation and how quickly some places are moving and that is a push back by the Indigenous population themselves. This is not just...I think there's going to be moments of friction and moments of peace until we get it right (PA232);

and

I can't eat the whole cookie all at once, even though I want to, but this is one of those projects that I'm going to have to, to bite off really small nibbles if we're going to do it properly (PC443);

and

I hear from other more established schools that they've got courses, or they're into professional courses in it, or whatever. I thought, "Oh, boy, we haven't done that yet" (PF47);

and

We're starting to make a huge amount of progress, nothing gets changed overnight. I just see that white men conservatism so much so often and you just feel like you're banging your head against a brick wall. (PC392)

To some participants, doing things “the right way” often meant moving slowly through the work, over a long period of time and also meant living through moments of friction. In addition, language used to express what that meant to participants included words such as “*organic*,” “*natural*,” “*authentic*,” and “*genuine*.” Some participants described this as “*walking*



*slowly*” or “*walking softly*,” and expressed anxiety over being perceived by Indigenous communities to be moving too quickly (PA189). Participants also spoke to the anxiety associated with change processes within their schools; the last participant excerpt (PC392) speaks to the frustration attached to the challenges of doing this work within mainstream institutions and in the context of continued neocolonialism. Regardless, participants in this study were most often in agreement that slow progress was, indeed, the right way to move forward, and that taking their time would ensure that foundations are built to support long-lasting and fully embedded programming. As one participant notes, “It’ll be long, but if it’s long-term and everybody is working on it, then it’s far more likely to be embedded and it’s far more likely to be there forever” (PB494).

To multiple participants, the duty to engage in this work was seen as a collective responsibility. One participant has resisted setting up a special committee within her SON to address IH, defending that “if you have a sub-committee, then it’s some people’s responsibility and not everybody’s. It needs to be everybody’s responsibility. The only way to really make real structural changes, particularly in education, is for everybody to own it.” (PB19/485). This participant speaks to the ultimate goal of ensuring change at the structural level, not only at the individual level.

Overall, participants in this study valued a team approach, and rejected the notion that as leaders, they alone should be guiding the decision-making processes behind this work, as one participant notes;

I very much believe that I’m not the boss. I happen to be the one from inside that helps keep things moving forward, but the school is our school, and it’s all our voices. This is very much what we together have decided. It’s how we need to move forward. (PG195)

Whereas participants expressed that decision-making processes and enacting change required a collective or team effort, they also were aware of the fact that a collective approach also requires strong leadership.

*Subtheme 1b. Steering the ship.*

Participants generally expressed clarity in terms of their roles as leaders and what their responsibilities would be moving forward in this work within their SON. Examples are provided in the following interview exemplars by some participants;

I am the leader of the school, so my role is to lead by example, obviously and promote and support our faculty in their own efforts to gain new knowledge and receive education about some of the initiatives that are underway (PD8);

and

The staff by themselves took themselves off for a half day retreat [to an Indigenous ceremony]. That was because they decided that this was a good first step for them and this is the way that they want to move forward. I think what I have to do is create space for that. (PB486)

Provision of leadership through example was a commonly-held view. In addition, although the main priority among participants was clearly supporting faculty and staff development, creating space for faculty and staff autonomy with regards to how they approach their own learning was also of particular importance for these participants.

In a slightly different vein, participants spoke further to the concept of “steering the ship”;

I'm going to leave a lot of it up to the faculty in terms of how we are going to approach it, what exactly are we going to approach, but I'm going to lay the foundation and push it forward. (PC447)

Although this participant understood faculty and staff autonomy was important, she also saw her role as pushing this agenda forward. Another participant speaks to this further in the following;

It starts with getting the topic going and we figure it out and then we build on it later [...]

To me, as long as I'm talking about it with the faculty and the other members that we make sure that we draw attention to it in our courses is important. (PF172-192)

The creation of ongoing dialogue was articulated as an important piece of this work, with some participants facilitating intimate conversations in which faculty and staff were encouraged to reflect, and others ensuring that the topic was on the agenda during all leadership meetings. Discussion was found to be essential in terms of faculty reflection and buy-in, disseminating the TRC, and ensuring the topic remains at the forefront of program planning. Some SON leaders found innovative ways to engage the faculty and staff in their discussion. For example, the genesis of an Indigenous book club was found to be particularly effective in generating discussion and reflection among faculty;

The discussions have been good. I do think that people are affected by what they're reading. You need to be able to be nudged off so that the rock that you sit on in terms of what you believe. You've got to be nudged from that in order to see things differently. I would say that yes, people are actually pretty surprised about what they're learning through the readings. (PH192)

Here, the participant notes the importance of the readings as a modality for sparking faculty and staff self-reflection and engagement with the issues posed in the area of Indigenous health.

Participants also spoke to strategies targeted at the organizational level. As one participant shares in the following;

You have to play with the movers and the shakers, right? You need to be able to engage those people and help them understand why this is important to the university mission and their place within the community as an institution, as a university, and the important impact this could have on the health of individuals. (PC192)

This participant speaks to the importance of engagement with the senior leaders of their respective institutions; if structural change is going to take place, e.g., resources allocated to support curriculum shifts and faculty and staff professional development, then this is essential. Participants were typically active members of their University's council, senate, boards, or senior leadership table, often finding themselves keeping the discussion on the agenda at meetings with stakeholders at that level.

Leaders also felt it was their responsibility to remain vigilant in seeking new opportunities that could either offer avenues for change or help maintain the current momentum of the work (PB502, PC18, PH329), with one participant describing this process metaphorically as “keeping a finger on the pulse” (PE446). Several participants indicated that these opportunities occasionally arose in the form of individuals with the capacity to mobilize efforts to increase the visibility of IH within their SON; therefore, leaders saw recruitment of “the right people” as a key part of their role. “That's what I do. I hire the right people, I put them in the right place and then, I mentor them, and I want to champion them.” (PA412).

In SONs, the importance of hiring practices was described as any or all of the following: purposefully hiring Indigenous scholars; increasing administrative support for curriculum change (PD48); movement of existing staff members into roles in which they have the capacity to enact

or support the work (PG96); addition of consultants who can facilitate building relationships with surrounding and remote Indigenous communities (PG251); and, hand-picking clinical instructors who can safely work with students in Indigenous clinical placements (PH297). A few participants had invested in specific individuals to take the lead in this work, some Indigenous themselves, and some not;

I do believe in choosing champions for different projects because we have so many projects on the goal right now with curriculum and with all of the reviews and everything we have to do. You have to have champions who are passionate about this project and will lead the rest of the faculty. We all cannot do everything, and we need to have people [to assist with this work]. (PA387)

Leaders held themselves accountable to find and grow champions for the cause; those who would pick up this mantle and run with it.

Several participants also described financial resources as essential to supporting this work, and leaders generally took the onus for this responsibility. Leaders of Schools described varying levels of responsibility in their role of advocating for and securing funding for any efforts that are to take place, and expressed varying levels of concern about cost. “Of course, we all think this is important work, but how are we going to pay for it? It costs a lot of money to revise curriculum.” (PD79). While this participant saw incorporating IH into curricula as a financial burden, another felt this was less of an issue, stating that “[i]t doesn't really cost money to add concepts into a curriculum... I personally don't think that those kinds of costs will be a barrier for our director because I see a strong commitment on her part to engage in the kind of learning that we all need to do.” (PH174)

While opinions on the cost of incorporating IH in more comprehensive ways into curricula varied, all participants agreed there were additional resource implications. For example, all participants spoke to their responsibility in allocation of funds to additional areas, which included hiring of consultants, development of specific Indigenous learning modules, contribution to Indigenous scholarships, and increasing Indigenous access to nursing education.

One participant optimistically stated that “it takes money to make sure that this is a priority, and we'll find the money. We'll do it any way we can. [...] it just takes determination and planning.” (PA645). The commitment to IH was clearly held by most of the participants.

***Subtheme 1c. Genuineness versus tokenism.***

In addition to seeing themselves as ‘steering the ship,’ all participants spoke to the importance of engaging in this work in a genuine way. As noted by one participant,

I have grave concern about that whole issue of the genuineness. I think that it's something that causes me to pause, to think about my place in terms of, what are the things that I can do that are genuine and related to being responsive to the things that are in the TRC. No, I don't want to be seen to be making all my token gestures. I want it to be real. (PH67)

The TRC Calls to Action (2015) has clearly laid out the responsibilities for health professional education and in particular, nursing and medicine, however, this participant speaks to her need to do this work out of a genuine sense of responsibility, rather than as a token act. Another participant goes on to speak to notion of tokenism in the following;

I know it sounds like tokenism and I don't mean it to sound like that, but it would be lovely if we had a faculty person of Indigenous heritage who could help us to do a better job but also help us create those partnerships. (PG277)

Here, the participant speaks to the need for the support of Indigenous perspectives in the work and the concern that this be perceived as a token gesture. Indigenous colleagues are being sought but often are difficult to find. Yet, for the work to have credibility, engagement with Indigenous colleagues and communities was described as essential. As noted on the website of the Canadian Indigenous Nurses Association (CINA) “nothing about us, without us” (2016). This concept is included within the framework of many other Indigenous organizations, as there is an expectation of collaboration on all matters affecting Indigenous people. However, this goal does have some complexity. As one participant notes, “I think that we have to address that tokenism issue and also be open to people having the drive and the desire to make that better that may not be Indigenous” (PC235). This participant speaks to the fact that there also are important non-Indigenous allies in this work that can provide assistance as well. Notably, it is about finding the right Indigenous and non-Indigenous people to assist with this work; being Indigenous does not mean the individual is necessarily the ‘right’ person or the only person who can assist. In a slightly different vein another participant speaks to tokenism in the following;

I’m afraid that [by] adopting a requirement that all undergraduates take one course [in Indigenous studies], that we might feel that we’ve done enough [...] ‘everyone has to take one course, we’ve done our Indigenous thing’ My God, we all know that’s not enough. (PG317-326)

Participants generally expressed the viewpoint that providing one IH course (elective or mandatory) was not good enough, rather this was a kind of tokenism. In addition, one course could imply this was enough. The general sentiment as expressed by one participant was that, “[w]e need to have something throughout the entire program. It's not just added in as a token. It's actually part of what we are and what we do.” (PA108). Participants instead saw “threading”

IH content throughout multiple areas in the program as a more genuine way to approach the addition of content. This will be discussed more fully under subsequent themes below.

Overall, participants described the necessity of attending to addressing the TRC recommendations and IH content in a genuine way; in the following section, they describe how being genuine also required critical individual self-reflection.

***Subtheme 1d. Unpacking your own truth.***

Some nursing leaders spoke to the personal work required to genuinely engage in efforts to engage with the TRC recommendations and IH in a good way. Many, such as participants PA and PH, admitted to their own location of unknowing, using statements such as “I don’t know what I don’t know,” and indicated that they have a personal obligation to learn more. As PA notes, “I don’t want to be ignorant anymore. I want to learn as much as I can. For myself, for my children, my family who I engage with, but also, for our students and faculty.” Here, the participant points to the need for all faculty and staff to engage with learning processes. Ignorance related to Indigenous health and related issues is widespread in Canada (Hardwick, 2015), and nursing leadership is no exception. Several participants described the importance of their new understanding of this, including this participant;

I’m so cautious to not be the person that says, ‘This is what you need to do,’ because I know that might not be the right fit for that community, or that individual. I’ve become super aware of my white privilege. (PC253)

Participants expressed an awareness of their “white privilege,” and how that affects both the way they approach the work and the way the work naturally unfolds. The participant above describes her fear that her whiteness would hold her back from the work in which she was wishing to engage. In a similar vein, other participants speak to this in the following;



I feel that I'm not always the right person, as a non-Indigenous woman, to be speaking about Indigenous matters. We should be reflecting on who are the right people to talk to our students and what is the best way to have these experiences unfold for students so that we would do it right (PE118);

and

[...] a white lady like me is [not] the person that goes out there and is the ambassador because I'm sure there are lots of things that I don't understand that don't open it up to be a trusting relationship (PG281).

Becoming more aware of their 'whiteness' has led these participants to examine the issue of voice and representation; specifically, who should be speaking on Indigenous issues;

You have to sometimes realize that you're not the expert and that's a hard thing for an academic to acknowledge. [You] may not have the answers as to how to do this the best way or how to teach that content. Maybe you shouldn't teach that content and that's okay; get a guest speaker. I think that we don't have to force ourselves to do everything all the time perfectly. (PC284)

This participant expands on the issue of voice, speaking to the notion of 'expert' and to being able to take a step back and acknowledge the limitations of the role of educators in this domain of practice.

Participants in this study also spoke to the very difficult task of engaging with their own history and an examination of colonial process and practices exemplified in the following;

Making a time to become informed, I think, having a willingness to examine the past. I grew up in an age where—I was a teenager when the '60s scoop was going on, but absolutely unaware of it. You've got to take a look at history through a different lens

than the one I was raised looking at things through... It takes mental work to reshape your perspective of the world. To do that there has to be some degree of willingness to look at things differently than the way you believed that they always have been. (PH156)

As this participant notes, a willingness to unpack one's own truth in terms of knowledge of colonial history and the biases one carries is essential to personal growth. Many Canadians know little about our colonial history because it was not taught; they were not exposed (Sefa Dai, 1993). Therefore, it is not at all surprising participants were at varying stages in their understanding and personal growth with respect to issues pertaining to IH. Participants all understood the implications of their own understanding in terms of this work and were more or less comfortable engaging with it. However, all understood it as their responsibility to push the IH agenda forward to support building program capacity.

## **Theme 2. Building program capacity.**

While course, curriculum, faculty, and staff development were found to be at the crux of initiating change within SONs, there are multiple additional dimensions that would add strength to the School's overall program, building capacity to deliver a safe program that incorporates IH in a comprehensive way. Subthemes found within this section are: (a) creation of authentic partnerships; (b) genuine engagement; (c) recruitment and retention of Indigenous students; (d) supporting PhD Indigenous scholars; and (e) creation of meaningful experiential learning opportunities.

### ***Subtheme 2a. Creating authentic partnerships.***

All participants spoke to the need to build authentic partnerships in one way or another to do this work. As one participant notes,

I think [the engagement with new partnerships] speaks to our institution's desire to work with our Indigenous partners in many ways and also then to provide the supports that are necessary for faculty to also be able to engage in effective and genuine ways with students. (PE182)

This participant speaks to how authentic Indigenous partnerships actually impact engagement with students, for instance by modeling effective relational practices. Participants spoke to other partnership processes, such as the ways in which the partnership agreements are broached: “If we do it, I don't want to be somebody from the outside [swooping] in. I want somebody on the inside helping us to create that so that it makes sense, walking slowly.” (PA169). This participant again points to the importance of “who” does this work; this provides credibility—it “makes sense.” Another participant elaborates on this further, stating that “[w]e've got to be able to work with them. It's a matter of establishing some connections, to be able to do that” (PH279), underlining how participants want to “work with” rather than “doing for,” that is to say, engage as allies in this work. Participant intention to create sound partnerships is captured in the following;

I'd like to approach the elders and the surrounding communities to work with them and say, "We'd like to work with you, see if the prerequisites [to nursing] are offered within the schools that the kids go to." [...] You have to create the conditions for success, right? You have to create the idea that this is a possibility for younger kids or high school students, right, that nursing is something that they could do. Then make sure that they have the pathways to do it (PC173-185)

Participants pointed to the need for authentic community partnerships to create or maintain access pathways for Indigenous students (e.g., PE and PG458). In this participant's opinion, this

manifests in a desire to work with communities to create optimal conditions for Indigenous people to go into nursing. This would include ensuring support for students to have access to prerequisite courses.

The creation or maintenance of authentic partnerships and relationships was also described as a challenge for several participants. While some schools had well-established relationships that had been nurtured over years, some experienced a distinct challenge in initiating contact to form relationships within communities. These challenges included lack of knowledge of issues, few accessible individuals within the community (PG360), the outsider status of the SON leader (PC246/G280), and the general fragility of those relationships. Another participant speaks to the challenges in the following;

I also feel that this is a very fragile course that we're going forward on and at any given time it can break, and relationships can break. It's just going to take somebody doing the wrong thing or saying the wrong [thing] and it'll all fall apart because we have to work on trust and we have to work on mutual respect. (PA670)

This participant's comments point again to the historical context of Indigenous health and well-being including the marginalization of Indigenous knowledge and ways of knowing; colonial relations and neocolonial policies and practices have undermined mutual trust and respect; something this participant wants to avoid.

Another participant elaborates on some of the inherent challenges to building relational capacity in the following;

One of the challenges that we experience is we get these connections and then the people [with whom we've connected] with move on, and that's happened repeatedly. It's very, very challenging... Every time we've [created a connection with a community member],

we've lost the person. I don't know whether it's because we've done the wrong thing or whether that's just part of the dynamics. (PG207,379)

Indigenous people sought to assist in the processes discussed here often are in huge demand. Competing demands often mean they cannot make commitments over long periods of time. Another participant goes on to elaborate further on this theme in the following,

Somehow, we've got to create relationships with people that aren't just relationships with [one single person], because when they disappear, if we've done a good enough job, whoever steps up into that position then is connect[ed] with us as well. (PG379)

Here, the participant raises two issues; the need for establishing relationships with groups of people (rather than with individuals only) and supporting the maintenance of those connections over time.

Challenges in creating relationships fostered a realization among many participants that their SON could not independently forge ahead in their attempts, rather engagement of this sort requires guidance on how to do so, and how to nurture those relationships once they are in place. Some Schools had an Indigenous champion on staff who assisted the leader in creating relationships, as described by this participant, “There is a process that she's educating us all about, about how to go about to do that, what are community partners, what the community partners and elders need, and just how to work together in a committee setting.” (PD192). Other Schools recruited consultants to speak to the faculty about “how to engage with the right people” (PB593), or were reliant on their institution’s Indigenous Centre to introduce them to individuals with whom to work (PC312). Regardless of pathways taken to establish these relationships, there was general agreement among the participants that initial contact should be done carefully,

in the right way, and guided by a knowledge holder, because as one participant put it, “it’s all about first impressions” (PC312).

Some participants already had established reciprocal relationships with Indigenous community partners. As noted by this participant,

I think we've created really strong working relationships with the organizations. We've had good partnerships with these health care delivery organizations. So I think they see the opportunity for us to have students in placement is almost like a recruitment opportunity for them. That is a facilitator for sure. There's a lot of work that goes into creating those affiliation agreements, but I think that that pays off on both ends. It's kind of a win-win thing, we are able to place students and they are able to potentially recruit. (PE325)

Reciprocity, a highly valued principle in Indigenous relationships (Kirkness & Barnhardt, 1991; Royal Commission on Aboriginal Peoples, 1996; L. T. Smith, 2012) was acknowledged by this participant in the context of existing relationships, and was also recognized among those who were working to establish or maintain new partnerships. Another participant elaborates on this further here,

I figured the more we can expose students, the more they can understand what some groups might be going through. Then also by having nursing students in these placements, it may actually inspire people to go into nursing as a profession so that you get that representation within the profession. (PC111)

This participant describes an incidental reciprocal arrangement to support future relationships and another points to the need for a cautious and deliberate approach to reciprocity

as follows, “I think we need to build those partnerships very carefully and slowly so it's very clear it's a two-way street” (PE367).

Strong partnerships were found to be of utmost importance to all participants, requiring significant investment. While some schools had well-established Indigenous community partnerships or affiliation agreements, others were still in the beginning stages of creating those relationships, or struggling to maintain them. All participants were in overwhelming agreement that to engage in this work in any context, creating partnerships with Indigenous individuals, communities, or organizations was essential to building capacity of the nursing program in an authentic way. While authentic partnerships were seen to be advantageous on both parts, they were simply one component of building program capacity. Meaningful engagement was found to be essential in forming these partnerships, seen as an important stance in all components of this work.

***Subtheme 2b. Genuine engagement.***

Engaging in this work in a genuine way was a common thread among all interviews and discussed in various ways. In the following interview excerpts the participants reflect on this idea;

When you see something that really didn't work, you have to acknowledge that it didn't work. You have to try and decide why it didn't work and what you could do about it separately, and why you shouldn't just keep repeating the same thing. (PB518)

and

I haven't connected with any of our elders and I probably should have done so. Again, that's one of those lack of time things that I should have made more of a priority. I'm

hoping as we move forward we will get there. I would like to make better connections.  
(PG340)

Participants had an acute awareness of when the work did not go well or could have been done in a different way, commenting on the importance of learning from errors. One participant describes her discomfort when observing misappropriation of Indigenous culture at a school event honouring an Indigenous person as follows: “It didn’t feel right. It wasn’t positioned well, and I was in the audience, and I was pretty embarrassed” (PB525). However, this event also was positioned by the participant as an opportunity to learn. Participants spent time thinking about the ‘how to’ of genuine engagement.

Consultation was a highly valued engagement activity by participants, often intersecting with the notion that to do things in a genuine way, one must go slowly. As one participant notes in the following, “[w]e value consultation... you can’t sometimes make quick decisions on things without consultation. That has served us well” (PE353). Sources of consultation were found in multiple places for participants, but one of the most valued was with their institution’s Indigenous Centre. Several participants noted that their respective Indigenous Centres offered a variety of resources to both faculty and students, including [educational] cultural events, academic supports, and counselling. Some leaders had collaborative relationships with their Indigenous Centre.

There’s a level of respect there; I’m not coming in to fix it, I’m coming in with options and our [Indigenous Centre] has acknowledged that I’m an advocate for this. So, even being seen as someone who’s interested to me is a facilitator because that opens other doors. (PC305)



As this participant notes, being recognized by the Indigenous Centre as an advocate for IH rather than an intruder is likely to create a willingness on the part of the Indigenous Centre to facilitate the building of new relationships between the SON and the Indigenous community.

Participants also placed great value on engaging with Elders to inform their work. In the following interview excerpt, the participant speaks to this experience;

He gave us the whole history of how we got to be this way in Ontario and all about the Truth and Reconciliation, and about what it was like to be Indigenous, and just healthcare in particular. He wanted them [students] to know going out to start their careers, what it was like to be Indigenous, and what things they should know for their future practice.

That was good. (PA87)

The knowledge shared by Elders was noted by participants to be particularly impactful; Elders fostered understanding of the history of Indigenous people and informed how this understanding needed to be reflected in everyday practice. This experience was described as profound by many.

The larger Indigenous community was also highly valued as a source of consultation, wherein members are invited to engage in committee work with SONs, collaborate with SONs to develop strategies to facilitate access to nursing education for Indigenous students, and contribute to strategic planning (PD193, PC178, PG200). As noted in the following interview excerpts;

To me, it's so important to have those partnerships where you can openly discuss issues, aspirations and such. I feel as though we started off the right way, we weren't going to do something without the input and consultation with the Indigenous community (PE338);  
and

Maybe sometimes we aren't able to place students for a variety of reasons, but it's not because they don't want our students, it's because something else is going on that interferes. We recognize that sometimes communities are unstable, or the nursing staff is unstable, and it wouldn't provide the best experience for students. I think we have good dialogue with our partners to be able to understand and I don't ever feel badly when something doesn't work out every year the same way it used to work, it has in the past. I think there's always mitigating circumstances. (PE343)

Genuine engagement with the Indigenous community was clearly described as that in which the level of dialogue between the SON and the Indigenous community was transparent, honest and respectful; a relationship that supported meeting the needs of all parties and being able to be clear when it wasn't working.

Overall, while participants in this study were in varying stages of building partnerships with Indigenous communities and organizations as described in subtheme 2a, all noted that this was more than simply initiating those partnerships; the SON needed to engage with their partners in a meaningful and ongoing way. Genuine engagement was found to be essential in other areas of building program capacity as well, particularly in terms of supporting Indigenous learners and educators.

### ***Subtheme 2c. Recruitment and retention of Indigenous students.***

Recruitment and retention of Indigenous students was seen as a priority by the participants in this study. However, although most universities had set aside seats for Indigenous students to access post-secondary education, SON leaders also expressed that without adequate support once the student had been admitted, the students may not be adequately positioned for success. However, some participants noted the barriers some students experience in their

communities to arriving at an academic level where they would meet the criteria for post-secondary education. As one participant notes,

It's not as simple as just having people come to school. That sometimes you may not have the prerequisites to come to school. It's opening it up to being-- You can't just have a place for students, you have to create [the opportunity]. You have to help create [the opportunity for] the student to come into the programs. (PC53)

As this participant notes, the first issue schools have to confront is the fact that over half of Indigenous students do not complete secondary school (Statistics Canada, 2015a), indicating that earlier educational supports may need to be put into place within Indigenous communities to help students complete their secondary education. Participants elaborate further on this theme in the following;

Most of us in the province have set aside seats for Indigenous students, who may not come in with the highest averages, because they haven't had the opportunity. We've created an opportunity that, if we get the opportunity to review those files, and those students will come into the program, perhaps, with supports in place, but also, maybe with lower GPAs than what they would normally be which is okay (PA116);  
and

For us, that seems like a good thing to be able to provide an opportunity for people who might otherwise not be able to come in to the university environment [...]. I think we are making a difference [...the program] has supports that are utilized by our nursing students all the way through the four years of the program. Yes, we are very proud of this. (PE82)

Participants acknowledged that supports for meeting the nursing program pre-requisites and support for success within the program were inadequate, however, many had created opportunities to facilitate access to Indigenous students who may not be academically prepared for nursing. Several participants described what is currently being done in their respective Schools to address this issue. For example, some Schools make exceptions for Indigenous students who are interested in nursing but are unable to meet the traditional entry criteria, as grade point averages (GPAs) tend for entry to nursing to be very high in the universities.<sup>3</sup> In addition, some Schools have created pre-nursing programming to bridge the gap between secondary school academic preparation and the academic requirements for entry into nursing school. While specific approaches to facilitating entry differed among Schools of Nursing, the overarching goal of all participants was to increase access to health education for Indigenous people. Participants also strongly felt that supporting nursing students throughout all years of their nursing education was imperative as noted here,

[W]e just don't want to say we have these seats and not do something about it, back it up with the support for students and also, the welcoming and the actual making sure that there is support in residences if they are staying in residence, supports on campus to meet others. (PA118)

This participant, among many others, expressed that there should be more supports than simply academic, indicating an awareness of the differing environments and experiences from which these students arrive. Thus, a variety of different strategies to holistically support these students was seen as imperative. While participants did not offer a plethora of distinct strategies for

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<sup>3</sup> Of note, there are many Indigenous students within nursing programs who meet the GPA requirements (some who would identify as Indigenous and some who would not). However, here I am speaking to those applicants who, because of the inequities in access to educational programs where they would be supported to complete the pre-requisite courses, and/or because they have been living in conditions in which higher education may not be adequately supported, would not have an equitable opportunity to access nursing programs.

retaining Indigenous students once in the program, they discussed the risk of not addressing the unintentional inequities embedded for some Indigenous students. Along these lines, one participant notes, “I worry that students who are Indigenous, who have self-identified are also pulled in to be the expert on all things Indigenous, either in small group learning or in their tutorials, and not all students are comfortable with that.” (PB164). Another participant goes on to explain this further in the following,

It's like saying in a class—say you're talking about diabetes and then pointing to a student and saying, "Do you want to give us some examples from your community? How many in your family suffer from diabetes?" That's terrible, but it's not done out of maliciousness. People think that they're allowing people to have space to talk. In fact, it doesn't. It actually makes a lot of people feel really uncomfortable. If a student puts their hand up and says, "Well, can I give an example from my community?" and they volunteer the information, then they've made the decision to share with you. But just because they're Indigenous doesn't mean to say that they have to be-- it's like sitting on every committee and participating. They shouldn't be seen as having to be the expert on everything that we think that they should. You can actually make them feel much worse and not included. (PB368)

Essentializing the experience of Indigenous students runs the risk of stereotyping; the classroom is a place where subtle forms of racism are manifest.

Participants also frequently discussed students' financial situations as another issue for some of their Indigenous students,

There are multiple ways that they may or may not get supported through funding, to attend university. We've gone to bat for them trying to have conversations regarding

whether it's an education authority or if it's the band that is distributing money. There's so many differences in the way in which students can be funded these days. We have tried our best to support our students from a funding perspective as well. (PE371)

Some SONs offered specific solutions to financial barriers. One participant provides an example in the following,

We have work opportunities, for example, in our sim[ulation] lab, and if we're going to offer a student work, we do think about those things, about those students that really could benefit from work that will help them be more successful in their program because they won't have to be working externally like going and working in Walmart or something. It'd be nice that if we got work that is a bit more aligned to what nursing is, but it's probably a better use if they have to work. (PB393).

Many students, Indigenous and non-Indigenous, face financial challenges during their post-secondary education experience given the costs associated, however, for some Indigenous students these costs are compounded by unique challenges attached to their community of origin, as noted here,

[Indigenous] students ha[ve] a whole host of other needs and competing demands, sometimes even resentment from community members that they were even going to school, and the access to school and not being able to get the courses that they needed in their high school programming to even come into nursing. It was really eye-opening like the whole working backwards piece definitely has informed my thinking moving forward. (PC60)

This participant illustrates not only the importance of looking at each Indigenous student's experience, context, and needs on an individual level, and tailoring the pathway to success for

that student, but also to the upstream barriers to those pathways that students need to surmount prior to even considering nursing education as a possibility.

***Subtheme 2d. Supporting PhD Indigenous scholars.***

Many participants emphasized that genuine investment in the success of Indigenous nursing students would contribute to the creation of Indigenous scholars; deemed by many participants to be essential in the evolution of this work;

We talk as a nursing faculty about how we don't have enough Indigenous PhD prepared nurses. I'm like, "Of course, not, you don't even have [Indigenous] nursing students.

How can you have PhD nurses?" (PC185)

This comment illustrates that although Indigenous PhD scholars are an important component to building program capacity, there are multiple steps that need to be taken to support the development of those individuals. Generally, SON leaders were hopeful that they could find and assist in the development of Indigenous PhD “champion[s]” or scholars, and many described distinct recruitment strategies, e.g., keeping abreast from where Indigenous PhD and Masters students were graduating. One participant uses the annual statistics on Indigenous nurse graduates in Canada to actively recruit. Another maintains contact with the School’s own Indigenous graduates, in hopes that she would be able to recruit them back to the SON for graduate education;

I wanted to hire an Indigenous nurse who I knew was finishing her PhD and I didn't want anybody else to know about it. We had a special competition because I knew she was finishing, and we successfully recruited her and I'm really happy, really, really happy.

(PB248)

Regardless of acquisition methods, participants generally were explicit in their hope to acquire an Indigenous scholar on their faculty.

In relation to Indigenous faculty, participants spoke at length about the responsibilities of such a faculty member, and the challenges they faced as a leader to support their academic success. A participant elaborates on their experience as follows;

The person that was hired, the Indigenous person that was teaching was very, very upset, because not only were they doing the job of tenure-track faculty, with all the responsibilities and milestones they have to reach in order to become tenured, but also their workload, their service, their research. They were also the token—again, that word; [the] person that was expected to change the culture within their unit because they were Indigenous, and that's not fair. (PA240)

And several other participants share their varied perspectives related to this “challenge”;

I think it would be a challenge to be seen as the representative of a population. It would be a challenge to be called upon multiple times, perhaps, to deliver content within the program. I think as a leader of the program, one needs to be mindful and protect people so that they're not overused or used for a purpose that's not the reason they were hired.

The person was hired because the person was a good fit with the curriculum and has expertise to deliver and is a scholar amongst us (PE402);

and

I think that we have this paucity of PhD, like when we look at the PhD prepared scholar we don't have a lot of people that are Indigenous. I can't imagine the pressure, I can't even imagine that it might be a perceived frustration of being the one that everyone always goes to because they're Indigenous. I can only imagine that it would be



infuriating right? 'You're Indigenous you can join this committee we need someone Indigenous on it' (PC223);

and

No, you don't have them on the committee just because they're Indigenous, you have somebody on a committee because they have something to really contribute. It's very token when it's just one person. If [the committee's] portfolio is going to include Indigenous issues, then there should be two or three people on the committee that can bring three or four different opinions ... or viewpoints. The tokenism is the thing that we have to avoid (PG541);

and

That is, to me, a real potential threat is that it becomes—everyone says, "Let's go to her and ask her, maybe she can teach this class or maybe she can do that maybe--" instead of respecting who she is and what she's hired to do. (PE412)

These interview exemplars illustrate some of the central challenges nursing schools face; the low numbers of Indigenous scholars working within faculties in the university and consequent low availability of Indigenous consultation, including within nursing programs, tokenism and the taking up of 'Indigenous' as expert in all things 'Indigenous,' i.e., the essentializing of 'Indigenous.' This was most often expressed in the context of Indigenous participation in committee and course work.

Regardless of these challenges, generally, participants in this study were vigilant in ensuring their Indigenous faculty were protected from being overwhelmed by responsibilities. Essentially, the nurse leaders in this study felt a responsibility to protect Indigenous scholars from other faculty tapping into their Indigeneity. Leaders saw this as a threat to the individual's

autonomy, and in many cases, the leader's role involved keeping staff from approaching their Indigenous colleague with requests. Participants found additional ways to support their Indigenous colleagues, for example connecting them with Indigenous mentors in other faculties, or providing them with their own administrative support.

***Subtheme 2e. Creation of meaningful experiential learning opportunities.***

While many SONs provided clinical placements offering exposure to Indigenous clients seeking health, these placements were not always explicitly Indigenous. Although clinical experience with Indigenous health issues varied greatly between the Schools represented in this study, it was agreed among all participants that nursing students require practice experience to transform their understanding of IH issues, and thus be able to practice safely with Indigenous clients. One participant noted, “the more we can expose students, the more they can understand what some groups might be going through” (PC109). As noted, Indigenous placement settings, and type of exposure to Indigenous clients varied between the Schools. By virtue of advantageous geography (for example a SON situated in a city surrounded by First Nations communities), some Schools were able to provide students with meaningful experiential learning experiences in acute care facilities due to a high representation of Indigenous people accessing services. However, most participants described placements in the community, rather than hospital-based care, as the most relevant for students to gain meaningful practical exposure to the context of Indigenous health issues. One participant described how the nature of certain community placements, specifically an Indigenous solvent use clinic and mental health placements that are “Indigenous in nature” (PE301) exposed students to a high representation of Indigenous clients seeking care. One SON in particular has created clinical placements within nearby correctional facilities, described here;

They often undertake clinical mental health in the prison system because there are lots of [Indigenous] men who are incarcerated, who have mental illness. That has contributed to whatever else is going on in their lives. The students pick it up pretty quickly, that they see an over-representation of people with mental illness, and Aboriginal men in the communities. It is the most amazing experience for students because they see their role in a quite different way, they're trying to provide healthcare in a therapeutic way in a place where in fact, people don't have the liberty to say 'no' in the same way that people have the liberty of saying 'no' when they're not in the correction system. (PB61-73)

All of these placements were thought to provide particularly beneficial student learning experiences. One element in common was the importance of providing students with an opportunity to see first-hand the impact/consequences of colonial and neocolonial Indigenous-state relations, for example, i) the consequences for mental health and well-being; ii) the overrepresentation of Indigenous people (in this case, men) within the correctional system; and iii) the challenges establishing relationships with clients within corrections.

However, not all student placements provided the same opportunities. For example, as two participants note in the following interview exemplars;

The classroom setting is one thing, but it's when you put a student in the ER and they hear it for the first time. They hear it. Racist comments, stereotyping, assumptions. We all know it's there. It's not just from healthcare professionals; it's from more than that. It's a deep-rooted issue (PD263);

and

Then, of course, I've heard students talk about some of the things that they witnessed in practice in terms of how clients in acute in acute care of settings who are Indigenous.

How they get treated differently? One group in particular, that I hear the students feeling quite shocked about are the chronic drug users in hospitals. The students are really quite stunned by the judgment that they see the nurses exercise with those patients... The stories that I've heard from students is pretty appalling, the way they get treated. (PH207)

These participants describe student exposure to blatant racism and discrimination expressed in the healthcare environment by some of the practitioners who mentor their students. These experiences could be an opportunity to foster critical self-reflection and generate productive discussion about racism, its effects and how it might be interrupted in this context, i.e., what the nursing student can do. However, as one participant questioned, "I'm not sure how that gets processed in terms of what kind of discussion do you have in a praxis session with a group of students? Is the issue even raised? I don't know. Would it be explored?" (PH210).

Discussion and reflection during clinical hours typically occur during "praxis" sessions, wherein the group of students and their clinical instructor (CI)<sup>4</sup> have a confidential group discussion about their clinical experience that day. Notably, education of CI faculty was an important consideration brought forward by the participants in this study. As one participant states here,

I think that that's something that we need to make sure that we do a better job at [educating faculty]. We continue to use these placements, but how do we prepare the faculty who's guiding the students in the placements? I would hate to create the impression that we do a good job in terms of how we even prepare students for placements with Indigenous clients [...] I'm thinking about, when there's a group that's assigned to a placement like that, who have you hired as the clinical instructor? What

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<sup>4</sup> A clinical instructor (CI) is typically a nurse practicing at partner sites or a nursing graduate student who is contracted part-time by the School to instruct undergraduate nursing students in a variety of clinical settings.

kind of support is there for the clinical instructor to be able to support the students and to work in a genuine way with the people at this agency? (PH240, PH292)

The importance of educating CIs so they are knowledgeable about IH issues, and then providing ongoing support to those instructors was brought up by several participants; clinical instructors typically have complete autonomy in how they guide their students through the placements, and what gets discussed in praxis sessions. The study participants and other full-time faculty typically were not privy to these sessions, leaving questions as to whether or not students were effectively engaged in discussions regarding, for example, the context of Indigenous health and health inequity, racism and discrimination and bystander approaches to racism as well as other effective strategies for managing the complex of issues associated with Indigenous health. One participant shared the story of a time in her career when she was the CI for a group of students at a local Indigenous community center; she felt as though she had not been adequately prepared to guide students through the issues faced by Indigenous clients in that setting.

This reflection prompted another identified concern that the participant felt was necessary to address moving forward—CIs may not have the knowledge necessary to address what students were experiencing in the clinical setting. If unprepared, CIs supervising students working with Indigenous clients may not be able to guide those students to provide what is deemed culturally safe care. This points to a distinct challenge noted by participants in not only assigning appropriate CIs to placements with a high representation of Indigenous clients, but also ensuring those CIs are well able to support the student's critical thinking and foster effective group discussion while working with Indigenous clients or groups.

As noted, CIs typically are nurses working in the practice setting who have agreed to teach clinical groups on a part time, contracted, or transient basis. They don't typically apply to

teach in any specific setting; they apply for a course consisting of a variety of placements and are assigned a clinical setting within that course. Therefore, given the limited availability of the CI, nurse educators experience a challenge related to including them in scheduled IH-related training provided to their faculty and staff. A participant speaks to the hiring of CIs in the following;

Anybody would be appropriate if they have developed the understanding of, what are the issues? And have a willingness to 'work with', as opposed to somebody who is the type who likes to 'do to.' It's got to be somebody that has an attitude of working with people and doing that without judgment. That should be the work of every nurse. It shouldn't be exceptional. It should be that any nurse that you hire as a clinical instructor, should be able to do that, but that's not the case. It's identifying people who have the knowledge and the willingness and the interest to establish those kinds of collaborations. (PH302)

However, this participant also noted there was no process or criteria currently in place at her SON to hand pick the "right" CI for Indigenous placements.

Regardless of how experiential learning is delivered, it is essential that students find it valuable in terms of supporting their understanding of the context of Indigenous health issues and what it means to provide culturally safe care. One participant eloquently sums this up; "It should be integrated into that clinical learning environment that's meaningful, and really does allow students to learn their own truth about this, as [our Indigenous lead] says, Truth and Reconciliation" (PD214).

### **Theme 3. Addressing institutional racism and inequity.**

The need to address institutional racism and inequity was a theme associated with the integration of IH in the Schools of Nursing represented in this study. Some Schools had gained momentum in this work years earlier and already had well-established processes in place, and

others were at the starting point. Four subthemes were identified within this area: (a) integration of Indigenous health; (b) course development; (c) faculty and staff development; and (d) colonial processes in nursing.

***Subtheme 3a. Integration of Indigenous health.***

Participants largely felt that IH content was currently “fragmented,” “being touched on,” “tacked on,” or “disconnected” within the curriculum. To most participants, this meant that IH was being introduced or discussed in classrooms in a token or incidental fashion. This was described by participants as using one Indigenous case study in a theory class, or a lecture in which the subject matter (for example the social determinants of health) may organically lead to discussion surrounding IH. A participant speaks to the issue of integration in the following,

Some schools are having a whole course called Indigenous health, but we decided that that means that then there is a perception that that's the only time they need to think about Indigenous health. Whereas we would rather see it marked, and we would see it and woven in so that it becomes normalized and part of healthcare. (PB462)

While TRC recommendation #24 does state that all medical and nursing schools require students to “take a course dealing with Aboriginal health issues” including colonial history (Truth and Reconciliation Canada, 2015, p. 164), participants unanimously agreed that the right way to include Indigenous content is to “thread” or “weave” it throughout the entire curriculum rather than create one required course. Two of participants speak to this in the following;

Well, I think by approaching it with integration, we have more options across our courses. We can incorporate right through from our clinical and our theoretical courses, to even our anatomy and pharmacology and some of our other science courses, but also our research (PD273);

and

If you're going to develop a module, say, on child health, can you think about a way that is more inclusive? Can you think about a way perhaps that this is an Indigenous child who is sick, and so that you adapt the module so that it is an example of not simply a white family, mother, father, two children? So that you adapt [the curriculum]. (PB415)

Participants were in varying stages of assessing their current curricula, identifying content areas in which IH content could easily fit with their current programming. Most thought the integration of content addressing Indigenous health would fit well into the content of current courses and as noted above, the Schools were in varying stages of addressing this integration.

As noted here, some participants in this study were still at the point of theorizing how they might thread the content into their existing curriculum, but others had identified areas in which IH was already being incorporated. The following participant interview excerpt provides further elaboration on processes related to IH integration,

To me, that was very important work. For one thing, it allowed all of us as faculty members to really reflect on what we were teaching in terms of Indigenous health, Indigenous knowledge, where we were teaching it, who was teaching it. We had some really profound discussions about that. I think it was important work that brought us all together on that topic (PE66)

Here, the importance of creating time and space for reflection and dialogue regarding a pedagogy for nursing teaching and learning is underlined. For example, a participant from a SON that uses problem-based scenarios noted that more routine updating of these scenarios could provide an opportunity to create a scenario addressing IH. A participant discusses this in the following,



Perhaps in case studies they could include more examples of Indigenous health. That's one thing. It's not really removing anything but it's revising something that might draw attention to [IH]. I would think that there's a way of massaging current things to look for ways to introduce into more Indigenous population or use case examples or something like that. I think that would be the way I would suggest doing it. (PF132)

Another participant goes on to discuss the selection of course readings,

In year one, we've always had the students complete a book review... In this instance, we have chosen to have the students read a book about how Indigenous people describe the healthcare that they've had provided to them. That's an example of choosing a book quite deliberately... So it's not to use them exclusively, but it is to be quite purposeful in where we find the literature. (PB28)

Several additional participants described purposefully selecting readings authored by Indigenous scholars for existing projects rather than only selecting material authored by non-Indigenous scholars, thus adapting their course rather than changing it to include Indigenous perspectives.

Although participants in this study provided good examples regarding how IH might be integrated into existing curricula, none explicitly discussed the option of deconstructing curriculum review processes prior to inserting IH content. In addition, while participants all agreed on some level that weaving the content throughout the curriculum was the best option, some participants still identified benefits to having one required course. One participant, as a member at the administrative leadership table, voted in favour of the University mandating that all students take a required course in IH/IK, even though she was of the opinion that this was a token gesture. However, she also reflected on a point in time wherein mandatory French language credits improved understanding and acceptance of a bilingual country at the time. In

that context, she alluded to the fact that a required IH course could, at the very least, increase awareness and knowledge of Indigenous history and issues. As another participant noted,

Whereas if it was a whole course that was focused on Indigenous health or whatever, then it would *have* to be taught. A comprehensive course and even better if it was a university-wide elective that everybody had to take. Even if it wasn't a health what it was more of a historical one or something that every student has to take it. (PF64)

While participants shared the general idea that IH content should be woven throughout courses rather than inserted into them as additional content, there remained the challenge of how to artfully execute this. This is further elaborated in the following.

***Subtheme 3b. Course development.***

As noted above, Schools of Nursing were in varying phases of curricular adjustments, ranging from assessing current content, to theorizing potential areas for development, to actively incorporating or sustaining IH content. Overall, curriculum development was overwhelmingly the top priority among the participants. There were several dimensions to this concept described by participants, for example the challenge of including all “cultures” into course content, and how prioritizing Indigenous culture might do a disservice to other groups that were prominent in their area and therefore requiring space within curricula. However, some participants had recently undergone a curricular restructure and were confident in their integration of IH.

Participants were able to identify several places where course content was a good fit with Indigenous health content. For example, as one participant notes,

We have used lenses like primary health care, social determinants of health, always to help guide our students to appreciate the context of the people that they care for. If you're

going to be in contact with Indigenous clients, then you're looking at primary health care and social determinants of health all along. (PE271)

In the absence of concrete direction, mandated curricula, or specific courses, several participants had begun to generate purposeful discussion around IH in the classrooms, finding opportunities to direct delivery of this content as part of longstanding nursing education topics or traditional nursing theories. Related to this, another participant speaks to one of the challenges to this approach in the following,

The challenge is that it's not about these many hours were spent on Indigenous health, it's really about making sure that whenever we're talking about anything; so say we're talking about diabetes, that we remember that there are groups who, unfortunately, suffer more diabetes than others do, but doing it in a way that [isn't] derogatory or negative. Trying to get away from stereotypes. (PB348)

In addition to determinants of health providing theoretical fodder for IH discussion, social justice, relational inquiry, and ways of knowing were also mentioned as nursing topics where there was an opportunity to embed course concepts in the context of Indigenous health. In addition, foci on particular illnesses provide an opportunity to embed Indigenous health content, however, this latter approach, as this participant describes, runs the risk of reproducing stereotypes sometimes associated with Indigenous people. Knowledge related to the context of Indigenous health and health inequity needs to be embedded alongside the presentation of this kind of information. In addition, the use of Indigenous case examples ought to be carefully scrutinized; speaking in the context of cultural safety, the participant's reflection above highlights the importance of quality content and as an educator, ensuring knowledge is always contextualized.

One of the remaining questions that participants shared is how they can be certain that IH is effectively and comprehensively woven into the program. The question of how to measure success in IH content delivery presented a challenge to the nurse leaders/educators in this study. One participant raises a number of important questions with regards to this in the following,

How do we ensure it's in there? How do we ensure that all the students understand it? Do we do it in more than one year? Are we measuring the effectiveness? That kind of thing. Is that every time we teach something or we provide information, do we necessarily have to have a test on it? Is a reflection to me something that would be interesting to do, if we had a guest speaker is a reflection probably good enough as far as I'm concerned? Yet if we go down like some of the other universities do and have a course, there's always got to be evaluation criteria. What do you do, do you assign a paper? Do you do an interview? Give a test? What's the best way? I don't have the answer for that one.

(PF278)

Some schools are at the point in their journey where evaluation of efficacy is imminent. For example, one SON that had recently undergone a curricular restructure, including integration of IH has just seen their first cohort complete the new curriculum, leaving the leader of that SON with a need to begin evaluation. Other Schools have already evaluated their curriculum and integration of IH and have been satisfied with their progress. One participant shares their School's progress in the following,

I'm creating course evaluations for faculty to complete on their courses that address a number of topics, like "how are you responding to technology in your class?" I'm including the TRC recommendations in Indigenous learning. (PC422).

It was this participant's hope this kind of evaluation will prompt faculty to recognize when they are not incorporating Indigenous content according to the standards of the SON, and direct their teaching strategies to improve in this area. This may not only strengthen the link between an effective curriculum and the educators' own awareness of how they deliver it, but perhaps prompt some self-reflection among those educators who aren't purposefully inclusive of IH, leading to necessary professional development.

***Subtheme 3c. Faculty and staff development.***

Participants acknowledged faculty and staff development as a necessary component to this work, and often described their purposeful facilitation of faculty and staff development in terms of offering additional education, including opportunities to attend conferences and other reflective group activities. As one participant noted in the following,

I think that first of all, I will speak for myself, I need to be better informed about the issues related to Indigenous health healing practices all of the—I need to know more. I don't feel that I can get up and teach yet about the Indigenous health issues. [laughs] It would just be me regurgitating something that I've read. I need to be aware at a different level about what the issues are I think to be a legitimate teacher. (PH130)

This excerpt describes how educators need to first understand the importance of this topic prior to educating students in classrooms. It also reflects the participant's commitment and willingness to engage in further learning. Participants speak to some of the challenges associated with this in the following;

I don't want it to be, "Oh, this is something else we have to do." I really want people to understand why it's important to do versus feeling that they have to do it and then working through it. How do we responsibly integrate Indigenous content or awareness or

topics into the curriculum versus just doing it as, "Okay, now we have to talk about cultural safety and we'll do it in the context of Indigenous communities" (PC130); and

People resist change for different reasons. If you've already completed your course and then you're being asked to make changes, that just triggers common frustrations from faculty or others. I think that people just when there is a lack of awareness, they respond differently. I think once people have been fully informed, it does shift the perceptions. (PD241)

Here the participants shared their fear that faculty would become resentful of added work if they were instructed to include IH content but did not have the knowledge of its importance.

Participants also were aware of the importance of personal investment with IH as shared in the following;

How we react is part of unpacking our own truth, "Why am I responding in that way? Why does that bother me so much?" That means that some of those thoughts, and some of those built-in systemic patterns of what's been dealt to us as a society are embedded in us more than we would like to admit. If you feel offended or put off or irritated by being asked to take this on, that's part of the truth, because then statements come out like, "Why do I have to do this? There's so many other issues." Well, that is true, but this is an issue that we actually need to own (PD351);

and

I find that sometimes people are afraid of it because if they don't understand it and they don't know why they need to do it or there's that knee-jerk reaction to, "Well, why are we

doing this? Why do we need to accommodate this group? Why do we have to talk about it?" (PC130)

Many leaders felt that in addition to investing time in gaining foundational knowledge about colonial history and Indigenous health, faculty were going to have to undergo significant personal development, i.e., critical self-reflection, to be able to engage with the material in a genuine way. Participants noted how nurse educators often are not aware of their own biases, which presents a significant barrier to genuine engagement in this work. In particular, as one example, participants acknowledged the challenge associated with engagement with the notion of “white privilege,” and “unpacking their own truth.”

One way in which SON leaders were supporting staff and faculty development was through the “Kairos Blanket Exercise” (2017) to help set staff on a path to understanding antecedents of Indigenous health. The purpose of this activity is to educate participants in an interactive way on the roles of First Nations, Inuit, and Métis groups through moments in history, including pre-contact, treaty-making, colonization, and resistance (Kairos Canada, 2017). The exercise involves trained facilitators who read scripts and physically “walk” participants on blankets, which metaphorically symbolize the lands of Indigenous peoples. The activity ends with a talking circle wherein participants share thoughts and reflect on what they have learned (Kairos Canada, 2017). One participant, whose SON collaborates with the University’s Indigenous Centre annually to host this activity for nursing students, describes what this activity looks like in the following:

We probably have groups of about 40 students, I'm thinking 40-50 because we must repeat it three times during that week. They sit in a large circle and everybody's given a blanket, or it might be a towel or it's something that would represent a blanket. That

blanket is your space, it's where you are, and everybody represents the [Indigenous] population... People are given cards to read, papers, things to read out loud and as each of these parts of history are read, blankets are removed from the circle. It starts to represent all the different losses for the various reasons that Canada's Indigenous people have experienced. When your blanket is removed, now you're sitting on the outside and you're looking at who's left and thinking about what has transpired to create those losses, whether it was disease or the whole host of things. It has profound impact on the students because sometimes until they go through the Blanket Exercise, they have no recollection of what life was like before the Europeans came to Canada, of how many losses our Indigenous people suffered as a result of treaties and other things. That kind of experiential learning has a great power to elicit discussion and such [...] For some, it's the very first time that they've talked about treaties and the impact that that has had on land and other resources, and the resources for living that, again, contribute to one's health. We really like it, that exercise. (PG217)

While some participants did not have a comprehensive understanding of what the activity entails, they were hopeful that it might initiate relevant dialogue and interaction among the staff and faculty. Others had already begun to incorporate the activity within their SON, finding that it had a profound effect (often bringing staff faculty and staff to tears), indicating that this activity may be an accessible facilitator for leaders to help faculty and staff “unpack their truth.” Of note, this exercise can be disturbing for some and requires careful monitoring and debriefing.

Other faculty and staff development ideas included something as simple as disseminating the TRC (2015) document to faculty and staff (PH335). One participant suggested that Indigenous cultural safety (ICS) training is as essential as any other required occupational



training (PD461). Overall, development of knowledge and awareness amongst the faculty and staff was thought to be the starting point for any work in terms of incorporating IH into SON programming, requiring attention prior to actively engaging in any of this work. The importance of this aspect was, as one participant put it, foundational: “We need to have the confidence before we can do any of this. It has to start with us” (PD96).

***Subtheme 3d. Colonial processes in nursing.***

Generally, in this study, participants agreed that colonial and neocolonial processes were evident in nursing, including nursing education. The following interview excerpts provide a glimpse into what participants had been thinking about in this regard;

Racism in healthcare has been very damaging to people because people come with attitudes that then affect how they provide care to Indigenous people. So, it's understanding your own embedded racism and then how you can make sure that it doesn't occur and doesn't affect the care that you provide. Us knowing that then, there will be more to make sure that how we teach is not racist either (PB156);

and

We're really white as a profession. We talk about cultural safety as nurses, but I don't necessarily know if we actually walk the talk in terms of education, that people may not be aware of their biases as educators. I think that's a huge barrier that there's things that we haven't let go of yet. It's still an old guard in a way within the nursing community. (PC259)

While participants generally did not use the language “colonial,” “colonized,” or “decolonize,” in the context of the work occurring at their SON to address the TRC recommendations and IH, several spoke to racism and discrimination within the clinical and university environment and the

importance of beginning with critical self-reflection as educators to address this issue. Another participant speaks to the importance of an anti-racism stance in the following;

I'm not an expert in cultural safety, but what I'm learning is that power differentials [exist], even in the learning environment. [W]e want our students to be feeling comfortable and not being asked to be the expert in the learning setting unless they want to (PD168).

The Indigenous Cultural Safety (ICS) training was a prompt for this participant to think about power differentials between students and their professors/instructors within the university setting. Thinking about how knowledge gets privileged and addressing relational power is an important aspect of ICS training; this is knowledge with application to practice in the clinical and educational environment. Importantly, cultural safety is an explicit anti-racism stance.

In relation to curriculum development, another participant speaks to a more general concern related to 'how' to do this work;

Indigenous health is a concept that is not necessarily explicit in the curriculum and so it would be really hard to even have a sense of how aware the students [are] of the Indigenous health issues. That is why we've got a lot of work to do to figure out, how do we change our curriculum to decolonize it? (PB117)

This interview excerpt points again to the complexity of curriculum review in the context of thinking about the 'decolonization' of nursing (including the curriculum). IH is not explicit in all curricula. The lack of IH knowledge within nursing curricula is reflected in student knowledge of IH issues; sometimes noted in student papers (as just one example provided by participants).

Participants were mainly in agreement that their Schools required significant changes and continuous review of the curriculum to address the TRC (2015) recommendations and integrate

IH, disrupting the status quo was a challenge because of the embeddedness of colonial and neocolonial relations.

**Theme 4. Disrupting the status quo: Challenges and facilitators.**

Participants identified multiple challenges and facilitators to engaging in this work. While some challenges were surmountable, participants found that others affected the mobilization of the work in profound ways, making it difficult to challenge the status quo within their Schools at multiple levels. There were five subthemes found within this theme: (a) competing demands; (b) Indigenous input; (c) commitment of senior leadership; (d) admissions pathways; and (e) reshaping culture.

***Subtheme 4a. Competing demands.***

Competing demands were prevalent among participants, who often noted that the usual work combined with extenuating circumstances often took precedence over actively working toward increasing IH within the school;

You can only stuff so much in a box, then it overflows and there are some things that need to come out. This is like cleaning a closet here. I think we're trying to put in interprofessional and Indigenous [health] and digitalization and, oh gosh, patient safety and quality improvement and we're trying to stuff all this stuff in the box. The box is breaking at the bottom and some things are going to fall out because it's too much.

(PA547)

Generally, participant engagement with curriculum review and development was ongoing and focused on multiple issues; this was noted as a common competing interest in terms of addressing the TRC (2015) recommendations and IH. Many participants, when discussing threading IH into existing curricula as described in previous sections, described this challenge at

length, often using the phrase, “you can’t teach everything.” To put more into the curriculum meant other things needed to be removed. Participants speak further to this challenge in the following,

Nurses always want to know the skills. They all want to know that when they leave that they can put a catheter in and they can look after this and look after the other, and although in the clinical setting, they will say, "Well, they need to hit the ground running," and I hate that term because that's not what nursing school is about (PB438);  
and

Our hospital system in particular has not moved to the point where they can embrace them, mentor them and not blame them for not having 25 years’ experience when they graduate, that they need time and once the time is given to them, they will excel, and they will be the leaders that the system needs them to be and wants them to be. (PA588)

The participants above describe the additional challenge of the profession’s traditional focus on skill acquisition and expectations of acute care facilities for newly graduated nurses.

Partnerships within tertiary care facilities are valuable to Schools of Nursing, and leaders expressed that while the expectations of those facilities are sometimes unrealistic, foundational nursing knowledge, skill acquisition, safety science, quality improvement, and performance management are essential competencies regarding the preparation of ‘entry to practice nurses’; arguably so is cultural safety.

An additional competing demand expressed among the participants was the general busyness of individuals and the SON as a whole. Many participants indicated that they have had a “busy” or “tumultuous” year. “People are still wading through their teaching, and then they come up for air around this time of year, and then there's opportunity” (PD342). This participant

is one of many who were waiting for the summer months to provide an opportunity to get ahead in the work in terms of providing training, collecting resources, or assessing integration of IH into curricula. The nature of teaching within nursing education was noted to be very time consuming, given course development and preparation time required by educators to deliver quality content, as well as other general items of importance that arose. One participant plainly stated that other items within the SON that she felt were of equal importance to IH often arose, requiring immediate attention and at times causing IH to become “lost” in the everyday work (PG296). In addition, some schools experienced structural issues that added to the “busyness” of managing a SON, preventing leaders from fully engaging in the work. Items such as accreditation, strike action, and personal circumstances that took a leader away from the work, were all noted to have a detrimental effect on the progress of this work.

***Subtheme 4b. Indigenous input.***

As noted above, recruitment of Indigenous faculty and/or staff, engagement with Indigenous Elders and scholars, other community members and Indigenous Student Center faculty and/or staff all facilitated addressing the TRC (2015) recommendations and IH within nursing programs. Indigenous input was noted by participants as affecting their work; one participant described her school as “blessed” with an Indigenous nurse who was willing to join their faculty, and another noted it would be “helpful” to recruit a non-Indigenous tenure track person with experience doing research in Indigenous communities. Having an Indigenous “champion” who was invested in this work was perceived as advantageous. These individuals were noted to contribute positively to the work in terms of the ability of Schools to recruit involvement from Indigenous communities, generate Indigenous-led nursing research, and guide curricular changes. In addition, some schools had a non-Indigenous “champion” who was very

able to contribute in positive ways to the momentum of the work through their influence on the rest of the staff.

However, regardless of the access to Indigenous people to assist them, there were challenges, in particular related to protocols regarding knowledge sharing. As one participant explains,

There is a political system within the Indigenous communities themselves that provide really big barriers—the permissions, who's the holder of the knowledge, whether or not they can share that knowledge and in what setting and with whom. (PA663)

This “political system” was found to affect the ability of Indigenous and non-Indigenous people to contribute to the work. For example, one participant’s Indigenous consultant had to wait for permission from her band to share specific knowledge that could influence the curriculum.

Another participant’s non-Indigenous champion at times expressed anxiety about overstepping the boundaries of knowledge sharing.

However, as several participants noted in this study, finding and engaging with “the right way” of doing things is essential to this work;

I believe that the Indigenous people themselves are owners of their knowledge and that's something they value that they have. You can't take that away from them. We've already taken too much away from them, so they need to provide that to us. (PA688)

The above quote indicates that participants are generally aware of the risk of misappropriating knowledge, hence the perceived need to employ individuals who are well-versed, willing, and able to share knowledge with staff and students in the right way.

Beyond the walls of the Schools of Nursing, other opportunities for Indigenous input were found by participants to be valuable. For example, consultation on curricula was sought

from Indigenous navigators and coordinators in acute care facilities, which has facilitated alignment between nursing education and cultural safety practices within tertiary care (PA667, PE152). Participant leaders also sought guidance from their Indigenous graduates who are working elsewhere but still remain interested in helping their Schools succeed in addressing the TRC (2015) recommendations (PB281, PE134), and welcome any input volunteered by Indigenous nurses in the area.

Participants in this study clearly valued knowledge received from Indigenous Elders in the community, and most had purposively sought that knowledge;

Every time I listen to one of the Elders, [I'm reminded that] we've lost our way as a population on this earth. If we followed more of what they've been taught, maybe the earth wouldn't be in so much trouble. It's a comfort in listening to their stories for me because they seem very wise. If they're willing to share that with us then, we could grow to because we're lost as a community in some ways and we need to hear those stories. I think we've become so technical within our own societies that we've stopped telling stories and there's a great value in telling stories and hearing other's stories. (PA373)

As reflected in this participant's interview, nursing leaders in this study felt that knowledge shared by Elders is important for not just nursing, but society as a whole. Elders are often invited to sit on committees, speak at meetings, participate in strategic planning, and participate in program and curriculum development. Those who have not yet established trusting relationships with Elders in their community expressed their need to do so in the near future.

*Subtheme 4c. Commitment of senior leadership.*

Commitment to meeting the TRC recommendations by senior leadership at the University level was seen to facilitate efforts within the Schools. Two participants describe this commitment in the following,

This University is taking a very proactive role because [the] TRC mentioned schools of education, law, medicine, and nursing very specifically, and we have all four of those here. Each of the faculties are taking a very proactive approach (PB93);  
and

This is coming from the top, this is coming from our president and our vice-president.

This is an institution-wide initiative, we are responding to the calls to action. (PD71)

In these Schools, involvement of senior leadership was as straightforward as the University mandating that all faculties begin work to address the TRC recommendations relevant to them. Some participants described very specific strategies that were being rolled out across the institution, most commonly in the form of required Indigenous course credits for all students, and others described more participatory ways in which their University was moving the recommendations forward. These included interactive sessions on equity, diversity, and Indigenous ways of knowing, special Commissions that addressed racism at the University with special focus on racism targeting Indigenous people, and opportunities for all faculties to strategize integration of Indigenous health and knowledge across multiple levels. As one participant explains,

The principal of the university felt that this is where we need to start; as a change in attitudes and a change in belief and actually an acquisition of knowledge can't happen



serendipitously, we have to be purposeful in it. I'm considered to be in that senior leadership group, so I participated. (PB147)

This type of purposeful approach taken by senior leadership was seen as a facilitator, allowing SON leaders to participate at that level.

However, the University's level of involvement varied among the participants. One University had two full-time appointments at the senior administration level specifically to address the TRC and other Indigenous initiatives, providing a support system for faculty engagement. At other schools, the autonomy and support that the University provided Schools of Nursing while engaging in their own efforts at the senior leadership level was a facilitator. In other locales, while the senior leadership was supportive of the SON's efforts, some work was required to put that support into motion.

We didn't have enough money to do it all by ourselves and there were some things we needed to do [...] What we did was, we partnered with medicine and other faculties, and collectively, we got some money from the University and then we were able to do it.

(PA647)

A collective effort between several faculties provided the means to coordinate an educational visit from an Indigenous chief and although senior leadership was supportive of this effort, this the participant's quote underlines to the implicit challenge in taking action in a large institution where there are multiple faculties and potentially partners. Another participant describes their process as "clawing, scratching, [and] hitting the side of [the] desk. We have had to go through various university levels as we did things like put the foundations in place" (PG169).

Overall, however, participants were pleased with the level of commitment of their institution as reflected in the following;

The already willingness, that's the commitment of the whole school, to move this forward. Thank God, it makes it easy, I have never had to sell it. They've educated and sold me to some extent, I would say. (PG329)

This reflection illuminates the importance of full commitment of senior leadership, and the institution as a collective, in moving the TRC (2015) recommendations forward to foster much needed change.

***Subtheme 4d. Admission pathways.***

One way in which participants generally felt supported by the University's leadership was the flexibility of the admission process for Indigenous students. Most universities facilitated entry across all faculties, which facilitated some Schools to create specific entry pathways into nursing for Indigenous students. However, there are several nuances to be considered when discussing Indigenous seats.

The Indigenous admissions policy is one example that there was that willingness to acknowledge that we're not giving special status, we're considering people's experiences.

I think that's a huge step so that gives me some hope. (PC295)

This participant speaks to the idea that it's more than simply admitting people of Indigenous heritage into programs, it should be about individual experiences and contexts. Therefore, while designated Indigenous seats were available at all universities, different Schools executed their admission policies in different ways. One school has piggybacked on the University's Indigenous admission process by creating a nursing-specific pathway to admission, consulting with each student accessing that pathway to design individualized courses and electives that would set that person up most effectively for success in nursing (PG130). Another has used the

policy to create pre-admission programming within the SON (PA116). Some participants were even pioneers in the creation of such a process, as described here;

When I first was appointed here, I was the chair of admissions and people were just beginning to say, 'how do we make sure that Indigenous populations have as much encouragement to come into the profession of nursing?' We were very early adopters of an Indigenous applicant method. Students out of high school could identify that they wanted to be considered to be an Indigenous person and then we set up a different way for evaluating their applications. (PB215)

However, while the universities' Indigenous admissions process created opportunities for SONs to independently guarantee access to nursing education for Indigenous people, the choice students have to identify as Indigenous, prevents special access for those who do not identify;

It is about self-identification, so any alternate pathways or supportive pathways for admission, in order for them to be exercised there has to be self-identification. That's about all I can say about it from my view, from my point. There's been more students self-identifying, [but] I think there's only about [a small percentage] of our student body in the whole university is identified as Indigenous. We can only do this if we know (PD35);

and

We fill our placements and we know that some students choose not to be adjudicated differently because they just wish to be treated like everybody else (PB222);

and,

Depending on when they want to tell us that they're Indigenous, that's up to them. (PA133)

Identification as an Indigenous person carries some risk for Indigenous people; racism and discrimination, as already noted in this thesis, being one. Student choice to identify was largely supported by the participants in the study, however, it also meant there was differential access to special pathway opportunities.

***Subtheme 4e. Reshaping culture.***

In addition to curriculum review and revision, in this study, shifting the School ‘culture’ was seen as an essential part of addressing the TRC (2015) recommendations and integrating IH;

I think its building the capacity for understanding what the issues are for Indigenous people in this country and helping to broaden our understanding of the things that are in the TRC. Among all employees in the school, so that's not just the faculty but also our staff. Anybody who would really have any interaction with students is being included in all of these things. I see it as an opportunity to influence the culture of the school, not just the curriculum. (PH51)

Participants discussed the concept of a shifting culture in the contexts of countering existing discourses. However, to do this, participants felt faculty and staff needed to come face to face with the realities of the context of Indigenous health;

I don't think people understand unless they've actually driven through an Indigenous community or actually had that experience to see why it's important to pay attention to. I find that in southern Ontario there is an overarching sort of like, well, it's that problem. (PC91)

and

[We] are taking a very proactive approach, but also trying to be mindful and respectful so that [IH] doesn't become siloed and it also doesn't become... it's the wrong word, but I

think sort of ‘ghettoized’ [as though] this is all about a problem, because it's not that.

(PB96)

Here, the participants also point to the importance of shedding light on Indigenous issues without problematizing Indigenous people; a well-documented challenge in this work and a part of reshaping nursing culture within the Schools in this study. Another participant explains this further in the following;

First of all, we've got to learn something ourselves in order to really understand how we ended up where we are at this moment in time, in terms of relations with Indigenous people in this country. We need to be able to provide some... we as faculty and staff in the school need to be able to be seen to be genuine in that, in terms of be able to reshape the culture, to be more sensitive to those Indigenous health issues, teachings, and practices. (PH61)

Faculty and staff buy-in was important to shifting school culture to attend to the TRC (2015) recommendations and the integration of IH in the curriculum. This was a notable starting point, and included elements such as promoting self-reflection, providing experiential learning, and opportunities to discuss the understanding of IH contexts while ensuring IH issues are not conflated with problematizing people. One of the important elements in relation to the latter is ensuring the educational gaze remains on the systems and structures that shape IH and garnering support for strengths-based approaches to health and well-being as defined by Indigenous people.

### **Theme 5. Journey toward the vision.**

Participants often used the concept of a “journey” to describe their process for this work, or the varying places they were in the context of creating lasting change within their SON.

Within this concept of “the journey”, four subthemes were identified: (a) being at the “front end”; (b) setting goals; (c) toward a vision of a safe nursing program; and (d) waiting to mobilize.

***Subtheme 5a. Being at the “front end”.***

Participants all saw “the journey” as ongoing, without a specific end point. One participant shares their experience in the following,

It started about three years ago, and no one was doing anything at that point, they were just starting to look at it. Now I've seen the momentum increasing, it seems to be given more resources now, but it's just starting. (PF37)

Most leaders admitted that they were only just beginning their journey, often using phrases such as “not as far ahead as we would like to be” or “we’re at the beginning stages.” Some even indicated that they were not yet at the stage of strategizing how to move forward with this work, stating that they were still “trying to get a handle on what [they] need to do” or “looking at where to start.” Participants who are starting to see momentum in the work felt encouraged. Some have even found that as they were gaining headway, more resources had become available, indicating that the sooner purposeful movements toward the TRC recommendations are made, the more attention, resources, and support will be received in these efforts. However, other participants felt critical of their SON in terms of a lack of progress. As one participant noted,

It's just been a part of our school, but we haven't lived it very well. Do you know what I mean? It has been part of our thinking. We haven't put the pen to the paper and done it as well as we should have. (PG153)

Starting on the journey created lots of questions;

Do we introduce it in the first or second year and then really follow up in third and fourth year with the more senior? It depends at what point in the curriculum you would get the most wow factor out of it, when they would do the reflecting. Because sometimes thinking of first year the students are so overwhelmed with all the stuff and the research skills that they have to learn but you won't be able to really appreciate the reflectiveness until later on. They might be introduced to it first and second year but in third and fourth year having an Indigenous speaker come in and talk to them about what it was like to me would probably be more powerful. (PF250)

Participants who were just beginning their journey often reflected that they were unsure where to even start. This participant's questions reflect the overall sentiment of the participants in this study to do the "right thing" in the "right way." While this participant thought it best to start educating students, another recognized that the best place to begin this work was with the faculty and staff, but faced a conundrum to how, precisely, she would address their uncertainty. As one participant explains,

If we all need to do this work, if we all need to provide Indigenous health content that's specific to our nursing program, should we all be doing this? Can we not use some of the position statement work or frameworks that were developed by CNA or CASN, or other organizations that have already done a lot of work on this? (PD204)

Many participants believed support of nursing's Canadian leadership bodies would be helpful, but there was a distinct lack of consensus about how, precisely, they might guide the nursing leaders in the Schools toward the concrete starting point for which they were searching. One participant outlines the approach taken at their School;

We have a document that was guided by our TRC recommendations, but it's part of our strategic plan which is not just simply Indigenous health, but increasing Indigenous staff members, faculty members, and understanding, getting clinical placements, is everything.

We have that as a separate document that we monitor every year. (PB609)

This participant was little further along in their journey than some; strategic planning was an enormously helpful way to get started. Other participants share their approach as follows;

I'm hoping that I can sneak it [into our strategic planning] as being something that we need to address, and then working with faculty to identify which we're going to do first. Like, which is the easiest for us to accomplish that we feel that we've done something, and we've done it well? (PC440);

and

I think we developed terms of reference for the strategy in the steering committee and [our Indigenous lead] was very thoughtful about some of the language that's being used, and that the language is part of it. We are nervous about language, we are hesitant to use wording, and we're all a little bit uncertain about how to approach things. (PD329)

As these interview exemplars suggest, people were at very different stages in addressing the TRC recommendations and had similar and yet different approaches—some direct and some more indirect—and most with some guidance by Indigenous people along the way. Most participants were clear that guidance on the how to do this work was important, including the language used—again thinking about doing “the right thing in the right way.”

***Subtheme 5b. Setting goals.***

As previously discussed, most participants have prioritized curriculum mapping, and many have indicated that they are in the midst of a curriculum revision or overhaul. While the



purpose of overhauling the curriculum was not to address IH exclusively, this does create an opportunity to assess integration of IH. While some Schools do not yet have a concrete strategy to integrate IH into curricula, others are beginning their efforts by including some IH content into existing curricula to begin establishing those topics, for example “making sure that at least some of the content is covered in some of the courses...” (PF92). Analysis of existing IH content was underway as part of most curricular revisions, and as the Schools worked through this process, specific goals included integrating IH into courses addressing determinants of health, and the creation of a nursing-specific Indigenous health course.

Other immediate goals among participants included hiring administrative support for curriculum revisions, formal evaluation of how the curriculum is currently addressing IH, seeking out avenues that facilitate engagement with Elders, improving faculty engagement, creating community health placements that will ensure student exposure to IH issues, and seeking input from Indigenous clients about the care they have received from students. Some participants discussed goals in future terms, such as ensuring that undergraduate students have base knowledge of the colonial history of Indigenous people in Canada, while others had overarching goals that they would take small steps to meet, such as moving the TRC recommendations #23 and #24 forward (PG24).

Given the weight of this work, participants felt the way forward was to create attainable goals. In the following a participant sums up their process for engaging in the work in such a way that it does not become overwhelming, “Again, not trying to think you can do everything you want two years, but actually recognizing that this could be a long-term project, but you still can make baby steps every month” (PB645).

*Subtheme 5c. Toward a vision of a safe program.*

To many participants, a program that encompassed IH in a safe and inclusive way was visualized in terms of the creation of more Indigenous nurses. Two participants describe an element of this vision in the following,

I think we would probably agree that people's healthcare needs are best met by somebody who understands their lived experience. Knowing that the health situations that Indigenous people find themselves in with higher incidences of many chronic diseases, higher instances of issues related to maybe mental health and addictions, that the belief is and I think we share that, is that if you could provide opportunity for people from Indigenous communities to become registered nurses and that they would work within their communities or within other Indigenous communities, that they would be able to help foster different ways of working with people, maybe even from a strengths-based perspective or something to help them reach better health outcomes. For us, that seems like a good thing to be able to provide an opportunity for people who might otherwise not be able to come in to the university environment. This year we did have [Indigenous] graduate[s]. They tend to work in places where Indigenous people seek health. I think we are making a difference (PE73);

and

I do think we need more Indigenous nurses. That might be the doorway in for all of us to work together because we can learn so much from them, their rich history, their value of life, their value of the earth. (PA367)

One common perception among the study participants was that more Indigenous students entering and succeeding within nursing programs would, in turn, foster more Indigenous people

to go into nursing. This was thought to contribute to a critical mass of Indigenous nurses which would then improve Indigenous health, a notion that is supported in the literature (Evans, White, & Berg, 2014; West et al., 2010).

Although not all Indigenous nursing students will want to work in their respective communities or solely within the area of Indigenous health, several of the participants articulated this as an important focal point in their respective programs. However, the need for more Indigenous nurses also was seen as an important element of nursing because of their potential contribution to the nursing profession and healthcare more broadly.

Participants in this study all envisioned integrating the notion of cultural competence and/or cultural safety within their nursing programs. Two participants speak to this in the following,

I think what we would want to achieve in our curriculum, that all graduates of our nursing program would have an appreciation of the lived experience of Canada's Indigenous people, would be able to understand why it's important to know that history in order to provide culturally competent care that those patients would say was culturally safe. That is what we want, we want our graduates to be able to do that and that's all of them. We would want all of us, faculty, clinical instructors, to model that as well

(PE424);

and

At the end of the day, what is it the students need to be ready to practice. They have to have an awareness of what's happened. Cultural competence, that's really important no matter whether it's Indigenous or any other. Cultural competence is essential. The awareness is also really essential. (PF220)

Aside from a common goal of increasing the number of Indigenous nurses in the workforce, participants described their vision in terms of providing their students with a comprehensive curriculum containing lasting, heavily embedded knowledge and context of Indigenous health issues, prior to entering practice. In addition, and related to cultural safety, one participant also speaks to social action in nursing;

I think it's the only way that there will be evidence of a genuine interest to reconcile the damage that has been done across time. I can only imagine that for Indigenous colleagues to really feel as though they're being heard and respected. There needs to be some genuine action. (PH151)

For this participant, curriculum work was secondary to the idea of a program that facilitates political action. She describes a vision in which faculty, staff and students try to influence policy or become involved with Indigenous community work. It was the thought of this participant that political action was the only way to truly demonstrate reconciliation on a large scale.

***Subtheme 5d. Waiting to mobilize.***

Despite having set concrete goals to further incorporate IH into SON programming for the following academic year, many participants described the concept of waiting, often looking to the nursing leadership and regulatory bodies or other Schools for guidance on how to proceed with their work. Many were hoping for some kind of structure to direct the work prior to beginning their journey. For example, “waiting for direction from CASN about what the standards will be for accreditation” (PA105), or “the CNO competencies, entry to practice competencies, [as] our starting point” (PF109). Many participants expected that the upcoming revisions to the College of Nurses’ entry-to-practice competencies will provide a structure by which schools can match IH content in curricula to relevant competencies.

I think that they're going to be embedded, but I'm curious, I'm just curious. I would expect that there should be some that are actually very specific, but we'll see. I worry that in fact what they might be is Indigenous and refugees and immigrants [...] that they might well be embedded together, but let's see (PB552).

Here the participant is speaking to the concern that culturally safe practice might not delineate groups, rather they might lump them together; Indigenous health requires its own set of standards.

However, for some, the new competencies were felt to be a place where some structure might be found;

If the College of Nurses says, 'thou must teach this,' that sometimes would help because if you've got a body that has so much influence over what you teach something like that then it would be okay, we have to do it. The Truth and Reconciliation, those were recommendations, those weren't 'thou shalt'. Sometimes it's easy if we're told we must do this, for example switching to the NCLEX. That was 'thou shalt' so we all had to do it. (PF337)

Some participants described the upcoming revisions of the CNO competencies as a "prime opportunity" to ensure that they were already meeting the requirements within their curriculum and for others, like this participant, it would provide a welcomed structure.

While many participants are waiting for nursing's leadership and regulatory bodies to provide guidance, some are waiting for their University to make the first move, thus providing the SON a starting point from which they can build their own work.

We're waiting now for a top-down approach. [...] We're in a wait and see mode right now to see what the university does because that might drive, so if they say, 'every student has to take this course,' for example, then that's helpful to us. (PF202)

Several leaders verbalized that they would like to see what other Schools are doing before embarking on their own journey;

I think there's a very basic something that all schools should be doing and should be measured on. This should be metrics to say that we are doing that. Then there are probably some schools that will take this to another level (PA490);

and

Well, if we're all going to create foundational knowledge about truth and reconciliation, and how that relates... if other schools of nursing are undertaking this, is there a way for us to share our initiatives?" (PD218).

Both participants spoke to the value added when working together to address the TRC recommendations. As another participant notes, "we're in this journey together" (PA826).

Despite the unanimous and enthusiastic acknowledgement of the importance of addressing Indigenous health in nursing education, creating a safe program for Indigenous nursing students, and preparing all nursing students for culturally competent practice with Indigenous clients, several participants in this study expressed that they were at a loss as to where to start, how to gain momentum, and where they were going with this initiative.

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### **Chapter Three: Discussion, Recommendations, Conclusion**

In this qualitative descriptive study, I explored the experiences of eight academic nurse educator/leaders who have been working to incorporate Indigenous health, and the recommendations set by the Truth and Reconciliation Commission Calls to Action (2015), into their nursing programs. This was a timely study, as the TRC (2015) recommendations are gaining momentum throughout the country, and the current political climate, as one participant described (PH109) has given Indigenous people a greater voice than ever before.

The problems that underpin this study are the reported poor quality of care, health inequities, and poorer health outcomes for Indigenous people than non-Indigenous people in this

country, resulting from racism and discrimination (Adelson, 2005; Allan & Smylie, 2015; Public Health Agency of Canada, 2016; Statistics Canada, 2015b). Therefore, there is an urgent need for culturally safe care and health professional educational programs that are responsive to this issue. In response to unsafe care, the TRC Calls to Action (2015) has made the following recommendations that impact health professional education:

We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the healthcare field.
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- iii. Provide cultural competency training for all health care professionals. (TRC, 2015, p. 322, #23)

We call upon medical and nursing schools in Canada to require all students to take a course dealing with aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (TRC, 2015, p. 323, #24)

We call upon the federal, provincial, and territorial governments, in consultation and collaboration with Survivors, Aboriginal peoples, and educators, to: [...] provide the necessary funding to post-secondary institutions to educate teachers on how to integrate Indigenous knowledge and teaching methods into classrooms. (TRC, 2015, p. 331, #62, ii)

The experiences and progress of nursing programs to address the lack of attention to Indigenous health and the impact of colonization and neocolonial policies and practices on nursing and nursing education in Canada have varied. It is clear, however, that these recommendations have presented nursing programs with a challenge. Although there was a clear commitment of nursing leaders within this study to understand how to do the “right thing in the right way” and to push ahead with this work, they all agreed this is a complex process and there is a great deal of work ahead.

### **Discussion**

The nurse educator/leaders in this study were in varying stages of their respective work, but all noted the following:

- i) There is a lack of Indigenous content that is integrated throughout the entire curriculum. Although Indigenous health courses were employed in some programs, there was general agreement that this was not nearly enough; there is a need for full integration of Indigenous health content.
- ii) There is a general lack of readiness of nursing programs to support Indigenous health fully, indicating a need to “decolonize” nursing programs—both inside nursing itself and within the larger colonial structure of the University.
- iii) There is a general recognition that many faculty and staff within nursing programs have not yet addressed their own biases, assumptions and stereotypes, posing a challenge in educational environments.
- iv) There is a need for more Indigenous nursing students. However, this is confounded by the challenges of recruitment, as well as retention of those students in an educational environment that may not necessarily be culturally safe.

Overall, the experiences described by Schools of Nursing (SON) leaders in this study have pointed to the following major points for discussion: a) meaningful collaboration with Indigenous community at multiple levels, including Elder engagement; b) decolonizing nursing education and the need to critically reflect on curriculum and the historical, philosophical and theoretical underpinnings of nursing more generally; c) how to teach culture and cultural safety in ways that avoid and challenge culturalist and essentialist understandings of culture; d) attracting and supporting Indigenous people into nursing, including support for nurses to become Masters-prepared and PhD scholars (educators/researchers); and e) the challenge of mobilizing action in tangible, practical, and “the right” ways.

**Collaboration: “Nothing For Us—Without Us”**

Participants were unanimous in their urge to seek Indigenous input at all levels. They described a respect for Indigenous knowledge, and routinely sought guidance from their Indigenous graduates, Indigenous contacts within their clinical placement partners, and members of surrounding Indigenous communities. Collaboration with the communities with whom participants wished to work was described in many ways as essential to the progression of this work, specifically in the areas of doing things “the right way,” avoiding tokenism, and respecting Indigenous students, staff, and faculty. In addition, several participants described this work as everyone’s responsibility, indicating that ongoing collaboration is needed to move forward with their efforts. This is consistent within existing literature in all areas of health research concerning Indigenous people. Maar et al. (2011), while seeking qualitative Indigenous input into culturally appropriate public health research methods, found that participants valued collaboration as an essential part of authentic engagement in all areas of research and development. This includes health education research. In their review of documents describing



Indigenous content in health education in Australia, Power et al., summarized that Indigenous collaboration was required for curriculum development, countering dominant negative discourses within academia, and supporting relationships among Indigenous scholars, students, and practice arenas (Power, Geia, & West, 2013). Further, Virdun et al. (2013) found that through a collaborative multi-phased process, Indigenous input was able to support non-Indigenous nurse educators in gaining confidence in delivering Indigenous content or cultural safety in authentic ways in classrooms.

It is clear among the literature that Indigenous people ought to have a voice at any table discussing issues that affect them. This is purposefully addressed by CINA's formal development of collaborative strategies to be employed when developing partnerships with non-Indigenous stakeholders, exemplified by the phrase, "nothing for us—without us" (2016). This partnership model is rights-based; collaboration, consultation, and co-operation are listed as rights of Indigenous people concerning any action to do with them within the United Nations Declaration of the Rights of Indigenous People (UNDRIP) (United Nations, 2008). The UNDRIP is endorsed by the TRC as an appropriate framework by which to enable partnerships and enact the TRC's recommendations, thus binding those who are addressing them to ensure collaboration is at the forefront of all Indigenous matters (Truth and Reconciliation Canada, 2010).

Finally, the importance of Indigenous collaboration is recognized by national nursing organizations in Canada, demonstrated by the formal signing of a partnership accord between the Canadian Nurses Association (CNA) and CINA, symbolizing a partnership in addressing structural barriers to Indigenous health and building capacity of nurses working with Indigenous clients (Canadian Nurses Association, 2016). The sense of duty to collaborate with Indigenous

partners as described by my participants is thus a significant strength for them, enabling them to move forward in this work in an authentic, or “the right” way.

### **Decolonizing Nursing Education: Looking Within**

When examining the state of nursing education in Canada as described and informed in the literature reviewed earlier in this thesis, it could be argued that undergraduate nursing education is largely influenced by ethnocentric and biomedical traditions. For example, although there is an emphasis put on understanding health disparities within undergraduate nursing education, there is less attention paid to understanding those disparities in relation to colonial and neocolonial policies and practices and Indigenous determinants of health such as land, language, geography, or race. Participants in this study generally agreed that current practice is not enough and have prioritized making manageable changes to curricula in relation to these important topics.

Effective Indigenous health nursing requires an emancipatory knowledge base that acknowledges colonial and neocolonial processes and practices as major determinants of Indigenous health (ANAC, 2009); a lack of acknowledgment of these power relations and other determinants of Indigenous peoples’ health within the healthcare system inadequately prepares nurses to safely address Indigenous health issues resulting in poorer health outcomes for Indigenous people. This point is illustrated in a qualitative study conducted by Rahaman, Holmes, & Chartrand (2017) wherein the researchers explored challenges and facilitators to health care providers addressing health inequities in Northern communities. In this study, Rahaman et al. found that nurses typically attributed being “Native” to particular disease/illness etiology; as a result, these erroneous assumptions led to inappropriate health planning and interventions. Examples included the assumption that type 2 diabetes mellitus was a reversible

problem; and that sexually transmitted infections would be eradicated in the community with simple educational interventions (Rahaman et al., 2017). Participants in my study acknowledged that the thinking of their students ought to reflect a more emancipatory knowledge base and have begun to address this by purposeful selection of Indigenous readings and clinical scenarios.

Tuhiwai Smith defines decolonization as “a long term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power” (2012, p. 101). Participants in my study were aware of the lengthy and complex nature of this work and willing to spend the time to engage authentically by way of building relationships to foster collaboration. However, they did not refer to the work as *decolonization*, nor did they discuss examining or deconstructing existing structures within their programs that they felt were challenges to this work. Instead, emphasis was placed on adding Indigenous elements to those existing structures, reflecting the more adaptive concept of “*Indigenization*”<sup>5</sup> (Gaudry & Lorenz, 2018). Deconstructing rather than inserting or “threading” Indigenous content into existing courses/curriculum could open the curriculum to other ways of knowing, including Indigenous perspectives. Although not currently incorporated into nursing education as an exclusive epistemology, Indigenous knowledge involves ways of knowing comparable to those found among nursing theories: empirical observation, traditional teachings, and revelation (Lavallee, 2009). While benefits to existing nursing concepts commonly taught at the undergraduate level such as relational practice or strengths-based nursing were described by participants; inclusion of Indigenous knowledge can facilitate a shift away from medicalizing and pathologizing Indigenous health and toward emotional and spiritual relations to health including land and

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<sup>5</sup> *Decolonization* can be defined as “the process of undoing the impact of a colonial state” (Bourque Bearskin & Jakubec, 2017, p. 391). *Indigenization*, by contrast, involved adding Indigenous perspectives while maintaining existing structures (Gaudry & Lorenz, 2018).

environment, and reframe a deficit-based view of Indigenous health into strengths-based perspectives (Stansfield & Browne, 2013). In addition, inclusion of Indigenous knowledge into course content can introduce students to how colonization, structural violence, and racism are inextricably linked to Indigenous health, and critical reflection as a useful skill to counter dominant discourses (Acton, Salter, Lenoy, & Stevenson, 2017; Stansfield & Browne, 2013). However, inclusion of that knowledge is dependent upon the Indigenous input required to share it, and some participants had not yet come to a place where they could collaborate with Indigenous partners openly. While this limits their ability to disseminate Indigenous knowledge fully, they did voice a commitment to cultural safety, and were in various stages of engaging with this concept.

### **Teaching Culture and Cultural Safety: A Slippery Slope**

The nurse educators/leaders in this study were generally committed to engaging with the concept of cultural safety within their respective nursing programs, however, there were several challenges in the uptake of this concept. While the importance of culturally safe care is known (ANAC, 2009; Papps & Ramsden, 1996) and the uptake of the concept by nursing and other health organizations in Canada and internationally has increased over the past two decades (ANAC, 2009; CASN, 2014; CNA, 2010; Midwifery Council of New Zealand, 2012; National Aboriginal Health Organization [NAHO], 2007), there have been a number of challenges that contribute to the seemingly slow uptake and enactment of the concept in nursing education and of nurses in clinical practice more generally.

Here, I return to how the notion of ‘culture’ is typically taken up in nursing education as discussed earlier in this thesis; as Gregory et al. (2010) note, despite a significant body of research identifying that essentialist models of teaching culture are historically ubiquitous in

nursing education, Schools of Nursing have not, generally, made significant movements toward deconstructing essentialist pedagogy in favour of models of teaching cultural safety. This is evidenced by the mixed methods study conducted by Rowan et al. (2013), in which authors reviewed the processes and outcomes of Canadian SONs incorporating cultural safety; these findings revealed that despite a general awareness of the A.N.A.C. document *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing* (2009), the document was only moderately distributed to faculty, and survey respondents were not consistently using the document to teach.

Cultural safety (CS) as a complex concept is difficult to teach; there is a need (as noted earlier) to avoid supporting essentialism and culturalism and a need for faculty to engage in critical self-reflection. There are multiple layers of understanding that are required for nurse educators to disseminate the concept of cultural safety competently to their students. Firstly, in addition to having examined their own positions in terms of learned racism and biases, educators would benefit from a comprehensive understanding of relational nursing practice, given the strong connection between the respectful and authentic inquiry of relational practice and Ramsden's notion of asking rather than assuming as a component of CS in practice (Richardson, Yarwood, & Richardson, 2017). Secondly, the importance of addressing power relations is essential knowledge for educators, not only in terms of those between provider and client, but also those between themselves and their students, in the classroom. Blanchet Garneau, Brown, and Varcoe (2017) argue that when educators assume the correctness of nursing pedagogy and the ideologies within, the classroom can become an arena in which social inequities are replicated, running the risk of indoctrinating learners. Critical appraisal of the power they hold in the classroom and the ideologies they teach is thus essential for nursing educators to

competently teach CS. Finally, an understanding of relationships as bicultural, that is, each person bringing their own culture into an encounter, would further ground educators' knowledge of CS. In their interpretive study exploring CS as described by nurses in New Zealand, Doutrich et al. found the concept of the bicultural relationship relevant to nursing in two ways: the relationship between Indigenous and non-Indigenous person, and the relationship between client and health care provider (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). Each person within those relationships ought to understand the influence of their own culture on that relationship; nursing educators are thus tasked with eloquently translating that intricate concept into their teaching, with special attention paid to how their own culture, as educators, affects their relationships with students in their classrooms. Given the barrier of lack of time for course development and preparation identified by my participants, it would not be surprising if faculty were simply unable to find time to develop specific strategies to tackle this complex concept, and the associated practices required to do so as described above.

Blanchet Garneau & Pepin (2015) also point out that CS can be criticized for the difficulty in assessing students' understanding of the concept, which Rowan et al. (2013) corroborate, having found that very few schools have measured whether students have successfully learned the concept of cultural safety. In addition, care is only deemed 'culturally safe' from the perspective of the client who receives care; therefore, evaluation of its success needs to be measured in ways that involve client feedback.

Terminology relating to culture used in nursing pedagogy could also be a source of confusion for educators. The concept of culture has traditionally been taught on a continuum using several different terms such as awareness, sensitivity, competence, and safety (ANAC, 2009; Gerlach, 2012), all of which have differing definitions ranging from a simple awareness of

various worldviews to a more complex understanding of how power differentials lead to inequities in health care delivery. To add to the confusion, in their review of cultural competence and cultural safety literature, Blanchet Garneau and Pepin discovered that the two concepts have rarely been developed in an integrated fashion, but more in parallel (2015). The authors argue that because of this conceptual problem, neither definition truly captures the ideal of culturally competent nursing care or education. That is to say, cultural competence is not the same as cultural safety.

Unfortunately, as mentioned earlier in the thesis, research on this topic has not yet measured nurse educators' own cultural safety and competency in relation to teaching Indigenous content (Lane & Petrovic, 2018). Based on this gap in the literature, I had made the prior assumption that nurse educators may not be provided with the educational supports necessary to teach cultural safety, however, I found within my interviews that SON educator/leaders have indeed made strides to increase knowledge among their faculty and staff. For example, there are a number of strategies currently being employed with nursing education programs, including access to online Indigenous Cultural Safety (ICS) training (PD91), and activities such as 'the Blanket exercise,'<sup>6</sup> in hopes that these strategies would result in effective self-reflection and autonomous learning across faculty and staff.

The need for critical self-reflection among faculty and staff also is illustrated by the inherent "whiteness" in nursing education that poses a ubiquitous challenge (McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014; A. M. Nielsen, Stuart, & Gorman, 2014; Puzan, 2003). A summary of several studies testing cultural safety teaching interventions in health care

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<sup>6</sup> The 'Blanket exercise' involves trained facilitators who read scripts and physically "walk" participants on blankets, which metaphorically symbolize the lands of Indigenous peoples. The purpose of this activity is to educate participants in an interactive way on the roles of First Nations, Inuit, and Métis groups through moments in history, including pre-contact, treaty-making, colonization, and resistance (Kairos Canada, 2017)

disciplines revealed that although cultural safety information increased knowledge of Indigenous health issues, it only shifted attitudes and preparedness for working with Indigenous people for cases *in which the instructor was Indigenous* (Jamieson et al., 2017). Further, in Holland's (2015) study with Caucasian nurse educators teaching about race, racism, and antiracism, results showed that the experience of white privilege contexts among nursing educators obscured their understanding of these topics, rendering them unprepared and lacking the scholarly knowledge required to incorporate comprehensive Indigenous or cultural safety content into their courses. Arguably, this supports a call for more Indigenous nurse educators, leaders, and scholars. However, SONs first require more Indigenous nursing students.

### **The Conundrum of Indigenous Nursing Student Recruitment**

SONs generally have already developed supportive pathways into nursing education in several ways, as a response to the known inequities prospective Indigenous students experience in seeking post-secondary education. As examples, accessibility and affordability are an issue, as Indigenous students must often leave their communities behind entirely to attend the universities of their choice, and many are ill-prepared to enter post-secondary education at all due to limited educational opportunities within some Indigenous communities (Green, 2016). As a result, Indigenous nurses are under-represented among the profession, making up less than 3% of the profession, yet they comprise nearly 5% of the total Canadian population (ANAC, 2014; Statistics Canada, 2017). Further, when comparing statistics across provinces and territories, Ontario has among the lowest proportion of Indigenous nurses in the Canadian nursing workforce, with only 1.9% of nurses in the province reporting Indigenous heritage despite the province making up over one third of the total number of nurses in Canada (ANAC, 2014). In fact, it has been documented that health services for Indigenous people are delivered primarily



by non-Indigenous providers who often lack the understanding and skills to provide culturally safe care (Jamieson et al., 2017), understanding that Indigenous ancestry does not necessarily ensure the provision of culturally safe care. A lack of safe care makes a direct contribution to the known health disparities of Indigenous populations.

Thus, the recognized need to increase the presence of Indigenous nurses within the profession (ANAC, 2009) is reflected in TRC recommendation #23 (as outlined above), and particularly relevant to the Ontario context. Participants in this study have identified recommendation #23 as a priority for their Schools and are currently striving to address it by increasing Indigenous access to nursing education and providing support for those students to pursue graduate education. In this way, participants were not only addressing the underrepresentation of Indigenous nurses within the field, but also within academia. It was the shared hope of participants that Indigenous nurse scholars could contribute meaningfully to policy and structural change that would, in turn, support Indigenous nurses, nursing students, and other nurse educators.

Participants described several benefits of increasing the number of Indigenous nurses, including their unique contribution to nursing knowledge, perpetuation of more Indigenous nurses to reach a critical mass, and increased health status of Indigenous people in general (i.e., PA368, PE73, PG434). Literature corroborates this belief, suggesting that the nursing profession as a whole would benefit from increasing the numbers of Indigenous nurses in the field; the unique knowledge, skills, and worldviews of Indigenous nurses can increase safe access to health services to the Indigenous population, as well as facilitate culturally appropriate care delivery among non-Indigenous nurses (West et al., 2010).

Many participants in the study believed Indigenous health care needs are best met by those who understand the lived experience, however, they also were careful not to assume that all Indigenous nursing students would return to their own or other Indigenous communities upon program completion. The idea that Indigenous nurses are an important addition to Indigenous healthcare is supported by a study conducted by West and colleagues (2010), in which the authors identified barriers to increasing Indigenous presence within the nursing profession; Indigenous nurses reported that their Indigenous patients were more likely to return for follow up when they felt understood and respected (West et al., 2010), which has implications for maintenance of chronic health issues among Indigenous people. In another qualitative study exploring the experiences of Indigenous nurses, authors found that although all nurses were taught to treat all people equally regardless of race, non-Indigenous nurses often demonstrated a lack of understanding of the contexts that contribute to health inequities of their Indigenous clients. (Nielsen, Stuart, & Gorman, 2014). In yet a third qualitative study exploring the experiences of Indigenous clients seeking health services, authors found an increase in satisfaction when those clients accessed health services that were provided by Indigenous people (Evans et al., 2014).

While participants did not explicitly compare Indigenous nurses to non-Indigenous nurses, they did indicate that the “whiteness” of the profession poses a challenge, and that students were often exposed to culturally unsafe treatment of Indigenous clients in practice. When considering the wealth of literature describing poor quality of health care in encounters between Indigenous clients and non-Indigenous nurses, it is concerning that impressionable nursing students are gaining their experiential learning in settings where (a) violence from Indigenous patients is normalized; (b) nursing staff are resentful of a population deemed to be

wasting taxpayers' money; (c) Indigenous people are perceived as responsible for their own health problems; and (d) discourses of “the drunk Indian” and drug-seeking visibly create outright denial of access to care (Browne et al., 2011; Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014; Martin, Houston, Yasui, Wild, & Saunders, 2013; Rahaman, Holmes, & Chartrand, 2017; Tang, Browne, Mussell, Smye, & Rodney, 2015). It therefore stands to reason that if nursing students are consistently exposed to the negative aspects of Indigenous health, their opinions of Indigenous people as “other” will be supported. However, the blame should not be placed entirely on the nurses who set these examples in the practice setting: “[w]ithout tools for thinking about poverty as the legacy of forced state dependency, health professionals can associate Aboriginal ‘culture’ with the cultures of poverty, substance abuse, and dependency—and invoke discourses on individual responsibility and choice” (Browne, Smye, & Varcoe, 2005, p.30).

Therefore, in the absence of the critical number of Indigenous nurses required to potentially shift these discourses in the field, professional nursing bodies recommend cultural safety education. Thus, we must look to nursing education when we ask why nurses in the field are not practicing safely, and how educators can protect nursing students from absorbing the biases found within unsafe practice.

### **The Challenge of Mobilization**

Participants in this study were clearly committed to action in this work but seemed to experience challenges in taking concrete action. Several referred to the initiative as “big,” and described being at the beginning of their journey, indicating a sense of being overwhelmed by how much work remains. While some SONs were confidently established in the work, leaders at others seemed to be somewhat immobilized. Reasons behind this immobilization varied; some

participants were afraid to misstep, others found themselves without Indigenous input and were not comfortable moving forward without collaboration, still others were waiting on concrete direction from their University or nursing's professional and regulating bodies. This demonstrates one aspect of the true experience of academic nursing leaders in incorporating Indigenous health into their nursing programs and addressing the TRC recommendations. For many participants, it seems as though the damage caused by colonialism is so extensive, that repairing it, or reconciliation seems to be an insurmountable task. Participants described how Indigenous people in Canada have a history of mistrust that is well-founded, and how they are afraid to add further insult by taking steps that are well-meaning but unintentionally misdirected. These experiences are compounded with the multi-faceted challenges of teaching cultural safety, the required personal reflective work, the competing demands, the difficulty in recruiting and retaining Indigenous nursing students, and the realization that the profession to which they have devoted their careers is not safely serving Indigenous people. It is thus unsurprising that my participants often expressed sensations of helplessness, being overwhelmed, and being fearful to create action, resulting in immobility. However, despite the cumulative effect of these challenges, the commitment of my participants to engage fully in this work was clear.

### **Recommendations**

Nursing education has been discussed in the literature as foundationally colonial (e.g., Green, 2016; McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014). Although the nursing leaders in this study did not note this explicitly, all were committed to engaging with the TRC Calls to Action (2015) and to addressing the lack of attention to Indigenous health and related issues within their respective programs. While the main implications and recommendations

stemming from this project are in the educational arena, others are highlighted in the areas of research, practice, and policy, all discussed below.

### **Education**

In the area of education, I would like to highlight the following recommendations:

- i) Provision of Indigenous Cultural Safety training for all faculty and staff;
- ii) Provision of extra support for clinical instructors who teach nursing students in clinical settings that serve Indigenous clients;
- iii) Implementation of the ‘Blanket exercise’ routinely throughout the academic year;
- iv) Consideration of decolonizing nursing curricula in terms of educator self-evaluation, followed by critical examination and deconstruction of current processes prior to adding Indigenous content;
- v) Assessment of the efficacy of current Indigenous pathways into nursing in tandem with ensuring that the program is culturally safe for students accessing those pathways; and
- vi) Cultivation of reciprocal relationships with Indigenous communities, practice partners, Elders, and the University’s Indigenous center.

#### **Cultural safety training.**

Given the results of this study and the current literature, cultural safety training is recommended for faculty and staff within Schools of Nursing. This type of training fosters deep reflection on not only the contextual, structural, and historical issues that affect Indigenous health, but also self-reflection on how the individual might begin to identify and challenge one’s own biases, assumptions and privilege as well as address racism and discrimination. This would be particularly helpful to clinical instructors (CIs) who may or may not teach nursing students in

clinical settings where Indigenous people seek care. CIs are often temporary, transient, or cyclical faculty within nursing programs, therefore training should be offered at more than one point throughout the academic year. Extra support should also be provided for CIs who work in clinical settings that support Indigenous clients, as these placements offer the most context and therefore opportunity for discussion for students. This will empower those CIs to lead praxis discussions with students in a way that fosters critical reflection and counteracts existing stereotypes among those students. In addition, cultural safety training should be included in the orientation of all incoming staff and faculty, as well as those who are nearing retirement, as those individuals are in a position to mentor new staff and CIs. Sweeping and universal required cultural safety education could ultimately create a shift of culture within the SON. In the absence of available formal cultural safety education, the Blanket exercise would be an excellent starting point, as some participants pointed out that even knowledge of colonial history, which should arguably be the basis of all further education, was lacking amongst faculty and staff. If funding is an issue for SON leaders, they might look to the federal government for support. After all, the TRC has tasked the government with this explicitly:

We call upon the federal, provincial, and territorial cup governments, in consultation and collaboration with Survivors, Aboriginal peoples, and educators, to: [...] provide the necessary funding to post-secondary institutions to educate teachers on how to integrate Indigenous knowledge and teaching methods into classrooms. (TRC, 2015, p. 331, #62, ii)

Thus, the onus should not lie solely with SON leaders to facilitate this training.

**Decolonizing nursing education.**

Whereas participants did not explicitly use the notion of “decolonizing” their nursing programs, all discussed the importance of their educators reflecting on how they are representing IH within their courses/curriculum. One way in which SONs could link these two items is having the educators, as one participant described, self-evaluate their efficacy on teaching specific markers within their courses, including IH and the TRC (PC422). This is described by Tuhiwai Smith (2017) as a starting point for culturally competent nursing educators, and could provide an opportunity for educators to first identify whether they are meeting the recommendation of threading IH content into the course material, and, if they are not, to deconstruct their courses so that they are incorporating IH in a more comprehensive way. This baseline evaluation could be useful for leaders to begin to assess the current state of classroom content more concretely, creating an avenue down which leaders could begin to truly decolonize their program to ensure cultural safety within.

Tuhiwai Smith (2012) describes decolonization as a process of centering one’s concerns and worldviews, then coming to an understanding of theory and research from those perspectives. This process could lend itself to creation of ongoing dialogue within nursing programs, for example, some Schools have created forums for discussion such as an Indigenous engagement committees or Indigenous book clubs. While arenas such as these would be beneficial for all Schools of Nursing, Indigenous collaboration is essential to Indigenous self-determination. It is therefore recommended that SONs seek Elder involvement in any decolonizing endeavour, particularly those in which ongoing dialogue could result in change within the program. Elders are considered knowledgeable ethical consultants, who are able to

counsel, support, mediate, provide local historical context, and conduct ceremony (Flicker et al., 2015).

### **Support for Indigenous education pathways.**

Participants were invested in facilitating access to Indigenous students into nursing, and many had established admissions pathways for those students. Some, however, had not yet reached a point where they were confident in their recruitment and retention of Indigenous nursing students. Indeed, one participant expressed that her school's modality for increasing Indigenous student recruitment had not been as successful as she'd hoped. Leaders would thus benefit from assessing current recruitment practices and ensuring that these pathways have the support needed to increase the number of Indigenous nursing students. This includes but is not limited to creating new and maintaining strong partnerships with Indigenous communities, seeking input from Elders and other Indigenous community members, securing funding from the institution or government, or the creation of alternative pathways that can be tailored to each prospective student's needs.

Further, once those students are in the program, leaders ought to be certain that they are supported in many ways throughout all years. As discussed above, ensuring that all staff and faculty have undergone cultural safety training is essential to this, as this would contribute to a safe learning environment, as would deconstructing colonial processes within curricula in favour of Indigenous knowledge. In addition, strong and open relationships with Indigenous supports such as the institution's Indigenous centre should be cultivated.

It is important to note, however, that prior to recruiting large numbers of Indigenous students, SON leaders should have confidence that those students are entering an environment



that is addressing racism and structural violence. Increasing recruitment needs to be done in parallel with ensuring the program's cultural safety.

## **Research**

In the area of research, I would like to highlight the following recommendations:

- i) Collaboration and engagement with Indigenous colleagues and communities in research;
- ii) Creation of supportive pathways for Indigenous research;
- iii) Consideration of future research evaluating the efficacy of cultural safety training for nurse educators; and
- iv) Consideration of future research exploring Indigenous clients' experience of receiving culturally safe nursing care.

The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* states that community engagement is required for any research involving First Nations, Inuit and Métis people of Canada (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada [CIHR, NSERC, & SSHRC], 2014). Thus, collaboration should occur at multiple levels within any Indigenous nursing research generated by the SON. This includes research led by and/or conducted with Indigenous colleagues and research that includes Indigenous communities and should always be for the benefit of Indigenous people.

Most universities have a research mandate within their strategic plans. This could provide an opportunity to receive additional Indigenous input in the form of research conducted by Indigenous scholars. Given that research grants are required to meet specific criteria, the mandate could be revised to require continued special calls to the granting agencies to support

Indigenous research. Increasing research funding could also provide opportunities to create connections with Indigenous communities by supporting those communities to drive research interests that are important to them by way of resources offered by the University. This would require guidance on how to initiate and foster reciprocal, trusting relationships with those communities to ensure that the research is for their benefit.

In addition, participants indicated that evaluation of knowledge of Indigenous content or efficacy of cultural safety training is lacking. Indeed, as discussed in my review of the literature, there are no current studies to my knowledge that measure the cultural competence of nurse educators, nor the ways in which they disseminate Indigenous content to students (Lane & Petrovic, 2018). I therefore recommend that future research efforts address this gap and evaluate cultural safety-focussed interventions such as the formal training of nursing educators. In addition, given that culturally safe care is judged by those receiving it, future research should also evaluate whether or not Indigenous clients experience cultural safety within their health care encounters.

### **Clinical Practice**

In the area of clinical practice, I would like to highlight the following recommendation:

- i) Purposeful and ongoing consultation and collaboration at multiple points within practice settings to create authentic learning experiences for students.

Stronger linkages with clinical practice partners in general are essential moving forward in this work. Leaders should continue to reach out to adjunct educators and alumni, clinical educators, and other individuals in practice settings to ensure that knowledge translation occurs across institutions. Local Indigenous contacts in tertiary and community care should be consulted if available. These individuals present an opportunity to align nursing education with

the state of affairs in tertiary and community care in terms of Indigenous health. This could be a reciprocal relationship—participants described a need to prepare their students for the expectations of the hospitals, often expressing that it was difficult to prioritize IH over the skills expected of graduate nurses. An Indigenous liaison in the hospital and/or community care who is invested in working with nursing schools to prepare students for working with Indigenous people could use their position within their organization to a) critically appraise that organization's expectations of nurse practice in tertiary care and b) ensure that one of those expectations is that nurses are well prepared to practice safely with Indigenous clients.

### **Policy**

In the area of policy, I would like to highlight the following recommendations:

- i) Schools of Nursing begin their work with the creation of an overarching mission statement acknowledging their commitment to decolonizing their programs;
- ii) Schools of Nursing reassess, redesign and/or create Indigenous admissions pathways and policies to reflect a collaborative approach that meets the needs of the students who will be accessing them;
- iii) Nursing Education Leadership bodies facilitate funding for at least one delegate from each SON to attend all educational and professional development opportunities across the country; and
- iv) Development of a 'minimum standard' by the regulatory bodies of nursing education to guide Schools of Nursing in their beginning phases of this work.

Policies in place within SONs could be utilized to foster relationships with Indigenous communities. Schools with well-established entry pathways for Indigenous nursing students found that commitment, input, and investment from Indigenous communities were essential to

their inception. Collaborative relationships with Indigenous communities were described as essential by all participants, and while some found that their existing relationships facilitated the work in multiple ways, others were experiencing challenges in initiating, nurturing or maintaining them. Many identified that they required guidance on how to navigate those relationships or even to simply initiate contact, but further guideline and policy development in the area of Indigenous student recruitment could offer an avenue to purposefully create those relationships. Creation of a new pathway, or reassessment of an existing one could provide a reason to request collaboration with Indigenous individuals, communities, and organizations who could become invested stakeholders in the process, thus forming reciprocal and participatory relationships.

Some participants indicated that it would be helpful if the nursing education leadership bodies (e.g., the Canadian Association of Schools of Nursing [CASN], the Council of Ontario University Programs in Nursing [COUPN] & the Canadian Indigenous Nurses Association [CINA]) could provide a minimum standard which all Schools would be required to meet, for example, for accreditation by CASN. For example, given that participants often look to Schools in Western Canada for guidance. CASN and COUPN could require that all Ontario Schools of Nursing delegate at least one representative to any national conferences or educational opportunities that address Indigenous health in the provinces seen to be leaders in this area. This has the additional benefit of providing equal opportunity to all Ontario Schools of Nursing, which would address the sense of “not being as far ahead as other schools” that some leaders expressed and provide essential strategies for implementation of this work. In addition, if there were a required minimum standard, each school could expand upon this level playing field in the manner they choose—several participants highlighted that their schools have unique strengths

and facilitators, which they could use to build on the minimum standard in a fashion that allows their SON to highlight and utilize those strengths in the context of decolonizing their program.

As an overarching recommendation, participants should maintain an awareness that any aspect within this work will involve a significant change of culture within the school. Given that participants have described the possibility of resentment among staff when they are presented with mandatory learning or teaching, leaders may find that changing the culture is more complex than simply providing educational opportunities to staff, recruiting more Indigenous students, reframing strategic plans, and engaging in genuine collaboration. It requires astute and ongoing appraisal of dominant discourse, distinct anti-racism strategies, and collective trust among all staff, faculty, and students that fosters a safe environment in which all stakeholders can examine personal and structural knowledge systems.

This is not a simple task, yet the nurse leaders within this study are prepared for the challenge.

### **Conclusion**

As a profession, we have some work to do in terms of ‘decolonizing’ nursing education. Whereas there are competing demands to which several participants spoke, Indigenous health is high on the radar for nursing faculty and staff in Ontario universities. Participants are working to address this task in a multitude of ways, guided by the TRC and the moral obligation to “do things the right way,” with some SONs further ahead in this work than others. While all participants were engaging in the work enthusiastically, some were unsure how to prioritize their next steps, and many still acknowledged the need for Indigenous input at various levels to move forward. Regulatory bodies of nursing education such as the Canadian Association of Schools of Nursing (CASN) and the Council of Ontario University Programs of Nursing (COUPN) are

working together to try to address this issue; to support/facilitate this work, each have formed a TRC Working Group involving stakeholders from the Canadian Indigenous Nurses Association and Indigenous scholars. To further support this work there is a need for ongoing institutional commitment: resources (human and other), universal faculty and staff education, and the creation of supportive pathways for Indigenous students and researchers.

As Thorne states, “nursing is a discipline explicitly mandated to apply knowledge to the resolution of human health and illness problems within society” (2016, p. 47). In addition, it has been noted that nursing is known as the most promising profession to take leadership in reducing health inequities (Smith, 2007). Nursing is well situated because of its social mandate to address health inequity to address the Truth and Reconciliation Commission of Canada’s Calls to Action. As the TRC (2015) states,

We call upon those who can effect change within the Canadian healthcare system to recognize the value of aboriginal healing practises and use them in the treatment of aboriginal patients in collaboration with aboriginal healers and elders where requested by aboriginal patients. (Truth and Reconciliation Canada [TRC], 2015, p. 322, #22)

This recommendation illustrates the ultimate and true purpose of this work; providing culturally safe care to Indigenous clients (individuals, families, communities and populations), to support Indigenous well-being. It is thus imperative that nursing education provide a guiding light to practice.

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## **Appendices**

### **Appendix A: Interview Guide**

- 1) What interested you in participating in this particular study?
- 2) Tell me about your role in addressing Indigenous health within your school?
- 3) Tell me about your role in addressing Indigenous health within your organization?
- 4) What you have instituted within your school in the area of Indigenous health?
- 5) What you have instituted within your organization in the area of Indigenous health?
- 6) What prompted you to do this work?
- 7) What is your process for doing this work?
- 8) Who have you involved in this work?
- 9) What mechanisms were employed to recruit that involvement?
- 10) Who, if anyone, do you think has been missing?
- 11) What are some challenges to this work?
- 12) What are some facilitators within this work?
- 13) What are some opportunities you have found within this work?
- 14) What do you hope to achieve with your current work?
- 15) What are your future plans for the direction of this work?
- 16) What are some of the steps you have taken to address the recommendations set by the Truth and Reconciliation Commission?

## **Appendix B: Email Script for Recruitment**

Subject Line: Invitation to participate in research

Hello,

I have received your email address from your University's website, after receiving your name from the Council of Ontario University Programs in Nursing (COUPN) website. You are being invited to participate in a study that I, Danae Coggins, RN, am conducting under the supervision of Dr. Victoria Smye, RN, PhD. Briefly, the study involves a 60-90 minute video conference or telephone interview during which you will be asked about your experience of including Indigenous health into your curriculum, and addressing the recommendations set by the Truth and Reconciliation Commission of Canada (TRC) in your school of nursing.

I will send a reminder email in 2 weeks' time if I don't receive a response to this invitation.

I have attached a letter of information and consent to this email. If you would like more information on this study please contact the researcher at the contact information given below.

Thank you.

Danae Coggins, RN, MScN Candidate 2018  
Western University



## Appendix C: Letter of Information and Consent



**Project Title:** An Exploration of the Nursing Leaders' Experiences Addressing Indigenous Health in University Undergraduate Nursing Programs in Ontario

**Document Title:** Letter of Information and Consent – Nursing Academic Leader

### Principal Investigator + Contact

Dr. Victoria Smye  
Associate Professor and Director  
Arthur Labatt Family School of Nursing at Western University

### Additional Research Staff + Contact

Danae Coggins, RN  
MScN Candidate 2018  
Arthur Labatt Family School of Nursing at Western University

#### 1. Invitation to Participate

You are being invited to participate in this research study about the experience of including Indigenous health and incorporating the recommendations set by the Truth and Reconciliation Commission of Canada (TRC) into your school of nursing. You are invited because you are in an academic leadership position, with the ability to oversee and engage in this work.

#### 2. Why is this study being done?

Many schools of nursing across Canada have made great strides in addressing the recommendations set by the TRC into their schools. Although it is known among the among the schools of nursing recognized by the Council of Ontario University Programs in Nursing that this work is currently being done, there is a gap in existing literature identifying the factors involved in engaging in this work within the Ontario context.

The purpose of this study is therefore to explore factors that help or hinder this work within Ontario schools of nursing. The perspectives of nursing academic leaders who have insight into barriers, facilitators, and opportunities encountered while engaging in this work have the potential to further propagate this work within the Ontario schools of nursing.

#### 3. How long will you be in this study?

It is expected that there will be at least 1 interview during your participation in this study, with potential for a second interview, should new insights foster additional questions or

points of clarification. Each initial interview will take approximately 60-90 minutes, and potential second interviews will take 30 minutes.

#### **4. What are the study procedures?**

If you agree to participate you will be asked to participate in at least one 60-90 minute interview over video conference (preferred). Telephone interviewing may be used in place of video conference, if video conference is unavailable to the participant. When indicated, the researcher may call upon you for a second interview lasting 30 minutes, in the case that new information arises during subsequent data collection or analysis that requires further questions or clarification. During the initial interviews, the researcher will ask roughly 10 questions, and should there be additional interviews, questions will be guided by any new information that has arisen during the initial interview process.

The interview will take place through video conference, using applications such as Skype or FaceTime, whichever is most readily available for you. The researcher wishes to record the audio and video of this interview for transcription and subsequent data analysis. Video conference has been chosen over telephone conference due to the benefit of having both audio and visual cues during the interview process, as well as providing opportunity to facilitate rapport between researcher and participant when face-to-face meetings are not geographically convenient. The conference will be recorded with your consent, as data analysis will involve reading transcribed interviews alongside the video recordings. However, if you do not wish to be audio- or video-recorded, you may still participate in the study via telephone or video conference without recording, and the interviewer will take notes by hand.

The study will take place at a location convenient to you, where you have access to the video conference software or application of your choice.

Nature of measures:

This study is low-risk, with no personal information being gathered during the interviews. Your identity will be kept confidential, and the name of your school of nursing will not be disclosed. The information you provide will be confidential, and in the final manuscript, you will be referred to as "Participant-A", and your school as SON-A (school of nursing-A).

#### **5. What are the risks and harms of participating in this study?**

There are no known or anticipated risks or discomforts associated with participating in this study.

#### **6. What are the benefits of participating in this study?**

The possible benefits to you include contribution to a body of research that does not currently capture the Ontario context; and an understanding, after the final manuscript is accepted, of similar challenges and opportunities experienced by other nursing academic leaders throughout the province. The possible benefits to society include an

increased understanding of how Ontario schools of nursing are including Indigenous health and knowledge within their curricula and how they are addressing the recommendations set by the TRC in their schools. This has the potential to contribute to recruitment and retention of Indigenous nursing students, and support Indigenous scholars.

### **7. Can participants choose to leave the study?**

Should you decide to withdraw from the study, you have the right to request withdrawal of information collected about you. If you wish to have your information removed please let the researcher know. Should you decide to withdraw from the study, but agree that the information that was collected prior to you leaving the study can still be used, no new information will be collected without your permission.

### **8. How will participants' information be kept confidential?**

- Representatives of The University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.
- While we do our best to protect your information there is no guarantee that we will be able to do so. The inclusion of your position within the school and specifics of the work in which you are engaged may allow someone within nursing academia to link the data and identify you.
- While we do our best to protect your information there is no guarantee that we will be able to do so. If data is collected during the project which may be required to report by law we have a duty to report.
- The researcher will keep any personal information about you in a secure and confidential location for a minimum of 7 years. A list linking your study number with your name, title, school, email address, and phone number will be kept by the researcher in a secure place, separate from your study file.
- If the results of the study are published, your name will not be used.
- The researcher may wish to use personal quotes, titles, and pseudonyms of names and schools of nursing (SON) within the publication. For example, "Participant-A, administrator at SON-A".
- Audio-/video-recordings will be encrypted and password-protected and labelled only by their de-identified descriptor
- Audio-/video-recordings will be transcribed by a professional transcriptionist, who will sign a confidentiality/non-disclosure agreement prior to receiving any data.

- Audio-/video-recordings will not be disseminated with the results of the study

### **9. Are participants compensated to be in this study?**

You will not be compensated for your participation in this research.

### **10. What are the rights of participants?**

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your professional status in any way.

We will give you new information that is learned during the study that might affect your decision to stay in the study.

You do not waive any legal right by signing this consent form

If you are a First Nations or an indigenous person who has contact with spiritual 'Elders', you may want to talk to them before you make a decision about this research study.

### **11. Whom do participants contact for questions?**

If you have questions about this research study please contact:

Danae Coggins, RN  
Arthur Labatt Family School of Nursing at Western University

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics



## Appendix D: Curriculum Vitae

**EDUCATION**

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Master of Science in Nursing - Candidate

*Western University, 2018*

Focus on Leadership in Health Promotion, Advanced Practice Nursing, Indigenous Health.

Supervisor: Dr. Victoria Smye, Director, Arthur Labatt Family School of Nursing

Bachelor of Science in Nursing

*Western University, 2013*

Graduated "With Distinction"

**EMPLOYMENT**

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**REGISTERED NURSE | CLINICAL NEUROSCIENCES, LONDON HEALTH SCIENCES CENTRE**

January 2013 – Present

- Provide complete nursing care to patients with a variety of neurological, neurosurgical, and medical conditions.
- Trained in Level 2 hyper-acute stroke and neurosurgical intense observation units.
- Designated "in-charge person" or team leader.

**INSTRUCTOR | ARTHUR LABATT SCHOOL OF NURSING, WESTERN UNIVERSITY**

January 2014 - Present

- Instruct nursing theory and clinical practice to undergraduate nursing students of all levels in a variety of acute care and academic settings.
- Acute care settings include clinical neurosciences, stroke and spinal cord rehabilitation, sub-acute and acute medicine, palliative care, and nephrology units.
- Use innovative teaching methods to engage students.

**REGISTERED NURSE | PARAMED HOME HEALTHCARE, LONDON**

2013 – 2014

- Provided complete nursing care to clients experiencing acute and chronic health issues in their homes.
- Provided comprehensive wound care.
- Provided complete, holistic, person- and family-centered assessments.

## PROFESSIONAL ORGANIZATIONS AND DEVELOPMENT

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Canadian Association of Neuroscience Nurses (CANN)

*Member and Conference Presenter 2017-2018; Conference Planning Committee & Social Director 2016*

Registered Nurses Association of Ontario

*Member; Guest Panelist 2017*

Clinical Neurosciences In-House Committees

*PSW Integration Committee, Falls Prevention Committee, CNS Website Steering Committee, Accreditation Committee, Our People Working Group, Wellness Committee*

Arthur Labatt Family School of Nursing In-House Committees

*Indigenous Engagement Committee, Legacy 2020 Centennial Planning Committee*

Sigma Theta Tau International Honor Society of Nursing

*Member*

Ontario Nurses Association

*Member*

## SCHOLARLY ACTIVITIES

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Teaching Assistantships, 2016-present

*Responsibilities include leading learning activities in lab sessions, lecturing, and in-depth evaluation of students' written scholarly work. These positions have provided me with opportunities for reflection on the basics of nursing academia to support learning at the graduate level.*

Mentorship, 2014-Present

*Provision of ongoing mentorship to all students I have previously taught in clinical settings. This allows me to contribute to the evolution of the profession by offering support to new nurses with whom I have an established teacher-student relationship.*

Nursing Students' Council, 2009-2012

*Represented all years of BScN students; planned fundraising and social events. Provided leadership skill-development and facilitation of undergraduate students to become involved in community efforts.*

## RECOGNITIONS

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San'Yas Indigenous Cultural Safety Training—Certificate of Completion: 2018

Canadian Association of Neuroscience Nurses Scientific Sessions—Presenter: 2018

Canadian Stroke Congress—Certificate of Completion: 2015

Western-Fanshawe Collaborative BScN Program—Certificate of Preceptor Appreciation: 2014, 2015

Western Faculty of Health Sciences—Recognition of Excellence: 2015

Canadian Association of Wound Care—Certificate of Completion: 2015

Western University Students' Council—Teaching Honour Roll, Award of Excellence: 2014-2017